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Directors' Duty of Care to Monitor Information Systems in HMOs: Some Lessons from the Oxford Health Plan

Mary E. O'Byrne

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DIRECTORS' DUTY OF CARE TO MONITOR INFORMATION SYSTEMS IN HMOS: SOME LESSONS FROM THE OXFORD HEALTH PLAN

MARY E. O'BYRNE¹

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INTRODUCTION

Directors of “for profit” and “nonprofit” health maintenance organizations (HMOs), like all corporate directors, are subject to the duty of care in their oversight of the business. This duty extends over business performance as well as compliance with applicable laws and regulations. Within the scope of this duty is the responsibility for attentive oversight of the corporation’s information systems.

Directors may be held personally liable for business losses stemming from the failure to meet their duty of care. Most states apply the gross negligence standard when evaluating directors’ conduct. This standard reflects the statutory and judicial views that corporate goals, and those of the nation’s economy, are best served by a degree of risk-taking that may be greater than that of the prudent person. Only where directors’ actions are based in self-dealing, fraud or are found to be wholly lacking in good faith will courts find conduct which constitutes gross negligence.

The art and science of managed care for the majority of health maintenance organizations (HMOs) is wholly dependent on the plan’s automated information systems. HMOs are distinctive for the volume, variability and volatility of the data on which they rely to conduct business. This degree of reliance makes effective information systems a fundamental prerequisite for the HMO’s success. Indeed, “[c]ompetition, employer concerns over costs, and government awareness of health care budgets are merely bit players in a drama that has information systems technology as the central character.”²

The HMO’s information management task is prodigious. The major areas of information requirements: membership, provider contracts, utilization review and

²Louis Rossiter, *The Research Agenda in Managed Care*, in MAKING MANAGED HEALTHCARE WORK 584 (Peter Boland ed., 1993).

claims payment – each in themselves complex – require a seamless integration in order to manage care effectively, run a business profitably, and comply with myriad external reporting requirements. It is common for HMOs to utilize multiple information systems, running the different business applications, e.g., enrollment and billing, claims and authorizations, and utilization review and case management, on separate operating software and hardware.³ In this paper, the terms “information system” and “systems” are used to refer generally to all of the computer based or automated business functions of an organization.

HMOs and other health insurers are subject to substantial state and federal regulatory requirements. Publicly traded companies must also comply with the rules of the Securities Exchange Commission (SEC) and the securities exchange markets on which the stock is traded. Violations of these requirements carry the risk of substantial fines, exclusion from government entitlement programs, criminal sanctions and delisting from the trading exchanges. Compliance with these requirements is heavily dependent on the quality and integrity of the HMO's information systems.

Information systems have evolved from an expense item to a strategic investment in the future of the company.⁴ Although the health care industry lags others in the extent of information systems investment, spending by managed care companies on information systems is about 2% of revenues and growing.⁵ Considering the scale of the larger HMOs such as Kaiser Permanente and the combined Blue Cross Blue Shield HMOs, the information system investment can be enormous. Kaiser, for example, plans on spending \$1.5 billion to upgrade its information systems over the next four years.⁶

Given this scale of investment, the centrality of information systems to the success of an HMO, the obligation of regulatory compliance, plus the attention now focused on the year 2000 “millenium bug” problem,⁷ information systems are clearly a major area of concern and oversight by corporate directors. This paper analyzes the role of information systems in HMOs and the nature of the HMO directors' duty of care in monitoring the integrity of the information systems to determine when directors may be held personally liable for losses suffered by the corporation when the systems collapse.

³Peter R. Kongstvedt, *Using Data in Medical Management*, in THE MANAGED HEALTH CARE HANDBOOK 440 (Peter R. Kongstvedt ed., 3d ed. 1996).

⁴Robert Reese, *Information Systems Operations and Organizational Structures*, in THE MANAGED HEALTH CARE HANDBOOK 455, 455 (Peter R. Kongstvedt ed., 3d ed. 1996) [hereinafter Reese, *Information Systems*].

⁵*Id.*

⁶Milt Freudenheim, *Kaiser HMO, Erring on Costs, Posts \$270 Million Loss for '97*, N.Y. TIMES, Feb. 14, 1998 at D1 [hereinafter Freudenheim, *Kaiser HMO, Erring on Costs*].

⁷The millenium bug problem stems from the wide spread practice in legacy systems of coding information systems to recognize a two digit date. When the year 2000 arrives the digits “00” will be interpreted as 1900. This was expected to result potentially disastrous systems failures, but the 2000 transition passed with relatively few computer problems in the U.S.

Section I addresses in general the nature of the corporate director's duty of care to monitor business performance. Section II considers the requirements of finding a director liable for negligence in failing to meet this duty. Section III gives an overview of the HMO industry's dependence on information systems. Section IV focuses specifically on the recent experience of the Oxford Health Plan. Section V discusses the potential liability of an HMO's board in light of the events at Oxford and applicable legal standards for the director's duty of care in monitoring. Section VI concludes with observations on the limits to directors' liability.

I. THE NATURE OF DIRECTORS' RESPONSIBILITIES

The structure of corporations is governed largely by state law. "Corporations are creatures of state law and it is state law which is the font of corporate directors' powers."⁸ Although some states base their corporate laws on the Revised Model Business Corporation Act (RMBCA) and others, such as Delaware and Maryland, have their own distinctive corporate codes, all states require that corporations be managed under the direction of a board of directors.⁹

In broad terms, the board of directors is responsible for the conduct of the business. In a large corporation, typically the day to day management responsibilities are delegated to the executive and other senior staff. This delegation does not release the directors from responsibility to oversee the actions of management.¹⁰

All corporate boards are accountable to certain groups. In a publicly owned corporation, the directors answer to the shareholders.¹¹ In a mutual benefit corporation accountability runs to the members.¹² In public benefit or religious corporations the state of incorporation, typically in the person of the attorney general, speaks for the beneficiaries under the doctrine of *parens patriae*, and may call the corporation's directors to account.¹³

Accountability may take different forms. A director may be voted out of office by shareholders or members if they do not approve of the director's performance.¹⁴

⁸Burks v. Lasker, 441 U.S. 471, 478 (1979).

⁹DEL. CODE ANN., tit. 8, § 141 (1991 & Supp. 1996); MD CODE ANN., CORPS. & ASS'NS § 2-401 (1993 & Supp. 1998).

¹⁰E. Norman Veasey & Julie M.S. Seitz, *The Business Judgment Rule in the Revised Model Act, the Trans-Union Case, and the ALI Project – A Strange Porridge*, 63 TEX. L. REV. 1483, 1501 (1985) [hereinafter Veasey & Seitz, *The Business Judgment Rule*].

¹¹Model Bus. Corp. Act §8.03(d) (revised 1997).

¹²See, e.g., Rowen v. Le Mars Mutual Ins. Co., 230 N.W.2d 905 (Iowa 1975); Amabile v. Lerner, 166 A.2d 603 (N.J. Super. Ct. Ch. Div. 1960), *aff'd* 181 A.2d 520 (1962).

¹³COMMITTEE ON NONPROFIT CORPORATIONS, AMERICAN BAR ASSOCIATION, *GUIDEBOOK FOR DIRECTORS OF NONPROFIT CORPORATIONS* 13-14 (George W. Overton ed., 1993) [hereinafter *GUIDEBOOK FOR DIRECTORS OF NONPROFIT CORPORATIONS*]; Deborah DeMott, *Self-Dealing Transactions in Nonprofit Corporations*, 59 BROOK. L. REV. 131, 145 (1993).

¹⁴Model Bus. Corp. Act, § 8.08(a) (revised 1997). See also, LEWIS SOLOMON ET. AL, *CORPORATIONS LAW AND POLICY* 531 (1994). Voting a director out of office can be an uphill battle for shareholders. *Id.* Incumbent directors and management, with access to the corporate proxy statement and corporate treasury, have the distinct advantage in any proxy fight. *Id.* As

Although a director cannot act on behalf of the corporation as an individual (unless the director is also an officer of the corporation) a director may be personally liable for failing to carry out her fiduciary duties. The usual vehicle for finding personal liability is a derivative suit, brought by shareholders¹⁵ or members¹⁶ on behalf of the corporation against the directors and officers. Such cases typically sound in negligence, alleging that the directors' conduct fell short of the duties of loyalty or care and as a result the corporation was harmed. These cases can result in substantial damages awards against directors.¹⁷ Corporations typically indemnify their directors by terms of the corporate bylaws or charters and acquire Directors and Officers liability insurance for this purpose.¹⁸

The specific roles and responsibilities of directors are not enumerated in great detail in corporation codes, rather the size and nature of the business will influence what exactly the board will do. The role of the director is largely one of monitoring, for example reviewing financial statements and other reports, overseeing compliance with local, state and federal laws, punctuated by relatively few decisions. One commentator characterizes the balance as ninety percent monitoring and ten percent decision-making.¹⁹ According to Newton Minow, former member of the Federal Commerce Commission and director of Sara Lee, Manpower and Aon, two of the most important decisions directors make are selecting a new chief executive officer and "figuring out what to do when the place is in trouble."²⁰ This observation appears to overlook the importance of the board's decision about how to evaluate the CEO. The choice of evaluation criteria, for example, long term versus short term results, may affect whether the corporation gets into trouble in the first place. The board will be involved in both the beginning and ending of any major corporate initiative, such as an acquisition or divestiture²¹ as well as any "material transactions affecting the assets of the enterprise."²²

While the specific activities of directors may vary greatly based on the business, all boards share certain responsibilities. Directors are fiduciaries. The qualities of fiduciary duty have brought forth stirring descriptions in legal opinions in keeping

a practical matter, "most public corporations are firmly controlled by self-perpetuating boards of directors or by the senior corporate officers that those boards ostensibly have elected." *Id.*

¹⁵Rev. Model Bus. Corp. Act § 7.40 (1997).

¹⁶O'Donnell v. Sardegna, 646 A.2d 398, 404 (1994).

¹⁷See, e.g., Smith v. Van Gorkom, 488 A.2d 858 (Del. 1985) (which ultimately resulted in multimillion dollar settlement awards against individual directors).

¹⁸William Knepper, *An Overview of D&O Liability for Insurance Company Directors and Officers*, 45 INS. COUNSEL J. 63, 67-68 (1978) [hereinafter Knepper, *An Overview of D&O Liability*]; Rev. Model Bus. Corp. Act § 8.50 (1997).

¹⁹Bayless Manning, *The Business Judgment Rule and the Director's Duty of Attention: Time for Reality*, 39 BUS. LAW. 1477, 1492-95 (1984) [hereinafter Manning, *Time for Reality*].

²⁰John A. Byrne et al., *The Best and Worst Boards*, BUS. WK., Dec. 8, 1997, at 92.

²¹GUIDEBOOK FOR DIRECTORS OF NONPROFIT CORPORATIONS, *supra* note 13, at 7.

²²COMMITTEE ON CORPORATE LAWS, AMERICAN BAR ASSOCIATION, CORPORATE DIRECTOR'S GUIDEBOOK (Rev. ed., 1978) reprinted in 33 BUS. LAWYER 1591-1644, 1607 (1978) [hereinafter CORPORATE DIRECTOR'S GUIDEBOOK].

with the weight of obligation the fiduciary shoulders. “Many forms of conduct permissible in a workaday world for those acting at arm’s length, are forbidden to those bound by fiduciary ties. A trustee is held to something stricter than the morals of the marketplace. Not honesty alone, but the punctilio of an honor the most sensitive, is then the standard of behavior.”²³

Implicit in the obligations of the fiduciary are the twin duties of loyalty and care.²⁴ These standards, derived from over a century of litigation, apply equally to business and nonprofit corporations.²⁵ The duty of loyalty requires the director to put the interests of the corporation first and her own interests last. The duty of care, the focus of this article, speaks to how a director carries out her job. Defining the duty of care with precision has proven a challenge to commentators, judges and regulators. The RMBCA adopts general standards for a director’s performance: to act in good faith, with the care an ordinarily prudent person in a like position would exercise, and in a manner reasonably expected to be in the best interests of the corporation.²⁶ The official comment to the RMBCA notes that the elements and circumstances of the director’s duty of care, referenced as an element of the business judgment rule, “are continuing to be developed by the courts.”²⁷

A. Duty of Care

In spite of the general terms of the RMBCA and the equally general, though differently phrased, terms of various state regulations,²⁸ some clarity can be found in decisions and commentary about the duty of care. “[T]he heart of the director’s true responsibility is attention to his ongoing multiple functions.”²⁹ For example, directors are expected to have a basic knowledge of the business; to read the materials provided them; and to inquire for adequate information prior to rendering a decision. Directors are entitled to trust the information given them by responsible persons in the corporation but only so long as the director has reason to trust, and no reason not to trust, the information.

“As a general rule, a director should acquire at least a rudimentary understanding of the business of the corporation. Accordingly, a director should become familiar with the fundamentals of the business in which the corporation is engaged.”³⁰ Professor Manning contends that the board has an inherent responsibility to ensure the structural integrity of the corporation. This means the board is responsible for

²³*Meinhard v. Salmon*, 164 N.E. 545 (N.Y. 1928).

²⁴CORPORATE DIRECTOR’S GUIDEBOOK, *supra* note 22, at 1599-1600.

²⁵GUIDEBOOK FOR DIRECTORS OF NONPROFIT CORPORATIONS, *supra* note 13, at 21.

²⁶Rev. Model Bus. Corp. Act § 8.30 (1997).

²⁷Official Comment, Model Bus. Corp. Act § 8.30 (revised 1997).

²⁸A number of states have adopted the RMBCA standard of the ordinarily prudent person in a like position under similar circumstances. *See, e.g.*, CAL. CORP. CODE § 309 (West 1997); MD. CODE ANN., CORPS & ASS’NS § 2-405.1 (1993 & Supp.1998); MASS. GEN. LAWS ch. 156B, § 65 (1998); N.J. STAT. ANN. § 14A: 6-14 (West 1997); PA. STAT. ANN. tit. 15, § 512 (West 1998).

²⁹Manning, *Time for Reality*, *supra* note 19, at 1492-95 (1984).

³⁰*Francis v. United Jersey Bank*, 432 A.2d 814, 821-22 (N.J. 1981).

seeing that there is a functioning management structure and an internal information system, *generally suitable to the company's character* to keep management informed and to provide accurate accounting data upon which to base financial statements.³¹ Meeting this responsibility requires a sufficient understanding of the nature of the business to know whether the management or information structures in place are adequate to their respective tasks.

The process by which a director informs herself will vary under the specific circumstances of the matter at hand, but every director must take steps to inform herself of the relevant background and circumstances before taking action.³² First among the logical steps is to read the materials provided to the board. "Needless to say, the director should read the information with which he or she is supplied."³³ Given the board's responsibility for the financial health of the corporation, directors should be familiar with the financial status of the corporation.³⁴ The commentary to the Model Act reinforces this obligation, by limiting the director's reliance to information of which they have first hand knowledge. If the director has not read, or heard in oral presentation, or otherwise taken steps to become familiar with certain information, she cannot later protect herself by claiming reliance.³⁵

B. Reliance

A director may place reasonable reliance on information, reports and statements prepared by officers or employees of the corporation, professional advisors and consultants, and committees of the board, provided she has a reasonable basis for doing so.³⁶ Similarly, where duties have been delegated to management, directors may rely on "the presumption of regularity, absent knowledge or notice to the contrary."³⁷ A director must reasonably believe that the persons presenting information merit her confidence.³⁸ A director who accepts or relies on information when she has knowledge which would make reliance unreasonable may be liable for any action taken on the basis of the unreliable information; this situation could arise, for example, if the director had knowledge that a report was based on faulty or incomplete information.

C. Duty of Inquiry

The reliance protection has limits, however, and there comes a point at which a director is obligated to inquire further. Precisely where that point lies is the subject

³¹Manning, *Time for Reality*, *supra* note 19, at 1499 (emphasis added).

³²Veasey & Seitz, *The Business Judgment Rule*, *supra* note 10, at 1495.

³³GUIDEBOOK FOR DIRECTORS OF NONPROFIT CORPORATIONS, *supra* note 13, at 23; CORPORATE DIRECTOR'S GUIDEBOOK, *supra* note 22, at 1602.

³⁴Francis, *supra* note 30, at 821-22.

³⁵Official Comment, Rev. Model Bus. Corp. Act § 8.30(b) (1997).

³⁶Model Bus. Corp. Act § 8.30(b) (revised 1997); DEL. CODE ANN., tit. 8, § 141(e) (1991 & Supp. 1996).

³⁷Official Comment, Rev. Model Bus. Corp. Act § 8.30(a)(1997).

³⁸Model Bus. Corp. Act § 8.30(b) (revised 1997).

of some disagreement among commentators. At one end of the spectrum, Professor Stuart Cohn suggests that the director's duty to inquire should take effect on the basis of alertness to potentially significant concerns.³⁹ This view recognizes that directors should be attentive to warnings of future problems. Manning would expect the director to inquire perhaps a little later, when she becomes aware of "credible signs of serious trouble."⁴⁰ The generally stated requirement found in the ALI Principles of Corporate Governance says that the duty of inquiry arises "when, but only when, the circumstances would alert a reasonable director ... to the need [for further inquiry]."⁴¹ The Commentary to the Model Act states that a problem must be obvious to the director before requiring inquiry,⁴² suggesting that the duty to inquire arises at a point later in time than warnings of potential problems.

Chief Justice of the Delaware Supreme Court, E. Norman Veasey has advocated the "red flag doctrine." Although directors are not expected to "ferret out" problems which they have no reason to suspect exist, Veasey states that when warning signs of trouble are obvious, the duty of further inquiry does arise.⁴³ This view recognizes the importance of attention to early warning signals, before a problem erupts. The warnings themselves must be obvious, so as to protect the board from having to respond to every possible signal of trouble ahead. Where, however, directors have actual evidence of serious problems within the company, commentators agree that directors must inquire further.

D. The Business Judgment Rule

The business judgment rule operates as a shield to protect directors from personal liability, under certain circumstances, for business decisions that have proved bad for the corporation. Provided the directors acted in good faith, without self-dealing or personal interest, and exercised reasonable diligence in making the decision, the business judgment rule will protect the directors from liability.⁴⁴ The policy underlying this rule recognizes that directors must make complex decisions, balancing risk and benefit to the corporation, often under pressures of time and imperfect information. Provided that the process used by the board to reach the decision is sound, and specifically that it conforms to the duty of care standard, it is unreasonable for courts to second guess the board. It is also highly unlikely that a judge, ruling years after the fact, will be able to reach any better result.⁴⁵

³⁹Stuart R. Cohn, *Demise of the Director's Duty of Care: Judicial Avoidance of Standards and Sanctions Through the Business Judgment Rule*, 62 TEX. L. REV. 591, 602 (1983) [hereinafter Cohn, *Demise of the Director's Duty of Care*].

⁴⁰Manning, *Time for Reality*, *supra* note 19, at 1484.

⁴¹*Principles of Corporate Governance*, § 4.01(a)(1), American Law Institute (Final draft, 1992).

⁴²Official comment, Model Bus. Corp. Act § 8.30(a) (revised 1997).

⁴³Veasey & Seitz, *The Business Judgment Rule*, *supra* note 10, at 1502 (referring to *Graham v. Allis-Chalmers Mfg. Co.*, 188 A.2d 125, 130 (Del. 1963)).

⁴⁴*Gries Sports Enters., Inc. v. Cleveland Browns Football Co., Inc.*, 496 N.E.2d 959, 963-64 (1986).

⁴⁵*Joy v. North*, 692 F.2d 880, 886 (2d Cir. 1982).

The business judgment rule — which focuses on decisions — and the director's duty of care — which focuses on the deliberative process — do come together. If directors fail to take adequate care in rendering a decision — to review information provided, to inquire for further information when appropriate, to understand the fundamentals of the business — then they will find no protection in the business judgment rule. If, however, the directors do reach their decision deliberatively, using the information available to them, with good faith in the quality and reliability of the information, then even a decision which proves disastrous for the corporation will not subject the directors to personal liability.⁴⁶

II. REQUIREMENTS FOR A FINDING OF PERSONAL LIABILITY FOR FAILURE TO MONITOR

A director may be held personally liable for losses incurred by the corporation which proximately result from the director's failure to monitor corporate operations. The director's obligation to monitor the activities of the corporation extends over business performance as well as compliance with relevant laws.⁴⁷ "Liability to the corporation for a loss may be said to arise from an *unconsidered failure of the board to act* in circumstances in which due attention would, arguably, have prevented the loss."⁴⁸ A negligence claim against a director for breach of duty of care requires proof of the elements of duty, breach, causation and harm.⁴⁹

Having discussed above the general nature of the directors' duty of care, the analysis next turns to these requirements, specifically: the appropriate standard governing directors' duty of care, whether information systems are within the scope of the directors' duty, the nature of the harm to the corporation which may subject the director to personal liability, and the difficult task of proving that directors' nonfeasance caused the harm.

A. Gross Negligence Standard

Although state statutory standards vary, "corporate directors are held to a gross negligence standard of care, either by statute or under the common law and judicial application of the business judgment rule."⁵⁰ Twelve states, including Florida, Kansas and Ohio, have established the gross negligence standard by statute.⁵¹ In these states, the statutory enactment appears to have been a direct response to the

⁴⁶Cohn, *Demise of the Director's Duty of Care*, *supra* note 39, at 602.

⁴⁷*In re Caremark Int'l Inc. Derivative Litig.*, 698 A.2d 959, 967 (Del. Ch. 1996) [hereinafter *In re Caremark*].

⁴⁸*Id.* (emphasis in original).

⁴⁹J.D. LEE & BARRY A. LINDAHL, MOD. TORT LAW § 3.02 (Rev. ed. 1994, 1998 Supp.)

⁵⁰Ronald W. Stevens & Bruce H. Nielson, *The Standard of Care for Directors and Officers of Federally Chartered Depository Institutions: It's Gross Negligence Regardless of Whether Section 1821(K) Preempts Federal Common Law*, 13 ANN. REV. BANKING L. 169, 193 (1994) [hereinafter Stevens & Neilson, *The Standard of Care for Directors and Officers*] (article analyses of state statutory and common law regarding corporate directors generally in addition to directors of financial institutions).

⁵¹*Id.* at 194-208.

savings and loan crisis of the 1980s. In the aftermath of this national financial debacle, states passed legislation to protect the directors of financial institutions from liability for simple negligence in myriad lawsuits by the Federal Deposit Insurance Corporation and its precursor, the Resolution Trust Corporation.⁵² In eighteen states, including Delaware, and the District of Columbia, courts have applied the gross negligence standard, often based on the business judgment rule⁵³. This common law rule prevails even where statutes suggest the simple negligence standard of the “ordinarily prudent person in like circumstances”, e.g, Maryland and New York.⁵⁴ Only four states fully apply the simple negligence standard for corporate directors: Georgia, Massachusetts, Mississippi, and Tennessee.⁵⁵ In the remaining sixteen states, including California, Illinois and Pennsylvania, “neither the legislature nor the courts have clearly established the standard of care for directors and officers of financial institutions or corporations.”⁵⁶

The business judgment rule and the gross negligence standard combine to establish the demanding evidentiary requirement that directors must be shown to have acted either in fraud, bad faith, self-dealing, conflict of interest⁵⁷ or to have acted recklessly or with malicious purpose or with deliberate, wanton and reckless disregard for the corporation’s interests.⁵⁸ The Delaware Chancery Court described this standard in the corporate context as meaning “reckless indifference to or a deliberate disregard of the whole body of shareholders” characterized by actions which are “without the bounds of reason.”⁵⁹

Underlying the applied gross negligence standard is the judicial view that corporations and the economy are not well served by directors who exercise only ordinary judgment and prudence. “The corporate form gets its utility in large part from its ability to allow diversified investors to accept greater investment risk.”⁶⁰ If directors are personally liable based on the standard of a person of average judgment and risk assessment, directors will tend to make less risky investment decisions, which will limit the corporation’s economic potential.⁶¹

It has been argued that the gross negligence standard might be moderated given the nature of the HMO business. One commentator suggested in 1981 that directors of HMOs should be held to a higher standard, that is, liable for simple negligence, on

⁵²*Id.* at 194. *See generally*, Atherton v. F.D.I.C., 519 U.S. 213 (1997).

⁵³Stevens & Nielson, *The Standard of Care for Directors and Officers*, *supra* note 50, at 208-18.

⁵⁴MD. CODE ANN., CORPS & ASS’NS § 2-405.1(a) (1993 & Supp. 1998); N.Y. BUS. CORP. § 717(a)(McKinney 1998).

⁵⁵Stevens & Nielson, *The Standard of Care for Directors and Officers*, *supra* note 50, at 218-21.

⁵⁶*Id.* at 221.

⁵⁷*Id.* at 190.

⁵⁸*Id.* at 199-201.

⁵⁹Tomczak v. Morton Thiokol, Inc., No. 7861, *slip op.* at 31 (Del. Ch. Apr. 5, 1990).

⁶⁰*In re Caremark*, 698 A.2d at 968.

⁶¹*Id.*

the reasoning that “[d]irectors of certain significant industries ... which are of particular public concern, are in fact judged by a higher standard of care. It is easy to make the argument that the HMO industry, like the insurance and banking industries, is so complex, important, and vital to the public interest that extraordinary standards of care should be imposed on such directors.”⁶² However easy the argument might have been in 1981, and despite public demand for a higher standard of liability for directors, the trend in corporate law has clearly headed in the opposite direction, with a greater focus on limiting the liability of corporate directors generally.⁶³

B. Information Systems are Within the Scope of the Directors' Duty of Care

In addition to the general nature of the director's duty of care is the question of whether a particular area of business concern is properly within the scope of that duty. Commentators, courts and regulators have all pinpointed information systems as falling within the responsibility of the board of directors.

A recent decision by the Court of Chancery of Delaware, *In re Caremark International Inc. Derivative Action*⁶⁴, emphasizes the importance of board oversight of information systems. Noting that timely and relevant information is “an essential predicate” for meeting a board's supervisory and monitoring role under Delaware law, the court characterizes the board's obligation as one of

assuring themselves that information and reporting systems exist in the organization that are reasonably designed to provide to senior management and ... the board itself timely, accurate information sufficient to allow management and the board, each within its scope, to reach informed judgments concerning both the corporation's compliance with law and its business performance.⁶⁵

The board is held to the standard of good faith in determining that the information system is conceptually and functionally adequate to the task of assuring the board that appropriate information is available in a timely manner.⁶⁶ The Chancellor goes on to say:

I am of the view that a director's obligation includes a duty to attempt in good faith to assure that a corporate information and reporting system, which the board concludes is adequate, exists, and that failure to do so under some circumstances may, in theory at least, render a director liable for losses caused by non-compliance with applicable legal standards.⁶⁷

⁶²Joanne B. Stern, *Potential Liability of the Board of Directors of a Health Maintenance Organization*, 3 WHITTIER L. REV. 1, 6-7 (1981).

⁶³Knepper, *An Overview of D&O Liability*, *supra* note 18, at 64.

⁶⁴*In re Caremark*, 698 A.2d 959.

⁶⁵*Id.* at 970.

⁶⁶*Id.*

⁶⁷*Id.*

Regulators also view oversight of information systems as a board responsibility. Anticipation of the year 2000 problem, a/k/a “the millenium bug,”⁶⁸ has prompted the Securities Exchange Commission to recommend requiring board approval of the year 2000 project plan for public companies.⁶⁹

Clearly directors cannot be expected to know the fine details of a system’s design or implementation.⁷⁰ Yet the board must seek credible assurances that adequate systems are in place.⁷¹ In seeking such assurances, directors are protected from liability when they reasonably rely on information from internal and external sources provided the directors have reason to believe such sources merit their confidence.⁷²

C. Proof of Harm

In the case of a shareholder derivative action on behalf of the corporation, the harm alleged is typically a decline in stock value owing to mismanagement or waste of corporate assets.⁷³ A shareholder may also sue for damages individually, where she can show injury peculiar to a particular class of shareholders or to shareholder interests, as opposed to those of the corporation itself.⁷⁴ With a nonprofit corporation, the alleged harm may be found in the depletion of corporate assets as caused, for example, by self-dealing by the directors⁷⁵, or outright fraud.⁷⁶ Alternatively, the harm may be found in the corporation’s failing to carry out its charge or the directors approving an act viewed as *ultra vires*.⁷⁷

⁶⁸See, e.g., Skadden, Arps, Slate, Meagher & Flom LLP and Affiliates, *Board Responsibility for Corporate Oversight: Heightened Risk/Mitigation Measures*, (Feb. 26, 1998). This problem has also given rise to a new specialty in systems consulting, see, e.g., *Y2K Damage Consultants* (visited Nov. 29, 1998) <<http://www.y2k-damage-expert.com>>. Promotional copy for this consultant places high priority on the issue of directors’ liability. *Id.* “Directors and officers may face scrutiny and potential liability for decisions made in connection with purchases of computer hardware and software, as well as their current actions in assessing and addressing potential Year 2000 problems.” *Id.*

⁶⁹SECURITIES AND EXCHANGE COMMISSION, *READINESS OF THE UNITED STATES SECURITIES INDUSTRY AND PUBLIC COMPANIES TO MEET THE INFORMATION PROCESSING CHALLENGES OF THE YEAR 2000*, at 8 (1999).

⁷⁰Manning, *Time for Reality*, *supra* note 19, at 1484.

⁷¹*Id.*

⁷²See *supra* notes 36-38 regarding reliance.

⁷³In re First Interstate Bancorp Consol. Shareholder Litig., 729 A.2d 851 (Del. Ch. 1998) [hereinafter, *In re First Interstate Bancorp*].

⁷⁴In re Walt Disney Co. Derivative Litig., 731 A.2d 342 (Del. Ch. 1998) [hereinafter *In re Walt Disney Co.*].

⁷⁵*Stern v. Lucy Webb Hayes Nat’l Training Sch. for Deaconesses and Missionaries*, 381 F. Supp. 1003, 1007 (D.D.C. 1974).

⁷⁶*U.S. v. Aramony*, 88 F.3d 1369 (4th Cir. 1996).

⁷⁷Harvey J. Goldschmid, *The Fiduciary Duties of Nonprofit Directors and Officers: Paradoxes, Problems, and Proposed Reforms*, 23 J. CORP. L. 631, 649 (1998).

D. Proof of Causation

Clearing the hurdles of establishing the presence and appropriate level of duty of care, the plaintiff must still prove causation. Where the claim lies in the nonfeasance of directors, the causation requirement is made more difficult. The plaintiff must first establish what would have been reasonable actions on the part of the board under the circumstances.⁷⁸ The plaintiff must then prove that the proper performance of the directors' duties would have avoided the loss, and further, what loss specifically would have been averted by such action.⁷⁹ Such a proximate cause proof can be fraught with speculation. "[W]hen a business fails from general mismanagement, business incapacity, or bad judgment, how is it possible to say that a single director could have made the company successful, or how much in dollars he could have saved?"⁸⁰

Bad results alone cannot be the basis on which to infer a breach of duty. In *Caremark*, the Delaware Chancellor noted that "[n]either the fact that the Board, although advised by lawyers and accountants, did not accurately predict the severe consequences to the company that would ultimately follow from the ... strategies and practices that ultimately led to this liability, nor the scale of the liability, gives rise to an inference of breach of any duty imposed by corporation law upon the directors of Caremark."⁸¹

A key factor in the causation analysis is the timing of directors' actions. Directors may not become aware of a problem until it is too late to take any effective remedial action. In *Briggs v. Spaulding*,⁸² a bank insolvency case, two directors who had recently joined the board were alleged to have breached their duty of care. The Supreme Court found the defendant directors were woefully inattentive to the affairs of the bank, particularly as to oversight of the cashier's practices. Yet, the Court recognized that even if these directors had made prompt and careful inquiries, such action could not have come in time to have saved the bank. The business was already ruined; nothing that the new directors might have done at that point could have changed the end result.⁸³

III. OVERVIEW OF THE HMO INDUSTRY

A detailed history of the HMO industry is beyond the scope of this paper. The following provides a general orientation to the industry and its operational challenges.

A. A Brief History of HMOs

HMOs exist on a broad continuum of managed care entities. Managed care is "a system which integrates the financing and delivery of appropriate medical care" employing features such as contracts with selected physicians and hospitals,

⁷⁸Francis v. United Jersey Bank, 432 A.2d 814, 826 (N.J. 1981).

⁷⁹Barnes v. Andrews, 298 F. 614, 616-617 (S.D.N.Y. 1924).

⁸⁰*Id.* at 616-17.

⁸¹*In re Caremark*, 698 A.2d at 961.

⁸²141 U.S. 132, 164 (1891).

⁸³*Id.*

utilization and quality controls, financial incentives for patients to stay within the contracted provider network; assumption of varying degrees of financial risk by providers.⁸⁴ HMOs are the most restrictive of managed care entities, typically requiring enrollees to seek care only through primary care gatekeepers and then only by referral to specialists and facilities within the HMOs contracted network.

The HMOs of today descend from a variety of arrangements under which physicians contracted on a pre-paid basis to provide medical services for a group of individuals or a business's employees.⁸⁵ During the 1930s and 1940s group practices formed to serve Kaiser employees at the company's shipbuilding and construction sites; these were the precursors to the Kaiser Foundation Health Plans.⁸⁶ The Group Health Cooperative of Puget Sound and the Health Insurance Plan of Greater New York were also established during this period, under similar principles of pre-paid group practice.⁸⁷

The pre-paid group practice model was not widely adopted in this country until the late 1980s. In the intervening forty years two things restrained the growth of HMOs: vigorous opposition by the American Medical Association and the relatively low rate of growth in health care costs. When health care costs began to increase sharply in the 1970s, the federal government championed the concept of pre-paid group practice with the enactment of the Health Maintenance Organization Act of 1973.⁸⁸ Even with government subsidies of over \$200 million during the 1970s to encourage the formation of HMOs by nonprofit groups, HMO enrollment was slow. By 1976, HMO membership had reached only six million – falling far short of the government's goal of 40 million by that date.⁸⁹ It was not until the 1980s when the cost of health care soared that employers turned to HMOs with enthusiasm in an effort to reduce their health benefits expenditure.⁹⁰ During the 1980s HMO enrollment more than tripled from 10.2 million to 39 million; in 1997 HMO enrollment stood at 78 million, including 30% of the population insured through the workplace.⁹¹

In the last two years the federal government and most states have turned to the HMO model and other forms of managed care to arrest continued cost escalation in

⁸⁴John K. Iglehart, *The American Health System*, 327 NEW ENG. J. MED. 742, 742 (1992) [hereinafter Iglehart, *The American Health System*].

⁸⁵BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 784 (3d ed. 1997) [hereinafter FURROW ET AL., HEALTH LAW].

⁸⁶Peter D. Fox, *An Overview of Managed Care*, in THE MANAGED HEALTH CARE HANDBOOK 5 (Peter R. Kongstvedt, ed., 3d ed. 1996).

⁸⁷*Id.*

⁸⁸42 U.S.C.A § 300e.

⁸⁹Iglehart, *supra* note 84, at 744.

⁹⁰*Id.*

⁹¹PRICEWATERHOUSECOOPERS, *Health Care Statistics: Percent of Employees Enrolled in Different Health Care Plans*, (visited Oct. 9, 1998) <<http://www.pwmc.com/charts/chart7.html>> (Foster Higgins/Mercer National Survey of Employer Sponsored Health Plans 1997).

Medicare and Medicaid.⁹² Although many HMOs courted this new membership aggressively, this new deal has not been altogether successful. Recent news reports document the steady exodus of managed care plans from these markets as companies have found the population more costly to care for than anticipated while reimbursement rates are ratcheted down.⁹³

B. Different Models of HMOs

HMOs operate under different models. In the early days of this delivery system the models were fairly distinct. The most common has been the independent practice association (IPA) model, in which the HMO entity contracts with independent provider associations or group practices to provide care for enrollees; forty-two percent of HMO members are in IPA model plans.⁹⁴ The staff model, in which the HMO employs physicians and other providers, is relatively rare and accounts for only about 1% of total HMO enrollment.⁹⁵ The true group model, in which a single physician group contracts exclusively with the health plan, as is the case with the various Permanente Medical Groups and the Kaiser Foundation Health Plans, accounts for just 11% of total HMO enrollment.⁹⁶ Under contractual arrangements, providers may be reimbursed on a capitation basis, i.e., paid a set fee for each patient for each period, on a fee for service basis according to a fee schedule, or on a global basis for a defined set of services.

As the industry has matured, and as employers have demanded greater flexibility in pricing and product design, the distinctions among models of care delivery have blurred. "Staff and group model HMOs, faced with limited capital and a need to expand into new territories, are forming IPA components. Meanwhile, some IPAs have created staff model primary care centers while continuing to contract with physicians in independent practices for specialty services. HMOs are offering PPO [preferred provider organizations] and POS [point of service] products, and some

⁹²PRICEWATERHOUSECOOPERS, *Health Care Statistics: Overall Healthcare Spending by Major Category* (visited Oct. 9, 1999) <<http://www.pwmc.com/charts/chart4.html>> (Health Care Financing Administration 1997). Since 1991 spending for the Medicare program has grown at 10% annually; in the Medicaid program spending has grown at an annual rate of 9%; PRICEWATERHOUSECOOPERS, *Health Care Statistics: Medicare Managed Care Penetration*, (visited Oct. 9, 1999) <<http://www.pwmc.com/charts/chart8.html>> (Health Care Financing Administration 1997). Managed care penetration in the Medicare program is currently estimated at around 14%; *National Summary of Medicaid Managed Care Programs and Enrollment, 1997*, Health Care Financing Administration. Managed care penetration in the Medicaid program in 1997 was 47.82%.

⁹³See e.g., Robert Pear, *H.M.O.'s Cut off Medicare, Leaving Many in Quandary*, N.Y. TIMES, Oct. 19, 1998 at A5.

⁹⁴PRICEWATERHOUSECOOPERS, *Health Care Statistics: Plan Characteristics for HMOs* (visited Oct. 9, 1999) <<http://www.pwmc.com/charts/chart49.html>> (Interstudy 1998). The total membership served by IPA physicians may in fact be much higher as mixed model HMOs, which combine different service delivery models, including IPAs, constitute 40% of HMO enrollment. *Id.*

⁹⁵*Id.*

⁹⁶*Id.*

PPOs are obtaining HMO licenses . . . In short, the managed care environment is becoming more complicated.”⁹⁷

Mixed model plans, those which combine more than one type of delivery model, are the fastest growing type of HMO today, increasing membership by 24.2% in 1997.⁹⁸ These models reflect the employers’ interest in controlling costs through negotiation of different levels of coverage, co-payments and other features for employees. By offering a range of benefits and product design to employers, HMOs not only help the employer satisfy their employees’ desire for choices, but also help the employer hold down the administrative costs by reducing the number of health plan providers with which the employer must work.

C. Growth of for Profit HMOs

Another change in the environment is the dominance of “for profit” plans. Although the earliest plans were nonprofit, and the HMO Act of 1973 actively encouraged the development of such plans, most HMO members today are enrolled in for profit plans. For profit plan enrollment has grown from forty-two percent in 1987 to the current rate of sixty-two percent.⁹⁹ An estimated sixty-eight percent¹⁰⁰ of the nation’s 760 HMOs are for profit,¹⁰¹ serving sixty-two percent of total HMO enrollment.¹⁰²

D. Competitive Environment

HMOs operate in a highly competitive environment characterized by rising costs, consolidation, and price sensitivity. In 1997, the overall increase in costs was 6.4%,¹⁰³ with a major contribution from the rise in pharmacy costs, the fastest growing line item in health plan budgets.¹⁰⁴ Health plans have raised premium prices, but analysts suggest that rate increases alone will not be enough to maintain profitability as payers will balk and look elsewhere for coverage.¹⁰⁵ Plans have had

⁹⁷*Id.*

⁹⁸*Id.*

⁹⁹PRICEWATERHOUSECOOPERS, *Health Care Statistics: Market Share Growth for For Profit HMOs* (visited Oct. 9, 1999) <<http://www.pwmc.com/charts/chart40.html>> (Interstudy 1998).

¹⁰⁰AMERICAN ASSOCIATION OF HEALTH PLANS, *HMO & PPO Industry Profile, 1995-1996*, 271 (1996).

¹⁰¹PRICEWATERHOUSECOOPERS, *Health Care Statistics: Trends in HMO Enrollment and Number of Plans*, (visited Oct. 9, 1999) <<http://www.pwmc.com/charts/chart25.html>> (Interstudy 1998).

¹⁰²*Health Care Statistics: Market Share Growth for For Profit HMOs*, *supra* note 99.

¹⁰³*Health Care Statistics: Overall U.S. Healthcare Spending by Major Category*, *supra* note 92.

¹⁰⁴Bruce Japsen, *Headaches Feared from Decline in Number of HMOs*, CHI. TRIB., Dec. 23, 1998, available in 1998 WL 23518251 [hereinafter Japsen, *Headaches Feared from Decline in Number of HMOs*].

¹⁰⁵*Id.*

to seek other strategies to maintain membership while keeping earnings in the black. Consolidation is one of these strategies.

Aetna's move to acquire Prudential Healthcare for \$1 billion is only the latest in a number of health care mergers and acquisitions.¹⁰⁶ In 1998, for example, Protective Life Corp. purchased United Dental Care, resulting in the nation's third-largest dental managed care company and WellPoint Health Networks, Inc. reached outside the west coast region to buy Cerulean Cos. Inc., the largest health insurer in Georgia.¹⁰⁷ Among Blue Cross Blue Shield (BCBS) plans, mergers and acquisitions have reduced the number of plans from 128 to 56 since 1975.¹⁰⁸ One of the most recent of these mergers will combine the BCBS plans in Delaware, Maryland and the District of Columbia.¹⁰⁹

Consolidation gives the HMO increased market power and leverage over providers. With health care costs on the rise, and payers resistant to bearing the whole burden, larger plans can exert concentrated pressure on providers to lower fees and costs.¹¹⁰ The potential for monopolistic market power is one reason why the A.M.A. urged the Department of Justice to prevent Aetna's acquiring Prudential.¹¹¹ Consolidation can give plans greater economies of scale. With more than 700 HMOs operating in the country, payers still have choices among HMOs in most areas of the country. By consolidating, plans can offer ever larger networks to payers in both local and regional markets, combined with the administrative convenience of dealing with a single health plan.

E. Regulatory Environment

HMOs are subject to extensive regulation at the state and federal levels. State insurance and health departments typically share responsibility for HMOs. Insurance department oversight usually includes approval of premium rates and contract terms, requirements for adequate cash reserves to cover projected claims and holding members harmless for the cost of care covered by premiums;¹¹² many states also impose interest penalties for late claims payment. State health departments oversee the provision of health care services, looking to ensure that access to care meets prescribed standards of waiting time and physicians' offices meet safety and equipment maintenance standards.¹¹³ Penalties for violations of state regulation can include fines and restrictions on new enrollment until required corrections are made.

¹⁰⁶Aetna Press Release, *Aetna to Acquire Prudential HealthCare for \$1 Billion*, (Dec. 10, 1998) <http://www.aetna.com/news/1988/pr_19981210.htm>.

¹⁰⁷Joanne Wojcik, *Health Care Merger Activity Continues*, BUS. INS. 28, Dec. 21, 1998, available in 1998 WL 23211998.

¹⁰⁸Sean Somerville & Jay Hancock, *Delaware Insurer to Join Blues of Md., D.C.* BALT. SUN, Dec. 24, 1998 at D1, D8.

¹⁰⁹*Id.*

¹¹⁰Japsen, *Headaches Feared from Decline in Number of HMOs*, *supra* note 104.

¹¹¹*Id.*

¹¹²*See, e.g.*, MD. REG. CODE, §§ 31.12.01.04 F-K (1998).

¹¹³*See, e.g.*, MD. CODE ANN., HEALTH-GEN. II § 19-701 *et seq.* (1996 Repl. vol; Supp. 1998).

At the federal level, HMOs are subject to stringent regulation. The HMO Act dictates how HMOs are organized and operated to maintain federal qualification.¹¹⁴ HMOs must comply with these rules in order to contract with the federal government for coverage of Medicare beneficiaries. The Medicare and Medicaid programs impose criminal fines and imprisonment penalties for fraud and abuse.¹¹⁵ U.S. Federal Sentencing Guidelines¹¹⁶ provide a uniform sentencing structure for organizations which violate federal criminal statutes and “provide for penalties that equal or often massively exceed those previously imposed on corporations.”¹¹⁷ The Guidelines provide an incentive for all organizations to have compliance programs in place. The knowing or willfully ignorant involvement of high-level personnel (which includes directors) in an offense covered by the Sentencing Guidelines creates a rebuttable presumption that the organization lacked an effective program to prevent and detect violations of the law.¹¹⁸

The civil penalties for Medicare fraud and abuse include fines and exclusion from federal programs. “For providers dependent on Medicare and Medicaid for a large share of their business, exclusion from these programs can be effectively a death warrant.”¹¹⁹

The Employee Retirement Income Security Act of 1974 (ERISA)¹²⁰ is also pertinent to HMOs, and specifically to directors. “Over 70% of privately-insured Americans are insured through employment-related group benefits plans that are subject to ERISA regulation”.¹²¹ With 30% of the privately-insured population enrolled in HMOs, it is to be expected that most HMOs have some members in ERISA plans. Among its myriad provisions governing the funding and administration of employee benefit plans, ERISA defines the duty of care of plan fiduciaries, which may include directors, officers, employees and well as organizations¹²², as that of a prudent person under like circumstances.¹²³ By statute, fiduciaries are personally liable for any losses suffered by the employee benefits plan which result from a breach of duty, and may additionally be subject to other

¹¹⁴42 U.S.C.A. § 300e, *supra* note 88.

¹¹⁵42 U.S.C.A. § 1320A-7B (1984).

¹¹⁶Sentencing Reform Act of 1984, Pub. L. No. 98-473, Title II, §212(a)(2); 18 U.S.C.A. §§ 3551-3656.

¹¹⁷*In re Caremark*, 698 A.2d at 969.

¹¹⁸U.S. Federal Sentencing Guidelines, § 8C2.5 (f), U.S. Sentencing Commission (1997).

¹¹⁹FURROW ET AL., HEALTH LAW, *supra* note 85, at 591.

¹²⁰Pub. L. No. 93-406, Title I, Sept. 2, 1974, 88 Stat. 829.

¹²¹FURROW ET AL., HEALTH LAW, *supra* note 85, at 782.

¹²²Pub. L. No 93-406, 88 Stat 829, § 3(21)(A): “A person is a fiduciary with respect to a plan to the extent (I) that he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets.” See also, *Libbey-Owens-Ford Co., v. Blue Cross & Blue Shield Mutual of Ohio*, 982 F.2d 1031, 1035 (6th Cir.), *cert. denied*, 570 U.S. 819, (1993) (finding Blue Cross & Blue Shield an ERISA fiduciary).

¹²³29 U.S.C.A. § 1104 (1999).

equitable and remedial relief as deemed appropriate by the courts.¹²⁴ In contrast to courts' application of the gross negligence standard under state statutes, courts applying ERISA have found fiduciaries liable using the simple negligence standard.¹²⁵

F. Operational and Data Processing Requirements for HMOs¹²⁶

To a great extent, managing care is an exercise in managing information. This is especially true in the plans that deliver health care services through contractual arrangements with hospitals, physicians and other providers. As noted above, distinctions in the delivery system are increasing and reimbursement arrangements with providers vary. This section summarizes at a high level the general requirements of an IPA model HMO.

Beyond the informational requirements of any business, such as payroll, general ledger, business accounts receivable and payable, HMOs' special data processing needs fall into three general categories: membership and accounts, provider contracts, and claims and benefits.¹²⁷

1. Membership

Membership demographics must be maintained for every enrolled member. This information includes name and address, date of birth, sex, additional coverage for coordination of benefits, and the selection of a primary care provider. Member information will be tied to the account under which members enroll, typically the employer group, but also government programs such as Medicare and Medicaid. Within a single employer group there may be subgroups such as management and hourly workers, union and non-union members, each of which may have different benefits. There may be different eligibility dates for members, for example, three months after hire.

2. Accounts

HMOs depend on the employer group to provide prompt updates of changes to membership. Particularly with large groups, such as those with multiple offices, keeping this information current is difficult. It is not uncommon for membership updates to be delayed. This results in retroactive disenrollment. The employer will deduct any premium payment for the employee on subsequent bills, as well as retroactive to the time the member lost eligibility. Practically speaking this means a

¹²⁴29 U.S.C.A. § 1109 (1999).

¹²⁵*Libbey-Owens-Ford Co., v. Blue Cross & Blue Shield Mutual of Ohio*, 982 F.2d 1031, 1035 (6th Cir.), *cert. denied*, 570 U.S. 819 (1993). *Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416, 419 (7th Cir. 1988).

¹²⁶The author draws on over ten years' experience in managed care and information systems, working with Kaiser Permanente, the Columbia-Free State Health Network, and the EDS-Maryland Health Information Network. The author is also indebted to Stuart Caplan, former Vice-President, Aetna/U.S. Healthcare for his comments.

¹²⁷Richard H. Eskow, *Collection, Correction, Application: The Information Cycle in MAKING MANAGED HEALTH CARE WORK* 445 (Peter Boland ed., 1993) [hereinafter Eskow, *Collection, Correction, Application*].

member can continue to receive care in the plan for weeks or months after he has left his job or dropped his insurance with no premium payment to offset the expense.

Certain accounts are prone to high turnover in their employees. Government accounts, among the largest customers of any insurance plan, experience steady ebb and flow of employees. Businesses which tend to hire large numbers of young people who stay for one or two years, such as consulting firms and large banks, also fit this pattern. Particularly prone to volatility are Medicaid plans because recipient eligibility can shift from month to month depending on changes in assets, income and family status. High volatility makes current and accurate membership reporting a challenge.

Employers may purchase unique benefits, adding to or reducing a standard package. Religious organizations often exclude abortion and sterilization services, government funded programs may limit these services to particular circumstances. One large national employer with ties to a particular church at one time extended dependent coverage beyond the usual age cut-off to those who were serving as missionaries.

The majority of employer groups renew in January, with most of the rest doing so in July. Although the decision-making process for members begins months in advance at the work site, this timing nonetheless results in a crush of work to set up accounts and complete enrollment at the HMO. Annual account contracts are the norm. This means that if there is an error in pricing the benefits, the HMO cannot change the premium for another year.

Many accounts will include performance measures in the HMO contract. Standards of timeliness and accuracy of claims payments and responsiveness in customer service are typical of such arrangements. Contractually agreed upon penalties may include premium reduction and interest payments.

3. Providers

HMOs collect and update detailed information on every provider with whom they contract. In the case of physicians and other individual practitioners, this information will include office addresses, specialty qualifications, fee schedule or capitation rates, limitations on services covered by the contract and tax identification numbers. A single provider practicing at the same location may have different contracts with the same HMO depending upon the provider's specialty. For example, a physician such as a pediatric cardiologist may have both a primary care contract at a capitated rate and a separate specialty contract for cardiology services reimbursed according to a fee schedule. In addition, providers who practice in two or more locations may have separate contracts and reimbursement rates based, for example, on the size of the enrolled membership in each region.

Primary care physicians are typically responsible for a defined group of patients, the "panel". For these providers an additional file of those members must be maintained for accurate calculation of monthly capitation as well as to determine whether the panel is open for new enrollment. The problem of retroactive disenrollment mentioned above is problematic for capitated providers. In this circumstance not only is the member dropped from the provider's panel but the retroactive capitation for that member will be deducted from the provider's reimbursement as well.

4. Claims and Benefits Administration

The major area in which membership and provider data must interact accurately is in claims and benefits administration. Typically when a patient leaves the capitation environment of primary care to seek specialty or hospital care, they must obtain an authorization from the primary care physician. The authorization operates as the ticket to the specialist's office; it also serves to alert the HMO of a pending claim liability. After the specialist treats the patient, a claim is sent to the HMO for payment.

For a claim to be paid properly the supporting data on the system must be current and valid.¹²⁸ The planets, as it were, must be in alignment. For example:

- The member must be currently enrolled at the time of service.
- The service must be covered by the member's benefit plan.
- The service must be age and sex appropriate (e.g., no gynecological services for men, no obstetrical services for women over or under certain ages).
- The nature and extent of the services performed must not exceed those that are authorized (e.g., a five day stay at a hospital when only three days have been authorized.)
- The provider number must be correct and the provider must be appropriate for the type of services billed (e.g., psychiatrists do not bill for orthopedic surgery.)
- The service performed must be appropriate for the setting in which it was performed (e.g., no open heart surgery at an office location.)
- There must be an authorization in the system which is current (many plans limit the life of an authorization to a period of days or months.)
- The reimbursement must be the correct amount for that provider at that location, either the agreed fee schedule rate or "usual and customary" as established by the plan.

Although not exhaustive, this list suffices to convey the general extent of information required for the task of claims payment.

5. Point of Service Plans

An HMO may also offer additional products or options to customers which increase the data intensity of the process just described. Point of service (POS) plans are one popular option in the managed care marketplace. Under a POS plan a member may directly seek care outside of the HMO network, providing they pay extra for the privilege. POS plans relieve some of the restrictions of the HMO by permitting members to see the specialist of their choice. In addition to paying a higher premium for this hybrid product, the member typically pays coinsurance of 20-30% of the usual and customary charge.¹²⁹ Some HMOs may vary the limitations, such as still requiring the primary care physician to authorize the visit.

¹²⁸See e.g., Eskow, *Collection, Correction, Application*, *supra* note 127 ("The timeliness of enrollment information is critical . . . in ensuring the accuracy of claims payment and the appropriateness of service authorizations").

¹²⁹Andrea Adelson, *Health Plans with Choice: Good Deals?*, N.Y. TIMES, Nov. 9, 1997, at C15.

The POS model offers the best of both worlds to accounts and members alike. Employers like the aspect of consumer choice, which keeps employees happy, yet the account benefits from the ongoing cost containment of HMOs because the employee pays the difference out of pocket. Members appreciate the safety valve aspect of POS plans, knowing that they have the option of seeing a desired provider who is not in the network, or an in-network provider for whom the primary care physician may be unwilling to issue an authorization.

The advantages of POS plans for consumers are not without drawbacks. Members may find their out-of-pocket expenses higher than expected when the HMO applies its own “usual and customary” limit to the provider’s bill. This can result in the member having to pay 100% of the excess charge in addition to the expected coinsurance.¹³⁰ In spite of this potential problem POS plans are the fastest growing sector in health insurance.¹³¹

For the HMO, the information system demands of this appealing product are considerable. The discussion above regarding the importance of coordinated and timely data takes on even greater weight with POS products. This is particularly true when a member opts to see a contracted specialist, but does so without an authorization. The information system will have to determine if the service is payable under the POS model (which means the member has to pay out of pocket, and the specialist’s reimbursement might be higher than the in-plan contracted rate) or if the service was an authorized visit for which the authorization has not yet hit the system (in which case the member pays no coinsurance and the provider is paid the appropriate contractual rate.)

Depending on the timing of the receipt of information, and the speed and accuracy of data entry, particularly for authorizations, providers may easily be paid at the wrong rates, members may be charged incorrectly for coinsurance, and both may experience delays in payment due to the absence of preliminary data on the system. These circumstances can effect not only the accuracy of payment, but also the quality of customer service to both members and providers, as well as regulatory requirements for prompt payment of valid claims. These operating and business risks of POS plans clearly raise the bar in demanding highly effective information systems for the HMO.

6. IBNR or “The Black Art”

IBNR stands for incurred but not reported. This acronym refers to “[t]he amount of money that the plan had better accrue for medical expenses that it knows nothing about yet. These are medical expenses that the authorization system has not captured and for which claims have not yet hit the door. Unexpected IBNRs have torpedoed more managed care plans than any other cause.”¹³²

HMOs operate on a future orientation. Premium rates are based on the expected utilization for a given population. At any one time, a substantial amount of the care for which a plan is liable lies in the future because the total membership is receiving care on an ongoing basis. “If the costs are simply booked as they come in, disaster is

¹³⁰*Id.*

¹³¹*Id.*

¹³²*Glossary, in THE MANAGED HEALTH CARE HANDBOOK 995-96 (Peter R. Kongstvedt ed., 3d ed. 1996).*

certain.”¹³³ IBNR is a primary vehicle for forecasting expenses and trends in care costs as well as trends in the type and setting of care which is being provided under the plan. It is also the basis on which plans calculate statutory reserve and cash flow requirements.

A particularly troublesome aspect of faulty accrual for IBNRs is the tailing effect. A plan which underaccrues for IBNR in one period cannot easily solve the problem in the next period because the expenses were already accrued and “keep rolling in.”¹³⁴ Each month’s accruals have to be adjusted, and the expenses for prior periods suffer as well as for the current one.¹³⁵ “Monthly performance gets muddied up with adjustments for prior performance, and managers find themselves chasing their tails.”¹³⁶ Other systemic problems which contribute to faulty INBRs include rapid growth in membership, inadequate premium due to low-balling rates or poor collections, or flawed rating methodologies.¹³⁷

Aptly characterized by the Wall Street Journal as “the black art”¹³⁸ of HMOs, accurate IBNR projections depend on the timeliness and quality of data already in the system. Any problems with the validity of membership, claims or authorizations data, the reporting system for these data, or the plan’s lag studies (which inform management of aging of claims and amounts paid out for past and current periods compared to accruals for these periods ¹³⁹) can severely affect the accuracy of the IBNR projections.

7. Medical Management

The same factors which influence the validity of the IBNR calculations are those on which HMOs rely to manage care. Unlike a retail store which can observe the flow of its physical inventory, HMOs depend entirely upon data to carry out managed care’s eponymous function. “Medical management reports are... absolutely necessary tools for managers of health plans.”¹⁴⁰ “Accurate membership counts are necessary to compute ‘cost per employee’ statistics, which are the basis of comparing utilization patterns from one period to the next.”¹⁴¹ Prompt and accurate claims and authorization systems are an obvious necessity for effective management

¹³³Peter R. Kongstvedt, *Common Operational Problems in Managed Health Care Plans*, in THE MANAGED HEALTH CARE HANDBOOK 627 (Peter R. Kongstvedt ed., 3d ed., 1996).

¹³⁴*Id.*

¹³⁵*Id.*

¹³⁶*Id.*

¹³⁷*Id.*

¹³⁸Ron Winslow & Scott J. Paltrow, *Ill-Managed Care: At Oxford Health, Financial ‘Controls’ Were Out of Control*, WALL ST. J., Apr. 29, 1998, at A1, A14 [hereinafter Winslow & Paltrow, *Ill-Managed Care*].

¹³⁹*Glossary*, *supra* note 132, at 996.

¹⁴⁰Peter R. Kongstvedt, *Using Data in Medical Management*, in THE MANAGED HEALTH CARE HANDBOOK 451 (Peter R. Kongstvedt, ed., 3d ed. 1996).

¹⁴¹John C. Erb & Robert F. Griffith, *Employer Utilization Data*, in MAKING MANAGED CARE WORK 511 (Peter Boland ed., 1993).

of the services for which a plan is liable. Only through data does the plan identify systemic utilization problems, such as plan-wide overuse of emergency room services. Trends of this type require different remedies than those that can be traced to a particular provider or medical group or population.¹⁴²

From this brief survey of the operational side of HMOs, it is apparent that a sound, well designed and properly implemented information system is perhaps the single most important determinant of an HMO's long term success. Accurate and timely information is essential for the successful delivery of the HMO's health care product. And, as with any business, the information system is the chief tool used by management and board to identify the signs of incipient business and compliance problems. The Board's responsibility to oversee the effectiveness of the information systems extends over all of these areas.

This article now turns to Oxford Health Plans, Inc., as a case study in how an HMO's faulty information system can precipitate business losses and regulatory violations and expose the directors to personal liability for their failure to monitor the system's development and implementation.

IV. A BRIEF HISTORY OF OXFORD HEALTH PLAN

Oxford Health Plans, Inc. (Oxford), a Delaware corporation, provides health benefit plans through various subsidiaries in New York, Connecticut, New Jersey, Pennsylvania, New Hampshire, Florida and Illinois. Oxford was founded by Stephen Wiggins in 1984 as an innovative, customer focused and non-bureaucratic organization which would win the hearts of its consumer customers.

Oxford experienced steady membership growth into the mid 1990s when the pace became explosive. By the end of 1997 total membership exceeded two million members.¹⁴³ Together with membership growth came a steady rise in earnings and stock price. The one-time darling of Wall Street made its initial public offering in 1991 at \$2.25; at its peak in July, 1997 Oxford's stock traded at \$89.¹⁴⁴ That was before October 27, 1997 when the stock fell sixty-two percent and the company shifted into a spiral of losses from which it has yet to recover fully.

A. Business Strategy and Culture

Like every other HMO, Oxford had a challenge in information systems, but certain characteristics of Oxford's business strategy and corporate culture put even greater demands on the systems.

Capitalizing early on the promise of point-of-service plans, Oxford introduced the "Freedom Plan" in 1988. This plan would account for 59.2% of total premiums, serving 1.3 million members by 1997.¹⁴⁵ As discussed above, POS plans make prodigious demands on the information systems for timeliness and accuracy; given the substantial membership enrolled in this program, the pressure on the system to perform was even greater.

¹⁴²Kongstvedt, *supra* note 140.

¹⁴³Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁴⁴*Id.*

¹⁴⁵Oxford Health Plans, Inc., 1997 Annual Report, 10-K/A 4 (1998).

Oxford was also an innovator in the types of service it would cover, being among the first HMOs to offer access to nontraditional types of care, such as acupuncture and herbal medicine within its network.¹⁴⁶ While undoubtedly a crowd pleaser, one result of this business strategy would have been an increased system demand to support an expansion of the provider network. Because access to non-traditional providers had not previously been offered, these practitioners would most likely not have been on the provider file, and so their addition represents a net increase in file volume. The files might also require some modification as the credentialing requirements for non-traditional providers could differ from traditional providers.

In 1997, in response to customer demand for better cost management, Oxford introduced an entirely new patient care and reimbursement strategy for members with chronic illnesses or other major health problems.¹⁴⁷ This program permitted qualified patients to select their own specialists without a referral. The reimbursement innovation was to pay the specialists a flat rate for the entire episode of care, from diagnostic tests, through surgery to post-operative rehabilitation. Although flat cases rates have been used by many HMOs, the scope of services subject to the rate was much greater than the industry norm.

The success of this innovative reimbursement and care program was highly dependent upon an effective information system. This program called for putting "a wealth of information at the members' fingertips, including [physicians'] backgrounds, rates, and results from previous cases and patient satisfaction surveys."¹⁴⁸ On the payment side, providers were to be paid in stages as the treatment progressed, based on reporting back to the health plan.¹⁴⁹ To support this program on an information system, some of the steps involved would be: to distinguish which patients were allowed under this payment scheme from those who were regular Oxford members; to distinguish for these specially participating providers a separate fee schedule and to establish a unique payment mechanism which recognizes an incremental and variable progression of treatment.

The information processing complexity of this unique payment scheme becomes apparent when compared to the conventional case rate contract. Obstetricians, for example, are often paid a flat rate for prenatal care, delivery and one post-partum visit; the rate will vary depending on whether the delivery was normal or via Cesarean.¹⁵⁰ A single payment is made following the delivery.

In contrast, the Oxford payment arrangement calls for incremental payments based on stages of progress in a treatment protocol, which may or may not be represented by a single procedure code, and may quite possibly comprise a number of procedures. This means the protocol itself must be coded into the system so as to permit incremental progress to be recorded; a pricing break-down of the incremental

¹⁴⁶Reed Abelson, *Behind the Bleeding at Oxford*, N.Y. TIMES, Dec. 9, 1997, at D1 [hereinafter Abelson, *Behind the Bleeding*].

¹⁴⁷Michele Bitoun Blecher, *The Gate Swings Wider*, Hosps. & Health Networks (June 20, 1997) <<http://www.hhnmag.com>> [hereinafter Blecher, *The Gate Swings Wider*].

¹⁴⁸*Id.*

¹⁴⁹*Id.*

¹⁵⁰Author's personal communication with Stuart Caplan, former Vice President, Aetna/U.S. Healthcare, Nov. 18, 1998.

steps is required; given the complexity of the patient's condition such as would put them into this program in the first place it is reasonable to assume that not all patients will have the same exact progress. Such a scheme is not impossible to analyze and code; it is, however, complex and time consuming.

Oxford was not modest in its expectations of the scale of this program, projecting savings of twenty to thirty percent over current specialty care costs.¹⁵¹ Given Oxford's total specialty care costs account for about \$1.7 billion out of a total \$2.2 billion of medical expenses,¹⁵² this program was projected to save between \$300 million and \$500 million.

The corporate culture of Oxford also contributed to extraordinary pressures on the information systems. Priding itself as iconoclastic and anti-bureaucratic, Oxford eschewed standard procedures. Provider contracts were creatively negotiated, sometimes with changes made at the last minute to mollify practitioners.¹⁵³ Such a strategy can improve relationships with providers by showing flexibility and responsiveness. But the fruits of creativity can often be hard to code into a logical system.¹⁵⁴ In 1997, Oxford had a provider network of over 60,000 providers, most of whom contracted individually and directly with the health plan.¹⁵⁵ Even if only a fraction of the providers negotiated unique contracts, the toll in human and system resources to code and maintain these special provisions could mount quickly.

B. Membership Growth

Added to the volatile mix of business strategy and corporate culture was explosive growth in membership. Of the two million members in the plan by the end of 1997 roughly half had joined in the last two years.¹⁵⁶ In the New York plan alone, the growth rate was 300% for this period.¹⁵⁷ A critical source of this growth came in the aggressive pursuit of Medicare and Medicaid business, bringing in members who

¹⁵¹Blecher, *The Gate Swings Wider*, *supra* note 147.

¹⁵²*Id.*

¹⁵³Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁵⁴Recall the dependent missionary coverage example from discussion *supra* section III.E.2. Because student dependent coverage is an industry norm, there is typically some provision for carrying student status on the insurer's or HMO's information system. Missionary status, however, is not a commonly used field. The method of verifying student status is also straightforward, a letter is automatically sent to the subscriber when the dependent reaches the threshold age, requesting verification of enrollment from the family or school. Missionary status can also be established, to be sure, but there is no obvious age threshold at which the health plan reminds itself and the subscriber to declare the dependent's status. Clearly such a provision can be handled somehow, whether a unique system fix for the account or entirely off-line. The point is that variations of this type take time to analyze, code, test and implement, not to mention price accurately.

¹⁵⁵Oxford Health Plans, Inc., 1997 Annual Report, 10-K/A 7 (1998).

¹⁵⁶Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁵⁷*Market Conduct Report on Examination of Oxford Insurance, Inc. and Oxford Health Plans (NY), Inc. as of Nov. 1997*, 15, New York Department of Insurance [hereinafter *Market Conduct Report*].

are usually sicker and certainly older than the rest of the plan's membership.¹⁵⁸ Medicare membership grew to 161,000 by year end 1997, or eight percent of total membership, yet this program accounted for twenty-two percent of total premiums.¹⁵⁹ Medicaid membership for the same period reached 189,600, accounting for 7.7% of total premiums.¹⁶⁰

C. In-house Development of Oxford's Information System

In 1993, Oxford decided to develop its own new information system, rejecting the option to buy an existing system. In early 1996, the old system was staggering under the pressures of membership growth and claims backlogs were growing.¹⁶¹ During 1996, company officials turned up the heat to complete the new system, "racing against the clock", according to one insider.¹⁶² In September 1996, the company converted from the old to the new system largely in "one fell swoop."¹⁶³

Almost immediately the system failed at essential tasks. The process of entering membership stretched up to fifteen minutes in some cases.¹⁶⁴ Efforts to link the old and new systems, to facilitate pulling up old information, ended up corrupting data on both sides.¹⁶⁵ Claims payment appears to have ground to a near halt.¹⁶⁶ By late 1996, unpaid provider claims had risen to \$625 million.¹⁶⁷

While no system implementation is immune from problems, it appears that haste and lack of testing are two obvious culprits in the disaster at Oxford.¹⁶⁸ Hubris, too, played a part. One company insider told the Wall Street Journal, "[T]hey thought they could do almost anything better than anybody else ... [b]ut they were novices at developing software."¹⁶⁹

While developing an in-house system in any business is neither impossible nor necessarily a recipe for disaster, there are known pitfalls. One industry expert suggests that self-developed software is often a poor business choice as, compared to expectations, it typically yields only half the desired functionality, but costs twice as much and takes twice as long to develop and implement.¹⁷⁰ This rule of thumb even applies to organizations which have experience in systems development.

¹⁵⁸Abelson, *Behind the Bleeding*, *supra* note 146.

¹⁵⁹Oxford Health Plans, Inc., 1997 Annual Report, 10-K/A 5 (1998).

¹⁶⁰*Id.* at 6.

¹⁶¹Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁶²*Id.*

¹⁶³*Id.*

¹⁶⁴*Id.*

¹⁶⁵*Id.*; Oxford Health Plans, Inc., 1997 Annual Report 10-K/A 10 (1998).

¹⁶⁶Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁶⁷*Id.*

¹⁶⁸*Market Conduct Report*, *supra* note 157, at 3, 17.

¹⁶⁹Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁷⁰Author's personal communication with J.T. (Jay) Westermeier, Partner, Piper & Marbury, Washington, D.C. Mr. Westermeier is past president of the Computer Law

A 1979 study by the General Accounting Office (GAO) on software development projects for government agencies found a number of common problems when organizations chose to develop software instead of purchasing existing products.¹⁷¹ While this study examined contracts with consultants for software development, many of the problems identified by the GAO apply equally in the case of a business developing its own systems. These included: failure of top management to commit appropriate management resources and trained staff to the project, failure of staff to prepare complete business requirements prior to system design, unanticipated changes to the scope of work and inadequate testing.¹⁷² This study also found that the total cost and development times for the software development work were twice the original estimates.¹⁷³

Migrating from one information system to another is no easy task. During the migration period both the old and new systems must be supported, as part of the process to verify the integrity of the new system.¹⁷⁴ “This [migration] process is complex and requires numerous resources, both user and IS [information systems] operations involvement, and a strong organizational commitment to be successful. Conversion strategies and work plans should be developed in advance for all of the following: infrastructure migration, application migration, process improvement (developing new procedures to capitalize on the efficiencies of the new application), training schedules and job definitions.”¹⁷⁵ This characterization of the steps necessary to assure a smooth conversion is at odds with insiders’ description of the process at Oxford as well as that of the New York Insurance Department (Department) which noted poor planning, inexperienced management, and inadequate systems testing as important factors in the system’s failure.¹⁷⁶

The system flaws at Oxford were stunningly apparent and largely unexpected.¹⁷⁷ Inability to process claims properly resulted in backlogs that stretched into the hundreds of millions of dollars. Oxford resorted to paying providers lump-sum settlements, explained as “loans” to be reconciled against actual claims when the company caught up with the claims backlog.¹⁷⁸ Without recent detailed claims history, it became difficult to project the IBNR expense or reserve requirements.

On the membership side, difficulties maintaining accurate membership data resulted in billing problems. Bills to accounts were often late or wrong; eventually it

Association, the largest association representing information technology lawyers around the world Jan. 7, 1999.

¹⁷¹*Contracting for Computer Software Development—Serious Problems Require Management Attention to Avoid Wasting Additional Millions*, Report of the Comptroller General, U.S. General Accounting Office, FGMSD-80-4 (Nov. 9, 1979).

¹⁷²*Id.* at 27.

¹⁷³*Id.* at i, ii.

¹⁷⁴Reese, *Information Systems*, *supra* note 4, at 460.

¹⁷⁵*Id.*

¹⁷⁶*Market Conduct Report*, *supra* note 157, at 3, 17.

¹⁷⁷*Id.*

¹⁷⁸Reed Abelson, *Market Place*, N.Y. TIMES, Dec. 8, 1997, at D2 [hereinafter Abelson, *Market Place*].

appears the plan just stopped billing some accounts entirely.¹⁷⁹ As a result Oxford didn't know how many members it had, who they were and whether or not their premiums were paid. Eventually the plan would write off care costs for some 30,000 members who had either disenrolled at the time they received care, or refused to pay because they had not been properly billed.¹⁸⁰

On the cost management front the inability to process claims and membership meant that no meaningful cost tracking could be maintained. During 1997, for example, while Medicare revenue rose 4.3%, unbeknownst to the company, the expenses for this population rose twenty-one percent.¹⁸¹

From the time of the system implementation in September, 1996, Oxford management had strenuously denied the extent of the problems. Stephen Wiggins repeatedly expressed confidence to members, providers and regulators that the systems problems were just about fixed. In response to a fiery complaint from the New York State Society of Oncologists and Hematologists, complaining of excuses for computer problems and delayed claims payments, Wiggins wrote back accusing the Society of "resort[ing] to extremism and slander in an attempt to serve your clients' interests."¹⁸² The company accepted that it had a big problem when the New York State Insurance Superintendent, Neil Levin, demanded to meet with the board of directors to discuss the Department's concerns about the company's operations.

D. Announcement of Losses Leads to Drop in Stock Price

On October 27, 1997, the day before Levin was to meet with the board, Oxford announced its first quarterly loss in its thirteen year history. The stock price plummeted sixty-two percent that day, resulting in a three billion dollar paper loss.¹⁸³ At the time of the announcement, Wiggins confidently estimated the company would return to profitability soon. He would never again have cause for such optimism. Later, "[u]nder pressure from the New York State Department of Insurance, Oxford acknowledged it had misjudged the cost of care and would take a charge against fourth quarter earnings and show a loss for the year."¹⁸⁴

E. Investigation by the New York Insurance Department

On May 9, 1997, spurred by complaints from consumers and providers about claims payment delays by HMOs and other insurance entities, New York Governor George Pataki ordered the state Insurance Department to launch a major investigation into the health insurers' claims payment practices.¹⁸⁵ Oxford was the first HMO targeted for this examination.

¹⁷⁹Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁸⁰*Id.*

¹⁸¹*Id.*

¹⁸²Abelson, *Market Place*, *supra* note 178.

¹⁸³Michele Bitoun Blecher, *Burned on the Street*, HOSPS. & HEALTH NETWORKS (Mar. 5, 1998) <<http://www.hhnmag.com>> [hereinafter Blecher, *Burned on the Street*].

¹⁸⁴Reed Abelson, *Oxford Says It Misjudged Cost of Care*, N.Y. TIMES, Dec. 10, 1997, at D1 [hereinafter Abelson, *Oxford Says it Misjudged*].

¹⁸⁵Press release, N.Y. Ins. Dept., May 9, 1997 <<http://www.ins.state.ny.us/p9705091.htm>>.

Following a months-long and contentious examination, the Insurance Department issued its Market Conduct Report on Oxford in late December, 1997. Specific to Oxford's operations and systems the report concluded that Oxford continued to experience significant delays in claims payment, still could not quantify the claims backlog, and lacked procedures to ensure compliance with New York state law and regulations.¹⁸⁶ While the report attributed much of the operational problems to the newly implemented information system, it found that "underlying [these concerns] is the problem that many of the issues described herein appear to be caused simply by poor planning and/or inexperienced management."¹⁸⁷

As a result of the investigation, the Department fined Oxford three million dollars for violations of state laws and regulations.¹⁸⁸ In addition, the Department ordered Oxford to pay \$500,000 in restitution to customers and health care providers related to unapproved contracts and rates.¹⁸⁹ Oxford agreed to a number of corrective actions. Among those related to the systems problems included commitments to:

1. Evaluate, augment and where necessary, replace senior management in consultation with the Board of Oxford Health Plans, Inc.
2. Strengthen the Board by the addition of at least two outside directors.
3. Retain an outside management consultant to evaluate the information systems, internal controls and management reporting.
4. Strengthen and augment internal controls and procedures capable of generating reliable data concerning claims, premiums and expenses.¹⁹⁰

When the dust finally cleared, Oxford reported losses of \$291 million for 1997,¹⁹¹ and paid an additional \$200 million into reserves.¹⁹² By the end of 1998, the company had lost a reported \$952 million over the previous five quarters.¹⁹³ The stock has fallen from a peak of \$89 a share in July, 1997¹⁹⁴ to a low of \$7.375 a year later.¹⁹⁵ The stock has recovered somewhat, trading at \$13.75 on December 23, 1998.¹⁹⁶

¹⁸⁶Press release, New York Ins. Dept., Dec. 23, 1997 <<http://www.ins.state.ny.us/p9712231.htm>>.

¹⁸⁷Market Conduct Report, *supra* note 157, at 3.

¹⁸⁸Press release, *supra* note 186.

¹⁸⁹*Id.*

¹⁹⁰Market Conduct Report, *supra* note 157, at 32.

¹⁹¹Oxford Health Plans, Inc., 1997 Annual Report 10-K/A 2 (1998).

¹⁹²Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁹³Bloomberg Online, *Auditors Feel Heat as Accounting Errors Mount: Tainted Ledgers* (Dec. 9, 1998) <<http://www.quote.bloomberg.com>> (requesting quote for Oxford Health Plans, Inc. (OXHP)), [hereinafter *Auditors Feel Heat*].

¹⁹⁴Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

¹⁹⁵Reed Abelson, *A Troubled Health Plan's Stock Price Ills*, N.Y. TIMES, July 31, 1998, C1 [hereinafter Abelson, *A Troubled Health Plan's Stock*].

¹⁹⁶Bloomberg Online (Dec. 23, 1998) <<http://www.quote.bloomberg.com>> (requesting quote for Oxford Health Plans, Inc. (OXHP)).

Unexpected payments to reserves resulted in a reduction of the company's equity to roughly \$400 million by year end 1997.¹⁹⁷ Oxford sought financing to meet its reserve requirements, borrowing \$100 million in short term funding from Donaldson, Lufkin & Jenrette in February and March, 1998.¹⁹⁸ The company also secured \$700 million in debt and additional equity financing, increasing internal borrowing costs and diluting the value of outstanding shares.¹⁹⁹ Investment analysts have been wary of continued losses which could result in increased reserve requirements and further dilution of outstanding shares.²⁰⁰

Stephen Wiggins resigned as chairman in February, 1998.²⁰¹ He remains on the Oxford board today, having served on a three member executive committee charged with helping turn around the company. In January, 1998 the company named Norman D. Payson, a physician and former CEO of Healthsource, Inc., as Oxford's new CEO-elect. Dr. Payson "plunked down \$10 million of his hard-earned money for Oxford's stock."²⁰² Not many others are following suit. Anxiety over the company's anticipated future losses and concern over the company's lack of communication with the investment community have made potential investors leery.²⁰³

As for the information system at the root of many of Oxford's problems, which cost upwards of \$100 million to develop, the company decided in March, 1998 to scrap it.²⁰⁴ At that time, Oxford was considering alternative systems approaches, including outsourcing functions to a third party or replacing the failed systems completely with one or more systems available on the market from third party vendors.²⁰⁵ The company estimated that it would take another twelve to eighteen months to identify and implement the alternative system solution.²⁰⁶

¹⁹⁷Reed Abelson, *Oxford Health Share Price Takes Another Beating*, N.Y. TIMES, Dec. 11, 1997, at D1, D16.

¹⁹⁸Reed Abelson & Laura M. Holson, *Troubled HMO Said to near Shift in Top Management*, N.Y. TIMES, Feb. 23, 1998, at A21.

¹⁹⁹Oxford Health Plans, Inc., 1997 Annual Report, 10-K/A 3 (1998).

²⁰⁰Abelson, *A Troubled Health Plan's Stock*, *supra* note 195.

²⁰¹Wiggins appointed William Sullivan as CEO in the summer of 1997, before the extent of the company's troubles were fully known. In the announcement at the time Wiggins lauded Sullivan's successful efforts in implementing the new information system. Sullivan relinquished the post in January 1998 and remained with the company until he resigned effective November 1, 1999.

²⁰²Abelson, *A Troubled Health Plan's Stock*, *supra* note 195.

²⁰³*Id.*

²⁰⁴Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138 (The company later reversed this decision, announcing in May, 1999 that it would improve the existing system rather than start anew or contract for a new system. Milt Freudenheim, *Oxford Health Turnaround is Still a Work in progress* N.Y. Times, May 13, 1999).

²⁰⁵Oxford Health Plans, Inc., 1997 Annual Report, 10-K/A 10 (1998).

²⁰⁶*Id.*

V. LESSONS FROM OXFORD - HOW DO DIRECTORS MEET THEIR DUTY OF CARE?

Oxford's management and directors will soon be subject to great scrutiny in the courts. In the aftermath of the stock price drop in late October, 1997, Oxford faces a battery of lawsuits and government inquiries. As of April, 1998, over forty-five suits were filed against the company and its officers and directors alleging violations of disclosure requirements under the Securities Exchange Act of 1934.²⁰⁷ In addition, at least ten shareholder derivative actions have been filed.²⁰⁸ Oxford expects more litigation to follow.²⁰⁹ The Attorney General of New York, the Securities Exchange Commission, and the Health Care Financing Administration have all initiated their own investigations of the company.²¹⁰

It will be some time before the details of the decisions and actions of Oxford's directors will be fully known. For this reason, much of the discussion which follows is speculative. Yet, Oxford's experience illustrates, by omission rather than commission, the steps that the board of a large HMO or health insurer might be expected to take when considering the strategic decision of changing the organization's information system, a decision with major implications for the success of the business and for effective corporate compliance with state and federal laws.

There are three timeframes of interest, each with a key question. First, at the point of the original decision in 1993 to develop a system internally, did the board fully understand the risks and benefits of this strategy? Second, once the decision was taken to build the system as opposed to buy one, what steps did the board take to monitor this project in keeping with the board's duty of oversight? Third, once the system conversion occurred, were there sufficient warning signs to trigger the board's duty of inquiry before October, 1997?

A. *Decision to Build an In-house Information System*

In general, courts are loathe to second guess a business decision by directors, provided that the process of reaching the decision is considered deliberately and in good faith, or was otherwise rational.²¹¹ In the case of Oxford, the existing information system was clearly inadequate for the anticipated growth in membership and complexity of current and future products.²¹² As such, a decision to change or enhance the system would have a rational basis as it would be viewed as essential for the future success of the business.

Given Oxford's innovative approach to product design and focus on customer service, the decision to reject existing systems from third party vendors may have been rational if the systems available on the market did not offer the unique functionality the company required. Companies routinely make "buy or build" decisions based on the specific needs of the business, the skills of management and

²⁰⁷*Id.* at 18-20. (Many of these cases have been consolidated in the United States District Court for Southern New York).

²⁰⁸*Id.* at 20-21.

²⁰⁹*Id.* at 18-20.

²¹⁰*Id.* at 19-22.

²¹¹*In re Caremark*, 698 A.2d at 967.

²¹²*Market Conduct Report*, *supra* note 157, at 16.

other personnel, and the relative costs and benefits of products available in the marketplace.

The key question in this circumstance is whether the board fully understood the business risks involved in developing the system in-house. Did management present information to the board which identified the potential risks, such as the likelihood that self-developed software ultimately yields lower functionality at greater cost and time to implement than anticipated? Was the board informed of the required skill level of personnel to lead and carry out such a project? Did the company employ or plan to recruit staff with these skills? Did management seek external expertise, such as management or systems consultants, to advise on the merits and risks of this decision? Was the board provided with the information from the consultants? A court would consider all of these factors when determining whether the board followed a reasonable process in reaching the decision.

Another element in a decision to develop a system in-house is the foregone protections of the vendor contract. Whether a business purchases a complete information system from, or develops one collaboratively with, a vendor the purchaser has the benefit of certain protections. First, presumably the vendor has expertise.²¹³ Additionally, the contract terms will typically include beneficial provisions for the purchaser, such as incremental delivery dates, financial penalties for missed deadlines, warranties such as assurances of Year 2000 compliance, binding arbitration provisions, and requirements that the vendor have adequate insurance coverage for errors and omission.²¹⁴

Because of the contractual relationship with the vendor, the purchaser also has a number of legal bases on which to rely. These may include actions for breach of warranty for fitness for a particular use, breach of implied warranty of merchantability, breach of express warranties as to the ability of the system to meet the client's objectives, common law fraud, violation of state deceptive practices statutes, and violation of the Lanham Act.²¹⁵ The law of contracts will permit a plaintiff to recover direct and consequential damages or alternatively to sue for specific performance.²¹⁶ Fraud actions may result in awards for punitive damages.²¹⁷

Obviously the threat of legal action on a contract is no guarantee of perfection, but the risk of legal action does serve, at a minimum, to incline the vendor towards agreed upon performance. In addition, the vendor company has its own reputation in the marketplace to consider, positively in terms of satisfied customers, and the predictable opposite.

²¹³Although there may well be exceptions if the allegations in *UOP v. Andersen Consulting*, 1997 WL 219820 (Conn. Super. Ct., 1997), *mem.*(alleging *inter alia* breach of contract, negligent misrepresentation, negligence and gross negligence by systems integrator) are proved.

²¹⁴Author's personal communication with Michael Oliver, member, Bowie & Jensen, L.L.C., Towson, MD, a firm concentrating in intellectual property law. Dec. 16, 1998.

²¹⁵*See, e.g.*, *L.S. Heath & Son, Inc. v. AT&T Info. Sys., Inc.*, 9 F.3d 561, 566 (7th Cir. 1993).

²¹⁶U.C.C. §§ 2-713--2-716.

²¹⁷*Dunn Appraisal Co. v. Honeywell Info. Sys., Inc.*, 687 F.2d 877, 881, 886 (6th Cir. 1982); *see also* Restatement (Second) of Contracts § 355 (1978).

Finally, because of the high rate of change in information technology, as well as in the health care industry, in-house development exposes the company to the risk of the system being out-of-date in a short time.²¹⁸ While vendors also assume this risk, a technology vendor can be expected to stay up-to-date in system and industry trends in order to compete effectively for new business; presumably the cost to the vendor in staff time and research is recovered through its pricing methodology. A purchaser in another business is less likely to make the investment in staff, education and research necessary to stay at the forefront of the information technology industry.

Once a company has decided to build an in-house system, its directors might reasonably be expected to inquire of management how the company would compensate for the lack of contractual protections. For example, will the company acquire systems expertise through hiring new staff? Will project leaders and staff receive incentive compensation based on value to the company of the fully implemented system? Can the project itself be insured? What specific actions can management take to mitigate the tendency of self-development projects to fail to meet expectations? By posing such questions directors can demonstrate their understanding of the risks inherent in the decision to build an in-house system.

B. Monitoring the Information Systems Development Project

Once the decision is made to build a system in-house, a board faces another set of questions related to appropriate monitoring of the development process. Who will be accountable for the project? What are the quality assurance procedures, plans and milestones for key phases in the design, development and implementation process? What are the fail-safe or fall back provisions in the event that development is delayed and business operations are threatened? What reports will the board receive throughout this process so that directors can judge for themselves that the project is proceeding according to plan? How can the reports be validated to ensure that they are accurate? How will the board assure itself that the ongoing business and compliance requirements of the company are being met during the system development and implementation phases?

When a system is developed entirely in-house, the corporation has neither the actual remedies nor the threat of meaningful legal action to encourage performance by staff. While a company may dismiss an employee for negligence, to recover damages the company must prove that the employee was accountable for the harm done. At Oxford, such accountability appeared to be wholly lacking. When the extent of the disaster became known in October, 1997, a number of the company's financial analysts offered their resignations. Wiggins refused to accept them, reportedly saying "[w]e were all blindsided here. This wasn't something you could point to a single person to hold responsible for."²¹⁹

That the chairman of the board believed there was no single person accountable for the success of a project of the scale, complexity and critical nature of this system in itself suggests that the board failed in at least this aspect of oversight. In any event, when the person perhaps most identified with the company's failure, Wiggins

²¹⁸ Author's personal communication with J.T. (Jay) Westermeier, Partner, Piper & Marbury, Washington, D.C., *supra* note 170.

²¹⁹ Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

himself, resigned as chairman in February 1998, Oxford's board voted to pay him a \$9 million severance package.

It can be inferred from the complete absence of public acrimony and accusations in the aftermath of such an enormous business setback that there were no major systems consultants retained by Oxford on this project. Neither the Market Conduct Report nor Oxford's 1997 Annual Report make any mention of management or systems consultants retained to assist in the development of the system.²²⁰ In contrast, the company's independent accountants, KPMG, have received considerable adverse press for its failure to identify the problems with the system and Oxford's financial position. In both 1996 and 1997, KPMG approved Oxford's books without qualification and made "no mention of the company's billing and payment woes."²²¹ KPMG has been added as a defendant in a number of the lawsuits pending against Oxford.²²² No other consultants have been named as defendants.

The use of consultants at the least to assist in planning and oversight of the project might well have brought a degree of rigor, accountability and proven procedures to a project of this scale on which the board could have reasonably relied for assurance of sound systems development. Given the apparent lack of software development experience among the Oxford staff, retention of experienced management consultants might fairly be viewed as a minimum requirement.

The time pressures imposed on the system development process due to the growth in membership in 1996 could also have reasonably suggested to the board that professional consulting help was vital. It is a common observation in the systems world that while one person can make a baby in nine months, it doesn't follow that nine people can make a baby in one month. Some things simply do take time to do well, especially adequate testing — which appears to have been lacking at Oxford. With more experienced help, it is at least plausible that the board would have been better informed of the requirements of a sound development process, the system's status and the company's performance as measured against those standards and the risks involved in speeding up too fast. Further, independent consultants might also have been more willing than insiders to alert senior management and the board to problems in the development process.

As discussed above, an HMO's information system is the source of information upon which much regulatory compliance depends. As a publicly traded company, Oxford was subject to Securities Exchange Commission (SEC) and NASDAQ requirements which call for timely disclosure of material facts regarding the

²²⁰Although the Market Conduct Report briefly refers to consultants *employed* by Oxford's Information Systems Department (*Market Conduct Report, supra* note 156, at 17), this reference appears to be to individuals hired to complement the existing staff, as opposed to management consultants. This interpretation is borne out in the phrasing of one of the corrective actions Oxford agreed to take: to *retain* an independent management consultant to evaluate the system. *Market Conduct Report, supra* note 156, at 17 (emphasis added).

²²¹*Auditors Feel Heat, supra* note 193.

²²²*Id.* (noting that in June, 1998, Oxford replaced KPMG with Ernst & Young as its independent accountants). *See also, Winslow & Paltrow, Ill-Managed Care, supra* note 137 (noting that the KPMG partners responsible for Oxford's audit team were reassigned following the revelations of Oct., 1997).

company's financial condition.²²³ Oxford was also subject to many federal and state insurance regulations governing operations, reporting and reserves. This additional burden on the information systems exposes the company to the risk of fines, suspension of trading or delisting by securities markets, exclusion from federal entitlement programs and being shut down by state insurance regulators. These factors add significantly to the risk assumed when a company embarks alone to develop and implement major systems.

Given every director's duty to understand the fundamentals of the business,²²⁴ it may be reasonable to expect the board to have recognized the types of problems the HMO might encounter during and following the time of the system implementation. The board had to have known the plan was growing at a feverish pace, that the high demand groups of Medicaid and Medicare were targeted areas of growth, and that the plan was embarking on strategic product initiatives — all of which would put added demands on the information system.

A widely used industry text, *The Managed Health Care Handbook*,²²⁵ devotes a chapter to common operational problems in managed health care plans.²²⁶ Oxford, at the time of the system development and implementation, was clearly experiencing two of these problems: uncontrolled growth and systems inability to manage the business.²²⁷ It is a reasonable argument that these factors alone should have been sufficient to alert the board to a need for close attention to the systems project on which so much depended. This attention is even more important, since the failure of any HMO's systems is a root cause of many other common problems: inaccurate IBNR calculations, failure to reconcile accounts receivable and membership, and failure to track medical costs and utilization correctly.²²⁸ This trifecta of problems formed the core of the plan's ultimate disaster.

In light of such risks, reasonable directors could be expected to ensure that the systems project was managed carefully by fully accountable and competent staff, that the board was kept apprised of the significant design and development milestones, that the project plan specifically addressed the key areas of business and compliance risk, and that the board would receive regular, meaningful and documented performance reports. In the absence of retained consultants, the board

²²³17 C.F.R. §§240.10b-5 (requiring full disclosure of material facts and prohibiting misleading statements in connection with the purchase or sale of securities). *See also*, Security Exchange Act Release No. 34- 8995 (1970) (calling for publicly held companies to make full and prompt disclosure of material facts regarding the company's financial condition; such disclosure is not limited to required periodic reporting). NASDAQ expressly incorporates the provisions of Rule 10b-5 in its requirements for listing securities in its market.

²²⁴*See Francis*, 432 A.2d 814, 821-22 (N.J. 1981).

²²⁵THE MANAGED CARE HANDBOOK, (Peter R. Kongstvedt, ed., 3d ed. 1996).

²²⁶Peter R. Kongstvedt, *Common Operational Problems in Managed Health Care Plans*, in THE MANAGED CARE HANDBOOK 622 (Peter R. Kongstvedt, ed. 3d ed. 1996).

²²⁷At this point in time it was the old system which was not able to support the business, not the new system.

²²⁸Kongstvedt, *supra* note 226, at 627-30.

would be expected to take additional steps to ensure that the staff with accountability for this project had the expertise to manage all the phases of the process.

C. Attention to Warning Signs of Trouble.

Once a new system is implemented, the effective functioning of the system and the information which it brings to light regarding the operation of the business must be continually monitored. For management and staff this monitoring is at a detailed level. For the board, this role is carried out at a much greater remove. Given this distance from the operational level, the board must rely on information from management. The key questions for the board in this situation include: What are the proper types of information which the board should review? What are the sources of this information? How does the board assure itself of the reliability of the information and the one who provides it? What are the indicators which the board should recognize as warning signs of potential problems?

Financial statements from internal sources and independent accountants are a chief source of information for directors. As noted above, Oxford's independent accountants found no problems with the company's systems prior to the Insurance Department investigation.²²⁹ In the absence of information to the contrary which would call into question the reliability of the accountant's reports, management and directors could have reasonably relied on this information. This being so, to the extent that the financial statements themselves showed red flags, Oxford's board was clearly on notice of problems with business operations. Three warnings were apparent from financial records as early as spring of 1997.

The trend of the financial bottom line for the eighteen months prior to October, 1997 was "picture perfect" with steadily rising profits and a constant medical loss ratio.²³⁰ But as is so often true, the devil is in the details. Oxford's quarterly statements showed unsettling changes in the company's financial position. Unpaid medical bills reached \$625 million by late 1996 and remained "stubbornly high."²³¹ Operating cash flow was negative starting in early 1997; it was to reach a nadir of negative \$107.3 million.²³² By the spring, premiums owed but uncollected - because accounts weren't being billed — amounted to some forty percent of revenue; this amount had doubled in the six months since the new system was installed in September 1996.²³³ All of these problems stemmed directly from a system which couldn't carry out basic functions: generating accurate bills, processing premiums, enrolling members and paying claims.

Should these kinds of anomalies have prompted the Oxford board, or any board, to inquire further? Were there other routine sources of information relating to the new system and operating performance available, such as might be generated by internal auditors? Was a board committee, such as the Audit Committee, delegated responsibility to oversee the system development more closely than the full board? If so, did this committee set its own agenda and request reporting from the internal

²²⁹Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

²³⁰Abelson, *Behind the Bleeding*, *supra* note 146.

²³¹Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

²³²Abelson, *Behind the Bleeding*, *supra* note 146.

²³³Winslow & Paltrow, *Ill-Managed Care*, *supra* note 138.

auditors or from management so as to assure its members that the performance of the system met the board's expectations?

The Oxford board presumably had other sources of information which could reasonably have prompted further inquiry into the conditions and performance of the information systems. When the volume of complaints from providers over delayed claims prompted New York's governor to order an investigation of the largest HMOs, it might have been reasonable for Oxford's board to initiate an inquiry of its own into the causes of and planned remedies for the claims backlogs. When the company began to issue lump-sum payments to providers as loans against future claims payment, an informed director, familiar with the fundamentals of the business, might have raised the question of the impact of the payments on the IBNR and required reporting. Finally, after months of poor system performance, with no noticeable improvements, a reasonable director might at least inquire as to the value of an independent consultant's assessment of the systems as a way to validate management's continued assertions that the system is almost fixed. Indeed this was one of the recommendations of Department to which Oxford belatedly agreed.

D. Application of the Gross Negligence Standard

As discussed previously, the vast majority of courts will apply the gross negligence standard when determining whether a corporation's board of directors met their duty of care. As to a decision to build an in-house house information system, a court's due care analysis will be guided by the business judgment rule. This rule gives rise to the presumption that, in the absence of fraud, self dealing or bad faith, directors are presumed to have reached a decision in good faith.²³⁴ Specifically, a court will "look for evidence as to whether the board has acted in a deliberate and knowledgeable way in identifying and exploring alternatives."²³⁵ The protective presumption can be rebutted where it can be shown that directors were not informed when making their decision in which case the directors may be found personally liable.

Courts will view certain factors as particularly relevant in assessing whether directors were adequately informed. These factors include extreme haste in the decisionmaking process where the circumstances of the decision do not indicate the need for speedy action; lack of board preparation as shown by the absence of, or inadequate time for the board to review in advance, meaningful and documented information supporting the reasons for and alternatives to the decision; and lack of questioning and involvement by the board to the extent that the board's action appears to be mere acquiescence to management recommendations.²³⁶

When reviewing the board's attentiveness to and oversight of the information system development and implementation once the decision is made, courts will look to see whether directors have "exercise[d] a good faith effort to be informed and ...

²³⁴Smith v. Van Gorkom, 488 A.2d 858, 872-873 (Del. 1985).

²³⁵Citron v. Fairchild Camera & Instrument Corp., 569 A.2d 53, 66 (Del. 1989).

²³⁶R. FRANKLIN BALOTTI & JESSE A. FINKELSTEIN, THE DELAWARE LAW OF CORPORATIONS AND BUSINESS ORGANIZATIONS, § 4.34, 4-224-29 (3d ed., 1997).

[have applied] appropriate judgment.²³⁷ Where directors are found to meet this standard, they will be “deemed to satisfy fully the duty of attention.”²³⁸

As a practical matter, conduct which fails to meet the measure of good faith must be egregious. “Only a sustained or systematic failure of the board to exercise oversight — such as an utter failure to attempt to assure a reasonable information and reporting system exists — will establish the lack of good faith that is a necessary condition to liability.”²³⁹ This standard is clearly “director-protective” in its qualifying language.²⁴⁰ Yet it also reflects the realistic limits on the ability of any board to assume operational responsibility for the ultimate success of the information system.

To determine whether the Oxford board met its duty of care in the decision to build its information system and the manner in which the board oversaw the development and implementation of the system, a court would be expected to scrutinize the process utilized by the board, the types and quality of information available and used by management and board, as well as the degree of informed and independent judgment used by the individual directors. Such an inquiry is wholly fact dependent and enormously detailed. Until the litigation against the Oxford directors has progressed and this level of information is publicly available, any suggestion as to whether or not the directors failed in their duty of care is purely speculative. However, the available information raises serious questions about the manner in which the board made this critical business decision.

E. Causation Analysis

In the event that a board of directors would be found to have breached its duty of care in the context of the decision to build and oversight of information systems, there remains the hurdle of proving the board’s conduct was the proximate cause of the losses to the corporation.

In the case of Oxford, causation could be particularly difficult prove because the company was not alone among HMOs in experiencing surprise losses in 1997. Managed care stocks as a whole dropped almost twelve percent that year.²⁴¹ One rating service found that fifty-seven percent of the nation’s HMOs ended the year in the red.²⁴² Industry leaders attributed the fall-off to rising medical costs and meager profit margins.²⁴³

Kaiser Permanente suffered its first-ever losses in 1997, for at least two of the same reasons as Oxford: difficulty forecasting rising health care costs and faster membership growth than the plan could handle.²⁴⁴ As late as November, 1997 Kaiser

²³⁷*In re Caremark*, 689 A.2d at 968.

²³⁸*Id.*

²³⁹*Id.* at 971.

²⁴⁰*Id.* at 967, 971.

²⁴¹Blecher, *Burned on the Street*, *supra* note 183.

²⁴²*Ratings firm says 57% of 506 HMOs in U.S. lost money last year*, BALT. SUN, Sept. 1, 1998, at 2C.

²⁴³Blecher, *Burned on the Street*, *supra* note 183.

²⁴⁴Freudenheim, *Kaiser HMO, Erring on Costs*, *supra* note 6.

was projecting a loss of fifty million dollars;²⁴⁵ the actual loss for the year proved to be \$270 million. Aetna/U.S. Healthcare, faced with care costs rising at fourteen percent, took a \$160 million charge in the third quarter of 1997 for unanticipated medical expenses.²⁴⁶

Like Oxford, a number of HMOs have found the Medicare HMO business a money loser. Aetna/U.S. Healthcare in September, 1998 announced it was leaving the Medicare HMO markets in six states and the District of Columbia because the government reimbursement rates rendered the program unprofitable.²⁴⁷ Prudential HealthCare has done the same.²⁴⁸

Against this backdrop of wide-spread industry losses and general failure to recognize the rising trend in medical costs, a court may have trouble tying Oxford's losses and drop in stock price to either Oxford's decision to build its own system or the board's lack of oversight. It might be argued that, had the system been functioning properly and providing prompt notice of cost trends, Oxford may have had the chance to change the cost trend through, e.g., targeted patient and provider education and increased attention to utilization review. Yet, the company's and the market's circumstances in 1997 make it unlikely that Oxford could have effected a significant cost turnaround on short notice.

The year long lock-in of premiums and time-consuming regulatory requirements for approval of rates would have prevented the company from raising prices promptly, the most effective means of countering higher costs. Much of the growth in costs was attributable to the new Medicare and Medicaid populations who were generally less familiar, and likely less compliant, with HMO rules. Although member education can be effective in reducing costs, it takes time for this effect to show up on the bottom line. In addition, efficient access to Medicare members may be a problem. An HMO can often utilize an employer's benefits or human resources staff to communicate with group members. Medicare members, in contrast, are individual enrollees, with no comparable intermediary through which the HMO can communicate efficiently. Finally, the success of provider education will be at least somewhat dependent on the quality of the relationship between the HMO and the provider community. Oxford had experienced claims payment problems under the old system; in addition, the company's financial results had for many years been stellar. Providers may not have been responsive to the company's efforts to minimize its losses by changing provider behavior or reimbursement.

Another factor in the causation analysis will be to separate out the specific effects of the information system from the general effects of the company's operating losses. The first big drop in Oxford's stock price occurred on the news that the plan was reporting its first ever quarterly loss. On October 27, 1997, the full extent of Oxford's systems disaster was not generally known. This information became public

²⁴⁵*Id.*

²⁴⁶Lucette Lagnado, *Personality Change: Old Line Aetna Adopts Managed-Care Tactics and Stirs a Backlash*, WALL ST. J., July 29, 1998, at A1, A6.

²⁴⁷M. William Salganik, *19,000 Elderly Must Find Other Coverage*, BALTIMORE SUN, Sept. 3, 1998, at 1D, 10D.

²⁴⁸M. William Salganik, *Optimum Choice Joins Rush from Maryland Medicare*, BALTIMORE SUN, Oct. 2, 1998, at 2C.

only later in 1997 and early 1998. While the systems were clearly implicated in the loss position of the company, it is arguable that even if the systems had been perfect, Oxford's first loss in eight years would still have sent the stock into a tailspin.

Even if the Oxford board was found to have breached its duty of care in failing to heed the various financial warning signals in late 1996 and early 1997, this conduct would probably not stand up to the cause-in-fact analysis. By the time the red flags should have been obvious to the board, in late 1996 and early 1997, the system was already in place and the damage largely done. It is highly unlikely that the system could have been fixed fast enough to have avoided the operational and stock losses given the lagging nature of HMO costs and the lingering quality of bad projections. Oxford's eventual decision to abandon its \$100 million investment in the system and seek alternative solutions suggests that even if the board had recognized the problems in a timely manner and demanded an emergency effort to fix the system the problems were simply too great to overcome in time to avoid the financial losses.

VI. CONCLUSION

It will be some time before Oxford's pending shareholder suits wend their way through the legal system and the details of the board's decisions and actions become known. As Delaware law will most likely govern the outcome, it is to be expected that the conduct of Oxford's directors will not be found to have risen to the level of gross negligence. No evidence of self-dealing or fraud by directors has been raised in the many media accounts or in the New York Insurance Department's Market Conduct Report. This leaves only the basis of lack of good faith on which to establish personal liability. A court will have to find that the directors failed utterly even to attempt to assure that the information system was effective; the *Caremark* good faith standard is "quite high" indeed.²⁴⁹ Given that management and the independent accountants appeared to have confidence in the company's financial statements up until October, 1997, the directors may find additional protection in their reasonable reliance on these documents as these statements, at the time, suggested that the system's problems did not affect the bottom line.

None of the parties to the pending shareholder litigation will be pleased with this outcome. Such a conclusion will obviously disappoint the Oxford shareholders who bore enormous losses due, in large part, to the systems disaster. The operating losses in 1997 and 1998 and the total waste of the investment in the failed system have deeply eroded the value of the company. Although the cost of litigation will be borne by the company's D&O insurance, Oxford will pay in the end, in higher insurance premiums.

The directors themselves will find little solace in vindication. They will pay a great personal price even in winning. The legal process will examine every step in their decisionmaking and oversight over the period from 1993 through 1997. While a court may spare the directors the extreme label of gross negligence, the public and the investment community will draw their own conclusions about the competence and attentiveness of Oxford's directors. The reputation of the individual directors will be tainted for a long time to come.

The ultimate beneficiaries of Oxford's downfall may well be the shareholders and directors of other HMOs and health insurers for whom Oxford's experience will

²⁴⁹*In re Caremark*, 689 A.2d at 971.

serve as a cautionary tale. For those companies embarking on major information systems initiatives in the future, the lessons from Oxford should result in far greater rigor in decisionmaking than appears to have occurred in Oxford's boardroom. It is to be hoped that other directors will recognize the need for competence, sophistication and pragmatism so that they can better meet their duty of attention in oversight of information systems. This is as it should be, given the strategic importance of information systems in HMOs and health insurance today.

The business and compliance pressures facing HMOs are enormous: the intensely competitive environment, the rapid rate of change within the industry, the constant tension between enhancing choice while reducing costs and the ever growing complexity of state and federal government requirements. Not one of these challenges can be met without effective information systems. It is a question of survival, let alone success. The best interests of the HMO corporation require an information system which can carry out its crucial business functions. This business imperative, if not the legal imperative, requires more of a director than merely the absence of bad faith to meet her duty of care in oversight of the HMO's information systems.

ABSTRACT

This paper examines the legal and strategic issues raised by the use of information systems in health maintenance organizations (HMOs) and other managed care organizations. Given the critical nature of information systems to an HMO's business success and regulatory compliance, the large financial investment HMOs make in their systems, and the widely publicized concerns over the year 2000 "millennium bug" problem, information systems are appropriately a matter of concern to an HMO's board of directors.

The recent experience of Oxford Health Plans, Inc. offers a case study in the apparent failure of the directors to monitor adequately the in-house development of an information system. The systems disaster which this corporation suffered in 1997 led to a dramatic drop in stock price, from which the company has yet to recover, as well as intense scrutiny by state and federal regulators and countless shareholder derivative actions against the directors.

Corporate directors are subject to the fiduciary duty of care. Despite statutes in some states requiring directors to act prudently, state courts almost always apply the standard of gross negligence. As a result, even when directors act without due deliberation in their decision, it is rare that a court will find them to have failed in their duty of care. The business and regulatory community may find otherwise, however, when directors fail to evaluate information systems options carefully and the business suffers as a result.