SFA BILL ANALYSIS

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Senate Bill 2 (Substitute S-2 as passed by the Senate)
Senate Bill 3 (Substitute S-2 as passed by the Senate)
Senate Bill 4 (Substitute S-2 as passed by the Senate)
Senate Bill 12 (Substitute S-2 as passed by the Senate)
Senate Bill 13 (Substitute S-3 as passed by the Senate)
Sponsor: Senator Nick Smith
Committee: Commerce and Technology

Date Completed: 4-12-89

RATIONALE

Michigan continues to experience what some have called a medical malpractice "crisis". In the last several years, the size of medical malpractice awards have skyrocketed and the length of trials has increased. Even with the liability reforms, enacted in 1986, that limit the size of some awards, the costs associated with litigation are considerable. Some have suggested that, rather than relying on drawn-out litigation processes, some form of alternative dispute resolution mechanisms should be implemented. Already established in State law, but seldom used, is a system of medical malpractice arbitration. Proponents of this system claim that it is cost-effective compared to litigation because of its shorter time frame, and that arbitration should be used more extensively. In order to facilitate greater use of the medical malpractice arbitration system, it has been suggested that the various types of health coverage offered in this State be permitted to include a revocable arbitration agreement.

CONTENT

Senate Bills 2 (S-2), 3 (S-2), 4 (S-2), 12 (S-2) and 13 (S-3) would amend various Acts to provide for notification of covered individuals when their health coverage contained an arbitration provision for a medical malpractice dispute; to specify persons to whom the provision would apply; specify the right of a covered individual to revoke an arbitration agreement; and specify the period of limitations for actions involving health care arbitration. Senate Bill 2 (S-2) would amend the Prudent Purchaser Act and apply to a prudent purchaser agreement and contract; Senate Bill 3 (S-2) would amend the Public Health Code and apply to health maintenance organization (HMO) contracts; Senate Bill 4 (S-2) would amend the Insurance Code relative to disability insurance policies and group disability insurance policies, and also would include "surplus lines insurers" within the definition of "malpractice insurer"; and Senate Bill 12 (S-2) would amend the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan.

Senate Bill 13 (S-3) would amend the Revised Judicature Act to set time frames for actions involving health care arbitration.

Notification

Senate Bills 2 (S-2), 3 (S-2), 4 (S-2), and 12 (S-2) would require a contract, policy, or

certificate (or rider or addendum to such an agreement) for health coverage that contained a provision for arbitration of a malpractice dispute to include a "statement of that fact in 12-point boldface type". Each person who had health coverage, and each competent adult dependent of that person, at the time the agreement was entered into or a rider containing the arbitration provision was added, would have to indicate on an enrollment card or contract whether he or she rejected or accepted the arbitration provision. Failure to indicate acceptance or rejection, however, would not indicate acceptance of the arbitration provision. The contract, policy, or certificate or rider also would have to specify, in 12-point boldface type, that the covered individual and each competent adult dependent could revoke an arbitration agreement within 60 days after the effective date of the arbitration provision and that execution of an arbitration agreement was not a prerequisite to health care or treatment. (Senate Bill 4 (S-2) would require the 12-point boldface statement for an individual policy, but for a group policy would require a "conspicuous statement".) Further, the contract or rider would have to provide that the covered individual and each competent adult dependent of the individual could revoke an arbitration agreement on any anniversary date specified in the contract or rider or within 10 days after the anniversary date. The bills also specify, however, that if a person who had health coverage accepted an arbitration provision in a contract, policy, or certificate and subsequently rejected an arbitration provision contained in another health care coverage or benefit plan under which the person was covered as a dependent, the person would continue to be bound under the arbitration provision in the first contract, policy, or certificate.

Further, if a competent adult dependent accepted an arbitration provision in a health care coverage contract, policy, or certificate, subsequently rejected an arbitration provision in another health care coverage or benefit plan under which the dependent was also covered as a dependent, and if the benefits of the first contract would be determined before the benefits of the second plan under the Coordination of Benefits Act, the competent adult dependent would be bound by the arbitration provision in the first contract, policy or certificate.

Finally, the bills provide that if a person with health coverage were a parent or guardian of a minor or incompetent adult dependent who also was covered as a dependent under another health care coverage or benefit plan and accepted an arbitration provision in a contract, policy, or certificate, and if the benefits of the contract, policy, or certificate would be determined before the benefits of the other health care coverage or benefit plan, the minor or incompetent adult dependent would continue to be bound by the arbitration provision in the contract, policy, or certificate, even if the arbitration provision in the other health care coverage or benefit plan were rejected by another parent or guardian of the minor or incompetent adult dependent.

In addition to the arbitration statement within the contract, policy, or certificate, each organization offering health care coverage would have to develop and implement a procedure for notifying potential provider members and covered individuals and their dependents about the arbitration agreement. Such a procedure would have to include, at a minimum, 1) notification that enrollment cards, contracts, policies, or certificates contained a statement, next to the signature line and in 12-point boldface type, describing the arbitration requirement; a statement, with a signature line where the person or competent adult dependent could sign, stating that the person or dependent rejected the arbitration provision; and a statement, with a signature line, stating that the person or dependent accepted the provision, and 2) the provision of an informational brochure that clearly explained the arbitration agreement and revocation provision. The brochure would have to be provided before the person accepted or rejected the arbitration provision.

In addition, Senate Bill 3 (S-2) would require HMOs to notify the Department of Public Health of "substantial" changes in health maintenance contracts within 30 days after that change; and Senate Bill 12 (S-2) provides that if a health care corporation added an arbitration provision to a certificate, it would have to notify the Insurance Commissioner within 30 days of the effective date of the provision.

Arbitration

The bills would require that arbitration of a malpractice dispute be conducted according to procedures for health care arbitration outlined in the Revised Judicature Act (MCL 600.5043-600.5059).

A health care contract, policy, certificate, or rider or addendum that contained an arbitration provision could not be considered a contract of adhesion, unconscionable, or otherwise improper because of the provision. An arbitration provision would apply to all individuals covered under the contract, policy, or certificate including their spouse and children, both born and in utero, and all incompetent adult dependents of the covered individual. In the case of a malpractice action involving the death of a covered individual, all persons to whom the individual, by law, owed a duty of support at the time of death would be considered covered by the arbitration agreement. In addition, the bills specify that if a contract, policy, or certificate included coverage for a minor or incompetent adult dependent, the contract, policy, or certificate, rider or addendum, could not be subject to disaffirmance if it were signed or otherwise agreed to by the minor's or adult dependent's parent or legal guardian. The parent or guardian of a minor or incompetent adult dependent would not be prohibited from rejecting or revoking an arbitration provision.

Right to Revoke

Within 60 days after the effective date of the arbitration, the covered individual or competent adult dependent could revoke the agreement to arbitrate. Further, the individual could revoke the agreement on any anniversary date of the contract, policy, rider or addendum or within 10 days after the anniversary date. Revocation of the agreement would be accomplished by notifying the insurer, health care corporation, HMO or PPO (prudent purchaser organization) in writing of the person's intent to revoke the agreement. Such a notice would have to include the covered individual's name, address, and contract, policy, or certificate number as well as a statement of the individual's intent to revoke. The revocation would be effective for any health care services rendered after the revocation. Proof of revocation would be a receipt from a letter sent by registered or certified mail or other acknowledgment of the revocation from the organization.

The bills would permit an insurer, health care corporation, HMO, or PPO to offer economic incentives in consideration of an agreement to accept an arbitration provision or not to revoke the arbitration agreement.

The bills would require the Commissioner of Insurance to report to the Legislature on the effect of arbitration agreements, including cost savings realized as a result of arbitration agreements. The report(s) would have to be submitted within five years after the bills' effective date(s). If the Commissioner determined that organizations using arbitration provisions in contracts providing coverage realized a cost savings as a result of using the arbitration provisions, the Commissioner would have to consider the cost savings in making rate determinations for organizations.

Health Care Arbitration Proceedings

Senate Bill 13 (S-3) would amend the Revised Judicature Act to provide that a proceeding under Chapter 50A, which governs health care arbitration, would be subject to the same period of limitations as an action involving a claim based on medical malpractice. (Generally, a medical malpractice action must be commenced within two years after the claim accrued or within six months after the plaintiff discovers or should have discovered the existence of the claim, whichever is later, but not later than six years after the date of the act or omission that is the basis for the claim. The six-year rule does not apply, however, if the injury involves the plaintiff's reproductive system, if a foreign object was wrongfully left in the body, or if a health care provider's fraudulent conduct prevented discovery of the existence of the claim. Further, if the plaintiff was 13 years old or younger when the claim accrued, the action must be brought by the person's 15th birthday.)

The bill also would move reference to "health maintenance organization" from the definition of "hospital" to the definition of "health care provider".

The bill is tie-barred to Senate Bill 3.

MCL 550.56 (Senate Bill 2)
500.3455 and 500.3612 (Senate Bill 4)
333.21031 (Senate Bill 3)
550.1204 and 550.1401 (Senate Bill 12)
600.5040 and 600.5043 (Senate Bill 13)

FISCAL IMPACT

The bills would have no fiscal impact on State or local government.

ARGUMENTS

Supporting Argument

The bills would provide a mechanism for decreasing the cost of medical malpractice disputes in Michigan. Although the legal authority and structure to resolve such disputes by way of arbitration proceedings already exist in Michigan, the process seldom is used. Proponents of arbitration claim the reason for this lack of use is simply that people are uninformed about the nuances or even the existence of arbitration as an alternative means for resolving disputes. The bills would serve the dual purpose of educating insureds about arbitration--through an informational brochure--and providing for greater use of arbitration in resolving medical malpractice disputes. Use of arbitration to resolve disputes would not be mandatory, however, since the bills would require individuals to indicate specifically whether they accepted or rejected an arbitration agreement, and if they accepted, would provide for a 60-day opt-out period, during which time covered individuals could unconditionally revoke an arbitration agreement. To encourage arbitration, however, insurers, health care corporations, HMOs, and PPOs could offer incentives in exchange for an agreement to accept or not to revoke the arbitration provision.

By promoting the use of arbitration to settle disputes, the bills would result in savings to all parties and quicker resolution of claims. Indeed, the Journal of Legal Medicine claims that an "examination of awards and data indicating the decreased time and cost for reaching a decision suggests that arbitration is a fair and cost effective method of dispute resolution". Although plaintiffs reportedly receive similar, or even greater, awards under the arbitration system, apparently there still are great savings to be realized. Physicians Insurance Company of Michigan, one of the two leading medical liability insurers in the State, reports that over 51% of its 1987 medical malpractice expenditures went toward legal expenses and fees. On the other hand, Kaiser-Permanente, a California-based HMO that insures over 11 million people, claims that its legal costs are 40% lower because it requires arbitration to resolve all medical malpractice claims. In addition, the entire arbitration process in Michigan takes no more than 17 months (including a 180-day discovery period). Given the backlog of the court system, it might take that long just to get to trial. Kaiser-Permanente claims that the length of an arbitration dispute is about one-half that of a litigated one.

The need to use arbitration proceedings as an alternative form of dispute resolution has been recognized by other states. Eighteen states have specific statutes covering the arbitration of medical claims, and Puerto Rico imposes arbitration requirements upon every medical malpractice claim. In addition, in its "Report on Medical Liability and Malpractice", the United States Department of Health and Human Services has urged that "states should authorize and encourage voluntary, binding arbitration of medical malpractice claims". Michigan should join the growing number of States that provide for this convenient, efficient means of resolving medical malpractice disputes.

Response: The bills are unnecessary. If dispute resolution through arbitration is so attractive, why is it seldom used? The Revised Judicature Act already includes provisions for arbitration of disputes relating to health care and there is nothing in law forbidding insurers from offering arbitration agreements. In fact, current law requires hospitals to offer arbitration as an option and allows physicians to do so. Although the bills technically would allow individuals to "opt-in" the arbitration system, most people are not concerned about potential malpractice claims and their right to a jury trial when they initially sign enrollment forms or contracts for health insurance. They would be as likely to agree to arbitration as not and unless they chose to revoke the agreement within 60 days or at a specified anniversary date, they would be bound to accept arbitration of their claims. A State law that would deny the option of litigation (after an agreement made by 60 days of inaction) is not good policy.

In addition, the bills apparently would not require providers to choose arbitration over litigation, but, after the 60-day revocation period, they would require claimants to arbitrate.

Claimants already have the option of pursuing dispute resolution through arbitration, but they simply have not chosen to do so in great numbers. Also, the provision that would allow insurers, HMOs, PPOs, and health care corporations to provide incentives to agree to accept or not to revoke the arbitration agreement is akin to blackmail. If arbitration itself is desirable, as its proponents suggest, why are insurer-induced incentives needed? Under the guise of promoting greater savings and efficiency, the bills would restrict the options that currently are available to claimants in a medical malpractice dispute. The time saving aspect of arbitration can be attributed to the small caseload to date. If the bills resulted in greater use of the arbitration system, as its proponents claim they would, then backlogs probably would develop, as they have in the court system, and delays would be experienced. One of the main benefits extolled by supporters of the arbitration system would disappear.

Opposing Argument

Arbitration apparently does result in savings to the health care provider against whom a claim has been filed and to his or her malpractice insurer, but what incentive do health insurers, HMOs, PPOs, and health care corporations have to provide arbitration agreements? The bills would permit these organizations to offer arbitration agreements, but without incentives to do so they would not be likely to offer such agreements. Health coverage providers rarely are named as parties in medical malpractice suits, so savings resulting from the use of the arbitration process would not accrue to them. The bills are misdirected; the arbitration agreement should be between the individual receiving health care and the individual or organization delivering health care, not the insurer.

Response: In the case of an HMO, the organization delivering health care and the organization providing coverage are one and the same. The health care professionals, in this case, are employed by the HMO and the HMO purchases malpractice insurance to protect them.

Legislative Analyst: L. Burghardt
Fiscal Analyst: J. Walker

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