HB 223

Department of Legislative Services

Maryland General Assembly
2001 Session

FISCAL NOTE

House Bill 223 (Delegate Branch, *et al*.)
Economic Matters

Managed Care Entities - Health Care Treatment Decisions - Liability

This bill establishes the liability of a health insurer, nonprofit health service plan, HMO, and dental plan organization (carrier) for damages that an enrollee suffers as a result of the carrier's health care treatment decision.

The bill may be construed only prospectively and may not be applied to any cause of action arising before July 1, 2001.

The bill takes effect July 1, 2001.

Fiscal Summary

State Effect: Special fund expenditures of the Maryland Insurance Administration could increase by $129,500 in FY 2002. Future year expenditures increase with annualization and inflation. Expenditures for the State Employee Health Benefits Plan could increase by a significant amount in FY 2002. Minimal general fund revenue increase from the State's 2% insurance premium tax on for-profit carriers. Minimal special fund revenue increase for the Maryland Insurance Administration from the $125 rate and form filing fee. To the extent that the bill results in an increased number of lawsuits, the Health Claims Arbitration Office and the Judiciary could experience workload and/or expenditure increases. Any additional complaints filed with the Department of Health and Mental Hygiene's Office of Health Care Quality could be handled with existing resources.

(in dollars)	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
GF Revenue	-	-	-	-	-
SF Revenue	-	0	0	0	0
SF Expenditure	129,500	166,900	175,800	185,400	195,600
GF/SF/FF Exp.*	-	-	-	-	-
Net Effect	($129,500)	($166,900)	($175,800)	($185,400)	($195,600)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect
**State Employee Health Benefits Plan – assumes a mix of 60% general funds, 20% special funds, and 20% federal funds; and 20% of expenditures are reimbursable through employee contributions.*

Local Effect: Expenditures for local jurisdiction employee health benefits could increase by a significant amount if carriers raise their premiums as a result of the bill's requirements. Revenues would not be affected.

Small Business Effect: Meaningful. Health insurance costs for small businesses could increase by a significant amount.

Analysis

Bill Summary: The bill imposes the duty to exercise ordinary care on a carrier when making health care treatment decisions and imposes liability for damages for harm to an enrollee for failure to do so. A carrier is liable for damages proximately caused by its agents or employees, but a carrier may claim as a defense that: (1) the carrier did not control, influence, or participate in the health care treatment decision; or (2) the carrier did not deny or delay payment for health care services recommended by a health care provider. The requirement that a carrier exercise an ordinary duty of care does not create an obligation for the carrier to provide an enrollee with a health care service or treatment that is not generally covered under its health benefit plan. Noneconomic damages resulting from a cause of action against a carrier are limited by Maryland's personal injury liability cap, which is currently $590,000, but may vary depending on when the injury occurs.

An enrollee (or representative of the enrollee) may not maintain a cause of action against a carrier unless the enrollee: (1) has exhausted the utilization review appeals process or the carrier's internal grievance process; or (2) gives written notice of the claim to the carrier and agrees to submit the claim, upon the carrier's request, to the Insurance Commissioner for review. An exemption from the above requirement will be made if the enrollee asserts that harm has already occurred to the enrollee and the review by the Commissioner would not be beneficial to the enrollee.

If an enrollee has not exhausted all appeals and grievance processes, a court may not dismiss the cause of action, but may instead order the parties to submit to an independent

review, mediation, or other nonbinding alternative dispute resolution process, and the court may stay the action for up to 30 days for the purpose of resolving the claim. If the requirement to exhaust appeals processes places the enrollee's health in serious jeopardy, the bill does not prohibit an enrollee from pursuing other appropriate remedies, such as injunctive relief, a declaratory judgment, or other relief available under the law.

Current Law: The federal Employee Retirement Income Security Act of 1974 (ERISA) preempts Maryland law as it relates to most employer-sponsored employee health benefit plans. ERISA's preemption of state laws related to liability applies regardless of whether the employer plan is insured or self-insured. An enrollee in an ERISA plan may sue only the carrier to recover the actual cost of any benefits denied and may not collect noneconomic damages.

Background: This bill is intended to provide a clear statutory basis on which a person may sue a carrier or managed care organization and is modeled on a Texas law enacted in 1997 that requires managed care organizations to exercise ordinary care when making health care treatment decisions and imposing liability for resulting damages.

The Texas statute was challenged by Aetna U.S. HealthCare, which argued in federal court that the law was preempted by ERISA. In September 1998, a federal district court judge ruled that the provisions of the Texas law giving individuals the right to sue their carrier are not preempted by ERISA if such a suit is based on a "quality of care" issue, not a "denial of benefits" issue. A Fifth Circuit opinion in another Texas case affirms this distinction between "quality of care" and "denial of benefits" causes of action. While these federal court rulings do not directly affect Maryland law, most states and the federal government are watching how Texas' HMO liability law is interpreted by the courts.

At the federal level, similar legislation has been considered in Congress. In July 1999, the Senate passed a Republican-sponsored version of the Patients' Bill of Rights Act of 1999 (S1344) that amended ERISA to include a grievance procedure for enrollees. The House passed HR 2723 in October 1999, a bipartisan measure, establishing the right to sue insurance companies for damages resulting from denial of care or maltreatment. HR 2723 and portions of S1344 were added as new matter to HR 2990. In February 2000, HR 2990 was tabled because the House and Senate could not reconcile differences within the bill. To date, the bill has not been addressed by the 107th Congress.

State Fiscal Effect:

Maryland Insurance Administration: The Maryland Insurance Administration (MIA) advises that its special fund expenditures would increase by an estimated $478,220 in fiscal 2002 as a result of the bill's requirement that a prospective plaintiff exhaust all

appeals and grievance procedures before filing suit against a managed care entity. This estimate reflects the cost of hiring three investigators, two nurse investigators, and two assistant attorneys general to handle a significant increase in appeals and grievance complaints filed with MIA. MIA's rationale for this caseload increase is threefold: (1) more people will file grievance claims with the intention to later file suit against a managed care entity; (2) the bill permits an individual to sue a "managed care entity," a term that, as defined, covers more than just a health insurance carrier and would expand MIA's grievance jurisdiction to cover more entities; and (3) the bill permits an individual to sue regarding a "health care treatment decision," which would expand MIA's grievance jurisdiction to include quality of care issues and not just coverage and medical necessity determinations.

The Department of Legislative Services (DLS) disagrees. While the bill's requirements would most likely increase the number of complaints filed with MIA, the bill does not change MIA's current role in the grievance process as specified in the Insurance Article. Currently, MIA has jurisdiction over determinations of medical necessity. If a complaint submitted to MIA does not involve a determination of medical necessity, MIA has the authority to transfer the complaint to the appropriate governmental agency for review. For example, quality of care complaints against HMOs are handled by the Department of Health and Mental Hygiene's Office of Health Care Quality. DLS advises that MIA special fund expenditures would increase by an estimated $129,513 in fiscal 2002, which accounts for a 90-day start-up delay. It reflects the cost of hiring one investigator, one nurse investigator, and one assistant attorney general to handle additional complaints. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salary and Fringe Benefits	$120,220
Operating Costs	9,293
Total FY 2002 State Expenditures	**$129,513**

Future year expenditures reflect: (1) full salaries with a 6.5% increase in fiscal 2003, 4.5% annual increases thereafter, and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Office of Health Care Quality: The Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ) maintains an HMO quality assurance unit responsible for investigating HMO quality of care claims that have been referred by the Insurance Administration. To the extent that the bill's requirements increase HMO quality of care complaints, the OHCQ's workload may increase. Any increase is assumed to be minimal and could be handled with existing resources.

State Employee Health Benefits Plan: State Employee Health Benefits Plan expenditures could increase by a significant amount in fiscal 2002. According to a U.S. Congressional Budget Office study of similar federal legislation, removing the ERISA preemption as a barrier to damage awards against health plans would increase health care premiums by 1.4%. *For illustrative purposes only*, if carrier premiums increase by 1.4%, expenditures for the State plan could increase by $6.3 million in fiscal 2002. This figure reflects $600 million in annual expenditures for medical, dental, and mental health benefits, a January 1, 2002, effective date for new premiums, and a mix of 60% general funds, 20% special funds, and 20% federal funds. Twenty percent of the expenditures are reimbursable through employee contributions.

Additional Information

Prior Introductions: Similar bills were introduced in the past three sessions. SB 9 of 2000 was reported unfavorably from the Senate Judicial Proceedings Committee. SB 261 of 1999 also was reported unfavorably from the Judicial Proceedings Committee. SB 84 of 1998 was not reported from the Judicial Proceedings Committee.

Cross File: None.

Information Source(s): United States Code, National Conference of State Legislatures, U.S. Senate, U.S. House of Representatives, U.S. Congressional Budget Office, Henry J. Kaiser Family Foundation, Department of Health and Mental Hygiene (Medicaid, Maryland Health Care Commission, Office of Health Care Quality), Maryland Insurance Administration, Department of Budget and Management (Employee Benefits Division), Department of Legislative Services

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