SUBJECT: Managed care entity liability for certain health care decisions

COMMITTEE: Insurance — committee substitute recommended

VOTE: 9 ayes — Smithee, Van de Putte, Averitt, Bonnen, Burnam, Eiland, G. Lewis, Olivo, Wise

0 nays

SENATE VOTE: On final passage, March 17 — 28-3 (Duncan, Fraser, Ogden)

WITNESSES: For — Harold Freeman, Texas Medical Association

Against — Jeff Kloster, Texas HMO Association; William Phillips, Texas Association of Business and Chambers of Commerce and Texas Business Group on Health; Janet Stokes, Texas Association of Health Underwriters; Jay Thompson, Will Davis and Michael Pollard, Texas Association of Life & Health Insurers; Robert Kamm, Texas Association of Business and Chambers of Commerce; David Kester

On — Rhonda Myron, Texas Department of Insurance

BACKGROUND: "Managed care" encompasses health care financing and delivery in health benefit plans that govern both the use and cost of health care services. The best known type is the health maintenance organization, or HMO. Another common arrangement is the preferred provider organization, or PPO, which is similar to traditional indemnity insurance except that consumers are offered a financial incentive for seeking care from a provider who is under contract. A point-of-service (POS) plan is a hybrid managed care plan that combines an HMO with a PPO or a major-medical insurance policy.

Health insurance plans are required to conform with utilization review (UR) requirements that govern the actions surrounding the determination of medical necessity of requested or rendered services and include grievance and appeals processes. HMOs are exempt from most UR requirements but are required to establish and maintain a complaint process for the resolution of enrollee complaints.

DIGEST:

CSSB 386 would amend the Civil Practices and Remedies Code to hold health insurance carriers, HMOs and other managed care entities liable for failure to exercise ordinary care when making health treatment decisions and would amend the Insurance Code to create standards for actions by utilization review and independent review organizations.

The bill would take effect September 1, 1997, and would apply to causes of action that accrue, and to adverse determinations made, on or after that date.

"Adverse determination" would be defined as a determination by an HMO or UR agent that the health care services furnished or proposed to be furnished to an enrollee or insured were not medically necessary or appropriate.

Duty and liability. A health insurance carrier, HMO or other managed care entity would have the duty to exercise ordinary care when making health care treatment decisions and would be liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care. Workers' compensation insurance coverage would be specifically exempt from this duty and liability.

"Ordinary care" would be defined to mean that degree of care of ordinary prudence that another HMO, insurer, managed care entity, or someone who is an employee, agent, ostensible agent or representative of such entities would use under same or similar circumstances.

"Managed care entity" would be defined as any entity, other than employers and licensed pharmacies, that delivers, administers or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization or costs and prices of such services.

"Health care treatment decision" would be defined to mean a determination made when medical services are actually provided by the health care plan and a decision that affects the quality of the diagnosis, care or treatment provided to the plan's insureds or enrollees.

The insurer, HMO or managed care entity also would be liable for damages for harm to an insured or enrollee proximately caused by the health care

treatment decisions made by its employees, agents, ostensible agents or representatives.

An insurer, HMO or managed care entity also could not:

- remove a physician or health care provider from its plan or refuse to renew the provider for advocating on behalf of an enrollee appropriate and medically necessary care; or
- enter into a contract with a physician, hospital or other provider that would indemnify or hold harmless the HMO, insurer or managed care entity for acts or conduct. Such a contract would be considered void.

Cause of action. In order to maintain a cause of action, a person would first have had to exhaust the entity's utilization review and appeals processes or give written notice of the claim of harm to the insurer, HMO or managed care entity and agree to submit the claim to a review by an independent review organization (IRO).

A claim could not be dismissed by the court if the utilization review or notification/IRO requirements were not met prior to filing a claim. However, the court could order the parties to submit to an independent review, mediation or nonbinding alternative for an abatement period not to exceed 30 days; such an action would be the sole remedy to a party's complaint of an enrollee's failure to comply with utilization review or notification/IRO requirements. Such an action also could not be used as evidence in any action between an enrollee and a managed care entity.

Enrollees would not have to comply with IRO requirements or abatement requirements if they in good faith filed a pleading alleging that harm had already occurred to the enrollee and the review would not be beneficial.

Enrollees and insureds would be specifically authorized to pursue other remedies, such as injunctive relief, if requirements for utilization review would place their health in serious jeopardy.

IRO standards. The commissioner of insurance would be responsible for the promulgation of rules and standards governing the certification, selection and operation of IROs, designate IROs that meet state standards and oversee IROs for compliance, and could charge payors fees as necessary to fund IRO

operations.

Standards would have to include that each IRO make determinations not later than the 15th day after the date the IRO received all the necessary information or by the 20th day the IRO received the request for determination, or in five days and eight days respectively for life-threatening situations.

To be certified, an IRO would have to annually submit required information to the commissioner, including the name of each owner of more than five percent of any stock and the name and biographical sketch of each director, officer and executive and their relationships with health benefit plans. An IRO could not be a subsidiary of, or in any way controlled by, a payor or a professional association of payors.

An IRO could not be liable for damages arising from a determination it made, except for acts or omissions made in bad faith or that involve gross negligence.

Utilization review-related requirements. Parties whose appeal of an adverse determination was denied by a UR agent or HMO could seek review of the determination by an IRO. Utilization review agents and HMOs would have to notify parties appealing the utilization review or HMO decision of their rights to seek review by an IRO, provide necessary records to the IRO, comply with the IRO's determination, and pay for the independent review.

An enrollee with a life-threatening condition would be entitled to an immediate appeal of an adverse determination to an IRO without complying with further UR or HMO internal review processes.

SUPPORTERS SAY:

CSSB 386 would ensure that managed care organizations are held accountable for health care treatment decisions that affect the quality of diagnosis and care of enrollees. It would provide two recourses that would allow an impartial review of claims and impose penalties for harm caused by an entity's failure to exercise care. The bill would protect the rendering of health care services for thousands of Texans. An estimated 12 percent of all Texans are enrolled in a managed care health plan, and the number of enrollees has grown by almost 65 percent since 1992.

This bill would not increase costs because it would not force managed care entities to practice "defensive medicine," and would not increase the liability of *responsible* providers; it would simply ensure that patient care and treatment are given the same weight as cost containment when decisions to pay for care are being made. CSSB 386 acknowledges the cost-containment benefits of managed care, but it would ensure that enrollees obtain the care that they are paying for and require quality to be a factor just as it is in the selling and purchase of any product on the market. Managed care entities would not be subject to additional liability or costs if they are living up to policy agreements and providing quality and necessary care.

Costs also would not increase due to the competitive health care marketplace. Managed care entities would not be able to pass all liability costs, if any, onto employers and consumers and keep their plans priced competitively affordable. Also, those managed care entities who become subject to a lot of lawsuits probably were not offering quality care to enrollees and soon would no longer be viewed as a desirable health benefit option by employers.

CSSB 386 would not create a new cause of action, but remove a commonly used defense that prevents managed care entities from being held accountable for their actions. Many HMOs hide behind protections under statutory prohibitions on the corporate practice of medicine, which, because it prohibits the practice of medicine by anyone other than doctors, removes from liability *organizations* that may also be in the business of making medical decisions. At least one court has already excluded an HMO from liability for malpractice under this protection. However, doctors can be sued for the care they provide, even if the managed care organization makes decisions about that care. This bill would just make all entities accountable for their decision making.

CSSB 386 would not be dismantling tort reforms enacted last session, but extending those reforms to include managed care entities. Doctors are already liable for bad outcomes, and CSSB 386 would extend the concepts of joint and several liability and proportional liability to target HMO accountability and make them liable proportionate to their policy decisions.

The coupling of tort liability on managed care entities with an independent review organization remedy would provide the necessary "hammer" to make sure decisions are made well and compliance with complaint review and appeals processes are maintained, especially for patients with life-threatening conditions who depend on rapid responses to their appeals. CSSB 386 would establish a dual system under which needed patient care would be expeditiously reviewed by an IRO and would prevent many bad outcomes before they occur. The court system would only be used to evaluate harm and punitive damages. Problems that occurred at the Kaiser-Permanente HMO, as reported by the Texas Department of Insurance, would have probably been prevented or quickly corrected if the IRO and tort liability reforms in CSSB 386 had been in place.

"Managed care entity" would be appropriately defined to include all providers who make health care treatment decisions. Even something as "simple" as pre-certification for a medical procedure can have a devastating effect on patients if needed medical care is denied.

Employers would not be made liable under this bill. CSSB 386 would clearly recognize that self-insured employers do not practice medicine; they simply buy health care benefits and monitor their use. Employers would be specifically excluded from the definition of managed care entity.

OPPONENTS SAY:

CSSB 386 would dramatically increase the cost of health care by increasing the liability on *all* health benefit plan providers, not just HMOs, and therefore increasing the delivery of unnecessary care and the amount of unnecessary litigation. It also would undermine UR and pre-authorization controls that are essential to containing runaway health care costs. Increased costs would limit the affordability and availability of health coverage for all Texans and could narrow the scope of available benefits by making POS plans too risky to offer.

The Congressional Budget Office has estimated that for every one percent increase in premiums, 200,000 people lose health care coverage. Health benefit costs could increase three to five percent, which for HMOs would mean an increase of about $183 million per year and another $417 million for PPOs and POS plans. Some of the cost increases would be due to the increased practice of "defensive medicine" that causes providers to render

unnecessary care to protect against lawsuits. Other cost increases would be related to the purchase of medical liability insurance by managed care entities to protect their risks. By gutting cost controls and raising the cost of delivering services, CSSB 386 also would eliminate most of the cost-savings and cost-efficiencies the state had hoped to realize when shifting Medicaid coverage into managed care programs.

CSSB 386 would cause an avalanche of suits that would benefit very few individuals and would hold managed care entities inappropriately to a medical malpractice standard. CSSB 386 would enact a new cause of action that would negate many of the tort reform measures enacted last session, and would make Texas the only state to establish such a broad provision. HMOs can be sued already without this bill, and some prominent trial lawyers have said a failure to enact CSSB 386 would not hinder their success. There also are plenty of other remedies in place to help consumers get the treatment they need, and many regulatory protections enacted during the interim are being proposed as law this session.

The court system is not the appropriate or best place to protect patient health care or to punish inappropriate behavior. Increased liability has not been found to increase quality; less than half of every liability dollar goes to anyone who is injured, most of the money covers lawyers' fees and court costs. Litigation can take years to resolve a complaint and can result in seemingly haphazard decisions in determining damages. CSSB 386 would increase litigation, not physician or provider responsibility, which could hinder physician group competition in the managed care field.

OTHER OPPONENTS SAY:

CSSB 386 would go too far. An IRO could be a useful tool in settling disputes quickly and impartially, but its effectiveness does not require a new tort as accompaniment. Florida Gov. Lawton Chiles vetoed a similar tort proposal last year, but Florida enacted a grievance board where complaints against HMOs are adjudicated by a broad panel. Texas should at the very least enact this bill in stages, by establishing IROs this session, and new tort actions, if needed, next session.

Managed care entities would be defined so broadly as to make liable many health care entities under the new tort, such as physician-hospital organizations and physician group practices, who contract to arrange or

provide a network of providers but who do not make health care treatment decisions. Indemnification plans and fee-for-service contracts also should be specifically excluded from the definition of managed care entity.

Managed care entities also would be held liable, as ostensible agents, for the decisions of non-network and POS physicians and other providers with whom they contract or reimburse but do not control through credentialling mechanisms or participation requirements.

Liability for managed care entities also would be too broad. Health care treatment decisions subject to liability would include more than just the denial of coverage by the HMO or insurer; it would include the types of services delivered and how those services were delivered — actions related to the skill and judgment of the doctor and not of the managed care entity.

The use of the standard "appropriate and medically necessary" is too broad and would not be consistent with the contractural definition of medical necessity as used in most health insurance policies. Medically necessity relates to what the plan will pay for, unlike "appropriate and medically necessary," which relates to whether or not services are needed.

Because the bill does not address the framework of existing medical malpractice claims, the bill would create possibilities for "double recovery" for patients for the same event. Also, IRO decisions should be allowed to be used as evidence in court; otherwise, making the parties go through the process would be nothing but a time consuming and costly pre-court exercise.

Although specifically excluded from the definition of managed care entity, employers could still be liable under this bill because the protections granted self-insured employers under federal law are not firmly established and case law is still evolving as it pertains to managed care entities. By mixing contractural rights with tort rights, CSSB 386 would remove employers' authority to design health benefit coverages that meet cost concerns as well as concerns of value.

NOTES: The committee substitute changed the Senate engrossed version by adding provisions relating to independent review organizations and by revising the utilization review, evidence of coverage, and HMO complaint process requirements.