House
Legislative
Analysis
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NEGLIGENCE LIABILITY FOR HMO TREATMENT DECISIONS

House Bill 5221 (Substitute H-2)
First Analysis (5-21-98)

Sponsor: Rep. Laura Baird
Committee: Judiciary

THE APPARENT PROBLEM:

With the proliferation of health maintenance organizations, more and more people are covered under health insurance provided by managed care plans or health maintenance organizations (HMOs) -- according to some, approximately 2.2 million people in Michigan and nearly 75 percent of Americans with health insurance. By emphasizing preventive care and coordinating care through primary care physicians, managed care plans control costs and limit access to medical specialists and expensive tests and treatments. Although many feel that the use of managed care plans like HMOs have lowered the costs of health care, many others believe that HMOs have taken cost containment too far. Many feel that in order to maintain costs, HMOs are making medically inappropriate decisions and are refusing or restricting medical treatment in order to protect their bottom line without concern for the potential consequences for the patient. Undeniably, managed care has altered the way that health care is delivered in America, and with that it has also changed the manner whereby medicine is practiced. Tests and treatment must be approved by the HMO, and when the treatment or test that is recommended by a physician is not approved many assume it is the HMO's concern for the bottom line that has taken precedence over the patient's well being. While managed care, by allocating resources in a more conservative manner, may cut costs, it also may deny needed treatment in the interest of lowering costs. In fact, horror stories about the apparent cruelty and consequences of HMOs' decisions regarding denials or delays in coverage for treatments or tests seem to be nearly as prolific as HMOs themselves.

It is believed that a significant part of the problem stems from the fact that HMOs are generally not liable for any of the consequences of their decisions to refuse tests or treatment. Physicians in particular urge that HMOs should be made liable for decisions that result in harm to patients. It is suggested that accountability is needed in order to ensure that HMOs are encouraged to make decisions that are prudent, not merely with regard to the plan's cost, but prudent for the patient as well.

THE CONTENT OF THE BILL:

The bill would amend the Public Health Code to make a health maintenance organization (HMO) liable for harm caused to its enrollee due to the HMO's negligence in making its health care treatment decisions regarding that enrollee. In addition, the bill would bar an HMO from unreasonably denying an enrollee's request for a covered treatment or service or a request to see a physician specialist for a covered treatment or service.

More specifically, an HMO would be responsible when its decision regarding the provision of medical services or a decision affecting the quality of a diagnosis, care, or treatment of an enrollee failed to meet the standard of ordinary care. An HMO would also be responsible for the negligent treatment decisions of its employees, agents, ostensible agents, or representatives acting on behalf of the HMO over whom the HMO had the right to exercise influence or control or had exercised influence or control. However, the mere fact that a health professional's name appeared in a listing of approved providers made available to the HMO's enrollees would not be sufficient, in and of itself, to prove that the health professional was an employee, agent, ostensible agent, or representative of the HMO.

An HMO accused of negligence in its treatment decisions could offer the following defenses: that neither the HMO nor its employees or representatives controlled, influenced, or participated in the treatment decision that led to the enrollee's injury; or that the HMO had not denied or delayed payment for any treatment that had been prescribed or recommended by a provider to the enrollee.

An HMO could not avoid liability for negligent treatment decisions by entering a contract with a health professional or facility that included an indemnification or hold harmless clause for the acts of the HMO. However, the bill would not obligate an HMO to provide treatment that was not covered by the HMO's contract with the enrollee. Nor would it create a medical malpractice cause of action or create liability on the part of an employer, employer purchasing group, welfare benefit group, or other entity that purchased coverage or assumed risk on behalf of its employees or participants.

The bill would define ordinary care as the degree of care that an HMO of ordinary prudence would use under the same or similar circumstances. For employees or others acting on behalf of the HMO, ordinary care would be defined as the care that a person of ordinary prudence in the same profession, specialty, or area of practice would use under the same or similar circumstances.

The bill would only apply to causes of action that were filed on or after the bill's effective date.

MCL 333.21035a, 333.21051a and 333.21051b

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

HMOs should be held liable for negligent decisions that result in harm to their enrollees. HMOs, unlike other insurers, make decisions managing the care provided to their enrollees. When an HMO decides not to allow a treatment or test that is allowed under the HMO's coverage and is suggested by a doctor, it is making a medical decision and should take responsibility for the consequences of that decision. HMOs limit costs by making decisions as to the necessity of certain treatments and tests; if the patient exhibits all or a certain number of listed symptoms, then the test is allowed, and if not, the test is not allowed. The necessity of treatments is determined in much the same fashion. One could cite an almost unending litany of individual stories of horror about treatments denied and tests unperformed that resulted in death or disability for the individual -- this is without even mentioning the lengthened periods of discomfort or suffering caused by delays or in cases where the consequences of the decisions to deny treatment were less severe. However, when decisions are made that result in harm and the HMO is found liable for not providing a covered service, the result has generally been that the person's damages are limited to the cost of the service that was denied, rather than any of the consequences that may have resulted from that denial. This is not an acceptable result; if HMOs are going to continue to make health care decisions, they should be made responsible for the consequences of those decisions. Currently, HMOs can make these decisions without fear of serious reprisal and as a result, if the stories are to be believed, are less concerned with patient consequences than they are with the bottom line. If the bill is enacted, the increased accountability (from none to some) will result in more prudent decisions being made by HMOs and this will better the health and lives of Michigan residents.

Response:

The assertion that HMOs face no civil liability for their actions is not entirely true. There is no barrier in state law that prohibits HMOs from facing civil liability. HMOs have been sued and likely will continue to be sued as long as there are lawyers. Theories of liability regarding HMOs are being developed through case law even now -- case by case. This is a preferable method to a legislatively enacted theory of liability. Legislatively enacted theories of liability face the lengthy process of clarification that usually takes place in such instances. Lawsuits are filed to test the limits of each term in the law, and eventually, after years of lawsuits and appeals to the highest courts, the law is well established and the terms are understood throughout the legal community.

Rebuttal:

Although HMOs may be subject to lawsuits, the cases currently filed rarely involve attempts to hold the HMO directly liable for its decision making in the fashion that this bill would allow. Furthermore, it doesn't appear that there is any controlling case law that has been tested through the Michigan Supreme Court or the court of appeals to support the contention that a common law cause of action against an HMO could be maintained. Even if there were such case law, it is not unusual for the legislature to codify a cause of action. In this case if a cause of action exists, it clearly needs clarification and strengthening so that it has an effect on the behavior of those HMOs that keep costs down at the expense of the health and well being of their enrollees.

Against:

The bill provides that an HMO could not unreasonably deny an enrollee's request for a covered treatment or

to see a physician specialist. This will end the effectiveness of managed care. Managed care depends upon its ability to lower costs by limiting access to certain treatments through its referral authorization process. If an HMO is no longer allowed to assess the appropriateness of care based on its procedures but instead must provide the patient with whatever care the patient asks for, the bill would have the effect of forcing an HMO to offer the same coverage as non-managed care plans. While it might make sense to require HMOs to exercise ordinary care in decisions regarding medical treatment, there is absolutely no good reason to require an HMO to cover every whim of every enrollee. What will be considered a reasonable denial? It is likely that, in this climate, no denial will be deemed reasonable. All coverage would be available to all enrollees at all times at the request of the enrollee.

Against:

The bill is unnecessary, or at the very least premature. The recent passage of the Patient Bill of Rights legislation strengthened enrollees' rights to contest coverage decisions. The legislation included stringent time standards for resolution of grievances requiring a final determination to be made within 90 days and a special expedited process for emergencies that requires a final determination within 3 days. Further, an impartial state hearing process is available before the Department of Community Health if the enrollee is not satisfied with the results of the grievance procedures. However, these changes just took effect on October 1, 1997 and as a result it is difficult to tell how effective these changes will be in changing some of the perceptions and some of the problems with HMOs.

Furthermore, the bill will lead to a vast increase in the number of lawsuits against HMOs and thereby will lead to an increase in the cost of health insurance or lower levels of care. When HMOs are forced to defend numerous lawsuits, the money that is used in the defense of those cases must come from somewhere. In most cases this means either that the HMO must increase its premiums or decrease the amount of coverage offered to patients. Furthermore, some studies have concluded that each one percent increase in the cost of health insurance premiums leads to a 2.6 percent drop in small business sponsorship of health insurance. Thus the bill could not only lead to decreased coverage for those who remain insured, but also may mean that many more people will end up without health insurance.

The results of this bill will lead to increases in the cost of health care and reduced access to health care coverage for large numbers of people, in order to provide limited recourse for a few citizens who believe they have been harmed by the actions of their HMO. This is not good public policy. The money that is paid for health coverage should be spent on prevention, diagnosis and treatment, not on legal fees and court costs.

Response:

If HMOs are already vulnerable to civil suits, then the bill shouldn't pose a problem of increasing lawsuits. Perhaps the problem is that HMOs fear an increase of litigation where the patient has a chance of winning. Current law allows only minimal recovery for lawsuits, without the threat of significant monetary loss. Without this bill, HMOs will do nothing to change their decision-making processes and enrollees will continue to be harmed. Allowing civil tort actions to be taken against HMOs increases the probability that they will take more care to consider the possible consequences of their decisions for the enrollee.

Rebuttal:

It is unlikely that the lawsuits filed against HMOs under this bill will only be based upon the "horror stories" of inappropriately denied care leading to tragic consequences. People will bring lawsuits where the HMO did nothing wrong hoping that the perception of HMOs as heartless, soulless bean counters concerned only with the bottom line will provoke a big judgment. Many lawsuits will be filed based solely on bad results without regard for whether the decisions leading to the result were reasonable, as currently occurs in cases against physicians.

Many people who repeat the HMO horror stories as supposed evidence of the evil practices of HMOs never stop to consider the other side of the story. They forget that HMOs, and other insurers for that matter, are running businesses, not charities. A fee is paid to the HMO and the HMO agrees to pay for covered care and treatment under the contract. Part of that contract requires the enrollee to accept that the HMO will use its referral authorization process to assess the appropriateness of care. When people are ill they tend to believe their health insurance should pay for any treatment for that illness, regardless of the cost or the strong probability that it won't work. If the enrollee wants treatment that the carrier does not cover then the carrier should not be expected to pay for it. The insurer agrees to pay for covered costs --

in HMOs they agree to pay covered costs for treatments allowed under its referral process. This is not a carte blanche agreement to treat and cure by whatever means necessary. If a person wants or even needs treatment that is not covered or not properly authorized the HMO has every right to deny those claims.

The HMO does not guarantee the health of it enrollees, nor does it promise to give them the highest and best treatment or care available under any circumstances. The HMO offers specified treatment under specified restrictions, at a significantly lower rate than companies that offer whatever care the patient desires. People often forget that they opted for a bargain rate insurance when they need its coverage. It's as though they purchased a bicycle and then complain when they have to ride it that it isn't a motorcycle.

Against:

The bill should require that lawsuits that proceed under the bill's provisions should be subject to the caps provided for malpractice cases. The bill essentially creates a malpractice cause of action and as such it should be subject to the same caps that have been provided by law for other malpractice actions.

POSITIONS:

The Michigan State Medical Society supports the bill. (5-20-98)

The Michigan Consumer Federation supports the bill. (5-19-98)

The Michigan Psychiatric Society supports the bill. (5-20-98)

Michigan Partners for Patient Advocacy supports the bill. (5-20-98)

The American Cancer Society supports the bill. (5-20-98)

The Crohn's & Colitis Foundation of America, Inc. supports the bill. (5-20-98)

The Michigan Osteopathic Association supports the bill. (5-20-98)

The Michigan Chamber of Commerce opposes the bill. (5-19-98)

The Michigan Association of Health Plans opposes the bill. (5-20-98)

The Michigan Health and Hospital Association opposes the bill. (5-20-98)

The Small Business Association of Michigan opposes the bill. (5-19-98)

The National Federation of Independent Business-Michigan opposes the bill. (5-19-98)

Blue Cross Blue Shield of Michigan/Blue Care Network opposes the bill. (5-20-98)

Analyst: W. Flory

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.