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FEDERAL AND STATE LEGISLATION AFFECTING MANAGED CARE LIABILITY

Thomas J. Bond, Esq.⁽¹⁾
(512) 499-6200

Introduction

The Texas legislature recently enacted the nation's first statutory cause of action to hold health insurers and managed care entities liable for health care treatment decisions. The Texas legislature is not the only legislative body currently wrestling with managed care liability issues, however. Since the enactment of Senate Bill 386, at least one state has removed a statutory shield from medical malpractice claims which health maintenance organizations once enjoyed, and several other states are considering similar bills. In California and New York, bills imposing tort liability on managed care entities have passed one legislative house. In California, where more than 100 managed care bills representing a mosaic of approaches are moving steadily through the legislature, Governor Pete Wilson has charged the atmosphere by announcing that he will veto all managed care legislation until the state's special managed care task force can formulate a comprehensive, coordinated approach to the issue.

The United States Congress is weighing in as well. One bill pending in Congress would create a federal cause of action against HMOs that seek to cut costs by denying covered benefits in a clinically or medically inappropriate manner. Another federal bill would amend ERISA to provide that state causes of action like that created by SB 386 are not pre-empted by federal law.

President Clinton has charged a Presidential Advisory Commission with the duty of formulating a Consumer Bill of Rights in the health care industry. It is not certain whether the Commission will directly address the issue of managed care liability, however.

Managed care liability is at the forefront of public policy debate in the nation's legislatures and executive branches. While Texas' SB 386 was the first piece of legislation to successfully navigate the legislative process, it represents only one type of the initiatives that are appearing across the country.

State Legislation

A. Texas

On May 12, 1997, the Texas Senate overwhelmingly concurred in house amendments, and by a vote of 25-5 enacted Senate Bill 386, making Texas the first state in the nation to allow patients to sue managed care entities for negligently denying or delaying treatment.⁽²⁾

Senator David Sibley, an influential Republican from Waco and crusader for tort reform, authored the bill which becomes effective September 1, 1997.⁽³⁾ The Texas Medical Association strongly supported Sibley's effort to pass SB 386 while the

effective September 1, 1997.⁽³⁾ The Texas Medical Association strongly supported Sibley's effort to pass SB 386 while the managed care industry, the Texas Association of Business and Chambers of Commerce, and other employer groups worked to defeat the measure.

Senate Bill 386 adds Chapter 88 to the Texas Civil Practice and Remedies Code. The statute creates a cause of action that allows insureds and enrollees to sue health insurance carriers, HMOs or other managed care entities for failing to exercise ordinary care when making "health care treatment decisions."⁽⁴⁾ A "health care treatment decision" is defined as "a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care, or treatment provided to the plan's insureds or enrollees."⁽⁵⁾ Defense lawyers for the managed care industry are likely to argue that the inclusion of the phrase, "when medical services are actually provided by the health care plan," will create difficult questions of fact for plaintiffs seeking to show that an HMO "actually provided" the medical services at issue.⁽⁶⁾ The language of SB 386 expressly disclaims an intent, however, to create an obligation on the part of managed care entities to provide treatments not covered by their plans.⁽⁷⁾

In the context of a health insurance carrier, HMO or other managed care entity, the new law defines "ordinary care" as "that degree of care that a health insurance carrier, health maintenance organization, or managed care entity or ordinary prudence would use under the same or similar circumstances."⁽⁸⁾ The bill also permits managed care entities to be held liable for damages when harm to an insured or enrollee is proximately caused by the health care treatment decisions of its employees, agents, ostensible agents or representatives.⁽⁹⁾ In this context, "ordinary care" is defined as "that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances."⁽¹⁰⁾ Although the scope of agents, ostensible agents, and representatives whose actions may create liability for a managed care entity will have to be decided through litigation, SB 386 specifies that the mere appearance of a person's name on a plan's list of approved providers is not alone sufficient to establish that person's status as the employee, agent or ostensible agent of the plan.⁽¹¹⁾

The statute applies to health insurance carriers, health maintenance organizations or "other managed care entit[ies]."⁽¹²⁾ A health insurance carrier is defined as an authorized insurance company that issues policies of accident and sickness insurance under Article 3.70-1 of the Texas Insurance Code.⁽¹³⁾ A health maintenance organization is an organization licensed under the Texas HMO Act (Chapter 20A, Vernon's Texas Insurance Code).⁽¹⁴⁾ A "managed care entity" is defined broadly. The term refers to "any entity which 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 to a defined enrollee population, but does not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by the State Board of Pharmacy."⁽¹⁵⁾ The new law is expressly not applicable to workers' compensation insurance coverage.⁽¹⁶⁾

The bill seeks to eliminate the corporate practice of medicine defense which has traditionally been used to shield HMOs from medical malpractice claims.⁽¹⁷⁾ Under the bill, a managed care entity will not be permitted to assert as a defense that its legal inability to practice medicine means that it could not be deemed to have made a medical or health care treatment decision that affected the delivery of medical treatment.

The statute prohibits managed care entities from removing physicians from their plans for advocating on behalf of an enrollee for "appropriate and medically necessary health care for the enrollee," and prohibits contracts whereby health care providers indemnify or hold harmless the managed care entity for the acts or omissions of the managed care entity.⁽¹⁸⁾

The bill appears to require that, before maintaining a cause of action, an enrollee must either exhaust the appeals and review process applicable under the utilization review procedures of the managed care entity or give written notice of the claim to the managed care entity and agree to submit to an independent review.⁽¹⁹⁾ Upon receiving notice of a claim, the managed care entity has 14 days to request an independent review.⁽²⁰⁾ These requirements are illusory for two reasons, however. First, even if an enrollee fails to exhaust the utilization review requirements of the managed care entity but pushes ahead to file a lawsuit under SB 386, the court cannot dismiss the claim on that basis.⁽²¹⁾ Rather, the court has the discretion to order the parties to submit either to an independent review or mediation or other non-binding alternative dispute resolution procedures.⁽²²⁾ Second, an enrollee is not required to submit his or her complaint to an independent review if the enrollee's complaint alleges that harm attributable to the managed care entity has already occurred and that the review would not be beneficial to the enrollee.⁽²³⁾

Texas Department of Insurance Regulations

Section 8 of SB 386 adds Article 21.58C to the Insurance Code, which requires the Insurance Commissioner to promulgate standards for independent review organizations ("IROs"). The Commissioner must establish rules for the certification, selection and operation of IROs and establish mechanisms for the oversight of IROs. The Texas Department of Insurance (the "Department") has recently proposed regulations to establish the standards and rules for IRO certification, selection, and operation in Texas.⁽²⁴⁾ The Department held a public hearing in Austin on August 13, 1997, to hear public comment on the proposed regulations.

The regulations address the following issues:

Certification of IROs. Under the proposed regulations, each prospective IRO must submit to the Department an application for certification, including a summary of its review plan, a copy of its policy regarding the confidentiality of medical records, and a copy of its bylaws. Publicly-held IROs must provide the name of any stockholder or owner of more than five percent of stock or options. All IROs must present the Department with a chart showing the internal organizational structure of the management and administrative staff and a chart showing its contractual arrangements. The IRO must disclose in its application the name of any holder of bonds or notes over \$100,000; the name and type of affiliated businesses with a chart illustrating the affiliation; biographical information about officers, directors and staff, which must include any relationship those individuals have with HMOs, insurance companies, utilization review agents or providers; and, a list of currently outstanding loans or contracts to provide services between the applicant and affiliates. The application must also disclose the compensation arrangements it has established or plans to establish with physicians and the percentage of the applicant's revenues that are anticipated to be derived from independent reviews. The Department must review the applications and notify each applicant in writing whether its application is certified or denied. Applicants will be given 30 days to correct omissions and deficiencies. The Commissioner is authorized to conduct an on-site qualifying examination of an applicant as a component of certification as an IRO.

Annual Renewal of Certification. The IRO must apply for renewal of its certification every year. If a completed renewal form and its required attachments are not received prior to the anniversary date, the certification automatically expires, and the IRO must complete and submit a new application.

Standards for Operation of IROs. An IRO's independent review plan must be implemented in accordance with standards developed in consultation with appropriate health care providers and reviewed and approved by a physician. The plan must include, in writing, reviewing procedures including time frames and procedures for notifying parties of its decisions. Each IRO must be under the direction of a physician currently licensed and in good standing to practice medicine by a state licensing agency in the United States. The IRO must maintain written screening criteria that are objective, clinically valid and flexible. It must also maintain review procedures that are evaluated and updated with appropriate involvement from physicians and other health care providers. All determinations of medical necessity must be made by physicians or dentists. The IRO's medical personnel must be trained, qualified and, if applicable, currently licensed or certified.

The proposed regulations also include provisions intended to prohibit conflicts of interest from influencing the review process. A person that is a subsidiary of, owned or controlled by a payor or trade or professional association of payors is not eligible to be certified as an independent review organization. IROs cannot establish a compensation scheme which would directly or indirectly effect an independent review decision.

In order to streamline the IRO process, a provider is allowed to designate an agent to whom the IRO should approach for information and records, but if the agent causes delay, the IRO must contact the doctor directly. The IRO cannot contact the patient or a provider in an unnecessarily or unreasonably repetitive way. The IRO must notify the Department within 24 hours of receipt of information regarding an independent review from the requesting utilization review agent that such documents have been delivered and the date of such delivery. The IRO must notify parties of its decisions within specified time limits. The proposed regulations also establish a method for random assignment of cases to IROs. Assignment of a case to an IRO will go to the first IRO on the Department's IRO list that does not have a conflict of interest. The Department is charged with the duty of screening for potential conflicts of interest. Upon being assigned to an independent review, an IRO moves to the bottom of the list for purposes of future assignments.

Standards for Confidentiality of Medical Records. Under the proposed regulations, IROs are required to preserve the confidentiality of individual medical records and other personal or proprietary information. When an IRO contacts a

confidentiality of individual medical records and other personal or proprietary information. When an IRO contacts a utilization review agent, a doctor's office or hospital, the IRO must provide its certification number and the caller's name and professional qualifications. Additionally, the IRO's review plan must specify the procedures it has in place to assure confidentiality and compliance with state and federal laws pertaining to confidentiality. An IRO must retain for at least two years information relating to a case in which an adverse decision was made, or information relating to a case which may be reopened. Any confidential patient information which is no longer needed must be disposed of in a manner which ensures complete destruction of the information.

Ongoing Oversight By the Department. The Department must investigate and respond to complaints that allege violations of these provisions, and the Department is authorized to make examinations concerning the quality, availability and accessibility of independent review services as often as is deemed necessary. A representative of the Commissioner may examine the administrative offices of any branch office of each IRO annually, or as frequently as necessary, for the purpose of reviewing the books and operations of the IRO. If the Department believes an IRO is in violation of the regulations, the Department may further investigate and compel production of documents. If the IRO is found to have violated any provision, the Commissioner may impose sanctions under Insurance Code, Article 1.10; issue a cease and desist order under the Insurance Code Article 1.10A; and/or assess administrative penalties under the Insurance Code, Article 1.10E.

Administration of Fee Structure. The Commissioner is required to establish, administer, and enforce the collection of fees to fund the operations of IROs. A four-tier fee structure has been proposed. Independent reviews in certain specialties, including cardiovascular diseases, gastroenterology and endocrinology are "Tier One" reviews and are conducted for a fee of \$350. A "Tier Two" review costs \$300 and pertains to reviews in other types of medical specialties and any subspecialties thereof. Reviews in the specialties of podiatry, optometry, dental, and any subspecialties thereof, are in "Tier 3" and cost \$200. The fourth tier consists of reviews in audiology, speech-language pathology, master social work, dietetics, professional counseling, psychology, occupational therapy, physical therapy, marriage and family therapy, chemical dependency counseling and any subspecialties thereof and requires payment of a \$150 fee. These fees are paid by the utilization review agents, which may recover the cost from the payors.

Legal Challenge to SB 386

On June 16, 1997, Aetna Health Plans of Texas, Inc. ("Aetna") filed suit against the Texas Department of Insurance and Insurance Commissioner Elton Bomer in the U.S. District Court, Southern District of Texas, asserting that the new law enacted by SB 386 is preempted by ERISA and the Federal Employees Health Benefit Act.⁽²⁵⁾ Aetna claims that ERISA preempts the new law because SB 386 relates to an employee benefit plan and is an "improper extension of state law into an area reserved for Congress."⁽²⁶⁾ According to the complaint, SB 386 impermissibly alters the contractual relationships between HMOs and physicians, turning what was an independent contractor arrangement into an agency or ostensible agency relationship and redefining contractual terms such as "appropriate and medically necessary."⁽²⁷⁾ Aetna also asserts that Congress, in passing the Federal Employees Health Benefit Act, intended to provide "comprehensive uniform benefits to government employees."⁽²⁸⁾ Aetna claims that SB 386 stands as an obstacle to national uniformity.⁽²⁹⁾

B. Legislation from Other States

The idea to address perceived problems in the delivery of health care through managed care entities is not unique to Texas. Subsequent to the Texas legislature's groundbreaking enactment, Missouri passed a law that imposes numerous restrictions on HMOs and removes a statutory provision that had been used to shield HMOs from medical malpractice suits.⁽³⁰⁾ The New York Assembly has overwhelmingly passed a bill that would make HMOs liable for damages caused by wrongful denial of care or payment for care.⁽³¹⁾ The bill awaits consideration by the state senate. In California, more than 100 bills regulating or imposing liability upon HMOs are in the legislative pipeline. However, the dizzying rate at which these bills have been advancing through the legislative process has recently been halted by Governor Pete Wilson's threat to veto "piecemeal" legislation until a commission can study the issue and formulate a comprehensive approach to managed care reform.

1. Missouri

On May 14, 1997, the Missouri House of Representatives approved a measure which will allow medical malpractice claims against HMOs, ban "gag clauses," and impose other rules on managed care plans.⁽³²⁾ The House passed House Bill 335, authored by Representative Tim Harlan, 140-15 after a 33-1 vote in the Senate, and the Governor approved the bill on June 25, 1997.⁽³³⁾

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Before HB 335, managed care entities were statutorily exempt from Missouri's medical malpractice laws because they were not deemed to be practicing medicine.⁽³⁴⁾ HB 335 added HMOs to the list of those entities which "practice medicine" and imposed a variety of other requirements upon HMOs.⁽³⁵⁾ Unlike the Texas law, the Missouri provision does not create a new cause of action or a new standard of care.⁽³⁶⁾ It merely removes the statutory shield which once protected HMOs from being sued for medical malpractice.⁽³⁷⁾

Among the other requirements imposed on HMOs is a prohibition on so-called "gag clauses." Under the Missouri law, an HMO is prohibited from restricting providers from disclosing to enrollees any information which the provider deems appropriate regarding the nature of treatment, risk of treatment or alternatives to treatment, availability of other therapy, the decision of any plan to authorize or deny services, or the process that the plan uses to authorize or deny benefits.⁽³⁸⁾

HMOs are required under the new law to maintain a network of providers that is large and diverse enough to provide its enrollees with access to all services without unreasonable delay.⁽³⁹⁾ Furthermore, enrollees must not be required to travel long distances or wait long periods for an appointment.⁽⁴⁰⁾⁽⁴¹⁾ If the HMO determines that its network does not include a provider who is capable of handling an enrollee's particular health care need, the HMO must refer the enrollee to a non-participating provider at a cost no greater than what the enrollee would otherwise pay for services received within the network.⁽⁴²⁾ The HMO is also required to allow an enrollee who needs ongoing care from a specialist to receive a standing referral from a primary care provider.⁽⁴³⁾ Finally, the law requires HMOs to permit female enrollees to see a participating obstetrician/gynecologist once a year without a referral from their primary care providers.⁽⁴⁴⁾

The bill's supporters considered, but ultimately dropped a provision which would have prohibited HMOs and providers from entering into contracts by which the provider agrees to hold harmless or indemnify the HMO.⁽⁴⁵⁾

2. California

In the California state legislature, approximately 100 bills regulating or imposing liability on managed care organizations are working their way through the legislative process, many of which are winning broad bipartisan support.⁽⁴⁶⁾ However, on August 4, 1997, Governor Wilson rejected what he called a "piecemeal" approach to managed care reform and vetoed a wildly popular measure that would have allowed female HMO members direct access to gynecologists.⁽⁴⁷⁾ The governor asked legislators to shelve all legislation until a report is issued by Wilson's Managed Health Care Improvement Task Force and promised to veto virtually every other managed care bill that reached his desk before the report, due out in January, is issued.⁽⁴⁸⁾ In a statement accompanying his veto, Governor Wilson said, "the prudent course of action for the Legislature would be to take a five-month hiatus from uncoordinated, reactive, piecemeal decisions."⁽⁴⁹⁾ The Governor stated that deferring to the commission would foster "comprehensive and coherent recommendations and policy guidance on the key, overarching policy questions raised by managed care."⁽⁵⁰⁾ According to Senate President Pro Tem Bill Lockyer, however, "The governor is using the task force as a fig leaf to cover his intense love for the insurance industry."⁽⁵¹⁾

Editorials from the state's largest newspaper, the Los Angeles Times, express favor for the governor's approach of rejecting a "piecemeal" approach but also express the belief that the governor should allow two bills currently in the legislature to be enacted.⁽⁵²⁾ The Times endorses enactment of SB 324, which would require that medical directors of HMOs, who decide on the medical necessity of medical care, be licensed to practice medicine, and of AB 536, which would require health plans to make available written copies of the criteria the plans use in deciding whether to authorize or deny care.⁽⁵³⁾

The approaches to reform taken by the California legislature vary. Pending legislation includes the following, for example:

a. SB 977

Before the Texas legislature passed SB 386, California State Senator Steve Peace was pushing a bill that would have established legislatively that HMOs practice medicine.⁽⁵⁴⁾ The bill would have required that individuals making coverage decisions obtain a state license to practice medicine, and would have subjected these individuals to personal medical malpractice liability.⁽⁵⁵⁾ However, when Texas passed SB 386, Senator Peace amended his bill to adopt the Texas approach of creating and imposing on HMOs a separate duty of ordinary care as a new and distinct cause of action.⁽⁵⁶⁾

creating and imposing on HMOs a separate duty of ordinary care as a new and distinct cause of action.⁽⁵⁶⁾

Introduced on February 27, 1997, Senator Peace's new bill, SB 977, states that its purpose is "to ensure that physicians, not the health care service plan, are in charge of patient care."⁽⁵⁷⁾ It provides that HMOs owe their enrollees a duty of ordinary care when making "health care treatment decisions" and are liable for damages for harm to an enrollee proximately caused by the HMO's failure to exercise ordinary care.⁽⁵⁸⁾ Unlike the Texas law, the California bill does not define "ordinary care." A "health care treatment decision" is defined in the bill, however, as "a determination made when a health care service plan arranges for medical services or a decision by the health care service plan that affects the quality of the diagnosis, care or treatment provided to enrollees of the plan."⁽⁵⁹⁾ By omission, the bill does not establish that HMOs are engaged in the practice of medicine and, therefore, California's caps on medical malpractice damages would not apply to causes of action brought pursuant to this bill.⁽⁶⁰⁾

California SB 977 is substantively equivalent to Senator Sibley's bill. The California bill's sponsors found the SB 386 approach attractive because a distinct cause of action would avert confusion over whether medical malpractice damages applied and because the Texas bill had successfully navigated the legislative process in a large state.⁽⁶¹⁾ Like Texas's SB 386, SB 977 contains a defense against liability if: (a) neither the health plan nor any employee, agent, ostensible agent or representative controlled, influenced, delayed or participated in the health care treatment decision *and* (b) the health plan did not deny or delay payment for any treatment prescribed or recommended by a provider to the enrollee.⁽⁶²⁾ It also requires a plaintiff to exhaust the health plan's appeals process before bringing suit unless harm has already occurred, the appeal process would place the health of the enrollee in serious jeopardy, or the review would not benefit the enrollee.⁽⁶³⁾ The bill does not create any liability on the part of an employer who purchases coverage or assumes risk on behalf of its employees.⁽⁶⁴⁾

SB 977 passed the California Senate by a vote of 21-15 on June 3, 1997, and it is expected to pass the State Assembly. The California Medical Association has indicated that the bill is consistent with its position that managed care entities should assume an appropriate measure of liability when they "alter or interfere with physician/patient health care decisions."⁽⁶⁵⁾ The California Association of Health Plans (CAHP) opposes the bill because it maintains that health plans' benefit determinations are not treatment decisions and do not constitute the practice of medicine.⁽⁶⁶⁾ Furthermore, the CAHP asserts that causes of action regarding benefit determinations sound in contract rather than tort.⁽⁶⁷⁾

b. AB 794

Assembly Member Liz Figueroa introduced Assembly Bill 794 on February 26, 1997. It would establish that any decision regarding the medical necessity or appropriateness of any diagnosis or treatment constitutes the practice of medicine.⁽⁶⁸⁾ The bill would also require that persons making decisions regarding medical necessity or appropriateness be licensed to practice medicine in California.⁽⁶⁹⁾ The bill is not intended to impose tort liability on HMOs.⁽⁷⁰⁾ Rather, the intent of the bill is to require that insurers employ medically qualified individuals to make coverage decisions and to impose on those individuals the duties and discipline of the medical community.⁽⁷¹⁾

Under the bill, if an enrollee's HMO-contracted physician determines that certain services are medically appropriate and necessary, the HMO cannot deny the services unless certain conditions are met.⁽⁷²⁾ The HMO may deny such services only if the individual denying the services has examined the patient's medical records and is an appropriately licensed health care professional with the education, training, and experience that is appropriate for evaluating the specific clinical issues involved in the denial.⁽⁷³⁾ If the condition being treated reasonably appears to pose a danger of significant impairment to the patient's health or body, the individual denying coverage must also physically examine the patient in a timely manner.⁽⁷⁴⁾ Life or disability insurers that violate this provision could incur administrative penalties of up to \$2,500 for the first violation and up to \$5,000 for each subsequent violation.⁽⁷⁵⁾ Life or disability insurers that violate this provision knowingly or with sufficient frequency to constitute a general business practice would be liable for administrative penalties of not less than \$15,000 and up to \$100,000 for each violation.⁽⁷⁶⁾ The bill also requires that the reasons for a denial of care be timely communicated in writing to both the patient and the physician whose recommendation is being denied.⁽⁷⁷⁾ AB 794 passed the Assembly by a vote of 50-22 on May 29, 1997, and it has passed two Senate committees.⁽⁷⁸⁾ However, the Governor's threat to veto any legislation that reaches his desk before the managed care task force issues its report has effectively stalled this bill until next year.⁽⁷⁹⁾

c. AB 823

Another bill pending in California, AB 823, redefines the practice of medicine to include making a decision regarding the medical necessity or appropriateness of any treatment or diagnosis.⁽⁸⁰⁾ It subjects any person who engages in this action to the Medical Practice Act.⁽⁸¹⁾ This bill passed the Assembly by a vote of 49-18 and has passed one Senate committee unanimously.⁽⁸²⁾ Like all other bills affecting managed care entities, AB 823 is in a holding pattern until California's managed care task force issues a report of its findings.

d. AB 536

This bill would require health care service plans to establish criteria for authorizing or denying payment for care and make these criteria generally available to the public.⁽⁸³⁾ Current law in California requires disability insurers and non-profit hospital service plans to disclose the specific rationale used when rejecting a claim. Under AB 536, the information would have to be disclosed within five working days.⁽⁸⁴⁾ AB 536 passed the Assembly 55-20 and has passed one Senate committee unanimously.⁽⁸⁵⁾ This is one of the two bills that the Los Angeles Times endorsed,⁽⁸⁶⁾ but it is uncertain whether the Governor will allow the bill to become law.

3. New York

On June 16, 1997, the New York State Assembly overwhelmingly (145-4) passed Assembly Bill 1816, which would make health care organizations liable for damages a patient suffers as a result of a wrongful denial of care or payment for care that the HMO is contractually or legally obligated to provide.⁽⁸⁷⁾ Introduced by Assemblyman Richard N. Gottfried, the bill imposes upon HMOs a duty to exercise ordinary care when making diagnosis and treatment decisions and when selecting and exercising influence or control over its employees, agents, ostensible agents or representatives acting on its behalf with regard to decisions that may affect the quality of the diagnosis, care, or treatment provided to its enrollees.⁽⁸⁸⁾

The bill prohibits provider contracts that require the provider to indemnify or hold harmless the HMO for liability resulting from the HMO's acts or omissions.⁽⁸⁹⁾ It also prohibits contracts between an HMO and providers that waive, limit or delegate the liability of the HMO to any health care provider and prohibits contracts between the HMO and any person which waive or limit any liability of the HMO to the person.⁽⁹⁰⁾

The bill's legislative findings indicate that the integration of the functions of paying for health care, determining what health care is paid for, and providing care is breaking down traditional distinctions.⁽⁹¹⁾ The bill purports to address the problem of payor determinations that encroach upon treatment decisions that once were the exclusive domain of the provider and the patient.⁽⁹²⁾

The New York legislature has recessed without the senate having considered AB 1816.⁽⁹³⁾ Shay Bergin, Executive Director of the New York State Health Commission, who has been tracking this bill closely for Assemblyman Gottfried, is uncertain when or even whether the Senate will take the bill up for consideration.⁽⁹⁴⁾

Managed care legislation is clearly at the forefront of public policy debate around the country. In addition to the legislative activity taking place in Texas, New York, California and Missouri, other states have enacted measures addressing similar issues:

The Florida legislature passed a bill this spring that imposes a variety of requirements on HMOs, but does not create a civil cause of action.⁽⁹⁵⁾ It bans "gag clauses," requires out-of-network referrals if a provider with the appropriate training is not available in the HMO's network, requires that HMOs provide standing referrals to specialists for enrollees with chronic and disabling conditions, allows continued care by a provider terminated from the plan in certain circumstances, and requires that HMOs maintain an expedited grievance procedure.⁽⁹⁶⁾

The Georgia legislature has also enacted a bill that requires HMOs to include in their annual report the formula or other method used to determine the compensation of providers.⁽⁹⁷⁾

On August 7, 1997, New Jersey Governor Christine Todd Whitman signed into law an extensive set of provisions regulating managed care.⁽⁹⁸⁾ One provision of the statute bars companies from giving financial incentives to providers for limiting treatment.⁽⁹⁹⁾ The law also requires health plans to offer a point-of-service option allowing enrollees to choose to pay additional amounts to select their own doctors and provides that an HMO's medical director must be a licensed physician.⁽¹⁰⁰⁾

additional amounts to select their own doctors and provides that an HMO's medical director must be a licensed physician.⁽¹⁰⁰⁾

At present, only Texas and Missouri have enacted provisions that could impose liability against managed care entities for health care treatment decisions. California and New York appear to be moving in a similar direction, however, and Alabama and Maryland are also currently considering managed care liability measures.⁽¹⁰¹⁾

Federal Legislation

Two important managed care bills are currently pending in Congress. One bill would amend the Public Health Service Act and ERISA to require health insurance issuers to comply with a host of new regulations. It would also amend ERISA to require that state causes of action are not pre-empted by federal law.⁽¹⁰²⁾ The other bill would create a federal cause of action similar to the new Texas law.⁽¹⁰³⁾

A. HR 1415

On April 23, 1997, Representative Charlie Norwood (R-GA) introduced a bill which would impose a number of new requirements on health insurance issuers under the Public Health Service Act and which would amend ERISA to declare that state laws that are more protective of consumers, presumably including state causes of action like SB 386, are not pre-empted by federal law.⁽¹⁰⁴⁾

The bill would prohibit health insurance issuers from requiring pre-authorization of emergency services, would require that plans provide access to specialized treatment when the patient's treating physician finds specialized treatment necessary, and would prohibit plans from offering incentives for providers to limit services.⁽¹⁰⁵⁾ Furthermore, the bill would require that every plan allow enrollees to choose to visit their own doctor, even a doctor who is not a member of the plan, for a reasonable premium increase.⁽¹⁰⁶⁾ It also would prohibit racial, sexual, and national origin discrimination in selecting doctors for the plan and in accepting enrollees and prohibit so-called "gag rules" and would establish criteria for utilization review procedures.⁽¹⁰⁷⁾

Perhaps the most significant aspect of the bill is its provision to amend ERISA to specifically declare that state causes of action like SB 386 are not pre-empted by federal law.⁽¹⁰⁸⁾ It provides that ERISA "shall not be construed to preclude any State cause of action to recover damages for personal injury or wrongful death against any person who provides insurance or administrative services to or for an employee welfare benefit plan maintained to provide health care benefits." This provision would eliminate the one issue that now threatens to derail popular legislative efforts in Texas, California, New York and Missouri.

B. HR 1749

On May 22, 1997, Representative Pete of California introduced a bill that would subject HMOs to actual and punitive damages for failing to provide covered services.⁽¹⁰⁹⁾ A health plan would be held liable if it fails to provide any covered benefit if such failure occurs pursuant to a "clinically or medically inappropriate decision or determination" which was the result of any cost containment technique or "any other medical care delivery policy decision which restricts the ability of providers of medical care from utilizing their full discretion for treatment of patients."⁽¹¹⁰⁾

The bill would not ban so-called "gag rules" whereby health plans contractually limit what options a provider can communicate to patients. However, the bill would require health plans to indemnify providers against any failure to provide a benefit if the provider's failure to supply the benefit was the "direct result of a plan restriction on medical communications under the plan."⁽¹¹¹⁾

C. President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry

On September 5, 1996, President Clinton established an Advisory Commission on Consumer Protection and Quality in the Health Care Industry (the "Commission").⁽¹¹²⁾ The Commission is charged with advising the President on changes occurring in the health care system and recommending ways to improve protections for enrollees, promote quality health care, and improve the availability of treatment and services.⁽¹¹³⁾ The Commission is comprised of 32 members, including consumers, institutional health care providers, health care professionals and other health care workers, health care insurers, health care purchasers, state and local government authorities and experts in health care quality, financing and administration.⁽¹¹⁴⁾ It is co-

purchasers, state and local government authorities and experts in health care quality, financing and administration.⁽¹¹⁴⁾ It is co-chaired by the Secretary of Health and Human Services, Donna Shalala, and the Secretary of Labor, Alexis M. Herman.⁽¹¹⁵⁾ The Commission is expected to produce a Consumer Bill of Rights this Fall.⁽¹¹⁶⁾ The President has also requested a final report from the Commission by March 30, 1998. Although the Commission is expected to examine many of the same issues that are the subject of pending state legislation, the chair of the Commission's Subcommittee on Consumer Rights, Protections and Responsibilities has stated that the issue of making HMOs liable for health care decisions is likely too controversial at this time to be addressed by the report of the Commission.⁽¹¹⁷⁾

Conclusion

In the coming months, all three branches of the federal government will take action regarding managed care liability. The federal courts will consider whether ERISA pre-empts the state cause of action enacted by the Texas legislature. Two bills in Congress, one which would create a federal cause of action similar to the Texas law and another which would extinguish the pre-emption issue, are under consideration. In addition, a Presidential Advisory Commission will almost certainly consider managed care liability even though the issue may not be addressed in its final report. Of the three most populous states, one has enacted a law imposing tort liability on HMOs, and bills have passed one legislative house in each of the other two. In many other states, legislatures have elected to increase the regulation of managed care entities in ways not directly involving a new cause of action against those entities. While Texas' SB 386 is the first of its kind to be enacted, it represents only one of many state and national initiatives to address perceived problems with managed care.

Endnotes

1. Thomas J. Bond is a partner in the Austin office of Akin, Gump, Strauss, Hauer & Feld, L.L.P., where he heads the insurance section. Susan Erickson Marin, an associate in the Austin office, assisted in the preparation of this article.

2. Tex. S.B. 386, 75th Leg., R.S. (1997); H.J. of Tex., 75th Leg., R.S. 2324 (1997).

3. Tex. S.B. 386, 75th Leg., R.S. (1997), 11.

4. TEX. CIV. PRAC. & REM. CODE ANN. 88.002(a).

5. *Id.* at 88.001(5).

6. Interestingly, the definition for a "health care treatment decision" included in a managed care liability bill pending in California refers to "a determination made when a health care service plan *arranges for* medical services" (Emphasis supplied.) See discussion of California SB 977, *infra*.

7. *Id.* at 88.002(d)-(e).

8. *Id.* at 88.001(10).

9. *Id.* at 88.002(b).

10. *Id.*

11. *Id.* at 88.002(i).

12. *Id.* at 88.002(a).

13. *Id.* at 88.001(6).

14. *Id.* at 88.001(7).
15. *Id.* at 88.001(8).
16. *Id.* at 88.002(j).
17. *Id.* at 88.002(h); *See Williams v. Good Health Plus, Inc.*, 743 S.W.2d 373 (Tex.App.--San Antonio 1988, no writ).
18. *Id.* at 88.002(f)-(g).
19. *Id.* at 88.003(a).
20. *Id.* at 88.003(c).
21. *Id.* at 88.003(d).
22. *Id.*
23. *Id.* at 38.003(e).
24. 22 Tex.Reg. 6914 (July 25, 1997) (proposed to be codified at 28 Tex. Admin. Code 12.1-12.502) (Tex. Ins. Dept.). (Note: The proposed regulations may be revised substantially before being adopted by the Department.)
25. Complaint for Declaratory Judgment and Permanent Injunction, *Corporate Heath Insurance, Inc, et al v. Texas Department of Insurance*, (No. H-97-2072 S.D.Tex 1997). The plaintiffs are Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Aetna Health Plans of North Texas, Inc., and Aetna Life Insurance Company (collectively referred to as "Aetna"). *Aetna Challenges HMO Law Allowing Malpractice Suits*, MEALEY'S LITIGATION REPORTS: MANAGED CARE, July 2, 1997.
26. Complaint for Declaratory Judgment and Permanent Injunction at 2-3, *Corporate Heath Insurance, Inc, et al v. Texas Department of Insurance*, (No. H-97-2072 S.D.Tex 1997).
27. *Id.* at 11.
28. *Id.* at 3.
29. *Id.*
30. Missouri HB 335, 89th General Assembly, (1997).
31. NY AB 1816-A, 1997-98 Regular Sess.
32. Missouri HB 335, 89th General Assembly, (1997); Telephone Interview with Tim Harlan, Missouri State Representative, Author of HB 335, (August 13, 1997).
33. *Id.*
34. 354.505(3) RSMo.
35. Missouri HB 335, 89th General Assembly, (1997) at 354.505(3).

36. Telephone Interview with Tim Harlan, Missouri State Representative, Author of HB 335, (August 13, 1997).
37. *Id.*
38. 354.441 RSMo.
39. 354.603 RSMo.
40. *Id.*
- 41.
42. 354.615(1)RSMo.
43. 354.615(2) RSMo.
44. 354.618(4) RSMo.
45. Telephone Interview with Tim Harlan, Missouri State Representative, Author of HB 335, (August 13, 1997).
46. Dan Smith, *Wilson Stalling to Shield HMOs, Critics Contend*, SACRAMENTO BEE, Aug. 6, 1997.
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
51. *Id.*
52. *Sacramento Should Avoid a Jumble in HMO Reform*, LOS ANGELES TIMES, August 11, 1997.
53. *Id.*
54. Telephone interview with Molly Hillis, Health Legislative Consultant to California Senator Peace (July 18, 1997).
55. *Id.*
56. *Id.*
57. California SB 977, 1997-98 Sess., 1(a).
58. *Id.* at 1(b).
59. *Id.* at 1(d).

60. Telephone Interview with Molly Hillis, Health Legislative Consultant to California Senator Peace. (July 18, 1997).
61. *Id.*
62. California SB 977, 1997-98 Sess., 1(e).
63. *Id.* at 2(a)-(b).
64. *Id.* at 1(g).
65. California SB 977, 1997-98 Sess., Bill Digest, Assembly Committee on Health, p.3
66. *Id.*
67. *Id.*
68. California AB 794, 1997-98 Sess., 1(b).
69. *Id.* at 1(a).
70. Telephone interview with David Link, Principal Consultant, California Assembly Insurance Committee, (August 11, 1997)
71. *Id.*
72. California AB 794, 1997-98 Sess., 3(a).
73. *Id.* at 3(a).
74. *Id.* at 1(a).
75. *Id.* at 5(b).
76. *Id.* at 5(c).
77. *Id.* at 6(c).
78. *Id.* at Bill History.
79. Telephone interview with David Link, Principal Consultant, CA Assembly Insurance Committee, (August 11, 1997).
80. California AB 823, 1997-98 Sess., 1(b).
81. *Id.*
82. *Id.* at Bill History.
83. California AB 536, 1997-98 Sess., 1.

84. *Id.* at 2.

85. *Id.* at Bill History.

86. *Sacramento Should Avoid a Jumble in HMO Reform*, LOS ANGELES TIMES, August 11, 1997.

87. NY AB 1816-A, 1997-98 Regular Sess.

88. *Id.* Telephone Interview with Shay Bergin, Executive Director, New York State Health Commission (July 18, 1997).

89. NY AB 1816-A, 1997-98 Regular Sess at 2(5).

90. *Id.*

91. *Id.* at 1.

92. *Id.*

93. Telephone Interview with Shay Bergin, Executive Director, New York State Health Commission (August 13, 1997).

94. *Id.*

95. Fla HB 297, Regular Sess. 1997, House of Representatives Committee on Health Care Standards & Regulatory Reform Bill Research & Economic Impact Statement.

96. *Id.*

97. Ga. SB 209 (1997).

98. N.J. SB 269 (1997).

99. *Id.*

100. *Id.*

101. Steven Findlay, *Loophole "Suitproofs" HMOs; Effort to Remove Shield Triggers Fierce, Wide-Ranging Debate*, THE DENVER POST, August 10, 1997 at A1.

102. H.R. 1415, 105th Cong., 1st Sess. (1997).

103. H.R.1749, 105th Cong., 1st Sess. (1997).

104. H.R. 1415, 105th Cong., 1st Sess. (1997).

105. *Id.* at 2-2771(b).

106. *Id.* at 2-2772(b).

107. *Id.* at 2-2773, 2-2774.

108. *Id.* at 4.

109. H.R.1749, 105th Cong., 1st Sess. (1997).

110. *Id.*

111. *Id.*

112. Exec. Order No. 13,017, 61 Fed. Reg. 47659 (1996).

113. See President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry Web Page at <http://www.hcqualitycommission.gov/charter.htm>.

114. *Id.*

115. *Id.*

116. *Id.*

117. Telephone Interview with Peter Thomas, Chairman, Subcommittee on Consumer Rights, Protections and Responsibilities, (July 17, 1997).