

Legislative History for Connecticut Act

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those voting yea, 0. Those absent and not voting, 3.

THE CHAIR:

The bill is passed.

THE CLERK:

Favorable Reports, Calendar Page 9, Calendar 621, File 432, Substitute for HB7032 An Act Concerning Managed Care Accountability, as amended by House Amendment Schedule "A" and "B". Favorable Report of the Committees on Public Health, Insurance and Real Estate, Government Administration and Elections, Judiciary, Appropriations, Human Services and General Law.

THE CHAIR:

Senator Harp.

SEN. HARP:

Thank you, Madam President. I move acceptance of the Joint Committee's Favorable Report and passage of the bill in concurrence with the House.

THE CHAIR:

The question is on passage in concurrence with the House. Will you remark?

SEN. HARP:

Thank you, Madam President. First of all, I want to say that this is probably one of the major works of the Public Health Committee --

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Senator Harp, just a moment. (GAVEL) Ladies and gentlemen, it's going to be a very long day. We don't have to make it any longer than possible. I would ask members to please take their seat. Staff and guests please take your conversation out into the hallway.

I would also remind members at this time that roll call votes will be coming fast and furious during the day. The machine will not be held open, so please stay close to the Chamber, and please direct your attention to the Senator who has the floor, in this case, Senator Harp.

SEN. HARP:

Thank you, Madam President. I believe that the bill before us is one of the most important bills to come before the Public Health Committee this year and that's saying a lot, because we've had over 300 bills.

It's probably one of the most important bills to come before the Insurance and Judiciary Committees. So I want to thank my Co-Chair, Mary Eberle, Representative Eberle for her hard work and I just want to say for the record that she probably has one of the finest technical minds in the Legislature and that her technical expertise both on insurance and health care matters has been immeasurable help to moving this agenda item forward, and I want to thank her.

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I also want to thank our President Pro Tempore Senator Kevin Sullivan for using his leadership to bring this issue forward. And some of the coverage issues that were not necessarily popular, but absolutely needed to be done and I want to thank him for using his leadership to assure that that could happen.

I also want to thank the Senate staff, our staff of attorneys led by Mark Taylor, Tony DeFillipis, our chief of staff and Joel Rudicoff for their excellent technical support and expertise and their long hours. This project began really last summer and I want to absolutely thank them for their commitment and unwavering intellectual support.

As well, I want to thank the Senators around this circle who worked on the working group. Senator Peters, Senator Prague, Senator Bozek, Senator Gunther, Senator DeLuca, Senator Aniskovich and Senator Cappiello.

So as you can see from that roster, this is a bipartisan effort. It's something that we worked hard on together. We many times knocked heads but we came together with a result that I think is better for the people of this state. So I want to thank everyone.

On the bill. This bill changes some of the operations, procedures and regulations of managed care organizations and other health care insurers. And what

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I would like to do is to have different people who have been involved in different aspects of this bill tell you a little bit about it. So, Madam President, I'd like to yield at this time to Senator Sullivan.

THE CHAIR:

Senator Sullivan, do you accept the yield?

SEN. SULLIVAN:

I'm very grateful and very honored to accept the yield from Senator Harp. And in so doing, Senator Harp has been generous as she always is, in expressing her appreciation to many people who worked on this. The many people who worked on this would multiply that appreciation, that gratitude and that praise for Senator Harp.

She is without question, one of the most dedicated members of this circle, one of the most hard working and a person who's vision has kept us on course for what we will pass today and I sincerely believe this, and I believe the people of the State of Connecticut will believe this, Senator Harp, is the single most important piece of health care legislation that this Legislature has had na opportunity to do in a very long time.

We were glad to work on it. I'm glad to be able to speak to my small piece of it in a moment, but it would not have happened without your work, your leadership,

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your guidance and your dedication. We all owe you appreciation and thanks for that.

The part that I am most appreciative of and happy to have an opportunity briefly to speak to here today has been long in coming for the State of Connecticut. And it is one that has not captured the imagination of groups of people around the state perhaps as much as some of the other items that will be talked about today in terms of coverage and care, but it is one that is in my humble estimation, the most significant extension of coverage that we do today.

A couple of years ago we had an opportunity for the first time in Connecticut to bring into required coverage, biologically based mental illness, and that was a major step.

Today, in this legislation, Connecticut joins the lead in this nation in full parity. Full equality of treatment and coverage for mental illness and mental health care.

I cannot overstate how grateful I am to Senator Harp and Representative Eberle for their willingness from the very beginning of this process to hang tough and hang together on the assurance that we will take Connecticut out of the dark ages and fully into the modern age of care and compassion and treatment by

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assuring that whatever form of coverage one has in this state, and whatever your needs are within the area of mental illness, that we will not turn you away and we will not offer you second class treatment and second class care any more.

Now, I know that some of my friends in the corporate community and I say my friends because they are my friends and I'm proud to work with them, that had misgivings about this portion of the legislation and I have tried and tried and tried as hard as I can to explain to them that old adage about an ounce of prevention being worth a pound of cure.

And that the things that we don't treat simply don't disappear, we pay for them in some other way. Nothing could be more true than this of the area of mental health care.

Just because we have not traditionally covered it, doesn't mean that there are not thousands upon thousands of people in this state who are not receiving mental health care and who are not working, not contributing, not participating, not leading their families and just because we don't cover it doesn't mean we haven't been paying for it.

We've been paying for it the wrong way. We've been paying for it when a person can't show up at work

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because of chronic and long-term depression and can't get treatment and care.

We pay for it when a person shows up at work with a treatable and curable mental illness that makes it impossible for them to be productive employees.

We pay for it when there are secondary symptoms of mental illness that manifest themselves because we will not treat and cure the underlying mental illness.

We pay for it in all those ways at far more cost than we will do under this requirement in this bill, because this says that you will get treatment early, you will get it fairly, and we will finally recognize in this state that mental illness is not some strange concoction in the mind of folks, it is a disease like any other disease, treatable and in many cases curable.

There has been a revolution in mental health care and mental health medication in this nation that goes on to this day and will continue to go on. Problems like chronic depression, the single most widespread illness in this society. Surprising statistic, but true. Not heart disease, not cancer, not all of the other things we talk about. But depression. Particularly among the elderly, but among everyone in this population."

We have an opportunity in this legislation to say that we know we can treat it. We know we can give

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people active and full lives and in many cases we know that we can relieve them of that mental illness and that's only one example.

That's what this bill does today. To thousands of people it gives hope. To thousands of people it gives care, and to all of us, all of us, it gives an assurance that the public policy of the State of Connecticut will at last recognize that mental health is part of the mainstream of medicine and is part of the mainstream of the expectation of care that each and every one of us should have.

Tipper Gore just this week convened at the national level, a national symposium on this topic. She is one of the many brave people in this country who have not been deterred by the traditional stigma against mental illness. She has spoken out and talked about what it has meant to her to fight with, struggle with, and overcome.

Today, we draw back that curtain on others and we say there's nothing wrong with you that we cannot help you to live with, to be cured of, and to be treated for.

And with this, and thank you, Senator Harp; Connecticut joins the leadership of America in saying that in this state, no person will be denied coverage.

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No person will be denied the opportunity to be a full and functioning member of this society because mental health care is not available under their coverage.

This is a day that I've waited for a long time. Senator Harp, you've made that day possible. Thank you.

THE CHAIR:

Thank you, Senator Sullivan. Senator Harp.

SEN. HARP:

Thank you, Madam President. I'd like to yield to Senator Williams.

THE CHAIR:

Senator Williams, do you accept the yield?

SEN. WILLIAMS:

Yes, thank you, Madam President. I rise to discuss the office of managed care ombudsman, but I would like to also thank Senator Harp for her extremely hard work in putting together an excellent, if not landmark legislation in terms of reform of managed care and also to thank her Co-Chair, Mary Eberle.

Mary and I served for a number of years on the Insurance Committee together and she has toiled long and hard on these issues as well and has worked very hard in putting together this package. And I've enjoyed working with her on this particular issue as to the ombudsman. And also again, to thank our leadership for making this

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a priority of the session.

Health care in the United States has changed dramatically in recent years, and it's to the point where I think the time is more than appropriate that we in Connecticut have an independent office, an independent ombudsman and advocate for our consumers of health care, the patients in need of assistance and medical care.

And what we have done here in this bill is to create that independent office of ombudsman. The powers of the ombudsman are as follows. The ombudsman may assist health insurance consumers with managed care plan selection, assist insurance consumers to understand their rights and responsibilities under managed care plans.

And I think this is extremely important because we've already embarked on some managed care reform in years past. We've created an independent appeals board which has great promise for the future but at present has been greatly underutilized.

So to the extent that we can reform the system and create new rights for consumers and new responsibilities for those who deliver health care, it's incumbent upon us and upon this office to make sure that patients and consumers know their rights and can take advantage of

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those rights and that the responsibilities that we impose upon HMOs in the managed care industry, that those responsibilities are fulfilled and that they deliver the first quality, top quality health care that we've come to expect in Connecticut.

In addition, the ombudsman will provide information to the public agencies, legislators and others regarding problems and concerns of health insurance consumers and to recommend positive change for the future, to assist consumers with the filing of complaints and appeals, to analyze and monitor the development and implementation of federal and state and local laws in what is an ever shifting quilt and we're looking to the federal government for new developments there and to be able to integrate those with what we do at the state level.

The ombudsman will be able to review the health insurance records of a consumer who's consented to such a review, to require that employers post a notice as to how to get in touch with the ombudsman so that the employees can learn about the rights that they will have in Connecticut.

To establish a toll free number so that consumers in Connecticut can have easy access to the managed care ombudsman and to pursue administrative remedies on behalf of and with consent of any health insurance

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consumers, so that to actually help with the filing of appeals and to see those through to the extent that consumers in Connecticut get the administrative remedies that they're entitled to.

In short, to assure to the greatest extent possible that the people in Connecticut who are entitled to the provision of health care at the highest level, get that health care, so that we do not have people who are denied care that they need that can adversely impact on their health.

The managed care ombudsman shall be a resident of the State of Connecticut with expertise in the fields of health care, health insurance and advocacy of the rights of consumers. We need to appoint, through a process by which we will have an advisory committee, which shall recommend candidates to the Governor and the Governor shall appoint by June 1st of next year the ombudsman.

And I think also I'd just like to briefly touch upon the fact that there's some very stringent conflict of interest provisions here. This has been ever more important in state government in recent years and I guess it's extremely important here that it be noted that there's the so-called revolving door provision.

So someone who is the health care advocate and ombudsman today cannot be the corporate director of the

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managed care company tomorrow.

And finally, Madam President, the managed care ombudsman will report back every single year to this Legislature to tell us about the progress that's been made in health care generally. Tell us about the progress of the office of the independent ombudsman and to make any recommendations about how we can improve the delivery of health care services to our people in Connecticut in the future.

So again, thanks to all of those legislators who have made this entire bill a package that we can be proud of this year. Thank you.

THE CHAIR:

Thank you, Sir. Will you remark further? Senator Cappiello.

SEN. CAPPIELLO:

Thank you, Madam President. I would also like to thank Senator Toni Harp and Representative Mary Eberle as well as the rest of the members of the working group.

There were times when we did knock heads on certain issues but in the end we all came together to compile what I think is a very good bill this year.

I think Senator Sullivan was right. This is landmark legislation and I would like to cover a few areas of the bill.

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Two years ago in 1997, we had passed a prompt payment legislation for physicians. And that legislation said that an HMO or insurance company must pay a provider within 45 days of receiving a claim unless otherwise specified in contract.

However, we found that there were some loopholes in that legislation. So this year we tightened up those loopholes and we are saying that right now after this bill takes effect, that an HMO must pay a physician or a provider within 45 days regardless of contract.

However, if their claim is unclear, if there are issues with the claim, the insurance company must report back to the insurer, or, to the provider, within 30 days what is unclear about their claim. Then once receiving the information back from the provider, the insurance company then has 30 days after receiving a clean claim, to make payments. After that, what is already specified in law they will pay interest on their payments.

We have also dealt with a section regarding coverage determination. This means that all health plans have to complete any coverage determination within 45 days of receiving the request. And in the case of a denial, they must notify the insured and the provider why they are denied.

I think we have done this because in some cases it

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may not be the insurance company who had made the mistake. Quite possibly, it could be the physician who may not have submitted something to the insurance company. This way, it puts some control into the hands of the consumer so they know who is at fault here.

We also have a, we have tightened up the appeals section, the internal appeals. This requires all health plans to complete all appeals, regardless of how many stages they have within 60 days from commencement and this is in compliance with the current NCQA regulations.

This can be extended if the member requests to do so.

And finally, the last section of the bill that I'll be covering is something that is near and dear to me, and that is mandating prostate cancer screening. This will mandate, cover all plans to cover PSA tests for gentlemen who are over 50 years of age or if they are in high risk categories or if their family is known to have prostate cancer.

And I think this will go a long way in helping deter, helping get to this issue very early on because we all know that curing prostate cancer, the first step is always early detection.

And I would like to now yield to Senator Louis DeLuca.

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Senator DeLuca, do you accept the yield? Senator DeLuca.

SEN. DELUCA:

Yes, I do, Madam President, and thank you. I also would like to thank Senator Harp and Representative Eberle for their leadership in bringing forth this managed care accountability bill that addresses many of the concerns of the people of the State of Connecticut, and also for their leadership in managing a diverse group of people who had many different ideas and at many times extremely different ideas, and bring them all together to product a work of this.

I'd like to talk about three sections of this bill.

The first one would be unfair methods and acts and practices. This section of the bill extends certain provisions of the insurance unfair prohibited practice law that currently applies to health care centers, otherwise known as HMOs, to managed care organizations which means that an insurer health care center, hospital and others of that.

These provisions include the prohibition against misrepresentations, false information in advertising and unfair claim settlement practice.

It also extends to managed care organizations the insurance commissioner's existing authority to enforce

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these prohibitions and to order cease and desist on those activities he believes to be unfair and prohibited practices.

Failure of managed care organizations to establish required confidentiality procedures for medical records would also be an unfair insurance practice under this act.

And it also allows the insurance commissioner to adopt regulations implementing these provisions.

If a violation is found, the commission must issue a cease and desist order after a hearing if he determines they have engaged in these type practices and it must be served in writing and served on the managed care organization. And if found guilty, there are a number of penalties that could be assigned starting from \$1,000 for minor acts up to \$50,000 in the aggregate for some serious ones.

And one last thing in this section that any response to a violation by the commissioner of these positions, does not and I must emphasize, does not relieve or absolve the managed care company from liability under any other state laws.

Another section that was added which is similar to that which was just explained by Senator Cappiello is diabetes training. In this section it requires that

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individual and group health policies cover outpatient self-management treatment and training for the treatment of insulin dependent or noninsulin using forms of diabetes.

It requires up to ten hours of initial training visits, including nutrition counseling and the proper use. Up to four hours of training after a doctor's subsequent diagnosis shows that the change may be, there may be a change in the symptoms that require modification and up to four hours because of new techniques.

And these would come under basic medical expenses and all policies in the State of Connecticut either issued or renewed or continued in the state beginning January 1st must contain this coverage.

And the last section addresses inpatient dental care which would cover general anesthesia, nursing and related hospital services provided within hospital dental services under certain conditions.

If the anesthesia, nursing and related services are deemed medically necessary by the treating dentist or oral surgeon, the patient if it's either a child under the age of four as determined by a licensed dentist in conjunction with the primary care physician and a person with development disability.

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The expenses of this anesthesia and other related hospital would be deemed a medical expense under the policy and cannot be subjected to any limits on dental benefits under the policy. And these also would have to be included in policies that are either issued, renewed or delivered starting with January 1, 2000.

And again, I'd like to thank all of those that participated in bringing this to this floor today and I would like to yield now to Senator Peters.

THE CHAIR:

Senator Peters, do you accept the yield?

SEN. PETERS:

I certainly do, Madam President. Thank you. Before I speak on the two brief areas in the bill, I'd just like to say that I have profound respect and admiration for my two friends, Toni Harp and Mary Eberle and their ability to bring about the debate, the dialogue and reach agreement on such a very difficult issue.

As a nurse for thirty plus years, some of that as a psychiatric nurse at all, I've got great interest in what we're doing with respect to the delivery of care, namely managed care in this state and I am so proud to be connected even in a very small way, not only to the two leaders of the committee, but to this initiative.

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And I want to thank you for allowing me to do that.

I'm going to be speaking on two areas, two that I care a great deal about. One being the experimental treatment coverage. And as someone who has watched the denial of treatment on many cases, and be very, very distraught, I'm happy to say that this really moves our state's policy forward in accepting cases based on a criteria and a protocol.

They will no longer be able to deny treatment willy nilly, based on the quote, unquote, definition of experimental. It ties it to the Food and Drug Administration Phase Three Clinical Trials.

It also speaks to where there is a threatened life expectancy of under two years, offers an expedited procedure to challenge through the HMO and then on to the appeal to the insurance commissioner. And the internal appeal is two days and it immediately goes to the external appeal. So we believe that by definition in this bill, we will be able to harness what protocols and procedures should speak to with respect to experimental treatment coverage.

The other part of this bill that I just am very pleased having been a recipient of Lyme Disease three times myself and I'd like to just add as a little anecdote here, Madam President, at 5:00 o'clock in the

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morning when we arrived home after session, my husband was waiting up so I could remove a tick from underneath his armpit. And being half blind, I was hoping to do the right thing and I can say that I clearly, having had the experience, as many Connecticut residents do, was able to take care of the situation.

So I stand here very proudly, Senator Harp, and members of the circle, to say that we are in fact taking a much more progressive approach and attitude toward our treatment, our recognition and our treatment of Lyme Disease in this state and I think we've earned that honor, certainly based on the cases that we've dealt with within our own borders.

So with that, briefly, I'd like to say that this not only, and it's a total of 90 days and this is initial, initial, 30 days of IV antibiotic therapy, 60 days of oral antibiotic therapy or both, bringing us a total of 90. And if that doesn't work, ladies and gentlemen, then you can go for a second opinion. And you have a realm of three specialties to get that second opinion.

This part is very important to me as a health care provider because I firmly believe that the reason why we have such extended cases of Lyme Disease in this state is that we have not had a unified approach to this, and

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that we do, in fact, have some caregivers not identifying and diagnosing the disease early enough to get early treatment.

This harnesses that for second opinion to rheumatologists, infectious disease specialists and neurologists, all specialists in the field of Lyme Disease and treating Lyme Disease.

So we're saying not only are we going to extend your treatment but we're saying that we're going to give you the second, the opportunity to go for a second opinion and we're saying you can go to the experts that can diagnose and treat effectively and that that treatment going forward will be covered under your HMO plan.

It also says that it follows the plan, depending on your plan, either out of network or out-of-state services. I think that this is just, I couldn't be more pleased. And I'd like to say that this not only involves the experts but it also involves the victim's concerns.

I want to thank Senator Harp and Senator Eberle for moving this forward.

THE CHAIR:

Thank you, Senator Peters. Will you remark further? Senator Peters.

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SEN. PETERS:

Thank you, Madam President. I would like to yield to Senator Bozek at this time.

THE CHAIR:

Senator Bozek, do you accept the yield?

SEN. BOZEK:

Thank you, Madam President. Madam President, I, myself being on the Insurance Committee, also wish to congratulate and thank all the participators who helped in the drafting of this language and brought information to the Committee during the few months that we worked on this particular project.

And I, too, want to commend leadership in the Connecticut Legislature. Among them, my Caucus, Senator Sullivan and Toni Harp, especially, and Senator Williams, who were leaders in moving legislation which came up in their committee with regard to the Judiciary Committee, the Public Health Committee and the Insurance Committee.

I wish to also point out the thanks and support that we received on the Insurance Committee and the members who I work with there, because numerous insurance measures exist in this bill, which were a reflection of bills that we have moved out of Committee that found themselves, of course in the foot area.

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But what happened is, the importance of moving these issues and some mandates forward allowed the Insurance Committee to demonstrate the importance that issues are with regard to this omnibus type bill.

And the cooperation between the three different committees is a product that we are looking at today. Just quickly let me point out an area that I want to make reference to that's very important as a consumer supportive person, and that is one that deals with the physician profiles. I'll do this very briefly and just enumerate some of the areas that are of concern.

The first piece of information that doctors, physicians will be required to give and that the consumer will be able to look at will be the education and the practice information that the doctor has in his background. The consumer will be able to understand and know the physician's medical education and his practice.

And his practice will include his medical school, his training, his discipline in the science, dates of post graduate education and his practice specialties.

They will also be able to know where his business addresses are with regard to his practice and his practice locations.

They will be able to know his current certification, when it was issued by the American Board

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of Medical Specialties and they'll be able to know which hospitals and nursing homes that the doctor has privileges to and also he'll be able to know about the appointments to the Connecticut Medical Society faculties, what faculties he's a member of and any publications that he's delivered and any peer reviews that have been brought forward in the literature that he's printed.

They will also list his professional services and his awards so they'll be able to know the background that the doctor has in his specialty and discipline.

They'll be able to know about with regard to the safety and sense of any type of actions that may have been brought against him. The disciplinary actions will be available and the profiles must indicate the disciplinary actions that the doctor has which pertain to any terminations, resignations or restrictions or privileges that have been beset him in his career practice in the last ten years.

They will also know of any criminal convictions within the last ten years and they'll be able to know whether he had pleaded guilty, no contest or he was found guilty after an innocent plea.

The last area within this concern of the physician's background is the medical malpractice

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claims. The file must contain all extended available information with regard to medical malpractice and court judgments, arbitration awards and settlements and safe to say, they will be able to know about the claims that were paid, the judgments that were made, settlements that were provide and all of this information will be in order to protect the physician himself.

There are some safeguards with regard to him being able to say not how much they were, what the exact figures are behind them, but that they occurred and that there were different types of settlements.

Also, malpractice claims may have happened years before the payment was made and its work in legal system and they'll be able to delineate the fact that while they were sued some time ago, the relevant claim was settled over what period of time.

In order to protect the physician, any information that is put on this profile by the physician will be given to the physician to review before it's put on the Internet. And with regard to this information, the physician will have 60 days to review. If he disagrees with any of this publication, he will be able to disagree and what will go forward is all the other information until the disagreement is resolved.

And with regard to any other poor information that

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might have come forward for some other reason and was proven inaccurate for some other reason and he has some complaint, information will be omitted in the future. So with regard to the area of this omnibus bill and physician services and practices, the public will have the knowledge and sense, good sense of knowing about their doctor, his background, his education, any discrepancies and have the comfort level that they are attending and getting service from a doctor with regard to his competency should actually some way help their mental health, so to speak, in making sure that I'm going to the right doctor, I feel comfortable about the doctor.

In that regard there's no second opinion about getting some misnomer or some rumor that's being spread by somebody else about some physician who somebody had a disappointing service with.

With that, Madam President, let me conclude by saying I once again thank all the members who are on this amendment and all the people who served on the committee and especially the members of my Insurance Committee. Thank you very much.

THE CHAIR:

Will you remark further?

SEN. BOZEK:

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And I'd like to at this time yield to Senator Edith Prague.

THE CHAIR:

Senator Prague, do you accept the yield?

SEN. PRAGUE:

Yes, I will, Madam President, and through you, I thank Senator Bozek.

Madam President, I, too, want to thank Senator Harp and Representative Mary Eberle for their outstanding work on this issue. I honestly think that they have done more than they really realize, that this is the beginning of the upturn of this cycle in the delivery of health care in this state.

For too long, the insurance industry has controlled the delivery of health care. For them, as business people, the bottom line has been their profits.

At this point in time, we're beginning to turn that corner of the Legislature in control of the delivery of the health care needs of the people of this state and it is through the efforts of the people who worked on this legislation under the leadership of Senator Harp and Representative Eberle that this turn is now beginning to take place.

I want to address two of the issues in the bill that have been a source of difficulty, particularly for

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the seniors who have been on medications because of a chronic illness.

The section of this bill that deals with prescription drug formularies, clearly dictates that for those people who have been on a particular drug for a chronic illness will continue to stay on that drug and that their insurance coverage cannot change because they have changed their formulary, cannot change their access to that particular prescription.

It has to be documented by the physician that it's medically necessary which is fair. It has to be documented that other drugs could not do what this drug is doing for that particular patient. That's fair.

But the big victory for people is that in the final analysis, they will be able to stay on that particular drug that has worked so well for them and the fact that the insurance company no longer covers it is unimportant because for these people it will have to continue to cover it. This will be in effect as of January 1, 2000, and clearly, particularly for the senior population, this is a great victory.

The other issue that I'm going to bring out is the issue of public education. And I'm wondering how many people around this circle know about the appeals process and what the procedure is.

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The insurance commissioner will be mandated to get that information out there, to make it available through various community based groups about the availability of the appeals process and describe how that process takes place.

With the introduction of an ombudsman, the ombudsman will be very involved in helping to get that information out to people. So, ladies and gentlemen, I'm going to yield to Senator Harp, but before I do so, I sincerely want to thank her for the power that she has and in using that power for the benefit of the people in the delivery of health care in this state.

THE CHAIR:

Senator Harp.

SEN. HARP:

Thank you, Madam President. I want to thank everyone for helping me to bring out the bill. The last part that we're going to talk about very briefly is the confidentiality aspect and the bill extends existing standards for the collection, use and disclosure of personal information obtain in connection with insurance transactions to medical record information collected by the managed care organizations and other entities.

The bill prohibits the sale or the offering for sale of individually identifiable medical record

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information and for disclosure of that information, it requires written consent from the individual before disclosure for marketing.

An individual harmed by a violation of disclosure or sale of individually identifiable medical record information may sue for equitable relief, damages, or both. And the bill requires that the insurance institution and other entities develop written policies, standards, and procedures for the management, transfer and security of medical record information. If that is not maintained and if it's disclosed, there are violations.

I want to once again thank all of the members of the working group who worked on this very comprehensive bill and I want to urge your support.

THE CHAIR:

Thank you, Senator. Will you remark further?
Senator Aniskovich.

SEN. ANISKOVICH:

Thank you, Madam President. Madam President, I rise in support of this bill. I want to join my colleagues who have congratulated for their hard work, Senator Harp and Representative Eberle.

As a member of the working group, I had witnessed personally, their devotion and perseverance in crafting

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at difficult times, a piece of legislation that would balance the variety of interests that are at issue here on a piece of legislation like this.

Madam President, at the beginning of the session and I think well back into the last campaign cycle, many of us stood before our constituents and said what I think we would all agree with today and that is, that the time had come in Connecticut to put people at the center of our debates about the managed care law in Connecticut.

For many years we have listened to a variety of voices influence the process of managed care reform, and we agreed with many of those voices and took steps to protect the important policy concerns that they presented to us and articulated, and we made it possible I think, to craft laws that serve the best interests of the people of Connecticut.

We heard voices in the business community that complained that the cost of health care had risen to a point where it had become a negative factor in maintaining a job base in Connecticut and so we allowed the introduction of managed care as a means of keeping premiums down for businesses who pay a bulk of that cost in Connecticut.

We listened to providers whose voices said that

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they wanted to get paid on time and that they didn't want the interference of nonmedical professionals in making determinations about the quality of care and over the years we have moved into areas where there were clearly, clearly places where insurance companies and other entities had made the wrong kinds of decisions whether it was drive by deliveries or other areas where we needed to step in and say as a matter of public policy that providers are right.

We heard those voices and I think we responded correctly to make sure that the best interests of all our constituents were heard.

We listened to insurance companies, whose voices told us that they wanted to be able to price products in a manner that allowed them to get coverage to most people, to get coverage to as many people as possible while still being able to make a profit on those products and we recognize the importance of that aspect of this industry and we heard those voices and we responded in ways both statutorily and otherwise, both in proactive measures and in not enacting certain things that would allow them to continue to engage in that process of pricing products in a profitable manner.

Madam President, today we celebrate the fact that the voices of people who receive health care have

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finally had their voice heard. This bill, by balancing a variety of claims to public policy resources and to laws and statutes, allows people to get the attention that they want.

They're not concerned when they are sick, when their children are sick, when they're grandparents and the other elderly citizens who they know are in trouble with what the state of the managed care law is with respect to insurance pricing, with respect to timely payment of claims, with respect to what the premiums are and how that affects the macro economic situation of business in Connecticut.

When people are sick, they want attention to their health care needs. In fact, what this bill says is, they deserve attention to their health care needs and the voices of people who need health care should be placed at the forefront of our public policy debates.

But more so than the people whose voices have been heard in those areas today because of the hard work of people like Senator Sullivan and Senator Harp, people whose voices are not typically heard, even in this building, the voices of the mentally ill and the voices of substance abusers are going to be addressed as well.

People who will never reach a place in this building that is equivalent to the power of the business

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community or the provider community or the insurance industry.

Those people will not get the attention that they deserve unless those of us in this building rise to articulate the issues of primary concern to them, and this bill, through its provisions with respect to confidentiality and parity, finally begin to address the real situation that applies to those populations in Connecticut.

As Senator Sullivan pointed out, we are paying the costs associated with mental illness and substance abuse. We are paying the costs in other areas, in other institutions of our state where it is much more costly to pay for their needs, where it is much less humane and much less capable of producing a long-term positive result than addressing the issue up front in the health care system.

Madam President, this bill through a balance will allow us to serve the needs of the people of our state and to walk away from this building and feel very satisfied that we have made a very beneficial step in the direction of quality health care for the people who live in our state.

And I thank the people who worked on this bill the most and I thank the members of this Legislature and

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already the House who will make this possible for us to send this to the Governor for his signature and I am sure that it will move down to the benefit of the people who live in this state. Thank you, Madam President.

THE CHAIR:

Thank you, Sir. Senator Freedman.

SEN. FREEDMAN:

Thank you, Madam President. I, too, rise in support of this piece of legislation and I would like to thank all the people that worked so diligently on it.

Having just done similar work on a bill through the Education Committee, I know how much time and how much discussion there has been to arrive at a compromise, and I would just like to thank Senator Harp because I think she addressed many of the concerns that we have heard from our constituents and that she did take leadership in bringing all the various parties together.

I believe Senator Peters alluded to the area on the Lyme Disease which in my area has become really almost a massive invasion for people in terms of the deer, the ticks and people becoming ill and it's almost epidemic.

And one of the most interesting things has been, that I've heard from most of these people and they wanted to make sure that when we did changes in our health care that they would be part of the offerings of

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the insurance companies.

I think they will be at least happy that we've started to move in the direction to give them the needed coverage and I was happy to hear Senator Peters refer to the three types of physicians that would be also involved in this.

I'm not sure how many people realize it, that so often the symptoms from Lyme Disease to undetected because they are so bizarre. And until it is finally diagnosed and treatment can be accommodated, most people don't even realize that they're walking around with this malady.

I also would like to comment my colleagues on addressing the issue of prostate screening. Again, like mammography, it's all in the are of prevention and I believe Senator Sullivan said it correctly when he said prevention saves us the money up front for later on when it becomes very expensive.

So I would hope and I suspect that most people in this Chamber will vote in favor of this bill, recognizing that we have made a giant step in the right direction. That yes, we will probably have to come back and revisit, but at least we're starting to address the issues that the constituency has told us about, that the physicians have told us about. And for a healthy

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Connecticut, this is a move in the right direction.

Thank you, Madam President.

THE CHAIR:

Thank you. Senator Gunther.

SEN. GUNTHER:

Madam President, I rise to support the bill. I will say that maybe I expect too much out of the Legislature and that, but I was hoping that we could do everything we should have done this session because I think that the last election, health care and the deficiencies in health care and that was major issues in the State of Connecticut.

And there was an awful lot of promises made. I think almost by about 36 people in this circle, there were certain areas that were going to be addressed and I find some of them are not being addressed.

As far as we've gone, and incidentally, I think the accolades belong to Senator Harp and Senator, or rather, Representative Eberle, I almost moved her upstairs and the rest of the Committee. They certainly put a lot of time in.

However, there is predominance of the attitudes toward the language that's in this bill that relates more to insurance than health care.

In my other life, I spent 47 years as a

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naturopathic physician and of course, that's now known as alternative medicine. And I'll tell you, Madam President, I wouldn't want to practice medicine in the State of Connecticut, or for that matter, almost in the United States from what the doctors have to put up with.

If we could only put the doctors back in the practice of medicine, there's a lot of language that we wouldn't need in this bill. All these mandates that are set up in this bill, really, that is the doctor/patient relationship and one of these days we're going to have enough guts to come up here and put the doctor back into health care.

Now there's things in this bill, incidentally, I will say it was an improvement in the well, we don't call it ombudsman anymore, Senator Williams, we call it ally. Because that's a nasty word, ombudsman, and you don't want to talk about that. Unless we got another thing going for us.

Oh, I'm sorry, the nomenclature went back to ombudsman. I almost lost my head for a minute, Madam President. Everything in terminology again, ally, I thought that was interesting anyway, to have an ally in state government.

But the thing that bothers me with that and it's independent of the Insurance Department. I can't say

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that with the language that's in this bill, Madam President and the requirements for that ombudsman, leaves a lot to be desired. As in appointing that particular ombudsman, it shall be an elector of the state with expertise and experience in the field of health care and advocacy.

As far as I'm concerned, that should be a health care provider first. I'm afraid that we're going to wake up when we get to this appointment, which incidentally I think is one of the areas that we have politics being put into this, when we have the advisory committee made up of politicians, or maybe I should call them statesmen because it is the leadership of the House and the Senate and the leaders in the Legislature itself who are going to make that recommendation.

But I almost look over in the east there and I see some lawyer that needs a job that he might have the health care expertise being picked to go in there and be this ombudsman, when in my book it should be somebody who is in the health care professions and knows something about health care and not reading it out of the files of the Statutes of the State of Connecticut.

If I may take a couple of seconds here. There's areas in here, if we go back into the section relative to medical professionals. I brought this to the

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attention and I got an answer, but I want to be sure that the record shows that the description of medical professionals means persons who are licensed and it enumerates chiropractor, clinical dietician, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist and psychiatric social worker or speech therapist.

Madam President, it deletes my favorite subject, a doctor of natureopathy. Now, I understand that this language came out of the malpractice portion of the state statute. And that might be all well and good, but I think for intent, I would like to say physician as a title is actually either MD, MB or osteopathic physician and chiropractor.

So that to identify chiropractic physician in one section of it and then use the generalization of a physician I think should be clarified and all these professions should be included in the medical profession description. And I say, I take it that that's implied by the fact that they do use the term physician.

I get a little concerned in that section and it's repeated over and over and over again, that it can be a psychologist, a physician, and then it enumerates many other people who are in the health care for the mental

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disorder side of it.

Now, it also has terminology in here which implies, and I'm quite sure they don't mean it, and the interpretation that I'm afraid could be, and that is that the benefits payable for the services of a licensed physician or a psychologist or they then go and enumerate either social workers, marriage counselors and that type of thing.

I don't think there's an implication here that they're going to get the same fee as the physician or the psychologist. Because if it is, that is certainly not what I think was intended and I think there should be a definite knowing that that is not what this bill does and that is give parity as far as the fees are concerned with all of the rest of the health cares that are enumerated in this bill.

Incidentally, Madam President, I'm really almost amused at the descriptions that we're using for the disorders like the medical disorder of defining it in law when I think this is something that really has a broader interpretation that should be there by the licensed physicians of the State of Connecticut.

There is also a section here which relates to diseases that are medical complications of alcoholism which I find very interesting and that identifies

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cirrhosis of the liver, gastrointestinal bleeding, pneumonia, and when we get into that, frankly, alcoholism isn't the only cause of cirrhosis of the liver. I know teetotalers that have died of cirrhosis.

Gastrointestinal bleeding can be anything from hemorrhoids to gastric ulcers to ulceration of any part of the gastrointestinal system, much of which is a pathological condition which doesn't have to be associated with alcoholism, but we define it in law that that is a complication of alcoholism.

In the profile, and incidentally, Madam President, I support the profiling of medical people and everybody in the provider field. But I'm very concerned over part of the definition in this. It says all medical malpractice court judgments and all medical malpractice arbitration awards against the physician in which a payment was awarded or complaining party during the last ten years.

You know, having practiced as long as I have, 47 years, that there are, I know, and incidentally, I never had a complaint or a malpractice case brought against me and I've never had an award given. I'd be very happy to have my profile in the profiles of the State of Connecticut.

But I'm just concerned about so many of the doctors

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out there and this litigious society that for the last provocation or for anybody who has a good competent lawyer who would like to pursue a case, I worry about going back ten years of a doctor's record when many times nuisance cases might have been brought against him.

And maybe he took and said well, look, I'd rather bow out of this thing than have all the adverse publicity and went along and contended that the nuisance was okay, only to have this show up in his record without a full explanation of it. And yes, I know they can come in and say, look, I want a clarification of this.

But that's going to be open record and I would hate like the devil to take and see the insurance companies have all these nuisance cases settled and have them show up on the profile of doctors and have it go against many good, competent people.

I'm concerned also about the opportunity for them to rebut in the 30 day period the information that's in the profile. The doctors today are spending about 10% or 15% of their daily time just calling up HMOs and getting clearance for treatment and that.

If a letter comes in, only one notice comes in to that man in 30 days and it happens to get sidetracked in

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his busy office and he doesn't have an opportunity to take and rebut that, why that's going to be in his record and he has no recourse after that but to have it in his record. So I do think that there could be ways of having more than one notice to that.

I find in the description of how the boards, the various boards, and especially the medical board can authorize, restrict, suspend or revoke a license and identify some, oh, eleven areas where they can be brought up on charges and be restricted, suspended or revoked in their licensure.

One of them, number 7 is failure to adequately supervise a physician's assistant. We just passed a law this year that gives the advanced practice RN the opportunity to independent practice after having collaborated in the protocols with the doctor.

That should have been added to that particular area because if a doctor fails to properly get his protocols and observe that advanced practice RN, then certainly it should be opened up for the possibility of getting restricted or losing the license, depending on the severity of that particular complaint.

I get a little concerned, also, like I know Lyme Disease is very popular to have that mandated, and all I can say is, they've identified that for further

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treatment to get the recommendations by a board certified rheumatologist.

I think that many of the doctors in the field find out that having board certification, many times is desirable but we have many men who are in the field who are very, very competent who have never qualified and gone into the board certification and they should not be disqualified from being in that particular position, although you're talking about also allowing neurologists and people in specialties that can also be one of the second opinion people.

Incidentally, Madam President, I think that it might be a good idea because of the condition of Lyme Disease and knowing, there are many practitioners in the medical field and for that matter, in every other provider field that are not fully competent to either diagnose or to treat Lyme Disease.

Maybe seminars ought to be put on and be made mandatory in order to be covered for this particular type of mandated coverage in an insurance policy that they be mandated to take these seminars to be certain that they know of the latest treatments the latest protocols, the latest diagnostic procedures that should be brought into that.

These are just some of the deficiencies that I feel

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that we have in this bill. In fact, the one area I feel very badly about, and that is the liability that was supposed to be in this bill but it has, while I think it's gone down to the deep six earlier today.

I think it's unfortunate that we've gone through years, and being on the Public Health Committee, we've had testimony oh, for at least the past four or five years and the dialogue has always been, right now in the State of Connecticut we have the right to sue the HMOs and that, if they have actually been responsible for adverse affects on a patient.

And of course last year we see one case that went to the Supreme Court but it took them to go to the Supreme Court of the State of Connecticut so that they can get the opportunity, that they can bring that case against the HMO.

If this is the case and this is the law, there is no reason that we can't define that in the law of the State of Connecticut. I'm very disappointed to see that all the bills that were working their way through, that the liability has been sidetracked and of course, we're dead for another year.

Now we could all come up with amendments and that type of thing at this point, but I think we all know the truth of that. This is the last day and any possibility

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of getting an amendment on a major bill like this is pretty much like a snowball in hell, so that as far as I'm concerned, this is a deficiency that we shouldn't have left this session without clearing up and by having that into the state law.

And incidentally, the State of Texas has that law and if you'll take and look at the experience of Texas, they've had a minimum increase in the cost of policies because of that liability law being down there. There is experience down there in that. And of course, we can get enough statistics for every other are of things that we want that are going into this bill but we can't look at the experience, pardon me, of the State of Texas.

Madam President, I wish that we could have done a total job. I'll say it's a good job. I think there's been a lot of work in it. But I keep worrying that we keep getting the doctor to have more and more work and more administrative costs and there's nothing in this bill that will cut back on the administrative costs of the average doctor's office.

And you know, the day of the doctor, nurse, receptionist is gone, probably gone forever. You walk into a little one doctor, one nurse office. He's got five and six people in the front office just handling the documentation and the forms. He himself is taking,

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and I've been told, almost 10% of their time to try to get HMOs to take and authorize treatment.

This bill may help a little bit in that area, but we ought to be looking at the practice of medicine, the practice of the health providers in the State of Connecticut and get the administrative burden off their back.

This, I believe, is going to be an improvement, but I don't think it's going to be everything that we had hoped for, or maybe I'd say, everything that I had promised in my campaign in the last session, I'll say is not in this bill and I wish it were.

So, we're stuck with this for today. I shouldn't say stuck, I don't want to reflect badly on the committee, but I do wish we could have had the other components that should have been in it.

And if I may, I'd like to give my partner in crime an opportunity and I will defer to Senator McKinney.

THE CHAIR:

Senator McKinney.

SEN. MCKINNEY:

Thank you, Senator Gunther. Thank you, Madam President. Madam President, one of the things that I have perhaps enjoyed most of all as a public servant is meeting with, listening to, and talking to the many

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different people that I now represent. And during the course of the last campaign and in the past little less than a year that I've been fortunate to serve in the circle.

One of the issues that is on the top of everyone's mind is health care, access to quality health care, people dealing with denials of coverage, the bureaucracies in HMOs and insurance claims and I think that we have done a lot of good since January 6th.

But what we are doing here with this bill may be what I am most proud of out of this session. I think this is a great step forward into providing better quality health care to the people of this state. And I just simply want to thank and applaud the work of everyone that has gone into this. And just bring up two brief parts of this bill without repeating everything good about it.

One is the prostate cancer coverage. I certainly want to applaud Senator Cappiello for his hard work. I think this is a great step forward.

And two is with respect to Lyme Disease. Just to echo the words of Senator Freedman and Senator Peters, I have been quite frankly, shocked at the numbers of people in my district, in Easton, in Newtown and Fairfield who have really suffered and been debilitated

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by Lyme Disease.

This may not be everything that we can do for them, but I think we are doing a lot of good here and I hope we will continue to do more for those people.

And just lastly, Madam President, to again echo the words of Senator Gunther. I, too, pledged my support for health care initiatives beyond what we're doing here, and I think this is a great package and we can come back and continue to work on this to provide better quality health care and accountability in a system which will again, make the system better for all of our citizens.

And I want to thank Senator Gunther for the yield.

And I'll yield back to Senator Gunther.

THE CHAIR:

Senator Gunther. Senator Gunther.

SEN. GUNTHER:

You aren't encouraging me to continue are you, Madam President? All I can say is, I think that what has been done here has been a good job, almost to the job of being excellent, but I would have liked to see the excellence of all the things that I would have loved to have seen in there.

And I think that the health care and the providers and the doctors in this country certainly ought to get

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back into the practice of treating people and we should have them setting the policies.

You know, we took medical jurisprudence at college and that was to teach us what the law was and what we had to do. I don't know whether they're going to have to get a law degree in order to practice medicine one of these days to find out how they're going to qualify and how they can keep their nose clean and practice their medicine.

So that, without that, I think this is a good job. I think they've done a fine job, but I think we could have gone that little step further. Thank you.

THE CHAIR:

Thank you, Sir. Will you remark further? If not, would the Clerk please announce a roll call vote. The machine -- Senator Harp.

SEN. HARP:

Thank you. We just wanted to, for legislative intent, clarify for the record that on the physician profile aspect of the bill that we are just talking about physicians which are MDs as defined in Chapter 370.

Again, thank you.

THE CHAIR:

Thank you, Senator. Mr. Clerk, would you announce

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a roll call vote. The machine will be opened.

THE CLERK:

An immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber.

An immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber.

THE CHAIR:

Have all members voted? If all members have voted, the machine will be locked. The Clerk please announce the tally.

THE CLERK:

Motion is on passage of HB7032 in concurrence with the House.

Total number voting, 36; those voting yea, 36; those voting nay, 0. Those absent and not voting, 0.

THE CHAIR:

The bill is passed. Senator Jepsen.

SEN. JEPSEN:

Thank you, Madam President. If the Chamber could turn at this time to Page 4, Calendar 494 and if the Clerk could call Substitute for SB1126.

THE CLERK:

Calendar Page 4, Calendar 494, File 692, Substitute for SB1126 An Act Concerning the Authorization of Bonds of the State for Capital Improvements and Other

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House of Representatives

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REPRESENTATIVE GODFREY: (110th)

Madam Speaker?

SPEAKER PRO TEMPORE HARTLEY:

Representative Godfrey.

REPRESENTATIVE GODFREY: (110th)

I move that the House stand in recess, subject to the call of the Chair.

SPEAKER PRO TEMPORE HARTLEY:

The motion is to stand at recess, subject to the call of the Chair. So ordered.

(On motion of Representative Godfrey of the 110th District, the House recessed at 10:47 P.M., to reconvene at the call of the Chair.)

(The House reconvened at 12:35 A.M., Speaker Lyons of the 146th District in the Chair.)

SPEAKER LYONS:

Would the House please come to order? Would the House please come to order?

Would the Clerk please call Calendar 378?

THE CLERK:

On Page 22, Calendar 378, Substitute for House Bill No. 7032, An Act Concerning Managed Care Accountability.

Favorable Report of the Committee on General Law.

SPEAKER LYONS:

The Honorable Representative Eberle. You have the

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floor, Madam.

REPRESENTATIVE EBERLE: (15th)

Thank you, Madam Speaker. This bill has been a long time in the making and a lot of work has gone into it. I appreciate my colleagues' indulgence until this late hour so that we can finally get it done.

Before I start, I would like to give some acknowledgements and some Thank You's -- aha. I move for acceptance of the Joint Committee's Favorable Report and passage of the bill.

SPEAKER LYONS:

The question before the Chamber is on acceptance and passage.

That's understandable. It's late. And you've done an excellent job. So please proceed.

REPRESENTATIVE EBERLE: (15th)

Thank you. I guess I'm a little anxious to get this done.

I would like to thank -- before I get into the substance of the bill, there are some Thank You's that are very heartfelt on my part and that need to be made.

We did have a four-caucus working group on this with participation from the Governor's Office. I think if you look at the names on the amendment that I'm going to call shortly, you'll see who they are. And so, you

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know, to them, I thank them very, very much.

Our staff have been wonderful. Our Committee Administrator, Steve Lewis, and all our committee staff have just fielded question after question, getting us copy after copy, always been there with what we needed when we needed it. Our LCO's, David O'Connor and Louise Nadeau. Our OLR people, John Kasperack and Matt Rinelli. And our OFA people have been very, very good in staffing us and churning out language change after language change.

Also helping us have been caucus attorneys, Mark Taylor, Tony DeFillipo from the Senate and Jim Accabellis from the House. And they have been invaluable to me personally and to the working group.

From the Governor's Office, we've had Brenda Cisco and Ann George participating and also been very, very helpful.

Now, onto the bill. The Clerk has an amendment, LCO 10030. If he could call and I be allowed to summarize?

SPEAKER LYONS:

The Clerk has in his possession LCO 10030, which will be designated House "A". Will the Clerk please call? The lady has asked leave to summarize.

THE CLERK:

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LCO No. 10030, House "A", offered by Representative
Eberle, et al.

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Thank you, Madam Speaker. This amendment is a strike-everything and becomes the bill. There will be a follow-up amendment that will correct some technical flaws and make some minor changes. But, essentially, House "A" is the bill.

It's a comprehensive effort to address the gaps which have appeared in the managed care system since we adopted sweeping managed care reform in 1997. And it brings managed care organizations under the insurance -- Unfair Insurance Practices Act and brings a number of activities within the Connecticut Insurance Information Privacy Act.

It establishes an office of the managed care ombudsman. I know in House "A" we say "managed care ally." But one of the things that House "B" will do is change that to "ombudsman", which is a term I think people understand a little bit more widely.

This will assist health care consumers in accessing and understanding their health care benefits. It will complement the excellent job that has been done by our

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Insurance Commissioner and the Department of Insurance in their work to implement the sweeping reforms in the Managed Care Reform Act in '97. They've done a yeoman's job in getting the consumer report card and the external appeals process up and running. I think those are very valuable efforts. They are working very hard on consumer education and handling consumer complaints.

But it was felt that a managed care ombudsman established as an independent entity within the department for purposes of administration but operating directly with the consumers would complement this and be a little bit more accessible.

We clarify the current rules on the use and protection of individually identifiable medical records information and we ban the sale or offer for sale of such information for marketing purposes. We allow the disclosure of it for marketing purposes if you have prior authorization from the individual involved. We don't want to prohibit people from saying, "Yes. I'd like to receive more information on a condition I or someone in my family have." But we want it to be with their knowledge and permission.

We also require the plans to adopt written policies, standards and procedures on the collection, use, protection of such information so that the

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department can look at those policies and has sort of a map to go by within each company. The requirements for that are pretty specific and they're laid out in the bill.

We set some rules for the determination of what is experimental and for the protection of chronically ill patients when formularies are changed. We set time limits on the payment of claims to providers and on the granting or denial of precertification or prior authorization when requested by the -- when required by the plans.

We also some benefit mandates in the bill, the most important of which is bringing mental health and substance abuse to full parity. A couple of years ago or last year we did biologically based mental conditions. I think there were about eight or ten of them listed in the bill. This language will bring all mental or nervous conditions up to full parity and benefits.

We have some other mandates dealing with diabetes education, prostate cancer screening and Lyme Disease. We also remove an important obstacle to dental care for our youngest and our most disabled residents with the in-patient dental care provisions of the bill.

Lastly, but not least, we have established in the

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bill a physician bill at the Department of Public Health which will provide information on the education, specialties, disciplinary action and malpractice awards of the physicians in our state.

Massachusetts has done a similar thing. It's on the Internet and they've had over 1,200,000 inquiries to their site inquiring about the qualifications of their doctors.

And with that, I would move adoption of the amendment.

SPEAKER LYONS:

The question before the Chamber is on adoption. Will you remark? Will you remark further on the amendment that is before us?

REPRESENTATIVE FLEISCHMANN: (18th)

Madam Speaker.

SPEAKER PRO TEMPORE HARTLEY:

Representative Fleischmann.

REPRESENTATIVE FLEISCHMANN: (18th)

Thank you, Madam Speaker. Madam Speaker, the bill before us today is a strong bill that moves us down the road towards greater protections for consumers and patients. And I know that Representative Eberle and other members of the working group on this bill have worked extremely hard.

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And in terms of establishing an office of a managed care ombudsman, in terms of setting up standards for medical records privacy, in terms of mental health parity, in terms of protections for people with Lyme Disease, this bill is a strong bill.

There are aspects of this bill that disappoint me.

I had called in some amendments. I will not be calling those amendments this evening out of respect to those involved in this working group who put in so much time developing their compromise and to those in this Chamber who I think are comfortable with the compromise and not desirous of dealing with amendments at this hour.

But I would feel remiss if I didn't at least draw attention to some of the deficiencies that I see in the bill tonight so that should we deal with this issue further down the line, we can perhaps go a bit farther.

First, I would observe in Line 32 and 33 of the amendment before us, it mentions that the Office of Managed Care Ally, soon to be called Managed Care Ombudsman, shall assist health insurance consumers to understand their rights and responsibilities under managed care plans.

Earlier versions of this bill involved also informing consumers about their rights related to the privacy of medical records. Most people in Connecticut

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don't realize that they are going to have rights about the privacy of their medical records. I think it's critical that they be informed. And, certainly, given the fact that we set up such rights in this bill, it seems to me that, at least by my understanding, when consumers are informed about their rights, rights related to privacy of medical records needs to be strongly emphasized in that area.

The other concerns I have generally relate to the manner in which we treat privacy. I would draw my colleagues' attention to Line 341 in the bill on Page 12. In this section, we define "medical record information". And let me say the opening of this definition is extremely strong. It relates to "a person's physical, mental or behavioral health condition, medical history or medical treatment of an individual or a member of an individual's family." To me, that's quite clear and I think we should end right there.

But, instead, under current statute we define where the information is obtained from. In this amendment, we expand our understanding of where the information is obtained from.

But I would ask the question, what is the relevance of where the information is obtained from? We all

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understand from the first part of the section what medical record information is. And I think the narrowness of this definition does a disservice to patients.

If we move along to Line 382 of this bill, we give an individual who is harmed by a violation of this section the right to bring an action for equitable relief. I think the standard of harm is high. I don't see why an individual who is subject to a violation shouldn't get to go ahead and bring an action.

If we move forward in the bill to Lines 505, 512, we have set up penalties that will apply to those who violate those sections of this bill. In my view, those penalties could have been stronger. They were stronger in earlier drafts. We've got a \$50,000.00 penalty in Sub-Section B, \$100,000.00 in the aggregate penalty for multiple violations. That's an awfully small price to pay for totally violating someone's medical privacy.

In Line 576, we say that a summary of the policies, standards and procedures shall be made available to enrollees upon enrollment and upon request. I think it would make sense to let people know annually what's going on.

Lastly, in Line 579 of the bill -- well, let me just read that section to folks. Section 26. It's

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brief. "No person shall disclose individually identifiable medical record information as defined in Sub-Section R of Section 38a-976 of the General Statutes as amended by this Act with the malicious intent to damage an individual's reputation or character."

Malicious intent. That's a tremendously high standard that we've set up. It seems to me that if someone has the intent to damage an individual's reputation or character, that should be sufficient. Isn't that bad enough? To me, to add the adjective "malicious" sets up a standard that's higher than one that we ought to have to be protecting people whose very private medical information is disclosed.

Now, that all being said, let me observe that those concerns that I've raised arise in a bill that is 54 pages long. All of the language that I haven't talked about -- let me say I haven't had a chance to review every bit of it. But that of it that I have reviewed is extremely strong.

And I draw attention to these weaknesses tonight not to say that we shouldn't pass this bill, because I absolutely believe that we should and we must, but simply to point out that in this battle to protect patients there is further to go. And I look forward to working with others in this Chamber to make that further

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progress.

In the meantime, I urge my colleagues to join me in adopting this amendment.

SPEAKER LYONS:

Representative Cleary.

REPRESENTATIVE CLEARY: (80th)

Thank you, Madam Speaker. I rise in support of House "A" and in support of over 30 legislators and staff members who have worked over the last three months with every single medical association in the state of Connecticut and then some to try to put a bill together that would not only pass this Chamber but would meet the expectations of our brethren upstairs.

This is not at all a perfect bill and there may be a few minor technical things we may clean up tomorrow. But it certainly has, I believe, the support of the majority of people who worked on the working group.

I'd like to talk a little bit about the process that got us here. As you can see by the co-sponsors on House "A" -- I'm not even sure if that's everybody that worked on the working group because there were even more involved at different times during the process.

But each of these pieces are not only looked at but was put out to the general public within this legislature, both legislators and professional groups

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throughout the state of Connecticut for more input. Many times we got more input than we really expected and sometimes more input than we really wanted. We were still getting input up to ten minutes ago from some folks in the Chamber and some folks outside.

But I think this working group had a common goal. This working group also had, I think, a lot of leadership. And certainly, the Chairs of Public Health and particularly the House Chair, Chairman Eberle, I think did most of the heavy lifting on this piece of legislation in order to truly make a piece of legislation that really met people's needs, not only today but in the future.

And I guess there's probably some lines in here and there's some words in here, might even be a couple of sections in here that I don't necessarily 100-percent concur with. But everyone in the process had input. Every single piece of mail from within and outside this Chamber was reviewed. Many people on the legal staff wrote and rewrote and came up with something that I think will serve the people of the state of Connecticut.

So I guess, somewhat like Representative Fleischmann, there are some words in here I don't like.

But I've read it. I've probably read it 30 times in 30 different drafts. And in most cases, it got better each

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draft and has had major changes even over the last 24 hours to ensure not only that it would be passing in the House and the Senate and that it had a very broad spectrum of consensus amongst both Chambers, but that even the small technical details that were brought to us even hours ago were incorporated within this bill and a small cleanup amendment that I believe will be following.

So I'd really like to thank Chairman Eberle for really having an extremely open process. And there isn't anybody in this bill, including her and including the Senate Chair, that got everything that they wanted or that wrote this thing certainly in any kind of even artificial vacuum. But everybody participated. And if there's anybody in this Chamber who hasn't, it's because they were busy with other projects, not because they weren't invited, because the drafts kept coming out on a weekly basis and the letters that always were attached to them is "Please review and comment. We're looking for input. We're looking for constructive changes."

I think it's the first time maybe with a bill of this magnitude that I was involved in a working group quite this large, 30 and 40 people coming and going, and between our committee meetings and our votes around the building to come out with a package that I think has

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some bipartisan support and certainly support in both Chambers.

So I'm not here to say it's perfect. But I think it's a very good piece of legislation for the citizens of the state of Connecticut and I urge support for House "A".

REPRESENTATIVE AMANN: (118th)

Madam Speaker.

SPEAKER LYONS:

Thank you, sir, for your comments.

REPRESENTATIVE AMANN: (118th)

Madam Speaker? Madam Speaker?

SPEAKER LYONS:

Representative Amann.

REPRESENTATIVE AMANN: (118th)

Thank you, Madam Speaker. Madam Speaker, I think what we should do is think about where we've come in the last few years, starting with your leadership on managed care in 1997, and some of the things that we have accomplished as a legislative body, other bills such non-discrimination for cancer coverage, 48-hour maternity, 48-hour mastectomy bill, more access to OB-GYN's, the emergency room bill, diabetes coverage. We certainly have done a lot of things. And those are just a few I can think of off the top of my head to see that

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we are certainly a body that understands that the consumer needs protections and, when need be, as much as we don't like to do it sometimes, have to step in and do that wonderful thing of mandates that I know we find it so hard to do. But I think it's important that our consumers know that we'll do everything we can to make sure they get proper coverages.

And I thank the Chairman of the Public Health Committee to allow the Insurance Committee to have a few pieces of their legislation as part of the overall bill, one that many of us have been fighting for for a few years in this Chamber.

We did a lot of great things for women in the last few years in both the Insurance and Public Health Committee. And one thing that was held up the last couple of years, only because it was one of 14,000 different pieces of bills we could possibly do to cover diseases, and that was prostate cancer. And prostate cancer, basically, statistics have shown that prostate cancer is the most common cancer found in men and is second only to lung cancer in the number of men it kills. In most cases, if prostate cancer is detected early, it could be cured. And that is why it is essential that we make sure that the men get the proper tests needed, the PSA test, the screen for prostate

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cancer, because if you get early detection, that's prevention and, in the long run, we all save as consumers. So I am extremely happy that we are addressing prostate cancer this year. Like I said, it's been one we've been waiting to do for a few years in this Chamber. I know Wade Hyslop and Joe Serra and many other people in this Chamber have been fighting for that.

And at this time, Madam Chairman, I'd like to defer to Representative Serra.

SPEAKER LYONS:

Sir, are you yielding to Representative Serra?

REPRESENTATIVE AMANN: (118th)

I am yielding, yes. Thank you, Madam Chairman.

SPEAKER LYONS:

Okay. That is not necessary. But at this time, I would call on Representative Serra.

REPRESENTATIVE SERRA: (33rd)

Thank you, Madam Speaker. For me this evening, it's a -- it was a long, long walk when I started this back in 1996, as the Speaker knows, because I had conversed with her.

Prostate cancer is a major killer of adult men and the disease is increasing in frequency. In fact, in the last 25 years, it has increased 126 percent. Medical

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people don't know why. But that's a fact.

But through the provisions of early detection services, we can significantly reduce the mortality rate of men in this country. This legislation that we're going to pass tonight in this area will enhance the important initiatives passed by this General Assembly to cover early detection of breast and cervical cancer.

For the new members of the Chambers -- some of the older members have heard this story before. But I had a friend or I have a friend who retired from the State of Connecticut and went and got a physical. And his doctor said that he thought that as part of the physical he should have a PSA test. And my friend just felt great and he just turned to the doc and said, "Well, is it covered by my insurance policy?" Well, let me tell you, fortunately for him, it was. And he said, "Well, Doc, do it. You know. No harm."

Well, that test came back and it was double figures. And I know we have a few nurses in here and they know what that means. But to make a long story short, he was very fortunate. He had to have an operation. He's still walking around today. In fact, I had him up here testifying before the Insurance Committee along with a urologist.

What happens with this is that after the operation,

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you go back for blood tests. And, of course, what you're really looking for in numbers is a zero. And so he ended his comments by saying it's the first time in his life that he wanted a zero on a test.

And I think by employing this PSA test here, because there were other plans that did not pay for this -- this test is only 50 or \$60.00. And what always amazed me is the fact that they wouldn't pay 50 or \$60.00, but they would pay anywhere from 12 to \$15,000.00 for a hospital stay and surgery.

But I think with this test being part of this managed care, I think with more men utilizing this test, we can definitely have a zero mortality rate in this country.

And for you young men, at least the doctors today are saying from age 35 to 40, if your plans have it, you should have a PSA test at least every three years until you get to that age where the physician will tell you that he thinks you should have it every year.

Thank you, Madam Speaker.

SPEAKER LYONS:

Thank you, sir.

I believe, Representative Amann, you had yielded to Representative Serra.

REPRESENTATIVE AMANN:

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Yes, I did. Yes, I did, Madam Speaker. Madam Speaker, just on the other section, I'll be quick because of the late hour. The other one is having to do again with diabetes coverage. The reason why we decided to go forward with this is that current law requires health insurance plans to cover diabetes supplies. Basically what the new part of this managed care bill will do is require additional out-patient self-management training and education and nutrition therapy.

And I think, Madam Speaker, if I -- whether it be yield or if you could recognize Representative Googins, she could probably give you some more detail on that. And I appreciate the time, Madam Speaker.

SPEAKER LYONS:

Thank you, sir. I will recognize individuals when they stand to be recognized.

Representative Googins.

REPRESENTATIVE GOOGINS: (31st)

Thank you, Madam Speaker. The key to fighting many disease, as we know, is prevention, prevention and prevention. And this managed care bill this year addresses the four areas that have been mentioned before; diabetes nutrition, Lyme Disease, screening for prostate cancer and in-patient dental care.

The managed care industry has learned, too, that

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preventive health care is good financial policy and it contributes to the life of people.

You all received, as part of the campaign to get the diabetes nutrition, the rather gruesome and rather shocking picture of an artificial limb prosthesis from an amputation with a price tag on it of \$50,000.00. Preventing the complications like that, of having folks with kidney failure for dialysis, similar costs, stroke blindness, heart disease and so on and so forth, doesn't make any sense that for a couple of hundred dollars nutrition training program, you can prevent this. You can't totally eliminate it because it is going to happen to some people. But that \$200.00 or that training program can go a long way. Many of you are aware of it in this Chamber because you have the disease. Many of you are aware in this Chamber because you know some of the 200,000 people in this state who have diabetes. And this has gone a long way in helping to assist that.

I have two things in front of me here that I think illustrate what we've done in the past couple of years as far as diabetes is concerned. What we did the last time is in my hand. And some of us here use something like this. It's a testing kit. It's a glucose meter. It is a little pen that you stick yourself with in your finger and pull out a little drop of blood to test and

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little test strips. We made the provision for this. I use it. I've used it in this Chamber, in fact. And I particularly used it -- and I'm a little bit smarter about this because of my nutrition training -- with this little baby Snickers bar that I pilfered from Representative Boucher. I knew that after I ate the Snickers bar, I was going to pay the price. And I did.

I ate it. I used my kit and I found that my blood sugar level was at 292. In order to prevent it being that high, in order to prevent those complications, they tell you to keep it under 160. Nutrition training told me that's what I can do. So for the rest of the evening, I knew what I could or couldn't eat. Very small demonstration

I thank those responsible for including this aspect of managed care improvement in this bill. And we will all be better for it. And I think we can continue to do this so that the citizens under these kinds of projects -- under these kinds of programs in health care can benefit.

I thank you all for your time and urge your support and again thank all of those who moved this forward.

Thank you, Madam Speaker.

SPEAKER LYONS:

Thank you very much, Madam.

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Representative Rich Roy.

REPRESENTATIVE ROY: (119th)

Thank you, Madam Speaker. Representative Googins mentioned some of the more horrible aspects of what happens to diabetics or what used to happen to diabetics on a regular basis, the amputations, the heart failure, the kidney failure, the blindness.

With a minimum of education, we put that aside. And I say a minimum. The onset of diabetes, we're asking in that initial year a maximum of 10 hours of education with a dietician. Any year after where there's change in condition or change in medications, a maximum of four hours within a given year. This is not a lot of time. It's not a grand expense. But it will save thousands and thousands of dollars and years and years of grief.

I thank you for your time tonight. I ask you all to join us in voting for this. I think the future is brighter for everyone.

Thank you, Madam Speaker.

SPEAKER LYONS:

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

Representative Winkler.

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REPRESENTATIVE WINKLER: (41st)

Yes. Thank you, Madam Speaker. I rise in support of the amendment before us. And I'd like to take this opportunity to thank Representative Eberle for her leadership on this legislation. And I was very pleased to have an opportunity to be part of the working group.

I would just like to say that I -- the one area of concern that I have with the legislation that is before us deals with the formulary issue. And I just want to get this on the record. And I had mentioned this to Representative Eberle.

During the working group, this was the one area of concern that I mentioned numerous times when we were working on the legislation. And that's because all of the HMO's develop formularies, a list of medications that they'll cover. And frequently I see in the emergency room somebody will come in, be treated by the physician, be handed a prescription and leave.

Obviously, the physician gives the prescription that's the treatment of choice for the problem that they have.

They go to the pharmacy to have it filled and the pharmacy will invariably pick up the phone and call us and say, "I'm sorry. That medication is not covered." So it means grabbing the physician out of one of the exam rooms, coming back, talking to the pharmacy to find

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out just what medication is covered. It's usually not the treatment of choice. So the patient does get the prescription. Frequently, the patient does not get better, is required to come back and given another prescription. So, to me, it means that it's an added cost for a second trip to the emergency room and two prescriptions where, if we were able to give the person the right prescription the first time around or the treatment of choice -- let's put it that way -- that the patient would have gotten better from their problem.

In speaking with Representative Eberle, she had agreed -- and I just wanted to get this on the record -- that she would be willing to have or convene a meeting of those HMO's and the emergency physicians to sit down and address this situation, perhaps without legislation.

And I would just like to ask that, through you, Madam Speaker.

SPEAKER LYONS:

Thank you, Madam.

Representative Eberle?

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. If the question is am I still intending to do that, yes, I am. Thank you.

SPEAKER LYONS:

Representative Winkler.

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REPRESENTATIVE WINKLER: (41st)

Yes. Thank you, Madam Speaker. And I thank Representative Eberle for willing to go that extra step to address the concern that I had and the Connecticut Emergency Physicians, that they have.

It's a good bill. I think we've made some excellent progress here that will benefit all of the people in the state of Connecticut. I urge the Chamber's support and look forward to seeing the bill implemented.

Thank you, Madam Speaker.

SPEAKER LYONS:

Thank you for your remarks.

Will you remark further on the amendment that is before us?

SPEAKER LYONS:

Representative Hamzy.

REPRESENTATIVE HAMZY: (78th)

Thank you, Madam Speaker. Madam Speaker, before I remark, I'd like to preface what I'd like to say by thanking everybody who put the time and effort into working on this bill, staff, legislators and, in particular, Representative Eberle, who really showed a lot of leadership and a lot of dedication to facilitating discussion and a lot of thought-provoking

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ideas that eventually became this bill that we have before us.

Madam Speaker, I have just one question, through you, to Representative Eberle.

SPEAKER LYONS:

Please frame your question, sir.

REPRESENTATIVE HAMZY: (78th)

Representative Eberle, in Section 39, with regard to the marketing of individually identifiable medical records, is this section intended to impact disclosure between affiliates for purposes of underwriting and risk management? Through you, Madam Speaker.

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. I believe that's the section that deals with disclosure to affiliates for purposes of marketing services or goods. It is not intended to apply to underwriting situations where one entity may underwrite and the other entity service, only for the marketing of other goods than that which is being applied for. Through you, Madam Speaker.

SPEAKER LYONS:

Representative Hamzy.

REPRESENTATIVE HAMZY: (78th)

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Thank you, Madam Speaker. And I assumed that that was the answer. I just wanted to make sure for legislative intent that it was put on the record.

I just want to say that this group has worked very well over the last couple of months to develop this comprehensive bill that is now before us. And one of the things that I believe that we tried to do is to address some of the shortcomings in our current system.

And, in other words, we didn't want to go so far as to fix something that wasn't broken.

And I believe, as the members of the working group also shared, that one of the major problems in our current system is that people don't understand how it works. They don't understand that when they have health coverage, what it covers and what it doesn't cover and what basis some of the decisions that are made are made on. And I think we tried to remedy this by creating the outreach program that I think is so important.

And the other thing I think we tried to do is also through the physician profiling, giving people a way to better understand the system, the health care system that we currently have, and hopefully be able to negotiate it.

Now, is this bill perfect? Of course it's not perfect. Are all the interested parties happy with

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what's in here? Of course not. But that's what we get in a product of compromise.

Personally, I believe the Insurance Department has done an outstanding job with the duties that we delegated to them as part of the '97 Reform Act. The managed care report card, the external appeals and the outreach program, I think they've done a great job with that. And I think our system and the consumers who benefit from that are better off because of that reform.

However, in this amendment the managed care ombudsman, one of the problems as I see it is we are creating a new system of appointment that we don't have for any other commissioner. And basically what this managed care ombudsman is going to be is a commissioner.

And while I disagree with that one provision, I do want to stress that it's not such a huge disagreement or that my feelings for this provision do not override the overall good that I think the bill will hopefully provide.

I just want to say that I was very pleased with the process. I was very proud to be a part of it. And I would urge the members of this Chamber to join me in supporting it.

Thank you, Madam Speaker.

SPEAKER LYONS:

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Thank you, sir, for your remarks.

Will you remark further on the amendment that is before us?

Representative Nardello.

REPRESENTATIVE NARDELLO: (89th)

Madam Speaker, I rise in support of this amendment.

And I, too, would like to thank Representative Eberle and all the members of the working group on both sides of the aisle for their hard work on this issue.

Representative Cleary stated that each draft got better. And I have to agree with him. But for anyone that worked on electric deregulation with Representative Eberle, I think we could say that each draft of the deregulation bill got better as well. So we have experience in this area and that's what we find when we work with our House Chair.

I think that quality health care is the one issue that transcends partisan politics and brings people together toward a common goal. And I think that because of this bill, health care consumers will have the services of a managed care ombudsman.

I think this is extremely important because what's wrong with our system now is that we can't access answer to questions. We get lots of brochures that get sent to our house. We all lead busy lives and oftentimes we

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don't read them and we don't know what the rights and responsibilities are that go with them.

The fact that we're going to have an individual to call that will help us through an appeals process, to explain what independent appeals, external appeals and what may be in the plan or not in the plan, I think is going to be one of the best things that we can do for consumers and health care in the state of Connecticut.

I also want to comment that there's an education program to inform people of the appeals process. This provision takes the first step in improving communication between the Insurance Department providers and consumers. I think this is also extremely critical.

I think one of the problems that we have is that neither the providers nor the consumers nor even sometimes the people in the Insurance Department communicate enough to understand how the system works. And that's why we get to where we are today.

Many of the problems are caused by a lack of communication among all the parties involved. And I think a very comprehensive education system and stressing education of all the parties involved is going to go a long way to help our health care system.

I think many of my constituents have expressed concerns about the privacy of medical records, mental

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health parity, the timely coverage, termination and the use of formularies. I think the bill addresses the common concerns expressed by many of Connecticut's citizens and makes improvements in the current system.

Ensuring the quality of our health care system requires constant monitoring by the legislature. And I am proud to say that Connecticut has taken this responsibility very seriously through our previous managed care bill and through this new one.

I ask my fellow members to support this legislation. It's a great piece of legislation. It's probably going to be one of the best pieces of legislation you should take home to your constituents.

SPEAKER LYONS:

Thank you, Madam, for your remarks.

Will you remark further on the amendment that is before us?

Representative Farr.

REPRESENTATIVE FARR: (19th)

Thank you, Madam Speaker. Just a question, through you, to Representative Eberle.

SPEAKER LYONS:

Please frame your question, sir.

REPRESENTATIVE FARR: (19th)

Thank you. While I recognize that the bill is

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quite complex, one of the issues that apparently in the legislation is it expands coverage that HMO's must do to a number of different groups, including the mentally ill and, I believe, substance abusers. And one of the concerns whenever we do this is, while it's easy as legislators to do it, the ultimate result sometimes is to drive up cost.

Is there any estimate as to what the impact of this legislation will be on the cost of medical coverage in Connecticut?

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. If I could just have a second to find that part of the fiscal note? On the fiscal note, what OFA says is that the expansion of mandated coverage that was mandated in 1997 has not yet been quantified for the plans and, therefore, it is -- they cannot determine what the impact of this legislation might be. Given that '97 has taken a biennium to be able to quantify, my guess is any impact this will have will be not in this next budget biennium.

I think that it will be -- it will be limited by the fact that we already have a fair amount of mental health coverage in place. So we are not starting from scratch.

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We have both the biologically based parity that we enacted in '97 and we have minimum days of stay that apply to other mental health and substance abuse benefits under our prior laws which are the ones that we're bringing up to parity. So we're not starting from ground zero. We already have a fair amount in place.

I think, too, that the impact is going to be minimized by savings on the medical side. By treating these people earlier, we will hopefully avoid many of the very complicated medical conditions they develop. We will also treat them at an earlier stage, when it's easier to treat, and avoid some of the more complicated and more difficult mental conditions that they develop.

So the note as it is says that the costs are indeterminate at this time.

SPEAKER LYONS:

Thank you.

Representative Farr.

REPRESENTATIVE FARR:

(19th)

Yes. Thank you for that response. And I fully understand that a lot of what is in here, in this bill, is, in fact, preventive coverage. But did the industry make any representations as to what they thought the impact would be through the passage of this bill in terms of rates? Through you, Madam Speaker, to

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Representative Eberle.

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. There are a lot of different numbers out there. And one of the problems has been you don't know whether you're comparing apples to apples or apples to oranges, grapes and pineapples.

For -- I believe OPM used an estimate that came from the National Institutes of Health that mental health parity such as we have could result in increases of from two to five percent. I don't believe that's on fully managed plans, which ours are, and I don't believe -- I don't know whether that's on plans that already have a certain amount of mental health benefits in them.

One of the estimates I saw on fully managed plans is that the effect is only about one percent because you have the element of managed care being able to control some of the costs and being able to sort of bird dog it.

And I think that's an important element to the mental parity in this bill and it's one reason we spent so much time in the working group and making sure we had the privacy language just right because it is important for the plans to be able to manage the care when you go to mental health parity.

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So CBIA came out with an estimate that they had performed for them that I believe the parity that is in this final version would be approximately 1.4 to 1.6 percent. So it's kind of all over the board. Through you, Madam Speaker.

REPRESENTATIVE FARR: (19th)

Through you, Madam Speaker, to Representative Eberle. Is it only the mental health that would increase the cost or were there other factors that would increase the cost under this bill?

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. There are cost elements to both the managed care ombudsman and the physician profiles. But I believe there are amounts in the budget allocated for those.

On the other benefit mandates, the fiscal note basically says no impact or minimal impact. The mental health part for HUSKY Part B is "cannot be determined at this time" as it is for the other mental health.

REPRESENTATIVE FARR: (19th)

Thank you, Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

So I don't -- I don't think it's significant on the

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other part, on the other mandates. Through you, Madam Speaker.

REPRESENTATIVE FARR: (19th)

I didn't want to prolong the discussion. I know a lot of work has gone into it and I think the bill is basically a very good bill. I just -- it's -- but it's very easy for us to sit here and mandate additional coverage and as legislators say, "Boy, we got something free for our constituents." It usually isn't free. There's usually some cost involved. The cost you're describing seems to be pretty insignificant for the additional coverage that's here and I think the bill is otherwise very good.

Thank you.

SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

Representative Widlitz.

REPRESENTATIVE WIDLITZ: (98th)

Thank you, Madam Speaker. I also would like to thank everyone who worked on this bill. It's a very comprehensive bill. I'm particularly delighted to see the Office of Managed Care Ally.

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I do have a couple of questions, through you, Madam Speaker, to the proponent of the amendment?

SPEAKER LYONS:

Please frame your question, Madam.

REPRESENTATIVE WIDLITZ: (98th)

Thank you, Madam Speaker. Representative Eberle, since we already have within the Department of Insurance consumer advisors -- I'm not sure exactly what the title is -- to help people with questions about managed care and their rights, I'm just wondering what the differences are and what the responsibilities would be within this separate department and also about the staffing. Would it be comparable to what is there now?

Would there be additional staffing? I see that in the language it says we would have the Managed Care Ally and no more than three persons, a staff of no more than three persons. Is that going to be fully funded in this year's budget? And how does it compare to what we have now? Through you, Madam Speaker.

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. I believe the fiscal note on this portion indicates that the money that is in the budget will be sufficient to cover the language that

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is here. I guess the advantage of this over the current Consumer Affairs Division in the department is that these people will be dedicated just to helping consumers and answering their questions. The staff at the department also has to do complaint investigation and a number of other functions and they may be across insurance coverages. These people will be devoted just to health care and to managed care plans.

So I guess it's -- and I think many people felt that there was a value to having them set up independent of the department, in perception if not in reality. I happen to think that the department has done an outstanding job on behalf of consumers. I think it's probably one of the best-kept secrets in our Executive Branch. But a lot of people have trouble believing that that can be true. And this establishes them with some independence to engender more confidence in that. Through you, Madam Speaker.

SPEAKER LYONS:

Representative Widlitz.

REPRESENTATIVE WIDLITZ:

(98th)

Thank you, Madam Speaker. Again, I think this is a great improvement over what we have. I look forward to seeing how this actually works for our constituents. And I would just like to emphasize that I think the most

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important part of this, in my opinion, from receiving so many complaints from constituents about trying to navigate the system of managed care is the advocacy portion of this. There seems to be a lot of attention being paid to collecting information, commenting on laws and regulations and so forth. So I would just like to emphasize I'd like to see a really strong focus on advocating for our constituents. It's something that I think we really need to focus on.

Thank you.

SPEAKER LYONS:

Will you remark further on the amendment that is before us?

Representative Prelli.

REPRESENTATIVE PRELLI:

(63rd)

Thank you, Madam Speaker. Madam Speaker, I, too, would like to add my congratulations to the team that put this bill together because, having worked on those in the past, I know how difficult it is to come up with a compromise.

Madam Speaker, I came here with every thought that I was going to support a managed care bill. And maybe at the end, I will be supporting it. Madam Speaker, if I thought that this bill came forward with the -- with the Managed Care Ally, if that was the major portion of

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the bill and that was pretty much what it did, and maybe if it addressed the drug formularies, I'd be happy. And I think that's what was needed in this bill.

But I think we've gone too far. And I wish that we had been able to vote on this in two separate sections.

And at 1:30 at night, I'm not going to try to divide the question.

But I think that what we have done there is something I've talked about before which I can't support. We've added a tremendous amount of new coverages mandated on insurance policies in the state of Connecticut.

If you look at the fiscal note, it says the cost to municipalities is going to be significant. The only thing affecting the municipalities in this whole bill are the mandated coverages. Are they coverages that should be there? Are they coverages that people should be able to buy and participate in? Yes.

When we talked about the pill bill, I talked about an alternative measure. And I'm planning on talking about that more later on tonight after this amendment here.

But what we're doing here is mandating again coverages on the insurance policies and on the employers who buy insurance. That's going to drive up the cost of

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managed care in the state. We hear over and over again people complaining that enough people don't have insurance, that the cost of insurance is too high. Yet, we bring forward another part of a bill that affects that cost and drives it up.

Do I think we need the Managed Care Ally, ombudsman, whatever you want to call them? Yes. Do I think that's important and that's going to move forward? That will probably be what drives me in my final vote.

But, Madam Speaker, it would have been so much easier to do this in a couple of pieces and come out with important parts. And I don't think that the mandated coverages had to be part of that overall plan.

I don't think that should come as a surprise to anybody because I've been arguing that for about four years here.

But I think the overall -- the idea of having oversight, the idea that people can come with their complaints is very important. And I think that should move forward. I wish that was the part of the -- I wish that was all that this bill did because I think that's what we needed to do and that's what we needed to move forward.

Thank you, Madam Speaker.

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SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

Representative Powers.

REPRESENTATIVE POWERS:

(151st)

Thank you, Madam Speaker. Very briefly. Mary and I came in together and we work together in this building and also outside the building on a couple of State boards. And she did not disappoint me. She was -- she led the working group with grace and a firm hand. And we actually had fun along the way.

I want to address two particular sections in this bill which I went into the working group with a bit of an agenda on. And Mary was very patient with me on this, as well as some others.

Sections 47 and 48 deal with insurance coverage for Lyme Disease. What we've done here I think is a very important step. We have said that there are certain ways to treat Lyme Disease and that there is a consensus in the medical community about these particular parts. And we have been, I think, very responsive to the support groups and the patient groups who have come to us individually and as groups.

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And so I'm very pleased with this. I think the language that you have before you in this draft is the most inclusive and will benefit the largest number of patients.

So I join my colleagues on both sides of the aisle in thanking Representative Eberle for her leadership and also urge your support for the bill.

Thank you.

SPEAKER LYONS:

Thank you for your remarks.

Will you remark further on the amendment that is before us?

REPRESENTATIVE BELDEN: (113th)

Yes.

SPEAKER LYONS:

Representative Belden.

REPRESENTATIVE BELDEN: (113th)

Thank you, Madam Speaker. Madam Speaker, on an evening like this, I guess just a couple of years ago, I was the only vote against the managed care reform bill, as I was very lonely on the DRG bill late in the evening. It seems like we get these things late in the evening.

And, Mary, this is a great bill, for all those who worked on it. But I'd just like to talk about a few

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things. And Representative Prelli touched on a couple of them. You know, we may have the best insured smallest group of people in the country with this type of legislation. It's very good, very comprehensive. But it also has the effect of -- and it's a balance. But, Mary, I think you won me over. I'm probably going to vote for it. I'm really not quite there, but --

We have to understand that when we raise the cost of medical coverage for those who have it and for the municipalities and for State employees, most of whom are in the collective bargaining process, without ever having to go through that -- and believe me, next time in the discussions it won't be the fact that there was a significant increase in health benefits given without that benefit -- the negotiation will be, "Oh, inflation was six-and-a-half percent" or whatever the number is. That's kind of mercenary on my part. But that's reality, folks.

The reality is whatever these costs are -- and this is called the managed care bill. A lot of this stuff deals with any insurance coverage, any and all health care plans. These mandates cover them all -- is that there will be an increase in cost. That increase in cost will go into the cost of Connecticut products.

Now, if we're swift enough and smart enough and all

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the other things to be able to absorb it somewhere in the business world, we'll probably still be the highest cost, but if our product is the best, maybe we could still sell them. It's another part of the equation. Mary is, I'm sure, very well aware of that. I see her kind of looking over here smiling at me.

So, for those who can afford it, those businesses that supply it to their workers, they'll make a choice whether to keep supplying it or not supply it. But for those that do have it, we will probably have mandated in our law for those who have health insurance probably pretty near the best comprehensive coverage there is. And that's good.

There are some costs here. And I've heard a lot of discussion about the budget percentage of spending is up and the bonding spending is up. I took a quick look and I only saw this bill this evening. There's over a million dollars a year just in normal budget costs that I can just kind of pick out of here real quickly. I see a number -- and as Mary indicated earlier, Representative Eberle, that it might be less but OFA says two to five percent increase in the health care costs to fringe benefits to the 55,000 State employees we have and their families and probably to all of those other peripheral non-profits out there that are probably

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more than double those number of employees, just for the ones we can see and touch in the municipalities. So it's a tradeoff.

I wish there was some way -- and those that don't have it won't have it. That's the part that bothers me.

And I never thought I'd stand before this Chamber and say we need to do some nationally, not in Connecticut, but nationally.

Our high costs drive jobs out of here, but our high benefits sometimes bring people in here. And we have to balance that as well.

So this is a great bill. We need to control the HMO's. We need to let the doctors practice medicine. I'm really upset that the doctors have a lot of complaining to do. But, you know, if they got together, if they got together and said, "Look it. We're the doctors here." And rather than "I want to practice in your plan", to say, "If you want me to be in your plan, I need to be able to practice medicine." I think that's the way it ought to go.

But we have here on the last day of the session a bill or a change to our policy. And I guess that's what we're going to vote on today. And, Mary, I guess you won me over. I'm probably going to vote for it. But it's not all peaches and cream and it's not all the

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answers. And I worry about those who will not be covered.

Thank you.

SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

If not, let me try your minds. All those in favor please signify by saying Aye.

VOICES:

Aye.

SPEAKER LYONS:

Those opposed Nay? The Ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Madam Speaker? Madam Speaker?

SPEAKER LYONS:

Please proceed, Madam.

REPRESENTATIVE EBERLE: (15th)

The Clerk has an amendment, LCO 11077. If he could call and I be allowed to summarize?

SPEAKER LYONS:

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The Clerk has in his possession 11077. Would the Clerk please call? The lady has asked leave to summarize.

THE CLERK:

LCO No. 11077, House "B", offered by
Representatives Eberle and Cleary.

SPEAKER LYONS:

Representative Eberle, please proceed.

REPRESENTATIVE EBERLE: (15th)

Thank you, Madam Speaker. This House "B" contains some cleanup to some drafting errors that got into House "A" because we were -- it was a big effort to get out and we were changing it frequently as we went. And some of the changes got made very late. So, rather than keep redoing House "A", we had House "B" drafted for the cleanup.

It takes out the language in the ombudsman section.

It removes "pursue" so that he -- the ombudsman's job is to help the consumers understand the process, help them to prepare and even to file things, but he stops there. They pursue them on their own or with their own advocates. His job is then to be available to other consumers.

And this is the amendment that changes the word "ally" in all those sections to "ombudsman". And it

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also adds the requirement that the ombudsman have experience not just in health care and advocacy but also in health insurance because the system he's supposed to be helping people navigate is the managed care and insurance system.

It clarifies language in various sections involving timely payments, experimental treatments and in-patient dental. And it makes a change to the Lyme Disease mandate, which was submitted in response to the very great deal of lobbying that has gone on on our E-mails and our telephone calls.

It changes the language on the minimum treatment from 30 days intravenous or 60 days orally, antibiotics, or to 30 days intravenous, 60 days orally, antibiotics, or both. Before it, you have to see a specialist to get further treatment. And it adds specialists in infectious disease and neurology to the rheumatology specialists who can be consulted to authorize further treatment.

Basically, we want the general practitioners out there to be able to treat aggressively in the early stages. But if that doesn't work, we want the patients into the hands of specialists who know this disease, who know the diseases that it mimics and who are expert in either treating it, if it really is later-stage Lyme, or

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in figuring out what else it is if it isn't.

And this does not restrict the plans from allowing more treatment as routine before requiring referral.

But it does set a minimum floor.

And I move adoption of the amendment.

SPEAKER LYONS:

The question before the Chamber is on adoption. Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

REPRESENTATIVE OREFICE: (37th)

Madam Speaker.

SPEAKER LYONS:

Representative Orefice.

REPRESENTATIVE OREFICE: (37th)

Thank you, Madam Speaker. I would like to say this is an excellent balanced bill that will deliver quality health care to the people of Connecticut, I think at a reasonable cost. There are some sections of the bill that I would rather see worded a little differently. But I would like to direct my comments today to this last amendment, specifically Section 49 which deals with the Lyme Disease mandate.

I have the dubious distinction of representing the area of the state that is named after Lyme Disease.

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It's a terrible disease. And I also have the distinction of having contracted the disease several years ago. I was fortunate in the sense that it was recognized early. I had all the classic symptoms. And with a three-week course of antibiotics, I was cured and have had, thankfully, no further symptoms.

But I've been interested in Lyme Disease because I do know people in my district that have been decimated both medically and financially by this disease. And this is an issue that we've tried to get mandated coverage for over the last four years, without success until this year. So I'm very happy to see that we are, in fact, covering Lyme Disease, a very debilitating disease that has a lot of different faces.

As Representative Cleary said, we've changed this bill right up to the last couple of hours on the basis of, I think, if nothing else, the lobbying. We, the Lyme Disease section of this bill, has won the E-Mail Award for this session, without question, I think.

But its input that was valuable. It comes from people that have been hurt horribly by the disease and financially. And it expands the coverage. And I would like to just make it clear that this is not minimum coverage that's in the bill. What it does is it requires at least 30 days of antibiotic or 60 days of

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oral medication, but it does limit it. There's some of the E-mails that we got that indicated, well, that would be the limit. It's similar to the drive-through deliveries. If -- we mandated you had to stay in the hospital at least two days, but if you have a reason to continue to stay in the hospital, the coverage would be provided. It gives you a mandated floor. It doesn't limit it.

And, also, the provision does not call for a second opinion. It says that further treatment should be provided as long as it's recommended by a certified rheumatologist, infectious disease specialist or neurological licensed physician. This definition has been expanded because of the information that we got from the constituency today.

Lyme's is a multifaceted disease that manifests itself in different ways. And as you are aware, there's probably a great deal of disagreement in the medical community itself as to how to treat it and what it means and the implications.

But what we've done to this point is it is a mandated coverage. And just as in '97, we came back to change the managed care bill that we passed then to move it forward this year with an improved version. I think it will benefit the people of the state as a bill and as

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coverage.

And I would urge all my colleagues to support this amendment and the underlying bill. And hopefully, Representative Belden will come along and we will have a universal unanimous vote on the bill.

Thank you.

SPEAKER LYONS:

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

Representative Murphy.

REPRESENTATIVE MURPHY: (81st)

Thank you, Madam Speaker. I'd just like to echo the comments from Representative Orefice and Representative Powers in respect to the Lyme Disease portion.

Just, through you, Madam Speaker, very briefly in order to clarify some of the language in that section, I have just a few questions to Representative Eberle, if I may.

SPEAKER LYONS:

Please proceed, sir.

REPRESENTATIVE MURPHY: (81st)

In regard to the language specifying that the specialists that are enumerated in Section 47 have to be

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board certified, am I to understand that that does not restrict choice to Connecticut physicians, Connecticut specialists, that that's board certification nationwide?

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. Board certification is as a result of a national exam and is not state -- is not state-specific. Our intent with this is to -- is to have this requirement operate within the plans. You can go to a doctor on the network and have available to you your plan benefits. If you go out of network, then you have available to you whatever the plan says about out-of-network consultation. But your care would be covered. So that board certified does not restrict it just to Connecticut doctors. Through you, Madam Speaker.

SPEAKER LYONS:

Representative Murphy.

REPRESENTATIVE MURPHY: (81st)

Thank you, Representative Eberle. Also, if a specialist that's listed in Section 47 recommends that an evaluation or treatment recommendations be made by a specialist that's not listed in Section 47, does the mandate apply to that situation?

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SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. As long as it is in accordance with what's recommended by the specialist. Our goal was to get the later-stage cases to people who knew what they were dealing with and were expert in not only Lyme but also other diseases that, you know, Lyme may mimic or that the long-term antibiotics may mask so that we have some confidence that the real underlying issues are being dealt with and that where it's Lyme, they get treatment. Where it's not, they get treatment for what it is.

I think that's part of the difficulty with Lyme Disease is that it is very similar to many other diseases. And what the medical community has said to me is that it's important that people who know not just Lyme but what those other diseases are treat the patient because if it isn't responding to the early course, you need to very aggressively figure out what else it might be. Through you, Madam Speaker.

SPEAKER LYONS:

Representative Murphy.

REPRESENTATIVE MURPHY: (81st)

Thank you, Representative Eberle. I know this

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entire bill has been a herculean effort. But I'd like to thank you specifically for your willingness to work with legislators and advocates, especially in these last few crazy days. I think the changes that have been made today and the entire Lyme provision itself is an important step towards treating this debilitating disease.

Thank you.

SPEAKER LYONS:

Thank you for your remarks.

Representative Landino.

REPRESENTATIVE LANDINO: (35th)

Thank you, Madam Speaker. I'd just like to briefly echo the comments of previous legislators and commend Representative Amann and the Insurance Committee for moving the bill forward when it was in an imperfect stage. I believe Representatives Amann and Hamzy saved the portion of the bill that mandates coverage for Lyme Disease and allowed us to continue working on those imperfections until we developed a workable plan as of about two hours ago.

And then I'd like to thank Representatives Eberle and Cleary for being flexible and working with us to the eleventh hour to make the final changes which were consistent with the wishes and desires of the advocates.

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Finally, the advocates themselves were not professional lobbyists but were victims and families of victims of Lyme Disease and were very aggressive in their pursuit of legislators throughout the session. And their pursuit was one of the most sincerest motivations of all as they have suffered the effects of not only the disease but of the imperfections in the requirements for coverage and the discrepancies that resulted that caused pain not only with the lack of treatment but in the ability to get any type of reasonable coverage for Lyme Disease.

So, with that, I obviously urge adoption of the amendment.

SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us?

REPRESENTATIVE TERCYAK: (26th)

Madam Speaker?

SPEAKER LYONS:

Representative Tercyak.

REPRESENTATIVE TERCYAK: (26th)

Thank you, Madam Speaker. Madam Speaker, there has been a great deal of compromise in fashioning this amendment. Let's build on that compromise so that Lyme

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Disease sufferers may enjoy a decent quality of life and that of their families may be maximized.

Those folks who don't live on the coast, who don't live around Lyme and so forth, don't be too, too comfortable because I'm told that other hot spots in Connecticut are Bristol, Avon, Windham, Salisbury, Glastonbury, et cetera, et cetera. This is a disease that is growing faster than AIDS in this state. We expect around 40,000 people or more to be affected by the end of this year.

My gratitude, too, to Representative Eberle and her committee for the patience and the courteous -- the courtesy given to the folks who came here, the folks who called them, the folks who wrote them with respect to this bill.

We'll look forward to building on this bill in the future. And I thank you, Madam Speaker, and members of the committee.

SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

If not, let me try your minds. All those in favor please signify by saying Aye.

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VOICES:

Aye.

SPEAKER LYONS:

Those opposed Nay? The Ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?

Will you remark further on the bill as amended?

Representative Lockton.

REPRESENTATIVE LOCKTON: (149th)

Thank you, Madam Speaker. Madam Speaker, the Clerk has LCO 11078. Will he please call and I be allowed to summarize?

SPEAKER LYONS:

The Clerk has in his possession LCO 11078. Would the Clerk please call? The lady has asked leave to summarize.

THE CLERK:

LCO No. 11078, House "C", offered by Representative Lockton.

REPRESENTATIVE LOCKTON: (149th)

Thank you, Madam Speaker. Madam Speaker, the amendment before us addresses a significant step toward the prevention of Lyme Disease. We have heard today about prevention and avoidance and disease and illness.

We have a disease that we can prevent in the state of

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Connecticut. We have a disease that the insurance companies do not have to spend the money treating.

When you are bitten by an infected deer tick --

SPEAKER LYONS:

Are we all set over there?

REPRESENTATIVE LOCKTON: (149th)

When you are bitten by an infected deer tick, first shot out of the box, or a deer tick, it's two to \$500.00 for a blood test, for a visit to the doctor and for Doxycycline.

What the bill before us does or the amendment before us does, it authorizes the Commissioner of the Department of Environmental Protection to take action to reduce the number of deer found on ten acres or more in areas of the state where there is a threat to human health and safety.

I urge adoption.

SPEAKER LYONS:

The question before the Chamber is on adoption.

Will you remark?

REPRESENTATIVE EBERLE: (15th)

Madam Speaker?

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

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Thank you, Madam Speaker. I have to rise to oppose this amendment on this bill at this time. I don't know whether this has had a public hearing. I don't know what kind of opposition there is out there in the world outside to it. I know that issues of deer hunts in the past have been extremely controversial. And it was never proposed to the working group.

I think that it is certainly a stretch to put this on a managed care bill. And I would strongly urge my colleagues to reject it.

SPEAKER LYONS:

Thank you, Madam.

Will you remark further on the amendment that is before us?

REPRESENTATIVE TERCYAK: (26th)

Madam Speaker?

SPEAKER LYONS:

Representative Tercyak.

REPRESENTATIVE TERCYAK: (26th)

Thank you, Madam Speaker. I would also echo Representative Eberle's comments. But I must pass this information on to you. The Lyme tick is carried by migratory water fowl, by white-footed mice, by pigeons and the deer, among others. But then the ticks can be brought -- are generally rubbed off on grass, on leave,

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tree trunks, et cetera. So I don't think that we can put all the blame on the deer.

Thank you, Madam Speaker.

SPEAKER LYONS:

Will you remark further on the amendment that is before us? Will you remark further on the amendment that is before us?

Representative Lockton.

REPRESENTATIVE LOCKTON: (149th)

Thank you, Madam Speaker. In response to Representative Tercyak, the deer tick that carries Lyme Disease needs the deer as a host. Without the deer, we eliminate the possibility of Lyme Disease.

And it does belong on a managed care bill because we are talking about prevention of a disease. Now, we all know that rats carry the Bubonic Plague. Lyme Disease is a plague on the state, certainly in Fairfield County. I have had it. My husband has had it. My neighbors have had it. We have had Lyme Disease. And it is not -- it's a very, very serious illness.

So, once again, I urge adoption of the amendment. And I'll sit down. And perhaps then we can go home.

SPEAKER LYONS:

Will you remark? Will you remark further on the amendment that is before us?

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If not, let me try your minds. All those in favor please signify by saying Aye.

VOICES:

Aye.

SPEAKER LYONS:

Those opposed Nay?

VOICES:

No.

SPEAKER LYONS:

Amendment fails.

Representative Donovan.

REPRESENTATIVE DONOVAN: (84th)

Thank you, Madam Speaker. Madam Speaker, through you, I have a question to Representative Eberle.

SPEAKER LYONS:

Please frame your question, sir.

REPRESENTATIVE DONOVAN: (84th)

Thank you, Madam Speaker. Representative Eberle, in the bill before us as amended, there was a change which you alluded to with the -- I never could say that word right -- ombudsman from the original bill before the original amendment. In the original amendment, the advocate would assist consumers with the filing and pursuit of complaints rather than right now as amended, the bill, just assist consumers with the filing of

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complaints. I wonder if you could explain the difference between the original amendment and the bill before us. Through you, Madam Speaker.

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. The difference is in the intent of what this position is supposed to be. This is a Consumer Counsel. This is not an advocate position. This is an ombudsman position whose job is to help inform and educate and assist people to know what their coverage is and how to access it. It is not to be tied up in trials or external appeals. We're only staffing this with four people. And in order to be available for the next phone call, you can't be off in the hearing. This is not intended to be a free attorney for folks. It's just intended to be an educational office to help them understand what they have and how to access it. Through you, Madam Speaker.

REPRESENTATIVE DONOVAN: (84th)

Madam Speaker, through you, a follow-up to that question. I guess I have a question about the leeway of that ombudsman. Should somebody have a simple call that may take a call to a managed care organization to clear up a misunderstanding, would that fall under the duties

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of that person? Through you, Madam Speaker.

SPEAKER LYONS:

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Through you, Madam Speaker. Yes, it would.

REPRESENTATIVE DONOVAN: (84th)

Okay. Thank you. I guess I certainly would like to see -- I think a lot of consumers, sometimes a simple phone call to a managed care company could clear up a lot of problems. And the more information, the better.

I think I like the original amendment. And with that, I'll support the bill.

Thank you, Madam Speaker.

SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us?

Representative Prelli.

REPRESENTATIVE PRELLI: (63rd)

Thank you, Madam Speaker. Madam Speaker, the Clerk has an amendment. It's LCO No. 9580. Madam Speaker, could he please call and I be allowed to summarize?

SPEAKER LYONS:

The Clerk has in his possession LCO 9580. Would the Clerk please call? The gentleman has asked leave to

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summarize.

THE CLERK:

LCO No. 9580, House "D", offered by Representative
Prelli.

SPEAKER LYONS:

Representative Prelli.

REPRESENTATIVE PRELLI: (63rd)

Thank you, Madam Speaker. Madam Speaker, this is an issue I've talked on before. I'm not going to take a lot of time. This is the study that says we should go to cafeteria -- look at alternative plans like cafeteria plans to help drive down the cost. This does not change the bill in any way. It says the Insurance Department shall study it to look at alternative measures of providing health insurance. It really does not change the underlying bill in any way. And it just says they will report back on February 1.

I move adoption, Madam Speaker.

SPEAKER LYONS:

Thank you, sir.

The question before the Chamber is on adoption.

Will you remark?

Representative Eberle.

REPRESENTATIVE EBERLE: (15th)

Thank you, Madam Speaker. I rise to object to this

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amendment, not necessarily because I disagree with its underlying premise. It is an issue that has come before the insurance company several times before. I think it's an issue that belongs in that arena. And I think that it's inappropriate to be putting it on this bill at this time. It's an issue that has come up before. I just -- it was not brought up in the context of any of our discussions.

And I would urge rejection of the amendment.

SPEAKER LYONS:

Thank you, Madam.

Will you remark further on the amendment that is before us?

REPRESENTATIVE CLEARY: (80th)

Madam Speaker?

SPEAKER LYONS:

Representative Cleary.

REPRESENTATIVE CLEARY: (80th)

Thank you, Madam Speaker. I think this amendment could possibly get even better tomorrow. I think besides group policies we should also be looking at individual policies because they are cited in two different sections of statute. And I would hope to find a home for this amendment in a larger bill that might be coming up in the next 12 hours.

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Thank you, Madam Speaker.

SPEAKER LYONS:

Thank you, sir.

Will you remark further on the amendment that is before us?

If not, let me try your minds. All those in favor please signify by saying Aye.

VOICES:

Aye.

SPEAKER LYONS:

Those opposed Nay?

VOICES:

No.

SPEAKER LYONS:

Amendment fails.

Will you remark further on the bill as amended?

Will you remark further on the bill as amended?

If not, will staff and guests please come to the well and members take their seats. The machine will be open.

THE CLERK:

THE CLERK:

The House of Representatives is voting by roll call. Members to the Chamber. The House is voting by roll call. Members to the Chamber please.

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SPEAKER LYONS:

Have all the members voted? Have all the members voted? Would the members please check the board to make sure that your vote is accurately recorded. If all the members have voted, the machine will be locked and the Clerk will take a tally.

Representative Tercyak, how would you like to be recorded? Use your microphone, sir. How would you like to be recorded?

REPRESENTATIVE TERCYAK: (26th)

Thank you, Madam Speaker. In the affirmative.

SPEAKER LYONS:

Representative Tercyak in the affirmative.

Would the Clerk please announce the tally?

THE CLERK:

House Bill No. 7032 as amended by House "A" and "B". Total number voting, 136; necessary for passage, 69; those voting Yea, 134; those voting Nay, two; absent, not voting, 15.

SPEAKER LYONS:

The bill as amended passes.

Representative Godfrey.

REPRESENTATIVE GODFREY: (110th)

Thank you, Madam Speaker. Madam Speaker, I move that this item be immediately transferred to the Senate.

JOINT
STANDING
COMMITTEE
HEARINGS

PUBLIC
HEALTH
PART 8
2627-3001

1999

PUBLIC HEALTH March 23, 1999
kmg INSURANCE & REAL ESTATE AND JUDICIARY 9:30 a.m.

002631

PRESIDING CHAIRMAN: Senator Harp

PUBLIC HEALTH COMMITTEE MEMBERS:

SENATORS: Gunther, Prague, Kissel

REPRESENTATIVES: Eberle, McGrattan, Cleary,
Carson, Conway, Dickman,
Fahrbach, Nardello,
Orange, Raczka, Malone,
Mantilla, Ryan, Sayers,
Stone, Winkler

INSURANCE AND REAL ESTATE COMMITTEE MEMBERS:

SENATORS: Bozek, DeLuca

REPRESENTATIVES: Altobello, Dargan, Eberle,
Fontana, Geragosian,
Nardello, Amann, D'Amelio,
Feltman, Stone

JUDICIARY COMMITTEE MEMBERS:

SENATORS: Williams, Kissel

REPRESENTATIVES: Farr, Abrams, Amann,
Conway, Dandrow,
Demarinis, Dillon,
Feltman, Garcia, Hamm,
Martinez, O'Neill, Sauer,
Stone, Winkler

SENATOR HARP: Good morning. We're going to begin our public hearing. And our first hour is for state agency officials, legislators, and municipal officials. And our first speaker today is Attorney General Richard Blumenthal.

ATTORNEY GENERAL RICHARD BLUMENTHAL: Thank you, Madam Chairwoman and members of the committee. I know that the sole item on your agenda this morning is HB7032, and I am sure that there is a lot of interest in it, particularly on the part of the public.

So I'm going to just briefly summarize my written testimony and then leave it with you. The essence of this bill really is accountability. The purpose is to hold accountable organizations that now largely are exempt as a practical matter under our law for decisions that they heavily impact, if not make, in many instances.

And those decisions are treatment and care of people who are enrolled in HMO's, or who are otherwise covered by insurance. I should make very clear that my view is that they are now potentially liable for those decisions.

And indeed, in other states there have been decisions, court decisions, holding them liable. But the range of defenses now available to them as a practical matter puts them beyond the scope of accountability in most law suits.

And what we are doing here is saying in effect, denial or delay of medical care, if it results from decisions of HMO's, ought to make those organizations accountable.

And the key provision essentially is one that defines the standard of liability or accountability, which is to say that a managed care organization shall exercise ordinary care when making health care treatment decisions, and shall be liable for damages for harm to an enrollee proximately caused by its failure to exercise such ordinary care.

That is the common law standard of tort liability. This bill would simply make clear that this standard applies to HMO's. There are two provisions of the bill that I urge you to change.

One is the exemption for ERISA plans, or HMO's that qualify under the definition of ERISA. Which is, of course, the Federal Employee Retirement Income Security Act of 1974.

What we have seen in the courts, including a district court here in Connecticut, is a gradual

trend to hold accountable. That is, deny exemption to ERISA-covered HMO's when they are involved in treatment and care decisions as opposed to coverage issues.

And that is a very encouraging and significant trend which would be foreclosed or at least discouraged in Connecticut by the definition in Section 6, that says, a managed care plan does not mean the arrangements of managed care organizations, etcetera, established pursuant to the Federal Employment Security Act of 1974.

The other provision that I urge you to change relates to Section 3, that requires an enrollee to exhaust the appeal and review process before a law suit can be brought.

I recognize that later in the next Section, in fact, there is an exception made for individuals who are in serious jeopardy, who may seek injunctive or other relief, but that kind of relief would be problematic if the enrollee first has to show serious jeopardy, which of course is not really fully defined, or defined at all under the law as it's been proposed here.

Let me just summarize by saying that this bill really is a very sound and sensible proposal that will ultimately increase the quality as well as availability of care in this state.

By holding accountable HMO's it will compel them to give the kind of care and attention that their enrollees deserve when they are involved in decisions affecting the quality of medical care.

When they say, for example, as they did to a young man in Danbury that he could not stay in a specific hospital, or institution, and that young man then committed suicide as a result of their active involvement in that decision.

They should be held accountable. And they would be giving greater care to those kinds of decisions if a standard, the ordinary care standard, were applicable to them and the doctors that they

employ. And we would see higher quality care in this state. Thank you.

SEN. HARP: Thank you very much. Are there questions? Yes, Representative Farr.

REP. FARR: Yes, thank you. I just have some questions about understanding the legal relationship here. You talked, your last comment was that the doctors employed by the HMO's.

My understanding is that, that this is not an employment contract that anybody has, but a reimbursement. In that, in Connecticut, that the HMO cannot make a medical decision, that only the care giver himself can make a medical decision.

In other words, if I go to a doctor, and a doctor says that I need a certain type of medical process or procedure, the HMO cannot, as I understand it, tell the doctor not to perform that.

All the HMO can say is whether or not they will financially reimburse the doctor for that charge. And I wonder if you'd comment --

ATTY. GENERAL RICHARD BLUMENTHAL: Representative Farr, there is a legal fiction. And I use the word "fiction" advisedly, that corporations can't practice medicine. And this bill, in effect, would sweep away that fiction.

REP. FARR: Well, are you saying that --

ATTY. GENERAL RICHARD BLUMENTHAL: The reality is that HMO's may not practice medicine, but they heavily impact and influence medical decisions. And whatever their relationship financially with the doctor is on their staff, or in their employ, they use their expertise to deny or delay treatment.

REP. FARR: But, just so I understand it. I mean, if the, if my doctor says he thinks I should take a certain medication. And my HMO says, they won't pay for that medication.

My doctor can prescribe that medication. And I can

pay for that medication today. Are you saying this bill would now say that HMO's can, in fact, would now be able to tell the doctor whether or not I could use that medication?

ATTY. GENERAL RICHARD BLUMENTHAL: No. It would hold the HMO's accountable for their impact on the doctor's decisions if they deny coverage for a certain kind of care.

REP. FARR: Well, let me ask you the other concern I have in this area. Cause I'm having trouble in my own mind understanding the relationship. We passed tort reform. And under tort reform we provided that if you wanted to bring an action for malpractice against a doctor, you needed to do an affidavit from another, from a professional, stating that in fact the standard of care was different than, you know, that there was in fact some malpractice here, in essence.

Doesn't this law, in effect, negate all of the tort reform and say that if there's any malpractice, while you may have certain thresholds to get over before you sue the doctor.

Those thresholds don't exist with the HMO. So the doctor has more protection than the HMO. And doesn't this say that anybody has a malpractice issue, just sue the HMO because there's no threshold?

ATTY. GENERAL RICHARD BLUMENTHAL: Well, if those sorts of procedural protections in the legislature's wisdom were applied to HMO's, it might be perfectly appropriate to put them on the same level as doctors.

REP. FARR: Thank you.

SEN. HARP: Thank you. Senator Kissel.

SEN. KISSEL: Thank you very much, Madam Chairwoman. Attorney General, good to see you again.

ATTY. GENERAL RICHARD BLUMENTHAL: Senator.

SEN. KISSEL: First off, I'd like to apply your statements here today. I find them quite compelling. And it's been my belief since the beginning of the session, and it's no surprise to the co-chairs of the Public Health Committee, that I think that this legislature this year should pass legislation that would exactly afford individuals the right to sue health maintenance organizations.

And it's my belief that when you have that care provider overseeing the treatment decisions that, in effect what's occurring in the market place is that they are stepping into the shoes of a physician.

And that the proposal that you've presented here before us simply would afford our citizenry to hold them accountable to a regular negligence standard, quality of care, that we would expect out of a physician.

Indeed, we're simply proposing, I believe, to hold that health maintenance organization as responsible as the physician that they're making decisions for.

And I've been pushing this concept, and I don't know if I'm in the minority or the majority here in the legislature.

It seems to cross party boundaries. And it's quite hard to figure out exactly how it's going to shake out. But I have one major concern. Quite often when we work here in the legislature, half a loaf is better than none.

In other words, when we all sit down on different sides of an issue, and we hammer out a compromise, quite often I believe that that compromise at least gets us part of the way towards what we're trying to accomplish for our constituents.

When we come down to this proposal though, I have a great concern. Because as someone who advocates what you're advocating, it seems to me that if we end up passing legislation that requires an individual to go through that appeals process, or limits the legislation to ERISA, or non-ERISA providers, that in effect under the guise of reform

we will be actually limiting individual's rights in Connecticut, because we already have a federal court decision that has opened up that door.

And so my question to you is, as we get down to the final weeks of this legislature, and assuming we haven't moved on these bills in a final form, it is your view that we would be better off not passing anything, as opposed to passing something that would require an appeals process, would limit the kinds of HMO's that could be brought, an action can be brought against.

Because that half a loaf would actually be restrictive as to where the courts are directing us at this point in time. What should we do as a legislature regarding that key issue.

ATTY. GENERAL RICHARD BLUMENTHAL: Well, it is the key issue. And you've kind of cut to the, I think, core concern here. Because the trend really is toward applying the standard that is articulated in this bill.

And the standard is really kind of, as you've said, the standard is kind of a garden variety negligence standard. It's a plain vanilla, ordinary care standard that is applied to any professional, anybody doing work for you.

Generally, anybody who harms you. The ordinary care standard is the plain vanilla liability standard known throughout the country, in state law, and applicable in our state's law.

And I think in the future more and more applicable to HMO's, if the most recent federal court decisions are any guide. So, by applying restrictions, we may do more harm than good. And I would separate the two issues that I just articulated.

On the appeals process, I'm not sure what it means if someone has already been harmed by denial or delay of treatment, to force that person to go through the appeals process that is designed in many instances to, for people to make, for the HMO

to make a decision about coverage in the first place. So, I'm not sure what the effect of that provision is. I don't know what it means as a practical matter. And I might take a bill that included that provision on the theory that it's meaningless anyway.

SEN. KISSEL: Okay.

ATTY. GENERAL RICHARD BLUMENTHAL: And, maybe could be made even more meaningless, to use a sort of pejorative way of putting it. On ERISA, I think if we exempt ERISA, the legislature would be making a grave mistake.

Because that would have far reaching ramifications. Not only in this state, but also quite honestly, as a model for other states. There are very few states that have these kind of laws so far. Texas is the model for this statute. Being upheld in the courts.

And I would be very loathe to see a bill that restricts, in a very critical way, a very healthy and growing trend in the law that provides liability for ERISA plans when the HMO's are involved in care and treatment decisions.

SEN. KISSEL: So even though we might call that kind of legislation reform and make it a part of a "patients bill of rights," if we have those limitations and restrictions, we're not doing the patients and the recipients of health care in the State of Connecticut any big favors.

ATTY. GENERAL RICHARD BLUMENTHAL: It might well be a step backward instead of forward.

SEN. KISSEL: One last point. Right now when you want to bring a malpractice action against a physician, you, as Representative Farr indicated, you would need an affidavit by another qualified expert to form the grounds for your case.

Would you have any problem having that type of requirement, indeed under the theory that the HMO's are stepping into the shoes of a physician in

Connecticut, therefore, we will set up the same construct for an individual to bring a negligence case against that HMO?

ATTY. GENERAL RICHARD BLUMENTHAL: I think HMO's should be given the same kind of protection as other professionals, including doctors, against frivolous law suits. And there's no reason that those affidavits, if they're required for law suits against doctors who are charged with malpractice, no reason to treat the HMO's differently.

SEN. KISSEL: Thank you very much, Attorney General. Thank you, Madam Chairwoman.

SEN. HARP: Thank you. Representative Eberle.

REP. EBERLE: Thank you, Madam Chair. Good morning, Dick. How are you?

ATTY. GENERAL RICHARD BLUMENTHAL: Good morning.

REP. EBERLE: On the ERISA exemption issue, has the Texas case been up to the Supreme Court yet?

ATTY. GENERAL RICHARD BLUMENTHAL: No.

REP. EBERLE: No. I mean, isn't it true that over the 20, 25 years of ERISA that frequently the trial courts have held one way. And it's gotten up to Supreme Court, and Supreme Court's over turned it and held, yes, ERISA does preempt?

ATTY. GENERAL RICHARD BLUMENTHAL: It happens.

REP. EBERLE: Okay. I think it's a little premature. Either on our Connecticut case, or the Texas case, to say that they've been upheld until it gets to the Supreme Court, and the Supreme Court says, yes.

Because, too many times we thought we were there and it's been overturned. And so, I guess I'm not as confident as you are that the standard is set in the country yet.

ATTY. GENERAL RICHARD BLUMENTHAL: I'm not predicting, let alone promising what the United States Supreme

Court's going to do. But this provision assumes the worst. And if the best happens, we're stuck with the worst. Whereas, if the Supreme Court should say that there is a mandatory exemption for HMO's under ERISA no matter what they do, then it applies to Connecticut in any event, regardless of what you say in the statutes.

So I don't see what the gain is of having the limitation placed in our state statute. And, in fact, it might encourage an adverse United States Supreme Court decision.

REP. EBERLE: Okay. I guess part of our fears here is in leading people to believe they have a remedy they don't have if we can't enforce it against ERISA plans. Why pretend that we can? Why not tell people that it matters who your employer is?

ATTY. GENERAL RICHARD BLUMENTHAL: You know, Representative Eberle, it may be decades before the United States Supreme Court deals with this issue, if it does ever. And Congress may remove the doubt before the United State Supreme Court reaches it.

In the meantime, there are countless Connecticut consumers and patients who may have the benefit of the United States district court decision in our state. And in the meantime, we may see improvement in the quality of care, even if the law across the country is unsettled.

REP. EBERLE: Alright. On the appeals process. Right now we're looking at that. I mean that the independent appeals process that we have under the '97 law is, in effect, an independent medical review of the appropriateness of the medical necessity decision, or whatever that was made by the plan.

And about 50% of the time, of the cases that they've taken on for review, the patient has been upheld about roughly 50/50 patient versus plan. Isn't that similar to the medical affidavit that we require now in physician medical malpractice cases. And isn't there a function for that to play in this situation?

I think this situation is very different getting a doctor to sign an affidavit against a fellow doctor, versus getting them to sign it against an HMO. And I would argue that the appeals process is, in effect, that medical review check on frivolous law suits.

ATTY. GENERAL RICHARD BLUMENTHAL: I think the argument might be made for the appeals process functioning in that way, but I'm not sure that the people who are involved in the appeals process would have the qualifications to judge standard of care decisions.

And it would be very different than the affidavit process which enables the patient or consumer to come forward with a statement from someone of his or her choosing, as opposed to appeal process which, for better or worse, is a different set of people with ordinarily a different set of responsibilities. And I think also in terms of cost, time, it has different implications.

REP. EBERLE: I thought the independent panels are medical professionals looking at the standard of care?

ATTY. GENERAL RICHARD BLUMENTHAL: They are, but they aren't necessarily experts in the specific area of medicine that would be the subject of an affidavit in a malpractice law suit.

REP. EBERLE: Well, the testimony we had last week from the Insurance Department was that they require all of them to either have specialists on the panel or to have specialists available under contract to review cases that are beyond the expertise of the panel members.

So I think they probably, I think they do have the particular expertise. Or at least the Department expects them to obtain it to review special cases.

ATTY. GENERAL RICHARD BLUMENTHAL: Well, that may be the case in theory. They, and that's why I answered Senator Kissel's question the way I did. I wouldn't regard that provision as a show stopper

necessarily on the bill.

But, I don't know why HMO's should be given a different sort of threshold protection than the ordinary doctor who, in fairness, has fewer resources to defend. Although, may be covered by insurance. Why treat them differently if they have, if they're covered by the same standard?

REP. EBERLE: Well, one difference is the difference in time, the time it takes to process this appeal versus what it takes to process a law suit. I mean, what's the average time for a malpractice law suit to wind it's way through the courts? Even through the trial level.

ATTY. GENERAL RICHARD BLUMENTHAL: I don't know the answer to that question --

REP. EBERLE: The appeals process is a few months.

ATTY. GENERAL RICHARD BLUMENTHAL: -- I would guess that it varies tremendously. I don't know what the average is.

REP. EBERLE: Okay, thank you.

SEN. HARP: Thank you. Representative O'Neil, followed by Senator Gunther.

REP. O'NEIL: Good morning.

ATTY. GENERAL RICHARD BLUMENTHAL: Good morning.

REP. O'NEIL: Just wanted to try to get back to Representative, Senator Kissel's discussion, and make sure I understood. Seemed to me the point he was making was that it might actually be better to do nothing, in some circumstances.

Looking at what kind of bill we might end up with in terms of limitations and so forth. Because the courts are basically going in that direction. He seemed to be saying that the courts are moving, in the Danbury case, have moved.

At least as far as a motion to dismiss is

concerned. Which, I guess basically it says that you've made out a case that if all the facts were proven you could win it, so we're not going to dismiss the case. If I remember the standard of a 12-b-6 motion. So, if that's happening, and we're not -- and we're getting at sort of more or less straight negligence kind of standard, were you saying before that it might be better to just let the law develop in that direction versus have a bill that's loaded up with all sorts of limitations and complexities?

ATTY. GENERAL RICHARD BLUMENTHAL: Well, I'm here to support the bill. And I've urged what I regard are improvements in the bill. Some of which may be well founded, and others not, for reasons that have been well articulated.

I think that the basic standard ought to be ratified and approved by the legislature. It will help people in the courts to overcome defenses that now may be raised. And those defenses may be overcome anyway in future court decisions.

But this bill would be progress for individuals who have grievances because they are denied care, or their care is delayed as a result of HMO decisions.

There may be some restrictions or provisions that ought to doom the bill, as with any bill.

It wouldn't be the first time that a good bill became a bad bill because of some of the restrictions that it contained. But, overall I think this bill would be an important step forward.

I would urge strongly that the ERISA exemption be removed. I don't think it gains anything.

REP. O'NEIL: Well, actually that really is the central point, perhaps, of the discussion. That is, if the ERISA part were to stay, which means that I think ERISA covers about half the employees in the State of Connecticut. Half the people who have medical coverage, roughly, are covered by an ERISA plan.

Would it be better to just let the courts decide their way through this thing, rather than take half the people, so to speak, off the table? Is this a

show stopper, the ERISA, in your opinion?

ATTY. GENERAL RICHARD BLUMENTHAL: I think I would have to see the final wording of this provision as it emerged from this committee. For example, if it were made contingent on federal law. On clarification of federal law, it might be less objectionable. I don't want to speak against the bill simply because it contains a provision that right now I think is objectionable. I urge the legislature to adopt this basic standard without the restrictive bells and whistles that now are attached to it.

REP. O'NEIL: Thank you.

SEN. HARP: Thank you. Senator Gunther.

SEN. GUNTHER: Hi, Governor. What bothers me a bit, I -
- you know some of us have been up here for years.

ATTY. GENERAL RICHARD BLUMENTHAL: You're the author of the Patient's Bill of Rights, aren't you, Senator?

SEN. GUNTHER: I didn't know that. By God, is it a conflict that I talk here? Anyway, we've heard the dialog. It's in the law now, you know. And it took somebody to go right up to the Supreme Court in order to get the right to do it.

And I think there's a lot of promises that have been made. And it's time we cleaned it up and made it very succinct that they have the right. The same token, I'm sort of on a Catch-22, because I worry about the, it being a field day for the lawyers to take and implement the frivolous cases without getting some control in between there, between the ambulance chaser and the bona fide cases.

And I practiced 47 years. I've seen doctors put through hell just to have cases settled out of court and that type of thing, a mark on their record, you might say. And that sort of thing. Because somebody was doing a little non-legitimate suing in a particular case.

And I agree with you, the appeals process, in my book is not the route to go for a clearance of cases to get into court. I think the appeals process, the internal and external appeals, we've heard testimony last week on that. But what about having the same process that they have with malpractice cases against lawyer, doctors now, by having a panel.

And I'm saying out of the Insurance Department, because all our appeals now are in the Insurance. But have a panel of health care providers who would do the screening to find out if there were a legitimate basis. And they can eliminate the frivolous cases. Would that be a process that we could entertain in your mind?

ATTY. GENERAL RICHARD BLUMENTHAL: I assume, Senator, you're talking about a panel that would decide all malpractice law suits as against doctors, as well as HMO's, is that?

SEN. GUNTHER: No, well right now if it's something that could be applied to both, I think that's possible in my mind. At least to have a non-partial, but a competent group of people that know all the alternatives that were happening within that particular case on a professional basis, not on an Insurance basis.

And not in control of the Insurance Department regardless of whether they have their own panel of specialists. That's their own specialists that decide these appeals. I'm talking about a totally independent group.

And I'm not looking for another layer of government and that type of thing. Except, I worry about the courts being loaded up by some of the members of your profession who love to get a case and ride it in the ground for, whether it's a \$50 settlement, or whether they get the big ball game, you know.

ATTY. GENERAL RICHARD BLUMENTHAL: Well, Senator, let me react without ducking the question to say simply, I would be open to talking, considering, discussing, any of the ideas you or others may have for

improving the present sorts of protection against unfounded frivolous law suits.

That is, actions that very plainly can't withstand some sort of very preliminary or initial scrutiny.

My point is, there ought to be some parody, or equivalence between the protections that are afforded the doctors, and those that are afforded the HMO's.

They ought to be on the same level. The same playing field, so to speak. And there ought to be a parody or equivalence between them now, you know, maybe the appeals, maybe some kind of panel or group such as you're suggesting is a better vehicle than the present system.

But that's a much larger, or at least somewhat different topic. And as I mentioned, I'd be happy to talk to you about it.

SEN. GUNTHER: All I can say is, times a wasting. We're almost into April. And you thought about the appeals process that they put in here, the ERISA and that, be nice for you to take and come up with some suggestions on a possible independent panel.

Because I'm not looking for this to go back and do nothing. As far as I'm concerned, we've done nothing for years now, with the talk that we had this authority. I think it's time we got, you know, fish or cut bait. Get something out of this session.

ATTY. GENERAL RICHARD BLUMENTHAL: Well, on fishing or cutting bait, maybe the way to proceed at least for now, is as Representative Farr implied, as Senator Kissel implied. As others have indicated to me, the present system for requiring an affidavit ought to hold true in the case of HMO's as well as doctors. That would certainly be a way to go forward now.

SEN. GUNTHER: Thank you.

SEN. HARP: Thank you, Senator Prague.

SEN. PRAGUE: Thank you, Madam Chairman. Richard, it's always nice to see you come in --

ATTY. GENERAL RICHARD BLUMENTHAL: Thank you, Senator.

SEN. PRAGUE: -- and testify on behalf of the people of the State of Connecticut.

ATTY. GENERAL RICHARD BLUMENTHAL: Thank you.

SEN. PRAGUE: It's my understanding that ERISA covers thousands and thousands of employees who are employed by self-insured companies. If the State of Texas has passed their law suit, you're saying that in their legislation, they include companies that are self-insured who are protected under ERISA?

ATTY. GENERAL RICHARD BLUMENTHAL: They do.

SEN. PRAGUE: So that, if we don't do that in our legislation then we could ultimately exclude thousands and thousands of the residents of this state from the same advantage that people in the State of Texas have?

ATTY. GENERAL RICHARD BLUMENTHAL: Correct.

SEN. PRAGUE: You know, on that basis, what happens if somebody is denied services and they work for a company that's self-insured and protected under ERISA, and they proceed, if we change this legislation and include those companies, and they proceed to sue the HMO.

Is there, you're saying it could take years for that law suit to be decided, because we don't have a provision to be able to sue companies that are protected by ERISA? Was I clear in hearing you say that? Or, would you say the law suit would go forward if we changed this legislation?

ATTY. GENERAL RICHARD BLUMENTHAL: Well, it could take years. As it does often take years for any law suit to be concluded. My comment about length of time related to the federal courts clarifying federal law, as to the scope of the ERISA exemption

that is contained now in federal law.

As you know, the exemption for ERISA plans is a matter of federal preemption. Our state statute theoretically is preempted by federal law, which says that only the law of the United States can apply to liability issues --

SEN. PRAGUE: That was --

ATTY. GENERAL RICHARD BLUMENTHAL: -- and the exception to that exception, if you will, that was drawn by the United States district court here in Connecticut said in effect, that exception only applies to coverage decisions. Not to decisions that affect the quality or issues relating to treatment or care.

And so that theory, that rationale, if applied more generally for example, law suit that you hypothesized would enable someone to sue HMO's now here in this state. But this provision would un-do that progress.

SEN. PRAGUE: Well, in my opinion I certainly side with you in saying that we have to protect those people who are covered by self-employed companies who are protected by ERISA. We have to eliminate that protection of the ERISA from this legislation.

And I just for the record, I read an article about the Texas law. And at the point at which that legislation was passed, the HMO's were much more cautious about denying services because of the threat of law suits.

And even if cases in Connecticut take years, the fact that we have the legislation on the books that gives that, and providers, that chance to sue the HMO's, will in my opinion, certainly make the HMO's much more cautious about denying services that in the end cause serious harm or death.

So, with that, I support you completely. And, thank you for coming to testify today.

ATTY. GENERAL RICHARD BLUMENTHAL: Thank you, Senator.

SEN. HARP: Thank you. Representative Nardello.

REP. NARDELLO: Hi. Thank you, Dick. I think I need to clarify something. As someone who voted for the independent appeals process, I see this as two different issues. To me the independent appeals -- and I want to make sure you see it the same way. That's the point of my question.

The independent appeals process is for that individual who feels that they've been denied a service that is in their contract, but there's been no adverse effect. In other words, they went through surgery.

The surgery or whatever wasn't covered, or the hospital say, they came through it just fine. And they think they should have been covered for it. And it's the point of the independent appeals panel to determine that.

So when we look at the liability issue, it's for that individual who has been denied the service based on, you know, the HMO's ruling. And yet had an adverse effect. I mean, am I understanding this correctly, that it's two separate issues. One is based on an adverse effect, and one is not.

ATTY. GENERAL RICHARD BLUMENTHAL: You have put, better than I did, the statement that I made earlier about the different roles that the appeals process is supposed to take. One, under the bill that was passed and established the appeals process that now exists.

And the other that's envisioned by this bill. Which is why I am not sure how in fact it would work. I know, as Representative Eberle has suggested, that maybe it's role could be expanded, or extended to issues relating to liability.

And maybe that could be done. It would not be my recommendation that the appeals process be adopted or extended for that purpose. I think the same, and I apologize for repeating myself, the same right should be accorded the HMO's as the doctors

have rights against the frivolous or unfounded law suits which is the purpose of the affidavit.

REP. NARDELLO: I guess what I'm trying to establish for the record is that you do indeed see them as two separate things. Cause see, and that's how I look at the situation. There's two separate things.

We have an appeals process. It is to be used. It's used for certain instances. A liability issue is different from that appeals process. It needs to be considered differently.

ATTY. GENERAL RICHARD BLUMENTHAL: I basically, I agree. Although, as with many contractual or other liability decisions, the two can often overlap.

REP. NARDELLO: Clearly. And I think the Texas case illustrates that if you do it on quality of care also in Connecticut, it's not the quantity of care. It's not what coverage you have. And I think that's pretty clear.

And I think we all understand that. We need to make the public understand that. But if the quality of care is impacted and then you have an adverse affect, then you have a right of suit.

ATTY. GENERAL RICHARD BLUMENTHAL: Thank you.

SEN. HARP: Thank you, are there further questions? If not, thank you very much.

ATTY. GENERAL RICHARD BLUMENTHAL: Thank you very much.

SEN. HARP: Our next speaker is Representative Andrew Fleischmann.

REP. FLEISCHMANN: Good morning, Senator Harp, Chairwoman Eberle, members of the Judiciary, Public Health, and Insurance and Real Estate Committees. First, I'd like to thank you for raising HB7032, and holding a joint public hearing on this issue today.

I think all of us agree that it's an important issue. And I appreciate your setting aside the

time to do this. I strongly support ensuring and strengthening a patient's right to sue a managed care organization whose actions have led to injury or death on the part of the patient.

And like many of you on these committees, I introduced a bill to promote that result. However, I am concerned about a number of provisions in the bill that's before us here today.

And I'm here to ask that you either strengthen this measure and make it clearer, or take no action whatsoever. Why would I say this having introduced a bill myself on this topic?

Well, I shared the perspective of Senator Kissel that recent state and federal cases, most notably *Napoletano versus Cigna Health Care* at the state level. And *Moscovitch versus Danbury Hospital* at the federal level, have opened the door to malpractice law suits against managed care organizations.

The spirit in which I, and many of you, offered bills on the topic of liability for managed care organizations was to wedge a strong door stop under that open door, ensuring that Connecticut patients could sue for malpractice in appropriate circumstances.

HB7032 would actually, in my opinion, start to swing that door closed. Or so near to closed that very few Connecticut residents who wanted to sue could actually pass through that doorway any longer.

I'd like to give you some examples. First, Section 1, Subsection 4, of the bill says, it defines a health care treatment decision as a determination made when medical services are actually provided by the managed care plan.

That's at lines 12 of 13 of the bill. Well, what if medical services are not provided but should have been provided? It would seem that this bill doesn't cover that circumstance.

Next, Section 1, Subsection 8 of the bill. Says that, it defines ordinary care. And it says that it means in the case of a person who is an employee, agent, ostensible agent, or representative of a managed care organization, that degree of care that a person of ordinary prudence in the same profession, specialty, or area of practice as such person, would use under the same or similar circumstances.

Well, this standard has to do with someone's profession. What if the managed care organization has the wrong employee making medical decisions? That employee may have exercised what we consider ordinary prudence for someone in their profession.

But, someone in their profession perhaps should not have been making the decision in the first place. It would seem to me that this language before us would make it harder to sue in such a circumstance.

Third, Section 2, Subsection C of the bill, explaining certain defenses, or clarifying certain defenses that shall be available to managed care organizations. It says, it shall be a defense, and then in line 65, the managed care organization did not deny or delay payment for any treatment prescribed or recommended by a health care provider to the enrollee.

Well what if the managed care organization has guidelines, or formularies directing doctors not to prescribe or recommend certain treatments? It would seem to me that that instance is not covered under this bill.

Lastly, Section 3 of the bill, lines 89 to 94, says that no person may maintain a cause of action unless the enrollee has exhausted the appeals and review applicable under the utilization review requirements.

Well, what about protracted appeals processes? The fact is that when we passed our managed care bill of rights a few years ago, we did not set a time frame for internal appeals, or external appeals.

It seems to me by including this in the legislation, we've actually created an incentive for managed care organizations to drag out their appeals process, their internal appeals process, so that someone who may want to take action in the courts is prevented from doing so simply by the delay.

To conclude, it seems to me that the legislation before us today may create more new defenses than new grounds for action. I would recommend first, in support of the Attorney General's testimony, that we eliminate the ERISA exemption.

I think he made a very compelling case that in an area where we're currently in doubt as to whether ERISA plans will or will not be affected by recent court decisions, it makes sense to ensure that our citizens, nearly half of whom are now under these plans, are potentially able to sue. And that we don't carve them out.

Second, I would encourage your committee's to create a strong right to sue that is not encumbered by narrow definitions and provisos of the sort that I've discussed here. The State of Missouri simply said that, in the corporate practices, medicine defenses shall no longer apply.

It was a much more broad brush approach that was saying what defenses shall not apply, as opposed to setting up these narrow definitions. I would encourage your committees to move down that track. Or, do nothing.

Third, I would encourage you to set up a time limit for internal appeals processes and perhaps for external appeals as well, so that regardless of what we do in this area of legislation, we can assure people...

(gap in tape 1a - 1b)

...and to those appeals processes that they won't be caught in them forever. Lastly, all of us are aware that far fewer patients and consumers have taken advantage of the processes we set up under

our managed care bill of rights a few years ago than we would have expected, there had been far fewer appeals. I believe it would make sense for us to set up a consumer hot line and an office of consumer advocate for health care so that the people have a place to turn.

And they know that they can indeed get help, assistance, advice, and remedy, in circumstances where they feel that they haven't gotten properly treated by their managed care organization. With that, I am happy to answer any questions or concerns you may have.

SEN. HARP: Thank you very much. Are there questions? If not, thank you very much.

REP. FLEISCHMANN: Thank you.

SEN. HARP: During this break, I'd like to welcome the members of the Insurance Committee and the Judiciary Committee to our joint public hearing. We're now going to move on to the public portion of our hearing. And our first speaker is Jeff Boyd.

JEFF BOYD: Good morning, my name is Jeff Boyd. I'm executive vice president and general counsel of Oxford Health Plans. And with me is Susan Halpin of the Connecticut HMO Association.

I want to thank the Public Health and Judiciary and Insurance Committees for giving us the opportunity to offer our views in opposition to assembly bill HB7032. We believe that extending liability to managed care organizations is both costly and ineffective.

We believe that there are existing avenues of recovery for patients in our programs. And that using liability, tort liability, and litigation, is an ineffective way of addressing procedure problems with the system, and constitutes a poor trade off.

It should come as no surprise to anybody here that the general counsel of a large HMO is against liability extensions to managed care organizations, but I was also a business proprietor before coming

to Oxford, as partner in a large Hartford law firm.

And during the late 1980's and early 1990's we saw costs for health insurance for our employees go up in excess of 30% a year, year in and year out. The result of that was a requirement that we increase the contributions that our employees had to make to get coverage.

And we know from many small employers, the result has been not offering health insurance to their employees. It's the managed care organizations, health plans, have done a great service to the people of the State of Connecticut in helping control escalating costs and keeping health care affordable.

And that's what my testimony here today really is all about. I would also like to say that under existing regulatory frameworks, there are avenues of recovery for patients who believe they have been unfairly denied care.

Connecticut has extensive utilization review rules.

All health plans have their own internal appeal systems. And there also is external appeals in Connecticut. And unlike tort litigation, these avenues of appeal are calculated to bring a prompt result and get the patient the care that they need.

In looking at the bottom line results of a liability bill, I believe the conclusions will be more law suits, potentially large verdicts against HMO's, significant increases in premiums, up to five to eight percent, according to some significant studies, higher malpractice costs, evisceration of utilization review in the efficiencies of managed care.

Perhaps a greater strain on the relationship between health plans and their physicians. Perhaps a need to more narrowly restrict networks to control more greatly the care being given to avoid liability, which we believe is exactly the opposite of what the consumers in this state want.

The practice of defensive medicine, which some

experts calculate costs our economy ten to \$35 billion each year. And in particular where they studied states having tort reform for medical malpractice they found significantly increased costs without any benefit in terms of readmission and mortality in states where no tort reform was in place.

Defensive medicine is bad medicine. There is nobody in this room who would want to have unnecessary dangerous invasive procedures performed on them for defensive purposes. And yet, these studies show that's exactly the result when medical malpractice is the -- is the remedy of resort for patients.

Obviously, Connecticut wants to be competitive in attracting businesses to the state. Connecticut already has very high health care costs relative to many other states with which it competes. And adding liability to managed care organizations will only add to that problem.

I think, finally, just in looking at the winners in this legislation, it seems to us that perhaps the biggest winners will be the plaintiff's bar. A Rand Corporation study shows that 43% of dollars spent on malpractice litigation ends up to compensate the injured. The rest goes to pay for counsel and other costs.

And we've also seen in other studies that the malpractice system doesn't effectively compensate people who have been injured. In general, it compensates many folks that have not been injured. And folks that have been harmed go without.

So, in summary, we believe that the bill HB7032 is a costly and ineffective way to address problems which we think can be solved quickly through internal review to get patients the care that they need. And we would urge the committees not to pass legislation which could destroy the benefits that managed care has brought to the Connecticut economy.

SEN. HARP: Thank you very much. Representative Cleary

REP. CLEARY: Thank you, Madam Chairman. I guess a couple of questions. As the bill is currently drafted, it would require someone to complete the external appeal, internal and external appeal process, before going to litigation.

In your mind, could that hinder that process in that a company might have to more energetically defend their decision before that external appeal, and try to get that external appeal to uphold that decision.

Because, at least as it's drafted, that would be the gatekeeper in some sense, as to litigation. So could it bog down that whole process, where right now as I see it, it's a process to try to get people care expeditiously, before their condition worsens.

I just see it as, if that's the gatekeeper, then the companies are going to put up a lot more energetic defense to those appeals, if it's the gatekeeper to litigation.

JEFF BOYD: I think there's no question about that. Our company, and I think most companies would view the record of an external appeal as something that could end up being a key part of the litigation. So there would be a lot more time and expense involved in that process for sure.

REP. CLEARY: My other question is on ERISA, and what it takes to qualify an employer for ERISA protection. As I understand it, it could be an employer who has a group that is operated by your company, managed by your company, and might have the employer at 10% risk of premium as opposed to being 100% purely self-funded. Would that give them ERISA protection?

JEFF BOYD: Yes. A plan where the employer pays directly costs of health care, is a self-insured plan. Some self-insured plans have reinsurance, some don't. But, if the employer pays directly the cost of care, that's a self-insured plan, and it qualifies for ERISA protection.

REP. CLEARY: So even though an employer again may only be at risk because of the reinsurance for 10% variation in claims, they would still be able to get ERISA protection, and basically have their employees covered under a pretty basic plan that other employers would be covered by?

JEFF BOYD: I think that's correct, yes.

REP. CLEARY: Thank you.

SEN. HARP: Thank you, Senator Prague.

SEN. PRAGUE: Thank you, Madam Chairman. Does Oxford have different levels of appeals? For instance, how long is your appeals process?

JEFF BOYD: It depends on the thing being appealed. If the decision being appealed is one that is of an urgent nature, in other words, prompt decision is needed to protect the health of the patient, then that happens under statute very quickly, 24, 48 hours. That sort of time frame.

Even more promptly in some cases. For an appeal that doesn't involve something that's an immediate threat to the life or health, that can go on for 30 days in initial stage of appeal. And then there are stages of appeal after that.

SEN. PRAGUE: So do you have different levels of appeal then your appeal process (inaudible - microphone off) could last as long as 90 days? You have three levels of appeal?

JEFF BOYD: It's possible it could last 90 days. Many of them are resolved in much shorter time periods, however.

SEN. PRAGUE: But there is a possibility that the appeal could last, could take 90 days before it then goes to the external appeals process?

JEFF BOYD: That's correct. But again, that would not be the case if it was something of an urgent nature.

SEN. PRAGUE: But it's still, that's within Oxford. And I know that also Anthem Blue Cross has that same three level process of appeals where an appeal can take as long as 90 days.

JEFF BOYD: That's correct.

SEN. PRAGUE: Okay. Do you have any evidence that in the State of Texas premiums went up because of this law suit? Because of their legislation concerning the ability for providers and people to be able to sue HMO's?

JEFF BOYD: I have not seen anything that is empirical from Texas. Although I understand that advocates, as well as opponents of that legislation have taken contrary views. I've heard reports that premiums have, in fact, gone up. And I've heard others say that they haven't. My guess is that the studies just are not in yet.

SEN. PRAGUE: So you don't have any basis upon which to say that premiums would go up --

JEFF BOYD: Oh, no I --

SEN. PRAGUE: -- if this legislation, if legislation to sue HMO's is enacted?

JEFF BOYD: Oh, no. There have been several well-documented empirical studies indicating rates going up anywhere from 2.5 to 8.6%. KPMG Barents, I believe, I have one here.

SEN. PRAGUE: What are the studies based on?

JEFF BOYD: They're based on an analysis of both the direct and indirect costs of liability legislation. Things as simple as added insurance premiums. And we've spoken to our insurance carriers about what will happen to our premiums if liability legislation is passed in any of the states where we do business.

And we have been told that the premiums will go up. And it won't be a matter of a few cents. It's

significant increases in premiums. So, I feel very comfortable stating that our insurance premiums will increase if you pass this legislation. And I think that people should understand that health plans operate on very small margins, 2, 3, 4%.

So, very small increases in cost, 1, 2% really have to be passed on in the form of higher premiums. I can get you a citation of this study. I think it's KPMG Barents, that was performed in 1997.

SEN. PRAGUE: May I just follow up with another question? The basis of your statement though, is not what has happened in the one state that has passed legislation to be able to sue HMO's. You don't have any data from that state that their premiums have gone up. Is that correct?

JEFF BOYD: I don't have any data from Texas, one way or another.

SEN. PRAGUE: And that's the state that has passed the legislation to give people the ability to sue their HMO's?

JEFF BOYD: That's right.

SEN. PRAGUE: Okay. Your loss ratio in Oxford is, you said you operate on a 2 or 3% profit, so your loss ratio is?

JEFF BOYD: For companies like Oxford, what you seek to achieve is an operating margin before taxes of between 4 and 5%. Oxford is a different case, because Oxford has lost significant amounts of money in the last two years.

So our medical loss ratio, or our medical care ratio has been in the very high 80's, low 90's, as a total company.

SEN. PRAGUE: And just one more question, and I really thank you for coming here today to testify. But I'm curious, is your CEO salary, are factored in to your premiums?

JEFF BOYD: Our administrative costs include all of our

employee's salaries. I think that it's very important to note that when you see advertisements, or press stories about huge multi-million dollar compensation for managed care plan CEO's, what they're talking about is compensation in the form of stock options, and equity incentives.

Those amounts really are paid by the shareholders of our companies. They don't factor into our administrative loss ratios. They're not included in the premiums that we charge to our customers. They're really something that comes from our shareholders when the price of a company stock appreciates.

SEN. PRAGUE: Thank you.

SEN. HARP: Thank you. Representative Winkler.

REP. WINKLER: Thank you, Madam Chair. A question that I have. You had made the comment about the HMO's are controlling cost, keeping insurance affordable, and giving the care of providing care to the patients they need. Correct?

JEFF BOYD: I don't recall --

REP. WINKLER: Pretty much.

JEFF BOYD: -- what exact words I used. But I certainly said --

REP. WINKLER: Basically.

JEFF BOYD: -- they're promoting affordability.

REP. WINKLER: A question that I have which could be related to the bill that is before us. I understand that insurance companies have contracts with pharmaceutical companies to promote certain medications. Is that not correct?

JEFF BOYD: That's true.

REP. WINKLER: Very often I have seen patients that are treated, are given prescriptions for particular medications that are appropriate for their

diagnosis. Go to get them filled and they're denied by the pharmacy because they are not on your insurance formulary. Consequently, the medication gets changed. The patient leaves. Does not get better because they're not on the appropriate medication. Return to the facility and are treated the second time, which drives up health care costs. Is that not a factor?

JEFF BOYD: I can only answer with respect to how my company operates with respect to prescription drugs. For our plans, and I think for most plans, the physician writing the prescription has control over what medication the patient receives.

Some health plans use formularies, which substitute certain medications that are either the generic equivalent. In other words, the exact same medication, or equally effective. And those formularies are part of the contract that the member is signed onto.

So it's a matter of contractual obligation. In the case of our health plan, we follow what the prescription writing physician writes. There are certain medications that are very costly, and for which there are effective less-costly substitutes.

And we may have a lower co-payment to encourage physicians and patients to use those drugs.

But if there is ever a clinical reason for a member to have a specific medication, the member has that medication. And there is no system in place in Oxford that would substitute something that is less effective, or which has more side effects for something that a physician has written.

SUSAN HALPIN: Representative Winkler. Just for the record, also I believe that's consistent --

REP. WINKLER: (inaudible - microphone off) Could you give us your name, please?

SUSAN HALPIN: I'm sorry. Susan Halpin, representing the HMO Association. That policy is consistent throughout the industry. In fact, the Department of Insurance prohibits closed formularies. And

then there has to be a process for prescribing outside of the formulary according to the Department of Insurance. So that is consistent policy throughout.

REP. WINKLER: I won't belabor this, but I have seen more costly medications as a result being prescribed for patients that are not effective. And the reason is because of the contracts that the HMO's have with the pharmaceutical companies.

So there has to be some financial gain to the HMO for this contract that they have with the pharmaceutical companies. I do know that the one medication, and these aren't generics that I'm talking about. Thank you.

SEN. HARP: Thank you. Representative Dillon.

REP. DILLON: Thank you very much. I have a number of questions. One is just a simple housekeeping measure to follow up on Senator Prague's comments. I wonder if you could provide us with a copy of the study you were citing.

And I'm strapped to go on, not for any particular philosophical reason. I would just assume, given pharmacy costs and the aging of the population, that costs would go up over time no matter what happened. But I'd be very interested in seeing the study that you're citing.

JEFF BOYD: I've just handed a copy, and it really, it's not a study of overall cost increase. It's really limited to the direct and indirect cost of adding a liability mandate.

REP. DILLON: Thank you. Now, my question. The -- traditionally, the duty attached to the physician, and over time obviously the promise of managed care organizations and the structural of relationships that you've developed in the industry for a number of reasons, basically made some of those entities providers and insurers, partly because of the hands on role that they play.

And a lot of the organizational institution

arrangements vary from group to group. But it seems to me that there are a number of background questions facing what we're looking at today. And one of them is that, if historically we held, we assumed that the duty attached to the physician, and to the physician's clinical judgement, given the changing relationship between the on-site provider of care and the managed care organization, the question arises of whether or not a physician, for example, can serve two masters.

That is, the patient and the group that they have a financial relationship with. How would you, if you would oppose any legal exposure on the part of the managed care organization, where would a patient go for remedy if there were an untoward event? If there were an unfortunate misapplication of judgement if they didn't go to your company?

JEFF BOYD: I think under existing law, if -- and I think before answering the question I should make clear that physicians are the one's rendering care to patients. Managed care plans are not making treatment decisions.

We are not laying our hands on our patients. Physicians are the ones making the clinical decisions. And they have responsibility for the clinical decisions that they make in Connecticut, and are subject to liability for negligence for medical malpractice.

REP. DILLON: Right, we know -- I don't know why you paused. I wasn't trying to stop you. But, if I'm a physician and I'm in your plan, and you, and I recommend that you do a treatment for my patient and you deny that.

Do you provide me, and I want to advocate for my patient. Let's say theoretically certain penalties, depending on who the managed care group is, if I persist. Will your company provide me with the clinical algorithms on which you base that denial in order to defend my patient?

JEFF BOYD: First of all, there is no penalty or punitive aspect that a health plan applies to a

physician who advocates for patients. There is absolutely no action taken against a physician. And so I don't think that enters into the equation.

With respect to a decision on utilization review, there are usually a couple of different things involved. One may be just a construction of the contract between the health plan and the employer or the member as to whether a particular procedure is covered.

In some cases, utilization review involves decisions concerning the medical necessity of an extra day in the hospital if a patient is not receiving acute care in the hospital.

Those types of decisions are based on very well understood, nationally accepted, clinical pathways that are developed by doctors, understood by doctors, and it's a collaborative process between the health plan and the physician in most cases.

REP. DILLON: I won't take up the committee's time by engaging in a dispute over whether or not medical providers are penalized in any way by managed care organizations. Whether we, you use withhold or your warning letters, or whatever.

Industry wide, I think that that's a strong statement for you to make. And it's testable. But, the question that I asked you was, do you make the clinical algorithms available if I request, if I recommend a particular procedure and you deny it.

Do you give me the basis on which you made that judgement? And I'm getting back to that, because you responded by talking about well accepted practices within medicine, and that isn't what we're hearing elsewhere.

JEFF BOYD: I'm sorry if I didn't answer your question directly. If there was a utilization review decision made at Oxford, a denial, and somebody asked what the basis for the denial was, what was the reason? We certainly would give them the reason and the basis for which the decision was made.

REP. DILLON: In what format? We just don't pay for that? Or --

SUSAN HALPIN: Representative Dillon, those are made available.

REP. DILLON: Just one other, I mean, it seems to me that one of the questions that's driving this is that the, the burden, the problem that your company was facing it seems to me is that of uncertainty, looking at this legislation.

Looking at what happened, let's say, to your equity position in the market a few years ago, that one of the challenges facing a manager would be that you have to operate on the predictable averages of running an organization.

And you look at maintaining costs. The public looks at the outlines. We want to know when something bad happens, who will protect us? Where can we go for some, so that they're not going to look at what doctor maintains cost over time.

They're going to want to know if my six year old needs a liver transplant, who is going to pay for it? So it would seem to me that the collision here is that the, what's driving some of the public concern about it has to do with accountability, but also they outline cases. And what's driving the industry is the average.

JEFF BOYD: I understand your comment. But I think I would respond that for the six year old that needs a liver transplant, the solution to that is prompt external review of that decision to make sure that whatever decision is made is absolutely the right decision immediately so the six year old gets the care she needed. The right answer is not a \$115 million verdict against a managed care plan five years later.

REP. DILLON: Well, the committee's been very generous, and I won't take up any other, but I think that we have to be able to say something more to public than the right answer isn't. And I think you're

absolutely right that what makes it an attractive case is very often a lottery. You don't really know what, it doesn't provide justice to 100% of the population.

But if it's your child, it would seem to me that you'd like to know. And I think that's a question that we're going to have to really resolve, and to look at. Thank you.

SEN. HARP: Thank you. Representative Nardello.

REP. NARDELLO: Thank you. I think what I want to comment here and ask a question about is the issue of accountability. I think in our health care system now we do hold health care providers accountable.

We hold hospitals accountable. We hold nurses accountable, and doctors accountable, and everyone else accountable. Now, when we went into this realm of managed care, the whole reason that we had the rise of managed care organizations was because HMO's said, we can do it better.

We can do it. We can give you quality of care for less cost. And maybe you can do it better. Actually, you know, in certain instances you can. But if that is indeed the case, and you can do your job better, shouldn't you want to be accountable?

Because if you're doing it well, you won't have to worry about the liability. Because you're doing your job well, and the instance of suits are going to be minimal. So that's why I don't understand, as you sit before us today, that you don't want to be held accountable, because you tell us that you do it better. And I want to believe that you do it better. So can you respond to that?

JEFF BOYD: My response to that would be that I think health plans today, under existing law, are accountable. And I think most importantly, our accountability should be to have the availability of a prompt external review by an independent party of our decisions.

So at the time when it counts most, patient, our members can know whether they're entitled to a specific procedure or care, and not through a medical malpractice type system, which very credible studies show us is grossly inefficient, does not compensate the people who deserve to be compensated, and promotes the practice of defensive medicine.

REP. NARDELLO: Let me just comment. I support your comments about external review. But I don't know if you heard my comments earlier on. I had to leave to go and vote in another committee. And that was that there are two separate entities.

An external review process is very, very important to this. But it really deals with the individual who has not had an adverse affect. The liability issue deals with that individual that has gone through the process, okay.

Has been denied the needed procedure, and has had an adverse effect. So, therefore, there are two separate things as far as I'm concerned. Yes, we should all support the external review process. And it has a place.

But this goes beyond the external review process to say, what happens when that person was given a course of treatment that was different than their doctor recommended because the HMO chose to again, deny that procedure.

And then now we've had a major adverse effect. Because that's the only time, as far as I'm concerned, that liability is going to come into contention. Is only if there's an adverse effect. So that's what I'm not getting here. You come forth and say there should be external appeals, and we agree. For certain instances. But what happens when there's been an adverse effect?

JEFF BOYD: I mean, it seems to me if a patient has a physician recommend a course of treatment, and for some reason the managed care organization refuses to pay for that, that the patient should utilize the external appeal process.

That should be their avenue, their remedy. They shouldn't wait and see what happens. If they believe that another course of treatment is appropriate. They should appeal. And the independent entity will determine whether the decision by the managed care organization was appropriate given all the facts. And that should be the remedy.

REP. NARDELLO: I understand that. And in most cases, that's going to take care of it, okay. In most cases. But if it's your child, or your mother, or your father, that's had an adverse effect, and granted these do not happen that often. I will be the first one to say that, okay.

They really, in the scheme of things, in all the claims that you pay, I will be the first one to say to you, that it really is infrequent. But if it is your child, your mother, your father, you want to be able to have a course of action, and a remedy for what you feel has been incorrect judgement on the part of the health maintenance organization.

So, as I said, I think maybe we just see this a little bit differently. I think your point about external appeal, again is well taken. But there has to be a remedy for that individual who's had that adverse effect.

And it's going to happen infrequently. But they are literally left out in the cold if we don't address this situation.

SEN. HARP: Do you want to respond? Okay.

SUSAN HALPIN: I would just state, Representative Nardello, that I think the goal is to address the situations that you're referencing. And remedy those situations. And the way to do that is with external appeals, so that those situations don't come in, you know, don't happen, frankly.

JEFF BOYD: And I think the malpractice studies show us that if there is tort liability there, you will have many, many law suits when people suffer

adverse effects, when in effect nothing wrong was done.

When people have bad health outcomes, they will sue a managed care organization and a physician even if all of the right decisions were made at that time.

And those costs will be borne by everybody in the form of higher premiums.

REP. NARDELLO: Would you support, if we tightened up the process so that we eliminated the frivolous law suits? Would you support that under it? I mean, because you raised, we've all talked about this, a very important concern.

So, if we were able to eliminate that end of it. We would some how work out the miracle language. I'm not guaranteeing. But if we could, would you support that then?

JEFF BOYD: I don't think that I could. And it's not just because the miracle language is so difficult to come up with. Experience has shown us that in other types of situations involving tort liability, and tort reform, it's very, very difficult to effectively limit the frivolous law suits.

Because the nature of the litigation process is such that it's very, very easy to put together a complaint that will stand up through pretrial proceedings and motion practice, and so forth. So I believe that we'll still be stuck with a very high cost.

REP. NARDELLO: Thank you for your patience. Thank you for the committee's patience. But, I would like to make a final comment in that cost shouldn't be the only factor. Thank you.

SEN. HARP: Thank you. Are there other questions? Actually I have a question. In your statement earlier, you talked about there currently being recovery mechanisms.

Can you define for me how you're using the word "recovery" in your statement so that I'll understand what that means. Cause I would guess

that in a law suit that what you recover is different than the current recovery mechanisms that we have now. So could you explain to me the difference?

JEFF BOYD: Sure. There are two remedies basically that the members have. The first is the internal and external appeal process. And when, I think it should be clear when an HMO makes a coverage decision, that's not denying somebody the right to receive care.

That's only a determination as to whether or not the plan will pay for it. So that if, if my son needs a nose job, and the plan refuses to pay for it because it's cosmetic. I can still go get a nose job for my son.

And I can appeal that and try to get them to pay for it later. And if it turns out to be a covered benefit through the appeal process, it'll be paid for. So, our members, notwithstanding a denial of a coverage, still have the right to go get whatever care they wish from whatever physician they wish.

So the first avenue is the appeals process, both internal and external. The second avenue is, members do have the right under current law to sue a health plan for the cost of a procedure that's been wrongfully denied.

And that suit will stand up. And if the procedure's been wrongfully denied, they can recover the cost of that procedure. What they can't recover is punitive damages, pain and suffering, and the kinds of things that are lumped in to get you the huge multimillion dollar verdicts that are so widely known and bring such disrepute upon the legal process in this country.

So there is a recovery, a law suit. They could also sue for mandatory relief, an injunction, or an order, to have care provided at the time. So there are avenues of relief available today.

SEN. HARP: Okay, thank you. I'm looking at this report that you sent around on the impacts for legislative

provisions on managed care consumers. And under "direct effects," and I just want to ask you about that.

It says that you'd be required to, I guess, increase your malpractice insurance. Or even buy malpractice insurance. So the real, is what I'm getting from it, doesn't exactly say that. I was wondering if currently what kinds of liability insurance your companies have by and large. And whether or not you currently carry malpractice?

JEFF BOYD: For our health plans we do not have malpractice insurance per se. What we have is professional liability insurance, which covers liability that arises out of the conduct of a managed care organization's business.

And I think from my company's standpoint, what you would have is a change, you'd have to have a change in the terms of the policy so that it would explicitly cover liability arising from the type of statute proposed here. And, we've been told by our representatives, it would come with an increase in premium.

SEN. HARP: Okay. And I guess the other costs that they say would increase would be for additional utilization review and maintenance of records on treatment decisions. And could you kind of explain to me how that would differ under this law from what you currently do?

JEFF BOYD: I think I can give you some fairly general ideas what I think would happen, or what I think the possibilities are. Depending on exactly what form the legislation was passed in, the language of the bill is very broad.

The things for which a health care plan can be liable for is very, very broad. It might involve much more scrutiny of treatment decisions by network physicians, in the defensive sense.

Looking much more carefully at what's being done to make sure that we have sufficient evidence to justify the U.R. decisions in the event of a law

suit. I think some people have speculated it might result in smaller networks.

Because Oxford is a company that was founded on member choice. We have the largest networks in our markets. And we do that because that's what our customers want. But if we end up in a position where we have enormous risks of liability for treatment decisions in a very large network, we might have no choice but to skinny down the sides of the network and impose more controls on the physicians.

And to us it's very important to try to promote cooperative relationships among our physicians and let our physicians know that they are making the treatment decisions. That they are not under the heavy hand of a managed care organization.

So from my company's standpoint, those would be costly, and they would be adverse. Our customers wouldn't like it.

SEN. HARP: Can I just -- but the way that I interpret that, and maybe I interpret it wrong. Since you're letting your physicians make most of the decisions, wouldn't they be the ones that would be at risk to malpractice if they made a decision rather than you, since your market niche is to give them more independence than say, company x, who is your competitor?

JEFF BOYD: Our physicians have malpractice liability today. I mean, they are subject to that risk today as we sit here. So the only change for the physician in terms of their liability of passing this bill, it seems to me is that they'll be more law suits.

And every time a managed care plan, or almost every time a managed care plan is named in a law suit, I think you could bet that the physician will be named, too. Because I know how plaintiff's attorneys work.

They name everybody involved in the process. They want access to every insurance policy available.

And they want to make sure that every potential avenue of recovery is covered in their complaint. So when you have an increase in law suits against managed care plans, there will also be an increase in law suits against the physicians.

SEN. HARP: I guess I have another sort of comment to make around utilization review and it costing more. But, it reflects a concern that I've had which is that, that you have a doctor or a provider that is in your network who is also in maybe five other networks.

Each of you have different protocols under which you make a determination around whether or not certain types of services are served, are provided, or are denied under your insurance.

And the real question for me, and I think it gets to your point is, when you have these protocols or these guidelines, and each of them are different, how does, how do you communicate that to your network?

So that, in fact, you know that your network provider understands the basis upon which this protocol operates and that everything in the protocol is offered to the member.

We had Milliman and Robertson, I think is the name of the group, come and talk to us about their breast surgery protocol. And one of the things that I discovered is that the ultimate end is handed down by the insurance company around total days.

But on the other hand, the home supports, if the doctor is not aware of them, and they're not in place, then that really violates the whole protocol. If you -- do you see what I'm saying? And, I guess the real question for me becomes, what if the doctor wasn't that aware of it?

Then how do we -- whose decision is it really that made for a negative outcome? Was it the doctor's? Or, was it the decision that the insurance company didn't realize that their protocol wasn't even

known by the doctor or implemented by the doctor or by the system in the hospital?

JEFF BOYD: Let me try to answer the question and get to what you're looking for. For most treatment decisions that go on every day, providers don't have to consult an HMO's physician policy manual. They're really the level of invasion in what the doctors do by HMO's is overstated.

Most of the time they make treatment decisions. They see patients. They send their claims to the health plan, and the claims are paid. In some instances there are discussions between the health plan and a physician as to the appropriateness of a procedure, or for pre-certification of a particular diagnosis.

And those are typically granted. In a very rare case there is a dispute about that. And when there is a dispute, the physician has the right to know, and generally does know through policy manuals and other communications, what the basis for the health plan's decision is.

And in the case of somebody who is being hospitalized, it's very, very rare that a health plan will seek to send a patient home against the wishes of an attending physician.

If there are clinical reasons for somebody to be in the hospital, quality assurance, you know, these are nationally developed, quality-driven protocols that generally are understood and accepted by physicians.

So I don't think that there is as significant level of misunderstanding everyday than might appear because of some of the anecdotes that people here.

And the protocols and the utilization review is designed to ensure the appropriate care in the appropriate setting.

And they're only guidelines. They don't replace the attending physician's discretion. The discussions are had between doctor to doctor, as what the appropriate care is, and what setting.

SEN. HARP: I guess if that's the case, then why are we here today? I guess it would seem to me that if the doctors are able to make a decision then why are we here saying that the insurance companies, in fact, are making medical decisions, and many times, or some times, occasionally very few times, let's say, there's an adverse outcome?

JEFF BOYD: I think that it's the nature of the process that we're going through. The reform of the health care system that there are adverse outcomes even when all the appropriate actions were taken. And, people...

(gap in tape from 1b - 2a)

...want a remedy when something bad happens. Even when all the right steps were taken. And I think what this process has been about over the last several years is trying to make sure that there are appropriate avenues of appeal, of appropriate remedies for people who believe that they've been wrongly denied care.

Or, that they've been provided one level of care when they're entitled to another. And that's a legitimate concern. It's something that Oxford and every health plan is concerned about.

Not only to make sure that there is a remedy, but to make sure people are comfortable that they will be fairly treated by their health plan. That's one of the most important things to us, to the success and the survival of our business.

And so, we are very much interested in making sure people have appropriate remedies. And our mission is to get them the care they need when they need it. And the reason that I'm here is because we don't believe the right way to get there is by using the malpractice tort litigation method. That's costly and ineffective. We promote external review and other methods to get people the care they need when they need it.

SEN. HARP: Thank you. Representative Eberle.

REP. EBERLE: Thank you, Madam Chair. Do you generally consider yourselves liable, or jointly liable for any physician malpractice that occurs if a doctor is on your panel?

JEFF BOYD: No.

REP. EBERLE: Okay. So, you'd -- so you think that you don't have a liability for having a doctor participating and holding him out to your members as meeting your criteria?

JEFF BOYD: No.

REP. EBERLE: Okay. Do you keep any statistics on the number of times you get into a dispute with a treating physician and ultimately say no?

JEFF BOYD: We certainly keep track of denials and grievances and appeals, yes.

REP. EBERLE: Okay. Is that something that you provide to either the Insurance Department, or NCQA, or --

JEFF BOYD: Yes.

REP. EBERLE: -- is it something that we could get?

JEFF BOYD: Yes.

REP. EBERLE: Claims paid per month, versus numbers times claims were denied?

JEFF BOYD: Yes. Per member -- we certainly keep track of denials per member. Appeals, whether an appeal is overturned, etcetera.

REP. EBERLE: Could you get us those numbers so that we have some idea of the magnitude we're talking about.

SUSAN HALPIN: I believe, Representative Eberle, some of that is actually contained in the managed care report card the Department issues.

REP. EBERLE: And also, do you have any kind of a form

for your participating doctors to raise issues to you if they -- a doctor who doesn't like your protocol on a particular treatment? Or he doesn't like what you've done with a drug formulary or whatever, to be able to bring that to you and have an open discussion on it?

JEFF BOYD: Yes, we do. I mean, our medical directors speak with network physicians every day about such things. We have committees that are responsible for the adoption of quality-driven policies.

Network physicians sit on those committees. We also have network physicians independent of Oxford, sitting on the boards of directors of our Connecticut HMO, as well as our New York and New Jersey plans.

And our CEO, Dr. Payson, is very much committed to significant input from network physicians and others as part of the process of his developing consensus around our medical policy.

REP. EBERLE: Okay, so if a doctor feels that you're really stifling him, there's someplace he can go within the company to talk to other network doctors and try to get it resolved there?

JEFF BOYD: Yes, absolutely.

REP. EBERLE: Thank you.

SEN. HARP: Thank you. Are there further questions? If not, I want to thank you very much. I'm sure you felt very alive and challenged today. We appreciate your becoming before us. Our next speaker is a panel of speakers. Tim Moynihan and John Rothberg. What is it? Rathgeber? There we go. Welcome.

JOHN RATHGEBER: Good morning, Senator Harp, and Representative Eberle. For the record, my name is John Rathgeber. I'm used to being called a number of different things. And I'm the executive vice president for CBIA.

With me today is Tim Moynihan, who is the president

of the Metro Hartford Chamber of Commerce, which I keep saying Greater Hartford, but that's the old name of the organization.

We're here to speak in opposition to HB7032, which relies on expanded litigation as a means of resolving disputes with health care plans. While the business community shares some of the frustrations with health care plans experienced by providers and consumers, we believe that the proposals that increase law suits against health plans do nothing to address those frustrations.

On the contrary, we believe that expanded litigation will divert major dollars away from health care services and providers, increase the health care cost benefits, and drive up the numbers of uninsured in our state.

Examining proposals to expand tort liability, we are not venturing into uncharted waters. We don't need to speculate about how tort liability will work. We already know from our experience. And that experience tells us that litigation is extremely slow, expensive, and an inefficient means for dispute resolution.

And expanded tort liability will further drive up the cost of health care in our state through the practice of defensive medicine. Back in 1986, we were in a coalition with the State Medical Society trying to reduce the amount of litigation that was, medical malpractice litigation in the State of Connecticut.

And we did it because of our concern about the practice of defensive medicine, and the cost of medical coverage in the state. At that time, Dr. Leonard Kemler, who was speaking on the behalf of the medical society, before the Judiciary Committee, indicated that because of the pressures of our civil justice system, doctors are practicing defensive medicine.

And that defensive medicine is driving up the cost of health care. The cost of patient care and the cost of health care without any attributable

quality in the type of services that are being provided.

Basically, we're saying, we're doing a good job. We're doing what's right. But we're still being sued. And that's causing us to do things that are not necessary and driving up the cost.

The net result of those costs is obviously less access to health care. Both through increased numbers of uninsured, and also because employers when faced with more expensive coverages tend to skinny down their plans and have smaller benefit packages. We believe that a better approach is to work on the 1997 legislation, the external and internal appeals processes, and have resolution through that manner.

We have a membership of about 4,000 members. And about 3,500 of those members in the central part of Connecticut are small businesses of five or less employees. Access to health insurance for those companies, and their members, are the reason that we've had an interest in the subject for many years, and the reason that I'm here today.

To pile on mandates, which this General Assembly is inclined to do, and I was part of that process in the 80's when we had, every year there was a mandate of the year. Nobody worried about the economy was booming, until all of a sudden we found out that we couldn't afford all the mandates that we put into the system.

And the small market indemnity plans which were available to the small employers were no longer affordable by anyone. This General Assembly took leadership in creating the small market insurance reforms of the early 90's.

And that's really been a leader in the country. And has opened up access for small business and their employees to thousands of companies in the State of Connecticut as a result of those actions.

My concern is that the legislation before you here today, and before your various committees in this

General Assembly, numbering somewhere around 150, are going to create a market place that a -- or a -- ty an -- access -- ty coverage to t at small market is going to go away.

And I think you really have to take a good hard look at the costs of each and every item that you apply in terms of a mandate to the health care system. And I would suggest that this General Assembly create, as a matter of practice within this field, a medical cost fiscal note, where you either hire either through OFA, or through independent authority you price out each and every item and that it's a requirement before it go forward in terms of adoption for the General Assembly.

I served when we didn't have fiscal notes for state costs, never mind municipal costs. And we added those. And I think this is so critical to economic development and the success and growth of small business, and its access to health care, that you need to price out every mandate.

You ave to now w at you're vot'ng for. And you have to stand up and be counted in terms of transferring those costs to the small business people in your districts. It's a critical issue. And I think if it's not addressed properly by this General Assembly, you're going to have a situation in a year or two where we're priced out of the market place. And we'll be down to having thousands and thousands of individuals and their bus -- esses uncovered in the health insurance market. I would look forward to your questions.

SEN. HARP: Thank you. I just have one comment. I've never served in a day where we could actually layer mandates. What a lucky time you served in. We had to undo it all. Senator Kissel.

SEN. KISSEL: Hi, thank you for coming to testify. I understand the concerns that you raised. But I think I have to bring some points to bear on your arguments. First of all, the United States Supreme Court in a variety of decisions, have indicated, and such is the practice, that when a person sues

for a tort negligence and they receive proceeds, and a lot of people don't know this, but the plaintiff should they be successful, those proceeds are not taxable.

Are you gentlemen aware of that? And the rationale behind that is because those aren't profits. What the court ultimately viewed that as, is that that is compensation for a previous loss. In other words, when that person obtains compensation, they're merely being made whole. And thus, our highest court in the land has so determined.

So when you say you want a fiscal note for medical costs, I think that it's somewhat specious because do you just want say, the cost to an employer? Or the cost to someone buying the policy, without looking at the other costs on the other side?

Because there are other costs on the other side if there's negligence in the provision of medical coverage. And the reason I call it a cost, because when the person ultimately prevails, and in your testimony, which I reviewed, it says that about 49% of the cases the plaintiff ultimately prevails.

That's not income. That's merely compensation for a previous loss. My concern is this, as well. In every other area of our society, if there is a wrong done, there's a right to a remedy.

If you went to a hair stylist, and that was, there was a lot of people providing working on someone's hair, and it was owned by another entity, and they say you've got to use such-and-such coloring for everybody who comes in here, women that want their hair colored, or it could be men.

And their hair ultimately comes out of their head because it's an inferior product. You know, I think it's not what the public's looking for to say, here's your \$65 back. That that person might want to get compensation for the pain and suffering and humiliation that they felt.

And I agree with what Representative Nardello point as far as distinguishing the two things that we're

looking at. The appeals process is coverage. What we're talking about is a remedy when there's a wrong.

And in all, you know, there's a cost associated with that. If I go out and I buy a lawn mower and I pull the lawn mower and it blows up in my face. You don't need a lot of cases like that to have that company make a change in how that lawn mower is made. We don't allow that. We don't allow that in most areas of our society.

And I think that to avoid civil unrest, and people protesting in the streets, we have a tort system that affords a long cumbersome process that ultimately prevails to get you compensation.

I don't have to go out there and protest like crazy like in the 1920's when we had people working in factories and getting their arms chopped off. Thank God, we're a little bit more civilized than that.

So it seems to me that just throw costs in our face, and there's a question coming, to just throw costs in our face, that there's a cost on the other side to society. It's specifically regarding Section 3 of the proposed bill.

And I know you're against the proposed bill. But specifically regarding Section 3. It says that, in order to maintain a cause you have to exhaust your appeals process. Let's say we pass this legislation and there's a two-year statute of limitations.

Do you read this that if the appeals process hasn't been exhausted, when that two-year period comes up, that you're foreclosed from maintaining an action.

And if we did pass this bill as written, wouldn't it in effect cause people to delay that appeals process to get passed that statute of limitations period?

JOHN RATHGEBER: Senator, to your specific question, I really haven't considered that detail of the legislation. But if your cause of action doesn't

arise until you have completed your internal/external review processes, and I don't think it's told by the statute of limitations on the two year basis, because the cause of action isn't alive until you've created that.

But to your more fundamental philosophic question, I agree with you. You know, tort system in this country is an important civil right. I happen to think the balance in the tort system has gone too far, and is causing consumers in this country, costs which are embedded because of frivolous actions and defensive actions which are not necessary.

You know, you climb a ladder today, and if you ever stopped and read all the warnings on that ladder, you would never get to cleaning the gutters out before it became frozen up there.

Because we are so conditioned to do things to prevent the possibility of law suits that we've actually lost some common sense. And I think in medicine today, there are a lot of costs that are in the system that are then passed onto the consumer that prevents us from having access to health care in quarters of our population, or even where they have health care they don't have the levels of benefits that they should have because of costs embedded in there due to a tort system which has swung too far to the other side.

SEN. KISSEL: Well, let me just --

JOHN RATHGEBER: And that's my fear of this type of legislation.

SEN. KISSEL: Alright. One more follow up, and on the philosophical issue. And let me, and since you, and I appreciate the fact that you're addressing that. What I see with HMO's is that they've done a wonderful job over the last five to ten years of shrinking the excess costs that were embedded in a previous system of care.

And they've done well in maintaining profit margins, and still monitoring proper functioning of

health care provision to individuals. My concern is that absent an ability of address through the tort system, there's other pressures to bear on society.

Namely, or on these industries, namely we've got to keep returning profits, make this business attractive to shareholders, and we've got an all, you know, the fat out of the system. We've sort of picked the low lying fruit. And as we continue, my concern is that managers are going to look for other avenues to maximize profits.

And so, maybe they'll look at 24-hour mastectomies. Well, that doesn't go with the public. That's been addressed legislatively. Maybe we'll go for in and out births. Well that doesn't go. Public doesn't like that.

Maybe we're going to go for limited formularies. Well eventually the legislature is going to limit that. You're going from spot to spot to spot, trimming costs. And eventually, you're going to run out and you're going to impinge on the service that the consumers get.

And if they don't have a way to get damages, the appeals don't matter. I don't care about an appeal if I've lost a kidney and that was the wrong decision. It doesn't help me.

JOHN RATHGEBER: But there's another controlling factor in the market place. And that is that the employer wants both affordable health care and quality health care. And to the extent that the market place is a vibrant market place in which you have multiple managed care companies competing for market share, being innovative and trying to deliver quality services.

The employer community is the one who pushed for the report cards. Who pushed for the HEDIS reports. For the national standards. Because they want quality care.

If you're an employer in the State of Connecticut today, particularly with the labor shortage in the

State of Connecticut, one of the things you want to be, one of your top priorities is to be able to deliver to your employees, a quality health care benefit.

Now, for some employers that's not possible. One of the things that managed care has done is limited the numbers of employers who that isn't possible for. If, as Timmy said, we had stuck with indemnity plans, we have 10,000 members. A high percentage of our very small members would not be able to afford indemnity plans.

So you've got to balance, and understand what the market, what controls the market place already has in there for quality. And I know it's a tough issue.

SEN. KISSEL: I appreciate the fact that you acknowledge that we need to balance, and I think probably the point that's most impressive in your testimony is not just cost, but that with a certain level of cost we're going to lose people's ability to have any health care coverage whatsoever.

And I think that's a point well taken. And we'll have to balance that in our thoughts. Thank you. Thank you, Madam Chairwoman.

SEN. HARP: Thank you very much. Are there further questions? Yes, Representative Eberle.

REP. EBERLE: Thank you. You made the comment that you thought it would be better to work on improving the '97 reforms. And if you have suggestions for that, we'd be happy to hear them either now, or you can give them to us afterwards.

But I think part of making sure that the appeals process works, and works the way we need it to work, is an important part of this. You know, whether we ultimately go forward with some kind of tort liability or not, I think it serves everyone's best interest to have an appeals process that works well, because that's going to be the quickest way to get the majority of the questions and the majority of the challenges answered.

And in response to some of what you said, Senator Kissel, I think that it is important to remember where we were with worker's comp. That we had priced it to the point -- first of all, workers comp did away with tort liability, because it was inefficient.

And went for an automatic liability for limited items. Because that was the quickest way to get workers treatment. And to get the situations handled. And, rather than fighting for years about whether someone was negligent, we just said if it happens on the job you're covered.

And secondly, we had an awful lot of people out of work without any coverage. Because we drove the cost up so much. And tort liability is irrelevant then. If you don't have the insurance, you don't have the right to sue anybody. You don't have health care. And I think that's a very important point to keep in mind as we go forward in this debate.

SEN. HARP: You can respond.

JOHN RATHGEBER: I had, and this may not be prevailing wisdom in the industry, but I'm not here representing the industry. I'm representing the small business people who can't, sometimes can't afford the kinds of coverages we're talking about.

I think one issue with the external appeals, the one recommendation that I would have is that, some of the people point to the success of it because of the small number.

I think that's probably a lack of ready available information for the consumers. I would be more comfortable if there were more appeals that were successfully adjudicated by that process.

I don't think it's your construction of the process I don't think was in error. I just don't think there's enough knowledge out and about in terms of consumers. In terms of access to that process.

So that would be something that I would recommend that it, that literature is distributed, or however that's done, to be a broader recognition of the consumer's rights under the current system.

SEN. HARP: Thank you. Are there further questions? If not, thank you very much. Our next speaker is Adam L. Seidner. Adam L. Seidner? If he isn't here, Brian Benton.

DR. BRIAN BENTON: Good morning, chairs of the Public Health, Judiciary, and Insurance committees, and committee members. My name is Brian Benton. I'm a psychiatrist and the medical director of the Department of Psychiatric Services at the William W. Bacus Hospital in Norwich, Connecticut.

I'm also chairman of the Pharmacy and Therapeutics Committee at that hospital. I'm here today as a nominated president elect of the Connecticut Psychiatric Society to represent the 1,050 members of the Society and testifying in support of HB7032, AN ACT CONCERNING THE LIABILITY OF HEALTH MAINTENANCE ORGANIZATIONS.

HB7032 would allow injured individuals to sue their managed care companies if a health treatment decision made by the managed care company is the proximate cause of their injury.

We cannot stress enough the necessity for this type of legislation. As it currently stands, it is the physician who is held liable for a health treatment decision or denial of care.

However, with the advent of managed care, fewer and fewer medical decisions are actually being made by the physician. It is the managed care companies who are deciding which medications will be authorized for a patient.

Which treatments a patient may use. And how long a patient may stay in the hospital. This is especially true in the area of mental health, where the most fragile of patients are treated.

Psychiatrists and their patients are often at the

mercy of managed care companies who either deny or severely limit the treatment available to a patient. We've heard the argument, the decisions on health care treatments, and/or denials of care are not medical decisions, but rather they are payment decisions.

When denying the payment for the care that a physician says is medically necessary, or refusing to allow a medication because it is not on formulary, the managed care company is effectively denying medical treatment.

Very few people can actually afford to pay out of pocket. And besides they have already been paying premiums that should be going towards their care. This is incredibly frustrating for psychiatric doctors since the HMO has never actually seen the patient before denying care.

HB7032 will, for the first time in Connecticut, give the patient some recourse when he or she is injured by a health treatment decision made by an HMO. Traditional managed care reform legislation is not sufficient to rein in the egregious behavior of managed care organizations.

We believe that this is the only way to force managed care companies to carefully consider health treatment decisions. This type of legislation will not result in an explosion of litigation.

When there is a bad health care outcome, the law suits are already there. This bill would simply allow all involved parties to bear the appropriate responsibility. If managed care companies want to make medical decisions, they must live up to the consequences of those decisions.

We urge this committee to support HB7032.

SEN. HARP: Thank you, are there questions? If not, thank you very much.

DR. BRIAN BENTON: Thank you.

SEN. HARP: Our next speaker is Bill Sweeney.

ATTY. BILL SWEENEY: Good morning, Senator Harp and Representative Eberle, and other members of the committee. My name is Bill Sweeney. And I've submitted a written statement in order that we not get too bogged down in some of the legal questions that this bill creates.

And I'd be happy to address those at some other time if you want me to, or during the course of my remarks. But I would like to make some brief remarks. I'm here on behalf of the Connecticut Trial Lawyers Association, and in consultation with the Connecticut Citizens Action Group to oppose raised bill HB7032, and the companion SB1195.

For those of you who don't know, I was counsel to the plaintiff's in the case of Napoletano versus Cigna Health Care of Connecticut, and Hollis versus Cigna Health Care of Connecticut, which was the case decided by the Connecticut Supreme Court some two or three years ago regarding the issues of managed care and the right to sue in Connecticut.

The Napoletano case represented a, the Napoletano case was a group of physicians. The Hollis case was a group of patients who were affected by unilateral decision made by Cigna Health Care with regard to physician's provider list.

We went all the way to the United States Supreme Court defending the Connecticut Supreme Court's ruling that our actions were not preempted by ERISA. As you've been made aware also, in the, at the federal district court level, Judge Droney and the decision in the Moscovitch decision has basically sided with the ruling of the Third Circuit in holding that, in effect, actions about the quality of service are not preempted, but only issues as to coverage.

So, currently Connecticut enjoys a very unique status amongst the states in that we have a very, very wide birth to bring law suits against HMO's. And I'm here to testify that I believe that the legal maxima, if it ain't broke, don't fix it, applies.

I think what happened in Texas is a good example of what can happen to whatever you do here. Now, I'm not quite aware of what information the committee has before it with regard to the results of the Texas legislation.

But attached to my, I have numerous copies, but for the chairs, they're attached to the Texas statute, and the Texas decision in which the district court, federal district court of the southern district of Texas, while upholding portions of the Managed Care Act, preempted other sections of it.

And in fact, preempted sections that are currently a part of the present bill before you. It also preempted my, the basic holding in the Napoletano case. So that before you jump into the lake here, realize what you may be giving up.

My suggestion, and I believe that I have yet to hear a reason to leave the safe harbor of Napoletano, Hollis, and Moscovitch, for some unchartered course that is undoubtedly going to end up in federal court and be challenged on ERISA preemption grounds.

So because Connecticut is so unique, my belief is that to leave it alone. And if, in fact, we need to study this thing further, then let's do that. But the Texas case is on appeal to the Fifth Circuit.

So we don't know what they're going to do. We've all heard that Congress is going to do something about ERISA preemption. And as a educated projection, I would tell you that I don't think the U.S. Supreme Court wants to get involved in this stuff.

Because they have turned down certiorari. They did in our case. And they've done in numerous cases, where classically they would accept, i.e., the Third Circuit goes one way, the Fifth Circuit goes another way.

They haven't taken those cases. They didn't take

Napoletano. I mean, they could have ruled on this stuff and they chose not to, because they believe it's a state's issue.

Now, if you read the Texas decision, it's a very careful decision. And it reviews the ERISA preemption law pretty clearly, and talks about, you know, what that court thought about that legislation. I would submit to you that that may or may not apply if it happens here. You're going to go to federal court by one of these insurance companies.

And we all know today that there's no local angle to any of these companies. They're all nationally run. And they're going to do what they think is right. They all don't agree with each other.

So one of them is going to take you to court. And then the question becomes, do you want to go to Foxwoods, or do you want to go to court? I mean, what's it going to be? What part of your statute is going to be upheld, what part of it's going to get thrown out?

And I'm saying to you, given Moscovitch, given Napoletano, given Hollis, why go to the beach? So, I've said it out in more detail. I think that if you pass this law that, you know, just to step back, and not to be too lawyerly, if I may.

These cases all end up in federal court. You bring a medical malpractice case in the state court, like in Moscovitch, they get removed to federal court. And that's where they are attempted to be preempted.

And, of course, if you're under ERISA, you don't have a right to damages. So, effectively you've ended the law suit. So, what I'm saying to you is that, it may be well enough to study this thing. To see what happens in the Fifth Circuit.

And see what Congress does. Because we're going to be stuck with a law much like, and I use an analogy to the products liability law, and the many cases that have been decided since that act was passed,

where the Supreme Court of Connecticut has consistently said, this is the only remedy you have for this rising out of a product defect.

So, I anticipate that a Connecticut Supreme Court, when asked to review claims brought under your managed care act, is going to say the same thing. So, I'd be happy to answer any questions if you have them, and to talk to staff if that's requested as well.

SEN. HARP: Thank you. Representative Dillon.

REP. DILLON: Thank you very much. I'll just ask a couple of quick questions. I think your testimony is very important. Obviously, given your own particular experience, but I don't have the ability to read this at the same time I'm listening to you.

And I wonder if I could, if you could just very briefly characterize in a specific way, the Texas holding. What was preempted that, in that decision that you cited?

ATTY. BILL SWEENEY: Okay.

REP. DILLON: Was it a quality decision? Is that what you were getting to?

ATTY. BILL SWEENEY: Well, actually what was interesting about the Texas decision, actually if you go to your, if you go to House Bill 70, or raised bill HB7032, if I put overlaid the Connecticut decision on this, I would point out a couple of things to you.

Number one, the current bill as it defines managed care plan, says offer -- it says, it means a product offer by a managed care organization. Texas uses the term, any entity.

I would submit to you that that, while that's not a preemption issue, that's a more restrictive definition that was used in Texas. If you would look also to line 72, which is Section E, which has to do with indemnification agreements.

That was preempted from the Texas case. If you look at Section 3, that has to do with utilization review requirements. That was preempted. If you look at number 4, that was preempted.

Now, it also what was preempted which is of much concern to me, because of the Napoletano case, that we went so far and so long with over a very precise legal issue, they would take that right away, too.

I wouldn't want to give away Napoletano, which is what the Texas court did to the Texas statute. So, but that's what they did in Texas. What they might do here could be the same, could be different.

But I know one of the issues that has been talked a lot about is the utilization review process. That clearly goes. That clearly goes because if you look at the Texas decision, and I think that the case that Napoletano was based on, the case that got this all going in the different direction was the Traveller's case.

The Traveller's versus Empire, well the name changed as it went through the courts. But that, there's -- if you look at the decision on page, well it's page 17 of the copy I gave you.

They talk in terms about how the independent review takes it outside of the plan. And, therefore it really has to do with the administration of the plan, and therefore it would invoke ERISA preemption.

And it violates ERISA according to them. According to Texas court. And I think I heard comments earlier from Representative Prague indicating how do we deal with the ERISA plans.

Well, I'm suggesting to you that if you fool around with the ERISA plans, you're going to get burned. Because you're limited in what you can do. So, the question here really is, you know, okay what can you do and is it going to be worth it?

Given what we've got already in Connecticut. I'm not for, you know, I mean I'm for expanding

patient's rights. I want the right to sue. And I'm telling you that I'm satisfied with what we have right now.

I don't want to take the chance that what you do in an attempt to, I know you're trying to respond to your constituents concerns. I mean, I know that. But I'm also in the court system, and I also understand how this thing is going to work.

And the way it's going to work is, first of all, it's going to be very uncertain. And I don't know that you want that. I don't know that in your attempt to respond to constituent's needs you want to restrict rights. I'm afraid you're going to do that.

REP. DILLON: Just a, and I think we'd all agree that the history of ERISA is a classic tale of unintended consequences. And that I wonder that just as a matter of fact, and I should, the Fifth Circuit -- that, the Texas case is on appeal?

ATTY. BILL SWEENEY: Yes.

REP. DILLON: With the McGam case in the Fifth Circuit?

ATTY. BILL SWEENEY: No. The case that I'm talking about is the corporate --

REP. DILLON: No, the McGam, New Orleans?

ATTY. BILL SWEENEY: Well, the New Orleans case --

REP. DILLON: Where the court held that the --

ATTY. BILL SWEENEY: Is that the Cigna case or the -- there is a Cigna case on the willing provider, if that's what you're referring to.

REP. DILLON: No. It was 1990 McGam, the court held that the plan had an absolute right to deny benefits --

ATTY. BILL SWEENEY: I would respectfully respond --

REP. DILLON: Okay.

ATTY. BILL SWEENEY: -- to any law that you cite to me from 1990, is irrelevant. Because of the Traveller's case. I mean, it's changed things dramatically.

REP. DILLON: No. This is a court holding.

ATTY. BILL SWEENEY: I understand that. I'm talking about the U.S. Supreme Court case in the Traveller's supreme court, United State Supreme Court case I think has changed the whole outlook here.

REP. DILLON: Because it moved it in the other direction?

ATTY. BILL SWEENEY: Yes. I'm not sure that the McGam case has any relevance in today's world, is what I'm saying to you.

REP. DILLON: Oh, I don't know. I think that's disputable. Oh, you're talking about Traveller's Cuomo?

ATTY. BILL SWEENEY: Yes.

REP. DILLON: Uh, huh. So that you wouldn't necessarily -- so your argument basically that in that you wouldn't predict the outcome on the appeal in the Fifth?

ATTY. BILL SWEENEY: No way. I mean, the Fifth Circuit has taken a more restrictive view.

REP. DILLON: Right.

ATTY. BILL SWEENEY: So, I mean if they're consistent with, I mean, they're more -- they're the ones who preempted the annual and provider statute in the, it's a second -- it's a Fifth Circuit case, Cigna was a defendant in that case.

REP. DILLON: Right.

ATTY. BILL SWEENEY: And as an example, though, of what I was trying to say earlier about reading the tea

leaves as far as the U.S. Supreme Court, that case was -- they moved to have that case, they filed a petition for certiorari on that case.

The Supreme Court turned it down. Napoletano went up, okay. Almost going the other way, they turned that one down, too. I think there's a message here. They're sick of it.

If you read the Dillingham case, and Judge Justice Scalia's decision, he basically says, we tried to fool around with this. We got no where. We're walking away from it. So, I don't think you're going to get the relief. Unless it's framed differently.

REP. DILLON: Well, I'm just trying to sort out exactly what your bottom line argument is. Cause if you're not --

ATTY. BILL SWEENEY: My bottom line argument is --

REP. DILLON: But theoretically, you were saying that we're putting things at risk because --

ATTY. BILL SWEENEY: Yes.

REP. DILLON: -- because of the second, what's going on with the second and the fifth. But then you talked about Traveller's Cuomo, as having changed --

ATTY. BILL SWEENEY: Okay.

REP. DILLON: -- the context. And so, if what you're telling us is that the case law is doing what we need, and we shouldn't put it at risk by changing the statute, is that what you're saying?

ATTY. BILL SWEENEY: Yes. That is what I'm saying.

SEN. HARP: Thank you. Is that it, Representative Dillon?

REP. DILLON: I think so. Thank you very much.

SEN. HARP: Okay, great. Senator Kissel.

SEN. KISSEL: Thank you very much. And I thank the chair's for understanding that I have to leave in about ten minutes for another committee, aging committee hearing.

I hear what you're saying, Attorney Sweeney, and it's interesting. An unholy alliance of positions between the CBIA and the Connecticut Trial Lawyers Association. Doesn't happen very often. But it also, but also what both groups --

ATTY. BILL SWEENEY: For different reasons.

SEN. KISSEL: Well, both groups are urging us to do is sort of like telling a bird not to fly. Because a legislature legislates. And so many of us really want to continue with patients rights, and to really do something positive.

And to have people tell us, if you do absolutely nothing this year, that's the best thing you can do. That's very, that's a very hard thing to swallow. Microscopically, I, you know, the broad issues, I understand what you're saying.

Don't fix it, it isn't broke. There's enough of a playing field out there for me as a plaintiff's attorney to work. But specifically, if we end up doing something, is your position similar to the Attorney General's in that, make it broad so that don't lock out the ERISA people, because the courts in their ultimate decision making may include them.

And also, if you're going to create a construct, as much as you're against a construct, make it parallel and similar to the one we have for physician's malpractice.

And I believe I heard the Attorney General saying, although he indicated to the Chairwoman Eberle that there might be a way to use the appeals process. That's sort of up in the air.

But is it your view that the appeals process is distinct in that that should not be used as a gatekeeper situation if you're going to --

ATTY. BILL SWEENEY: I have absolutely no faith in that process. In the appeals process.

SEN. KISSEL: Could you tell us why?

ATTY. BILL SWEENEY: It's always a stacked deck. I mean, it's just not a process that people get a fair shake in.

SEN. KISSEL: Why?

ATTY. BILL SWEENEY: It's a -- why? I mean, you can go to the, for instance, the stockholder situations that are all, you have to go to binding arbitration there. I mean, those things are so geared. I mean, they don't even have hearings now in Connecticut.

You know, you've got to go to New York for a hearing. I mean, so you know, this happens over time. But I just don't see it as being the place to resolve these problems.

SEN. KISSEL: What about an affidavit situation like we have with the regular malpractice?

ATTY. BILL SWEENEY: Well, I would be opposed to that. I mean, I think that the certificate of good faith, which is rather unique to Connecticut for the physician's care. That's what's at issue.

I mean, if we're talking about regular, you know, ordinary negligence is the term you're using with regard to the management. If the, the problem I have is this. Is that, where's that line going to be drawn?

First of all, can there be a red line drawn on that question between the quality of the care and the coverage. In other words, the company takes the position, no this is a coverage question.

And the physician takes, no, no it's a quality issue. Where are you going to be stuck with that?

Cause if it's a quality issue, I mean if it's a coverage question, if somebody finds that it's coverage question, it's preempted.

According to Judge Droney's decision. And that's coming from the Third Circuit. And it's a very well respected decision.

SEN. KISSEL: (inaudible - microphone off) drawing that distinction in this decision by saying, this is not a coverage issue, this is a quality of care issue.

ATTY. BILL SWEENEY: I understand that. I understand that. But I can see situations -- I mean, let's, the psychiatrist that was just before us, I mean, most of these plans have limited numbers of psychiatric consultations, okay.

So, the person reaches the end of that line, has that -- those six sessions or whatever they give you, and the physician says they need more. And the plan says, oh it was only coverage for six. What are you going to do there?

SEN. KISSEL: (inaudible - microphone off) and one last point. I hear what you're saying. In Section 3, where it says, no person may maintain (inaudible) under the provision --

ATTY. BILL SWEENEY: Section three of the Connecticut, or Texas?

SEN. KISSEL: Of this proposed bill.

ATTY. BILL SWEENEY: Yes.

SEN. KISSEL: HB7032. Section 3 says that you have (inaudible - microphone off) process. And I guess what I'm saying is, if we went forward with the construct -- if we went forward with a construct such as this, and we also had somewhere out there a two-year statute of limitations, you cannot bring a cause, but within so many, so much period of time.

How would you envision these things interrelating? And my concern is this. Someone comes up to an attorney. They want to bring a cause of action. They're within about 30 days of the end of a statute...

(gap in tape 2a - 2b)

...but they haven't even started down this appeals process. It seems to me that they can never exhaust that process before that statute would trip them up. How do you see those two things working together?

ATTY. BILL SWEENEY: Well, number one, I mean in the medical malpractice setting, for instance, you passed a statute that said that you can file for an extension in three months.

So, I mean there's a mechanism to do this. You can -- but it requires passing another statute. Because that's just geared to medical malpractice. But I really think if you read the Texas decision, that that Section 3 would very likely be stricken from the bill.

If you follow the Texas decision, I mean I -- the decision is well written. It is a, and it's current. I mean, with respect to Representative Dillon's question. I mean this stuff is, every day is new.

I mean, it's not like you go back to Mrs. Pallsgraff or something, you know. There's nothing that's more than two or three years old that's really, you know, good precedent.

And that whole thing about being outside of the plan, that, they cite Traveller's. The judge in Texas cited the Traveller's case for the proposition that that would be preempted because that would affect plan administration.

If you read the Napoletano case, Justice Katz's decision, and I've cited a quite lengthy portion of it in the statement, she talks about affecting the plan, and why Napoletano and Hollis don't affect the plan. And why it should be allowed to continue.

But it's a very nebulous area. And it's very hard to predict. And I think one of the reasons the

Supreme Court has taken the position it has, is because they've tried to tinker with this thing for how many years, and they've just thrown their hands up and said, we're going to let everybody stay.

If New York wants to do it one way and Connecticut wants to do it another way, we're not going to find a federal question here. Leave it alone.

SEN. KISSEL: Thank you very much. Thank you (inaudible - microphone off) Madam Chairwoman.

SEN. HARP: Thank you. Yes, Representative Raczka.

REP. RACZKA: Just so I can understand what you're talking about. It's about staying in a safe harbor. I have a constituent who comes to me and tells a story where his doctor wanted to do one thing.

The doctor was overruled by his HMO. And he was injured. And he wants to bring a suit to recover for those injuries. Am I hearing you right that as the law stands in Connecticut today, that that constituent could come to your office and you could file a liability suit seeking damages against an HMO?

ATTY. BILL SWEENEY: Yes. That's what Moscovitch is all about.

REP. RACZKA: And so that's clear now. So you have no hesitation about that?

ATTY. BILL SWEENEY: No, I don't have any hesitation about that.

REP. RACZKA: Thank you.

SEN. HARP: Thank you. Representative Nardello.

ATTY. BILL SWEENEY: Well, let me just say, the only caveat I would put into that, no no, wait a minute. But this is a problem you're going to face regardless of what you do. Is that, you know, given the kind of plan he has, it may be a problem.

Given the kind of plan -- if he's got an, because again, if it's a, you know, a plan that is subject to ERISA, I mean you run a greater risk in those situations. So you have different plans of varying risks in that law suit, jurisdictional question, was what I'm trying to say to you.

It's not a one-size-fits-all. And I think you're trying -- and I understand why you're doing it. And I don't fault you for trying to do it, other than to tell you that if you try to do it, you may not be successful. There isn't a one-size-fit-all answer. That's the problem.

REP. RACZKA: I guess my, what I have to be concerned of, you know, as the State Representative from my humble little district, is I need to get a comfort level where I know that my constituents are protected from negligent decisions.

I have, you know, I really need to have that comfort level. Cause that's one of the reasons why they sent me here. And if it's out there, and I can tell them, you know, most days, most plans, you're safe.

Don't worry about it. You know, we resolve this through our court system. That's a good answer for me. I like that answer. But I need to know that that answer does, in fact, exist.

ATTY. BILL SWEENEY: That's the, the Moscovitch case would provide you with that kind of cover. And so does Napoletano. Napoletano wasn't a medical malpractice case, but it had to do with the patient's selection of doctors.

In other words, in the Hollis and Napoletano situation was, the Hollis people picked the doctors that are in Napoletano. They picked Cigna because those doctors were in the plan.

And then they through those doctors off the plan. And these patients said, wait a minute. You know, I had some patients in that case, people having cancer therapy. Things of a very sensitive nature that you just, it's not like going out and hiring

another internist.

So, in Napoletano the Supreme Court of Connecticut said that, as long as you don't affect the plan, the plan's administration, you can bring the law suit. So in the state court you've got cover. And in, with Judge Dorsey's decision, I mean Judge Droney's decision in the federal court you've got cover.

Now, you can't say that, you know, in Massachusetts. You can't say that in New York. You can't say that in Pennsylvania. But you can say it in Connecticut.

SEN. HARP: Thank you. Representative Nardello.

REP. NARDELLO: I'm trying to sort all this out after all this testimony. And it's certainly been an interesting hearing. In your testimony, I understand what your bottom line point is.

But the key word is, you say "may." So is what you're saying to us today, is that no bill can be crafted to make this a better system? Or, it has to be crafted very carefully.

We understand it has to be crafted very carefully. So which of these is it? Because if, that's extremely important as far as we're concerned.

ATTY. BILL SWEENEY: Well, I would answer your question by saying that it has to be crafted very carefully. What I would suggest to you is in doubt, is that what's left for you to legislate about as a state legislature, may or may not make the difference that you think it's going to make. That's what I'm trying to say.

REP. NARDELLO: And I understand that. And that probably applies to a lot of other things we do here.

ATTY. BILL SWEENEY: Well, I don't think you, I mean, you know this ERISA question is just, I mean, it's by itself is one of the more confusing things. And it is the classic, you know, state federal

struggle.

And I don't think that there's too much that you do here that has these inherent struggling questions about it. And, not to presuppose that I know all of what you do, but this is an issue that when I argued the Napoletano case in front of the Connecticut Supreme Court, I -- one of the arguments I made was, let's everybody agree that if the United States Supreme Court doesn't understand ERISA, nobody else in this room does either. And that was agreed to. And we went from there. I mean, that's the kind of -- it's the blind leading the blind in this question.

Because people say, oh you can't -- people told me we couldn't bring Napoletano. People said, oh you can't do that. Well, we did it. But, do you follow me? I mean, it's just that kind of stuff.

It's very difficult. And I would feel more comfortable, seeing what the Fifth Circuit does with the Connecticut -- with the Texas statute. Seeing what Congress does with it.

I mean, I don't see why you can't appoint some sort of a study committee to study this thing further. I can't see why you can't do that. Because I think, the problem you have is, for instance, when you accept, when you passed the product liability statute, when you, in 1987 or whenever it was.

That came from the Uniform Commissioners. You had some, you had a lot of people having input into it. You had a lot of people who had, in effect, signed off on it. This thing here is one of the more, is a mosaic.

And to say that, and I'm suggesting to you that, I'm not saying you can't do it. I'm saying (a) you've got to be very careful what you do. And (b) I don't, I'd want to see what some of the courts are going to do with this.

I'd like to see what the Fifth Circuit does with the Texas statute per se. Because they could throw the whole thing out. And if you believe that

they're going to be consistent with their prior decisions, and since they threw the Louisiana any willing provider out. I mean, I know they don't bet down there, but I'd offer a bet that I would not offer a hopeful prognostication.

REP. NARDELLO: Well, let me just say that what I'm taking from your testimony is, that the potential exists to draft a statute. It has to be drafted very carefully, and possibly could need further study.

ATTY. BILL SWEENEY: Correct.

REP. NARDELLO: Thank you.

SEN. HARP: Thank you. Representative Eberle.

REP. EBERLE: Thank you. And thank you, Attorney Sweeney. This is sort of reaffirming for what I've been saying, is that ERISA is not easy. And there's going to be very limited things that we can do under it.

We are exempting plans that are ERISA plans from the application of this statute. Would not, doesn't that get, I mean I know that may severely limit the plan --

ATTY. BILL SWEENEY: Can you tell me exactly where you do that?

REP. EBERLE: -- that we can effect.

ATTY. BILL SWEENEY: Can you tell me where you do that?

REP. EBERLE: In the definition of managed care plan, line 33 to 36.

ATTY. BILL SWEENEY: Okay.

REP. EBERLE: Okay.

ATTY. BILL SWEENEY: What bothers me about your definition is that, I think it's too restrictive.

REP. EBERLE: Okay. And then on one hand you're telling

us you're not going to -- don't do anything because you're not going to be able to get at the ERISA plans the way you think you can. On the other hand you're saying, are you saying what the Attorney General, don't exclude ERISA plans from the bill.

ATTY. BILL SWEENEY: I'm saying to you that, your definition may very well not contemplate who's going to be offering managed care. That's what I'm saying to you. There are a lot of organizations now that are considering being managed care companies that aren't managed care companies. Until a short time ago most of our insurers around here were not managed care companies.

They've become managed care companies. But I'm talking about non-traditional insurers, organizations, corporations, labor unions in some instances. So, be careful about that.

REP. EBERLE: But that's a separate issue from --

ATTY. BILL SWEENEY: I understand that. But it's in your definition that I --

REP. EBERLE: I'm talking about the last four lines of that definition, not the top. If we exempt, I mean if the Attorney General took issue with --

ATTY. BILL SWEENEY: I would agree with him, but --

REP. EBERLE: -- exempting ERISA plans --

ATTY. BILL SWEENEY: I would agree with him on that particular issue. I would agree with him. That you really do look for trouble by including them. I mean, I don't see --

REP. EBERLE: So you're saying don't exempt them, but you can't do what you want. And you're asking for trouble, so don't do the bill at all?

ATTY. BILL SWEENEY: I think I'm basically saying that, yes. I'm concerned that, I mean if you get this bill passed, and it is obviously the Texas bill with some changes. And the Texas bill is preempted, and totally preempted, then where does

that leave you?

REP. EBERLE: Well, it's preempted only for ERISA plans, right?

ATTY. BILL SWEENEY: I don't know about that. Because there's parts of the statute --

REP. EBERLE: But there -- the preemption is under ERISA. So if you're not an ERISA plan, the preemption doesn't apply, right?

ATTY. BILL SWEENEY: Well, it -- that's an interesting question, because if it relates to the plan, I don't see -- I'm of the opinion that if it's going to relate to a plan, as it's defined under ERISA, it's going to be preempted.

REP. EBERLE: Oh, I agree with you there. But what this says is that if you are an ERISA plan, we're not trying to legislate for you.

ATTY. BILL SWEENEY: Well, then I guess the question I ask you is, what's the public policy benefit of that? So some people have managed care rights and other people don't.

REP. EBERLE: Okay.

ATTY. BILL SWEENEY: I mean, I think this is kind of like an across the board kind of issue. And if you're going to, it's kind of almost, it's kind of like choice auto insurance or something. I mean, and I don't know that we want to go there with this. But who knows where we're going to go.

REP. EBERLE: Okay. And, can you clarify me on, for me, on Napoletano and Hollis, were those just directions from the Supreme Court to allow superior court cases to go forward? Or, have you gotten to final decision on those?

ATTY. BILL SWEENEY: Those cases have been settled.

REP. EBERLE: Okay. So, you never reached the ultimate decision. The Supreme Court holding was just that you could go forward with the case?

ATTY. BILL SWEENEY: That's right. The Supreme Court holding was on the issues of the procedural questions of whether you could proceed in the state court under, whether it could proceed under state court. And the cases were subsequently resolved.

REP. EBERLE: Okay. And Moscovitch also, as I understand, was the federal district court saying that you could go forward in the state court. It was not an ultimate decision --

ATTY. BILL SWEENEY: That's correct.

REP. EBERLE: -- that proves liability.

ATTY. BILL SWEENEY: I mean --

REP. EBERLE: Because I think that's important for folks to understand. We don't know yet whether we've got rights of action against ERISA plans yet, until the case actually goes --

ATTY. BILL SWEENEY: Exactly.

REP. EBERLE: -- through to adjudication.

ATTY. BILL SWEENEY: And, you know, there's been some talk earlier about lawyers trying to sue as many people as they can. Well, basically we're forced to do that under tort reform and under the apportionment of damages issues.

I mean, so that's why that's done. But, having said that, and admitting to you that I have to bring actions against people I don't think I would have done prior to tort reform because of their minimal responsibility.

But there are plenty of malpractice cases specifically where a jury, where there's four defendants, and the jury only comes in against one of them. Or comes in against two of them.

So, I mean, you know, we're basically deciding who gets in the starting gate. I'm suggesting to you that, I'm not saying to you that -- what I am

saying to you is that by effecting the rules at the starting gate, and not allowing the process to work, it doesn't make any sense.

I mean, you -- it implies there's no faith in the system. And, you know, I understand there's some people who don't have faith in the system. But if you're there on a daily basis and see what happens in the system, you have a different opinion.

That's all I can tell you. So that, these cases that proceed, ordinary negligence has to be proved. And if the managed care company can prove that it's not ordinarily negligent in the situation, then they're not going to have the judgement.

So, these are kind of preliminary rules that you're establishing. And, it doesn't contemplate that the process works it's way.

REP. EBERLE: Okay. Cause I think people think that the Moscovitch case says, you know, now we can go after --

ATTY. BILL SWEENEY: No, it doesn't say that.

REP. EBERLE: -- managed care plans. And I don't -- it doesn't say that.

ATTY. BILL SWEENEY: It says that the HMO doesn't get out on a technicality. And it Cigna, it says that Cigna doesn't get out on a technicality.

REP. EBERLE: The trial court is still going to have to find that it was quality of care, not quantity or benefit.

ATTY. BILL SWEENEY: The judge will charge the jury accordingly.

REP. EBERLE: And that can still be appealed and go on up if --

ATTY. BILL SWEENEY: Well, I mean, there's also a motion for summary judgement that could be filed. Which would be filed at the conclusion of the discovery section, or the discovery stage of the trial.

I would assume that there are plenty of cases, employment cases being one that come to mind most quickly, where summary judgement is part, is basically, a lot of cases get settled depending on that summary judgement.

Because if the action proceeds, people don't want to be exposed. In the Cigna case that I was involved in, there's certain things that people don't want to get involved in. They'd rather get the thing resolved. So, you know, there's plenty of things in the system. I mean, it's kind of ignoring the process that's already in place.

And it doesn't mean that because you allow a suit against an HMO to proceed, like Moscovitch does, that you're going to get a verdict against them either. But to say that they shouldn't be in the mix, or to affect their ability to be in the mix, is what I'm concerned about.

And I'm just saying to you, you got to make a decision. You got to weigh alternatives. And, I'm not sure that things as they stand today are in such a place where I could predict with any degree of certainty what's going to happen.

REP. EBERLE: Okay. I just want to clarify it that you're not saying that we have liability now so don't mess with it. You're saying that, because I see the whole situation as still totally influx.

ATTY. BILL SWEENEY: Okay, let me -- I'll say, we have jurisdiction over HMO's now.

REP. EBERLE: Under certain very limited claims.

ATTY. BILL SWEENEY: Under, yes --

REP. EBERLE: I mean, you have the ability to go forward at the trial level --

ATTY. BILL SWEENEY: If you go in there and you try to tell the HMO about what kind of standard, and if you, as I made reference to, the Texas federal court found that termination of physicians was

preemptive.

Which is what Napoletano upheld. So, when I talk about mixed bag decisions, I don't want to give away, you know, the holding in Napoletano. I don't think any of the people from the medical association want to do that.

REP. EBERLE: Can you tell me under this quality of care versus quantity, where decisions regarding appropriateness of care and decisions on formulary drugs, or decisions on the medical necessity of a procedure, where have the courts, have the different trial courts, or the different circuits ruled on that? And where do they come down? Cause I understand it's only quality of care that we --

ATTY. BILL SWEENEY: I don't -- first of all --

REP. EBERLE: -- jurisdiction over.

ATTY. BILL SWEENEY: -- as I again making reference to my response to Representative Dillon. I mean, this case in Texas is a year old. Napoletano is three years old, and it's almost irrelevant. So, the cases that you're reading about are cases about jurisdiction.

They're not about, you know, jury findings that get to the real issues of fact. I don't think those, those -- although the Kaiser case in California made a point about that though.

REP. EBERLE: Which was?

ATTY. BILL SWEENEY: About an, I think it was an \$80 million verdict against Kaiser for refusing or stalling the treatment of a cancer patient who eventually died. And they found all these memos that they were trying to stall the case. They were claiming that his treatment was experimental, and it was this and it was that. And a --

REP. EBERLE: Is that Kaiser or Aetna?

ATTY. BILL SWEENEY: No, this was Kaiser. And then, of course, there was the Aetna case.

REP. EBERLE: Okay. Was that an ERISA plan? The Aetna was not. That's the reason it went forward.

ATTY. BILL SWEENEY: I don't -- I can't tell you about the Kaiser situation. I mean, the specifics of it other than the verdict and what went into it.

REP. EBERLE: Okay. Well, thank you.

SEN. HARP: Thank you. Are there further questions? If not, thank you very much.

ATTY. BILL SWEENEY: Thank you.

SEN. HARP: Our next speaker is Edward Volpintesta.

DR. EDWARD VOLPINTESTA: Good afternoon. As you said, my name is Ed Volpintesta. I'm a family doctor from Bethel where I've been in practice for 25 years. I happen to be chairman of the board of trustees of the Fairfield County Medical Association.

And I am very much in favor of supporting HB7032. As you know, harmful and sometimes fatal outcomes occur when managed care organizations delay or deny care the physicians deem necessary.

In fact, the rights of patients to sue HMO's is essential issue that divides our political parties today. In the fall it was the one single issue that divided all interested parties discussing the patients bill of rights.

You've heard much testimony today about what's happened in Texas, so I'm just going to mention this briefly. But, the case in Texas, and the recent case here in Connecticut with Judge Droney, both instances the courts ruled that ERISA did not, in fact, hold and that the HMO's were liable.

I'd like to remind us all that ERISA, which was enacted in 1974, took place in a different time, and with a different set of circumstances. In 1974, most of us were insured under indemnity plans.

HMO's were just being contemplated. I think President Nixon was just putting aside some money to do some research into HMO's and to help them get started. It's my belief that our courts are beginning to understand that hiding behind ERISA's protection is really an abuse of the original intention of the act, which was really meant to protect employees benefits.

Managed care's strategies have taken on a life of their own in the past few years. In some instances cutting costs seem to have taken precedence over human decency, and profits seem to be more important than common sense.

Now what other conclusion can we draw when we consider the drive-through mastectomies and the 24 hour deliveries. Let me remind you that it required legislation to eliminate these practices.

Market oriented attitudes like these are incompatible with the soft intangible values that our citizens have come to expect from medicine as a caring profession.

Thus we need to prohibit health insurers from continuing to unilaterally decide what is medically necessary and what is not. If we don't, there is a real danger that their hard-edged market mentality will lead to excessive commercialization and routinization, and will replace individualized attention which should be the hallmark of medicine.

We need to assure that doctors make decisions for their patients without undue interference from insurers. Medical necessity must be determined according to a prudent physician standard.

If we pass HB7032, we will have taken a very important step toward assuring that managed care organizations take responsibility for their actions. This is necessary if Connecticut citizens are to be taken care of, not only cost effectively, but humanely as well. Thank you.

REP. EBERLE: Thank you. Can I ask, if your members get

a denial from a plan for a pre-approval, do they then offer the patient the option to go forward at their own expense with the treatment that is being recommended?

DR. EDWARD VOLPINTESTA: Representative Eberle, I mean, what I do is, we tell our patients exactly what happened. And in all fairness, it's not a very common occurrence. Most of the times, HMO's will -
- I'm a family doctor.

Most of the times they will honor my recommendation. It's when they don't that all the problems begin. It's an endless telephone confrontation. And --

REP. EBERLE: Are you saying it's not very often that they disagree with you. But they do occasionally.

DR. EDWARD VOLPINTESTA: They do.

REP. EBERLE: And when they do, do you tell the patient you have the option to go forward, but it's going to be at your own expense because your plan isn't going to pay for it?

DR. EDWARD VOLPINTESTA: Yes, I do.

REP. EBERLE: Okay. And do patients opt to do that?

DR. EDWARD VOLPINTESTA: Most of the times.

REP. EBERLE: Okay. Do you also tell them about the appeals process that they can appeal through the insurance department? I guess I'm asking, do most of the members of your association know that that exists?

DR. EDWARD VOLPINTESTA: Yes, they do. And I think most of us do tell them about the appeals process. In all honesty, I think the average ordinary citizens is kind of frightened about getting involved, and calling up HMO's and getting involved in the legal system. So I think they really don't avail themselves of that privilege.

REP. EBERLE: Would it help if we had a brochure with an

800 number that you could give to them?

DR. EDWARD VOLPINTESTA: Yes.

REP. EBERLE: Okay. Cause I think one of the things that we're very interested at looking at is making the appeals process more widely understood and more accessible. Because I think that that's an important avenue.

The other question that I guess you've answered, we hear all the time about what happens up to the point where the plan denies. We don't often hear about well what do you do after that? Do you go forward with the treatment and treat the patient anyway, or?

DR. EDWARD VOLPINTESTA: Yes, we do. I do. Sometimes we go out of plan. We have to send a patient to another city, something like that. Generally, we go ahead and do what we have to do.

REP. EBERLE: Okay. But I mean, that's the assumption that we may care that doctors have the obligation, you know, under their own oath. And under their own standards to go forward with treatment if they believe it that strongly.

DR. EDWARD VOLPINTESTA: See, where the problem comes in is, for example, in hospitalization as an example. Someone has their appendix taken out. And the HMO may say, well three days, two days, they should be back home.

And, every patient is an individual. And there's some people, a young child can go home in 24 hours. They're wonderfully resilient. Somebody my age needs three or four days. And we don't always get it.

And increasingly over the past few years, I've had more people going home, and a day or two later, right back in the hospital. Cause the HMO says, they have to go home. So then I tell the patient, well if I don't send you home today, there's going to be trouble and we're going to -- you may get stuck with the bill.

Which, you know, is a \$1,000 a day. And, of course, when people hear that, you know, very people have that kind of money laying around. And they will go home an extra day or two earlier, for example.

REP. EBERLE: Is this after you've talked with the insurance company about wanting this particular --

DR. EDWARD VOLPINTESTA: Sometimes.

REP. EBERLE: -- individual to stay?

DR. EDWARD VOLPINTESTA: Sometimes I don't talk to the insurance company.

REP. EBERLE: Okay.

DR. EDWARD VOLPINTESTA: Talking to the insurance company is as if I just, I can't express to you how much the administrative red tape has filled up my day, particularly as a primary care doctor. I'm not saying we go back to the days when doctors ordered and did anything they want, and health care costs skyrocketed.

Which is why we have managed care in the first place. But, my day is increased at least by one hour with telephone calls. Just filling out sheets of paper. And it's demoralizing. And it's tiring. It's distracting. And I sure wish we could eliminate that or diminish it as much as we could.

REP. EBERLE: Okay. Thank you. You've been very fair in your testimony. Representative Farr. Thank you.

REP. FARR: Yeah, just to follow up on some of that. Cause I think that was helpful, that testimony.

DR. EDWARD VOLPINTESTA: Sure. Love to.

REP. FARR: You're a primary care physician though, so actually the problems that most people associate with HMO's I would think would tend to be more at the specialist level?

DR. EDWARD VOLPINTESTA: That's right.

REP. FARR: Because, and what type of areas of care do you see that you have conflicts with HMO's, if any?

DR. EDWARD VOLPINTESTA: Representative Farr, I have, particularly when I, and you hit it right on the head. When I make a referral, let's say I had a long-standing relationship with a patient.

And I send him to a surgeon who has to fix his hip. And, while that surgeon may or may not be on the plan, but where we run into problems is, many of the surgeons have dropped out of many HMO plans, because their prices for procedures have been very slashed.

For example, getting a hip done. I forget what they -- I can't be, maybe four or \$5,000. But I think it's been decreased by one half. So sometimes I have to find a surgeon in a different town.

And, you know, it breaks that continuity of my relationship with the patient. I don't, I'm sure many times the other surgeon is adequate, is acceptable. But I don't know him, and I can't follow my patient through the hospital.

So that's one of the negative parts. I don't know, did I answer that question alright?

REP. FARR: Yeah. But in terms of your own treatment, I would assume that you don't actually get very many rejections --

DR. EDWARD VOLPINTESTA: I don't.

REP. FARR: -- maybe medications?

DR. EDWARD VOLPINTESTA: As a primary care doctor, I don't. My biggest problem probably would be with these formularies. I hate them. And I was going to bring them here today. Every, I belong to all the big HMO's.

And everyone sends me a little book, maybe about 100 pages, that breaks down various disease categories, and the medicines that they recommend. And they're all different. I mean, it's really impractical for me to stop to --

REP. FARR: Okay.

DR. EDWARD VOLPINTESTA: -- to change your blood pressure, or look at that little book with every patient I treat. That drives me crazy.

REP. FARR: And another thing. I mean, the Attorney General had, in his testimony, he I think inadvertently talked about the doctors as employees of the HMO's. But you're not an employee. And you recognize the independence of the physician. Is that correct? I think your testimony with Representative Eberle --

DR. EDWARD VOLPINTESTA: I feel like an employee, many days. I'll tell you why, for example. When I took my state licensing exam here in Connecticut, that gave me permission to practice unsupervised medicine anywhere in Connecticut.

Well, lo and behold, you know, twenty years later, HMO's own in a manner of speaking, the patients. What I'm saying is, I could, if an HMO gets upset with me because I'm not a good physician, or I'm not using their formulary, or whatever, and they drop me from their panel, that affects my livelihood so severely that it's like saying, you can't practice in Connecticut.

If only HMO's that I'm working for, with, whatever, suddenly dropped me, where would I -- I couldn't make a living. Which is frightening because in a way, it's a form of mind control over the medical profession. It's something we don't talk about very much.

REP. FARR: You mentioned the formularies, and the concern there. What particular types of cases do you see that being a real problem with, as inconsistencies?

DR. EDWARD VOLPINTESTA: Anti-hypertensin, blood pressure medicine. Every, you know, and every month literally, without exaggeration, there's a new one coming, a new medication coming on the market. And that list gets bigger and smaller. And all the permutations become impossible to deal with.

REP. FARR: So what you're saying, if you have five patients you're treating for hypertension, and they're in five different HMO's, you may have five different formularies in terms of how you're supposed to treat them?

DR. EDWARD VOLPINTESTA: Yes.

REP. FARR: And that's a major problem. I don't know an answer. But that's an interesting issue. Thank you. Just the other comment though on the -- I think we overemphasize the short term hospital cares, you know, in terms of being a major problem.

Because I'm more concerned about some of the other issues. Paperwork issues, the procedures. I mean, you end up spending more time on administrative work than you do in practicing medicine, which ought not to be the case.

But, you know, in my own experience, I mean people complain about short term hospital cares. I went in for a double hernia one time, and went in at one o'clock in the afternoon, I was back at home at six o'clock.

And I talked to my father-in-law, and he told me when he had his hernia thirty years ago, forty years ago, and he was in the hospital for seven days. I mean, I didn't get a hospital bed. But I can't say I was, mine was less successful.

Frankly, mine was more successful. I was in better shape than he was. So, I don't think that that's the major issue. There are a lot of other issues here. Thank you.

DR. EDWARD VOLPINTESTA: That's a good point. I just want you to know, we have much better anesthesia,

much better post-op care. So, you know, there's other --

REP. FARR: And frankly there, and the other problem is that hospitals become more dangerous places to stay as you have sicker people there in a concentration than there used to be.

DR. EDWARD VOLPINTESTA: That's true.

REP. FARR: Thank you.

SEN. HARP: Thank you very much. Are there further questions? If not, thank you.

DR. EDWARD VOLPINTESTA: Thank you.

SEN. HARP: Our next speaker is Mag Morelli, followed by Steve Karp.

MARGARET MORELLI: Good afternoon. My name is Margaret Morelli, and I'm the director of government relations for the Connecticut State Medical Society. I'm here today on behalf of the Connecticut State Medical Society, which represents over 7,000 physicians in the state, to speak in support of raised HB7032, AN ACT CONCERNING THE LIABILITY OF MANAGED CARE ORGANIZATIONS.

HB7032 is designed to hold health maintenance organizations and other managed care entities appropriately responsible for their actions that result in injury to patients.

Managed care organizations are increasingly encroaching on medical decisions, medical treatment decisions historically made by physicians and other health care providers.

When health care providers are negligent in making health care treatment decisions, they are held accountable through the legal system. Under HB7032, managed care organizations will be required to exercise ordinary care when making health care decisions, and would be held responsible for their failure to do so.

We strongly believe that Connecticut patients deserve no less. The managed care industry will argue that health care maintenance organizations and other managed care entities do not practice medicine.

However, when they deny payment for a covered benefit, or perform utilization review procedures negligently and thus delay needed care, or substitute inferior care, their actions impact the quality of medical care delivered to patients.

We believe they should be held accountable for those actions. Some may argue that this bill relieves physicians and other health care providers from their responsibility.

Nothing could be further from the truth. Physicians have been, and after this bill's enactment, will continue to be legally and ethically responsible for practicing medicine in accordance with accepted standards of care.

The intent of this bill is to clarify, but should not limit the accountability of managed care decisions for the decisions they make, holding defendants who are responsible for negligent injury appropriately liable.

The bill should be amended to clarify that patients who are harmed by their managed care organization's decisions have recourse regardless of whether or not their coverage is provided through an employer sponsored plan.

The legislation will not lead to an explosion of litigation. These law suits are already being brought. But physicians and hospitals and other health care providers are the only defendants, even when the harmful decision is made by a managed care organization.

The legislation would simply allow patients to hold managed care decision makers appropriately responsible for their actions. The managed care industry also asserts that defensive medicine will return as a result of this bill.

We believe that necessary medicine will return. If the care covered by the health plan is properly and promptly provided, it is more likely to save money in the long run.

I'd like to close today by emphasizing that with the power to make decisions affecting people's lives, should come the responsibility for making those decisions.

Physicians and other health care providers accept that responsibility. For the sake of the patient, shouldn't we require health maintenance organizations and other managed care entities to do the same. On behalf of the medical society, I appreciate your time. And I'd be happy to answer any questions.

SEN. HARP: Thank you very much. Representative Farr.

REP. FARR: Yeah, I have to comment on first of all, on the irony of the medical society coming and claiming that tort lawyers are the salvation of America. Having sat up here when we did tort reform, and the medical society coming up and saying that, that the tort lawyers were the, you know, the biggest evil in society.

I guess one of the issues that I raised before was that in tort reform we gave some protection from frivolous suits to the medical profession by requiring a threshold to be met before action is brought.

I don't see anything in this legislation that does that for HMO's. Does your organization suggest that HMO's have, allow -- that we allow frivolous suits against HMO's and not against doctors? Or should we give them the same protection that the medical society profession has? Or, should we take away the protection that the medical profession has?

MARGARET MORELLI: We would support the same protections that the medical profession has. We are not advocating for frivolous law suits, or even an

increase in law suits. We are more interested in supporting a level of accountability so that the managed care entity understands the same level of accountability, and the same standard of care that the physician holds when the, as a team, are making these decisions.

REP. FARR: Okay, thank you.

SEN. HARP: Thank you very much. Representative Nardello.

REP. NARDELLO: Mag, in your written testimony you refer to a Milliman and Robertson study regarding the cost of the Texas liability legislation at 34 cents per member per month. Could you, I don't believe you provided that to the committee. Could you do so?

MARGARET MORELLI: Yes, I will. I will provide that.

REP. NARDELLO: Thank you.

SEN. HARP: Thank you. Representative Eberle.

REP. EBERLE: Thank you, Madam Chairman. Good morning.

MARGARET MORELLI: Good morning.

REP. EBERLE: Afternoon, I guess. Following the line that I was using with Dr. Volpintesta, what do your members do when someone comes in without any insurance and needs care?

MARGARET MORELLI: I believe the majority of the members would provide care to that patient.

REP. EBERLE: Provide the care.

MARGARET MORELLI: They cannot reject someone who comes to their office seeking care.

REP. EBERLE: Okay, so if someone who had insurance came, and the insurance company, or the managed care company disagreed with the course of treatment, you would not refuse to go forward because the patient couldn't pay for it on their

own?

MARGARET MORELLI: Correct.

REP. EBERLE: Would that be considered malpractice on the doctor's part if they did?

MARGARET MORELLI: I believe it would have to be an informed consent with the patient. The patient may choose to opt a different treatment method, if they know the insurer will pay a different route of treatment, or a different method of treatment.

There are times when the managed care company will go directly to the patient with advice. For instance, in formularies in which medication to use. So I think it would depend on who made that decision and the informed consent of that decision.

If the physician advised against something and the patient still chose to go that route, I believe that that would be a defense for the physician.

REP. EBERLE: Okay. You think the managed care companies are talking directly with the patients about the formularies, other than maybe a post card that they send out to everybody, or?

MARGARET MORELLI: Well there were, at the hearing last week there was one of the physicians that testified, Dr. Schwartz, had a letter that had gone to one of his patients, specifically to that patient recommending one medication over another that Dr. Schwartz had prescribed, and then offering the patient a coupon for additional discount on that medication.

So it was sort of a direct marketing medical advice to the patient. And it seems to be that we're hearing more and more of that sort of direct -- particularly just in the formulary area, though.

REP. EBERLE: Was there anything in the letter saying, discuss this with your doctor, or?

MARGARET MORELLI: Yes. Well, because the doctor would have to make the substitution. So it did say to go back to the doctor and discuss it with the doctor.

REP. EBERLE: Okay, thank you.

SEN. HARP: Thank you. Are there further questions? Thank you. I just want to clarify something though. You said if a person didn't have insurance that a doctor would treat.

That's what the understanding that they had the ability to pay. Or are you saying that they would treat anyone who came to their office without regard to ability to pay?

MARGARET MORELLI: Well, it depends on the situation. If someone presents at the office who needs treatment, I do not believe a physician would turn that person away. And I don't believe they can turn that person away.

If someone is making an appointment for treatment and there's discussion of payment, the physician can require payment if there's no insurance when that person arrives for the appointment.

SEN. HARP: Thank you. Further questions? If not, thank you very much. Our next speaker is Steve Karp.

STEVE KARP: Good afternoon, excuse me. I'm Steve Karp. I'm the executive director for the National Association of Social Workers, Connecticut Chapter. ASW's always supported the concept that patients have the right to sue their managed care company.

However, we do have some concerns very similar to Attorney Sweeney's presentation earlier today that we not craft language that ultimately limits that right rather than expanding or keeping that right.

Given the fact that Connecticut, indeed, does have three different cases that were mentioned earlier that allowed people to go into the courts. We are very hesitant to go forward with legislation.

Unless you truly believe you can come forward with legislation that would be unlimited as to the rights of liability, we do suggest that we perhaps

study this further before moving forward.

We do think though that the real key here is trying to come up with legislation that helps avoid the need to ever go into a law suit. And there are several bills before you today that we'd like to just mention.

First of all, is the consumer advocate. And there is two bills, one before Public Health and one before Judiciary. The fact is that patients really can use an advocate because they're struggling to understand and navigate the complexities of managed care. Since patients do not know how their insurance coverage works until they need to use it. And since at that point you need coverage and run into problems with your managed care insurer, you're often ill and least able to deal with an intransigent managed care company.

An ombudsman, really we believe is critical to assuring that patients, and their families, receive all the rights under law and hopefully make it not necessary to move as far as a law suit.

We also are very concerned about this bill in terms of internal appeals. Currently, there's only the initial appeal that has a deadline. I believe it's 60 days deadline for a managed care company to act.

Last week in front of Public Health someone from Cigna spoke about the fact that he had at least four appeal levels. Today Oxford told you they had at least three appeal levels. This bill says that you must get through all internal appeals and then through the...

(gap in tape 2b - 3a)

...without regulation of internal appeals, the entire internal appeal process, this is only going to make the companies add more obstacles to keeping people from reaching external appeals, and keeping them from the risk of having their patient ultimately going to court.

We did attach to our testimony, language that we

have proposed regarding internal appeal process. We're suggesting to you that there should be no more than two levels.

That they should be fully regulated. What happens now is for instance people don't know that they even have the right to appeal. They don't understand that. We had a member who got a letter from their company saying that your appeal was denied.

You have the right to external appeal. But in our opinion, your case does not really apply to the external appeal. So then people are not even going that final step. Without regulation of internal appeals, I think we're not going to get anywhere's in this process.

Finally, we just want to point out that we know at some point down the road, and I know I mentioned this to Don Williams yesterday, Senator Williams yesterday. And he said at this point there's no talk about a trade off.

But it's somewhere's down the road, there's going to have to be a decision made as to how much regulation of managed care will occur this year. But we are concerned that we don't lose things like community benefits, internal appeals, consumer advocate.

We're concerned that they don't become a trade off for a much more high profile right to sue, which may not actually help as many people.

SEN. HARP: Thank you very much. Are there questions? If not, thank you very much.

STEVE KARP: Thank you.

SEN. HARP: Our next speaker is Suzanne Haviland, followed by A. Richard Tomanelli.

SUZANNE HAVILAND: Hello, my name is Suzanne Haviland. I'm the director of the Health Care For All Coalition. A coalition of more than 40 consumer, community, labor, senior, women's and provider

groups working together to reform the health care system, and to increase access for everyone.

Actually we just testified yesterday on this. And I wanted to clarify some things today, but also to go over a little bit of what I said yesterday. Which is that, over the past year, Health Care For All members have been vocal in our support for giving consumers the right to sue managed care companies for malpractice.

And we included it in a checklist we developed of 15 key consumer protections we felt should be included in the patients bill of rights that we've attached to our testimony today. We supported the right to sue because it is clearly a right that individuals should have.

Managed care companies say they don't practice medicine and shouldn't be liable like doctors. We say, they do practice medicine. And we know from countless hours of speaking to the public in the past few months, canvassing literally thousands of households that the average person is with us.

However, given the experience of other states and the court decisions in this state, we urge the legislature to take a second and third look at the language. We believe that there may be benefit to forming a study commission to analyze this issue more closely.

Unless we can be absolutely sure that the bill we pass does not actually limit people's existing rights. The court decisions leave the right to sue open for discussion. The wrong legislation could limit the court's interpretation of people's rights.

It is certainly not the intention of legislator advocates to limit the rights of consumers we know. That is why we say that we need to have a broader discussion about this bill before we act.

I cannot tell you today what the perfect language would be for this bill to avoid hurting people. I don't believe it exists now. We should work

together to find the language.

A study commission or a legislative task force could help. Bill HB7032 is not it. There is no reason why someone should have to exhaust all their appeals before they can sue.

And as is stated in Section 4 of this bill, who's going to decide if "medical decisions are actually provided by the managed care plan." Section 4 is of serious concern to us. Because, again, managed care companies say they don't provide medical services.

They simply issue policies and statements and opinions and mandates that have the power to heal or to hurt us. This year we suggest you put the real focus on two other appeal rights that currently do not exist in our law.

Every month we may get many phone calls from consumers who need help with obtaining coverage or understanding their rights. And that is, and there is no where they can turn. We ask that you regulate as Steve Karp from NASW pointed out, regulate and improve the internal appeals of HMO's.

Less than fifty people in one year use the state's external appeal program when they had a problem with denial of care by their insurer. You can't use the external appeal until you've exhausted your internal appeal.

Obviously people are getting lost for months in the system and give up. We believe that health companies should allow consumers to formally file a complaint over the telephone, other than in writing.

And this process should take no more than thirty days. And finally, we need to establish an office of consumer advocate for health care. This is the most important thing. We really think that people need somewhere that they can turn that can advocate for them, and help them with both concerns about obtaining coverage, and concerns about the coverage that they currently have. Thank you.

SEN. HARP: Thank you very much. Senator Williams.

SEN. WILLIAMS: Thank you. Good afternoon. I guess the problem that we face in the legislature on the legal liability issue, is in Connecticut, does it make sense to sit back and rely on judgement law, which ultimately is unpredictable at this point.

Or, does it make more sense to act as a legislature and set forth a statute which would clearly define the issues of liability as it relates to managed care. And, I'd just like your reaction on this question in terms of predictability, both for consumers and for companies, versus the rather uncertain playing field right now of the courts. And parenthetically I want to say, I do agree with the comments that have been made by you and others in terms of the appeals process, and not making access to the courts contingent upon exhausting every single appeal.

But any way, I'd just be interested in your reaction?

SUZANNE HAVILAND: Well, I'm not a lawyer. And I have called probably, I would say, and asked the opinions of approximately six prominent lawyers who have had some experience with this issue, to talk with them about their, you know, thoughts.

And I asked similar, this similar question to you.

And I keep hearing back that first of all, just because we may have gone, we may have come to a decision in a convoluted way, doesn't mean that that same path could not be taken again.

And that we need to look at the way in which, you know, we came to the decisions that we have come, and see whether or not that could be replicated in the future. I know that there are all across this U.S. there are a variety of court decisions which people are looking at and analyzing.

I don't, as an organization, I don't think all of us have, you know, that we have come to some specific decision on this and said, oh we shouldn't

do legislation. In fact, we'd like it clearly spelled out.

The question is, how will that be clearly spelled out? And we're not ready yet. We don't know what kind of language that would be. So I share your concern about wanting to put something very specific in language. It's just that we all want to make sure that we don't limit people's rights.

SEN. HARP: Okay, thank you. Further questions? If not, thank you very much. Our next speaker is A. Richard Tomanelli.

DR. A. RICHARD TOMANELLI: Chairpersons and Representatives on the committee, good afternoon. I'm Dr. Richard Tomanelli. I've been a psychologist in private practice in Greenwich for 22 years, and a consulting psychologist at the Veetam Residential Treatment Center for adolescents in Norwalk for twelve years.

I'll depart from my text for a moment and note, I've voided all my managed care contracts in July of 1998. I am here today to present the Connecticut Psychological Association's support for HB7032.

In 1995, Neti Moscovitch, a sixteen-year-old from Brookfield, took his life at the Veetam Center. Neti had been discharged from Danbury Hospital at the insistence of his family's managed care company, Physician's Health Service.

As a senior clinical resource person, it was my responsibility to conduct interventions with a devastated staff. It was a professional experience I would prefer not to have had.

In 1998, Joseph Plocica committed suicide following his discharge from the Texas hospital where he was being treated for substance abuse and major depression. The managed care mental health subsidiary for Aetna Health Plans, refused to authorize an extension of his stay, so that his antidepressant medications might be stabilized.

Both the Moscovitch and Plocica families have brought suits against their managed care plans. In both of these cases, the managed care companies claimed they were immune from such actions because the ERISA preemption shielded them from suits in state courts.

This federal legislation passed in 1974 prohibits suits against self-insured health plans. In 1974 a minority of Americans were enrolled in such plans.

At the present time, the number of enrollees in self-insured health plans has increased substantially.

And the Congress has implemented major initiatives aimed at allowing law suits to be brought in state courts. We call your attention to the Access to Quality Care Act. That's the Republican initiative.

And the Patients Bill of Rights Act of 1999, the Democratic initiative. The Moscovitch case has been returned by the federal circuit for trial in the state court, in Connecticut.

And the Plocica case has been ruled worthy of civil action, according to a law passed in Texas in 1997.

The Supreme Court of Pennsylvania has recently ruled that the ERISA preemption does not apply to a negligence claim against U.S. Health Care.

A proliferation of initiatives has developed in state legislatures throughout the country. The aim of which is to circumvent the ERISA preemption. These initiatives involve voiding so-called hold harmless clauses, and allowing claims to be brought for medical malpractice.

The hold harmless clause in contrast between a managed care company and a provider, enables the latter to indemnify the former when an action is brought by an enrollee. Connecticut was among the earliest states to prohibit such clauses in 1995.

Malpractice claims are based on the theory that a managed care company is effectively practicing medicine when it makes treatment decisions and thus

is liable when injury results to an enrollee as a result of those decisions.

In a substantial number of cases before the courts, the plaintiff is left with no remedy as a result of the continued existence of the ERISA preemption. Increasingly, the courts claim that they are powerless to change ERISA, and that this is the province of the Congress.

It is hoped and expected that this year the Congress will enact measures to enabled the injured or harmed enrollees of self-insured health plans to obtain proper consideration for their claims.

The Connecticut Psychological Association takes the position that the consumer of health care services is best protected by a combination, a combination of a secure and comprehensive external appeals process, and a firm liability law such as HB7032.

Such instruments will allow for unfettered access to consistently high quality treatment. We also applaud the language in Section 1, sub 1, which sets forth the definition of appropriate necessary care as determined by health care providers in accordance with the prevailing practices and standards of the medical profession and community.

In conclusion, as providers of behavioral health services, and consumers of health care, we strongly urge you to vote for HB7032, so that Connecticut will take a major step forward to protect the consumers of health care.

SEN. HARP: Thank you very much. Are there questions?
Yes, Representative Farr.

REP. FARR: Yes, thank you. I just, you said that the HMO's should be liable when they deny service. But the testimony before, on a previous doctor, was that if all the HMO is doing in these cases is saying they won't pay for hospitalization beyond a certain period of time.

Now that, presumably didn't someone tell the family that the HMO wouldn't pay beyond that time, and

that they have the option of paying themselves?

DR. A. RICHARD TOMANELLI: Representative Farr, it's been my understanding that doctors, I'm not a medical doctor. I'm a psychologist. It's been my understanding that the policies of health maintenance organizations with respect to uncovered services, it made pretty clear to families and to patients.

And so, right from the get go they're told, well your HMO will pay for three days. If you need to stay four or five, it's up to you. That's made pretty clear from the outset. People are not ignorant about that in my experience.

REP. FARR: Okay. So they do have the option of keeping somebody in a hospital longer?

DR. A. RICHARD TOMANELLI: Oh, certainly. Sure. It's up to you, you need to pay for it.

REP. FARR: Okay. Thank you.

SEN. HARP: Thank you. Are there further questions? I guess I would ask a question. And I don't know if you know the answer to this. But in terms of our biologically based parody bill, which we passed a couple of years ago, in your determination if the medical provider, who ever that be, psychologist, psychiatrist, made the determination that it was medically necessary for the patient to stay in the hospital beyond the days that were paid for, would that not be in violation of the biologically based parody law, if in fact that user, or client, had a biologically based reason for being hospitalized even though it was a mental health condition?

DR. A. RICHARD TOMANELLI: Mental health conditions are becoming, Senator Harp, more and more acknowledged to be the results of biologically based anomalies. That having been said, certainly it would seem to me that if an HMO denies the prescription of a provider in terms of required hospitalization, they would and should be held liable. Did I understand your question.

SEN. HARP: You certainly did. Thank you very much. I guess that's it unless there are other questions. Thank you for your patience today, been here a long time. Our next speaker is Norman Coutu.

NORMAN COUTU: Good day, Senator Harp, it's always a pleasure to see you. And I want to thank you for the opportunity of speaking today, and fellow committee members.

My name is Norman Coutu, and I am a member of CSEA Council 400 Retirees Legislative Action Committee. We represent approximately 14,000 employee retirees. CSEA is a member of the Health Care For All Coalition.

I would like to testify today on the right to sue legislation. CSEA has been a strong supporter of this kind of legislation since managed care reform bill of 1997. However, it has come to our attention that we need to be very careful what kind of language we put into any bill that allows the right to sue.

You may need to study the issue more closely. The intention of a bill is to help someone, and not to restrict their ability to sue, or hamper it in any way. We are not experts in this legislation, but we do know one thing.

We want to give people the right to sue an HMO for decisions that harm people. We don't care how you do it through the courts, or through the legislature. Just do it right.

If in the end, you aren't careful and people don't have the right, you will not have accomplished what many of you promised in your election campaigns. There are several things that you should do in addition to considering the right to sue legislation.

The most important right you can give people is to establish a state consumer advocate program for health care. This office should be independent, and could help people who are having problems with their HMO's.

It could especially be benefit to the seniors who are having difficulty in their Medicare HMO plans.

It could be one office where anyone could call that needs help with their current coverage, or if they have no coverage at all.

It could especially assist the state to document what kinds of problems people are having. And help legislators better understand what kind of legislation on health care would be most helpful.

Most importantly, this office should have the ability to advocate for people in need no matter who you are, or how old you are. I just want to let you know that I live down in Norwich area, and I was there when the people who were on Medicare had their plans dropped from PHS. And one of the other health plans.

And I'm fortunate to see that gentleman after he spoke and pleaded with him not to be dropped from the HMO's, and the problems he was having with, and his wife was being for a stroke and then dropped dead.

And so there are many articles throughout that have been written throughout the country and the newspaper. The weekly magazines. A few years ago there was over a thousand bills submitted through the state legislators throughout the country dealing with HMO problems.

It is important that we have a right to sue to give a message to the insurance companies that they have to be responsible. And if they're going to practice medicine. This -- this is so important that it affects everybody's lives. Thank you.

SEN. HARP: Thank you very much. And thank you for your patience, as well. Are there questions? If not, thank you very much for your advocacy. Our next speaker is Don Roll. We're waiting for you, Don.

DONALD ROLL: Thank you, Senator Harp, Representative Eberle, and other members of the three committees who are still here. I represent Anthem Blue Cross

and Blue Shield of Connecticut.

My name is Donald Roll. I'm a director of government relations, and associate general counsel. We are opposed to this bill because it, in our judgement, would drive up costs for health plans without improving care.

We're very concerned about anything that increases cost here in Connecticut because we're concerned about the price of our product, and the ability of employers to provide that product to their employees.

I really want to spend time trying to answer some of the other questions though that have been asked specifically. There have been a number of questions about the internal appeals mechanism. How long it takes. How long can it be drug out, etcetera.

Current Connecticut law requires that we respond to internal appeals within thirty days. Someone said that that was for the first level of appeal, but not for others. I disagree, respectfully.

I believe that any level of appeal that we have to respond to within thirty days. NCQA recommends, and our company certainly has two levels of appeal. The second level of appeal made up of people who had no participation in the first level of appeal.

That's to provide people with additional safeguards. But, in effect, we should be able to get an answer within sixty days, or maybe sixty-five days if it takes the person five days after the first appeal to appeal the second time or something.

But, it's a fairly quick process. And that is assuming that it is not a serious or life threatening situation. And serious or life threatening situations we're required by law to respond within 48 hours.

So we're talking, when we talk the sixty days, we're talking rather routine procedures, not

something that is life threatening, or very serious. I'd also like to respond to Representative Eberle's earlier question about whether there's a place within the plan for doctors to appeal protocols or question protocols that the company has.

Within Anthem we have numerous provider panels. We have a primary care panel made up of primary care physicians. And then we have numerous, I don't actually know the number, of specialty panels.

But the idea being that all of the major specialties, and even some of the subspecialties would have a panel of providers within our networks who are available to consult with us about our procedures. We submit all medical protocols to our various panels to be looked at before we implement them. So they are reviewed by Connecticut practicing physicians before we implement them.

And then if as things move along, doctors have problems with them, they are taken up again by the panels of actively practicing physicians to determine whether they continue to be correct.

Basically, we think there is a better way. That better way is the external appeals mechanism that we currently have in this state. That gets people a treatment decision very quickly. If it's a very serious situation, we've given them presumably two levels of appeal within about four days.

And then they can go to the external appeal mechanism. And that mechanism can work very quickly again, if it's a serious life-threatening situation. It's better to get people the care than it is to find out whether there's liability five years from now. Thank you.

SEN. HARP: Thank you. Representative Eberle.

REP. EBERLE: Thank you, Don. I just want to clarify something you said. You feel there's thirty days for the total internal appeal, or thirty days for each stage?

DONALD ROLL: I believe there are thirty days on each state.

REP. EBERLE: Okay.

DONALD ROLL: But, one of the people that spoke said there's thirty days for the first appeal, and no time limit on subsequent appeals, within the plan. That is incorrect. The current statute is thirty days for each level of appeal, I believe.

REP. EBERLE: Does the Insurance Department have to approve your internal appeals process?

DONALD ROLL: Well --

REP. EBERLE: Or, are you free to set up, I mean --

DONALD ROLL: We have to describe --

REP. EBERLE: -- Senator Prague's point is that you can set up as many levels as you want, depending on how long you want to stretch it out.

DONALD ROLL: Right.

REP. EBERLE: And, are there any breaks on that?

DONALD ROLL: There are in this sense, at least. We are required to have our policies approved by the Insurance Department. One of the things that we are required to describe in the policy is the appeals mechanism.

REP. EBERLE: Okay.

DONALD ROLL: So the Insurance Department has jurisdiction over the appeals mechanism in that sense. Within current Connecticut law, I don't recall there being a specific ability of the Department to, you know, to specifically say, three levels of appeal is unreasonable. Or, whatever.

I don't know of that being a specific authorization. I do know though that the Department does look at these things and say, you know, is what the plan wanting to do reasonable?

And they do say to us in our policies on various items, we don't think that's a reasonable provision, change it.

You know, as to the specifics of what they would consider to be reasonable or unreasonable, I guess you'd better ask them. I really don't know.

REP. EBERLE: Would, do you know if your company would have any objection if we made it thirty days total?

DONALD ROLL: I don't know. I don't know whether that is sufficient time. If it's, you know, if it's an appeal about that care that's already been rendered, and we're arguing about whether, how much we're paying for it, I just don't see the necessity for that kind of speed.

REP. EBERLE: What about if it's pre-approval?

DONALD ROLL: If it's pre-approval, you know, I would have to talk to people about the ability to do it. Whatever it is, I would recommend that you break it down though so that, I mean if you want to go thirty days total, than do it fifteen and fifteen, or something, you know, I mean.

REP. EBERLE: Well, I would rather leave the internal process --

DONALD ROLL: Okay, I see where you're going to.

REP. EBERLE: -- to you. And you put as many levels as you want in there. But you have to have a final company decision.

DONALD ROLL: Right.

REP. EBERLE: Within X amount of days. And I don't care how many -- and then I don't care how many levels you put in.

DONALD ROLL: I certainly will be happy to ask that question back among our -- whether it be -- I don't know whether there may be a, you know, may be a problem with that or not. But I'd certainly be happy to ask.

REP. EBERLE: Okay. I had another question, now I can't think of it. When -- do you take any action against a doctor who goes ahead and does treatment that you've said you won't pay for?

DONALD ROLL: Absolutely not.

REP. EBERLE: Do you know of any other plans that do?

DONALD ROLL: I do not. The only way we would take action is if, in certain of our contracts, normally hospital contracts, we have a member hold harmless provision that would say, if the hospital goes ahead and renders treatment, their argument is with us. It's not with the patient.

The patient is not going to get charged on anything more by the hospital. And the hospital and us will work out --

REP. EBERLE: You'll duke it out.

DONALD ROLL: -- you know whether, you know, we'll duke it out as to whether that treatment was reasonable or not.

REP. EBERLE: Is that the kind of thing that can be appealed to the external appeals? I mean, what form does the hospital have to challenge you then if they go ahead and let the patient stay?

DONALD ROLL: It's an arbitration, it's a, you know, non-traditional arbitration process under the contract using the American Arbitration Society. So I, you know, that is not an external appeal, appealable decision, I don't believe. Because the treatment has been rendered. And the patient is not going to be out any extra money.

REP. EBERLE: Okay, is that Blue Cross's policy as --

DONALD ROLL: That's what we do.

REP. EBERLE: Do you know is that typical in the industry or not?

DONALD ROLL: I do not know.

REP. EBERLE: Cause I think, seems to me the decision whether to foot a hospital bill on your own is a lot different than the decision to foot a doctor's bill on your own.

DONALD ROLL: That's correct. And those provisions are in hospital contracts. They are not in physician contracts.

REP. EBERLE: Okay. We need to find out if the other plans have similar things with the hospitals. Okay, thank you.

DONALD ROLL: Sure.

SEN. HARP: It just occurred to me to ask just based upon the previous testimony. Is it the same for medical hospitals as it is for mental health hospitals? This same kind of process that you have in place?

DONALD ROLL: I do not believe that it is. I believe that that contract provision is for acute care general hospitals.

SEN. HARP: Okay.

DONALD ROLL: I do not believe it applies to specialty hospitals. But I will have to check.

SEN. HARP: Okay, great. Could you let us know on that?

DONALD ROLL: Sure.

SEN. HARP: And then the other thing is, we've heard today that perhaps we don't even need a law in Connecticut because of cases that have occurred in Texas here in Connecticut and elsewhere. And so, knowing and understanding that, I was wondering the degree to which your company has malpractice insurance now or carries that?

DONALD ROLL: Believe it or not, I asked that question Friday, and I didn't get a response yesterday. So I don't know the answer to that. But we will find

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out, and I'll be happy to share that with you as well.

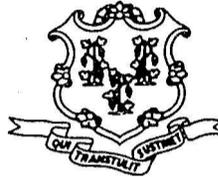
SEN. HARP: Okay, great. Thank you very much. Are there further questions? If not, thank you very much.

DONALD ROLL: Thank you.

SEN. HARP: Our next speaker is Ron Cretaro, if he's here? And if he is not here, then that is the last speaker that I have for today. And, unless there's someone in the audience who wishes to speak, going once, twice, three times. This public hearing is closed. Thank you very much.

(Whereupon, the Public Hearing was Adjourned.)

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State of Connecticut

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JOINT COMMITTEES ON PUBLIC HEALTH, JUDICIARY, AND INSURANCE AND REAL ESTATE Public Hearing, March 23, 1999

Testimony Regarding HB 7032 An Act Concerning Liability of Managed Care Organizations

Chairpersons Harp and Eberle, Williams and Lawlor, Bozek and Amann, I would like to thank you for raising HB 7032 for this joint public hearing today. Liability of managed care organizations (MCO's) is an important issue deserving of this attention.

Like most of you, I strongly support ensuring and strengthening a patient's right to sue a managed care organization whose actions lead to injury or death. Like many of you, I introduced a bill this session to achieve that end.

I am, however, deeply concerned about a number of provisions in the bill before you today, and have come here to ask that you either:

1. Pass a stronger, clearer measure than this one; or
2. Take no action whatsoever on this bill.

Why would I, an introducer of a bill to strengthen patients' rights to sue managed care companies, take this position?

Recent state and federal cases (Napoletano et al vs. CIGNA healthcare, Moscovitch vs. Danbury Hospital et al) have opened the door to malpractice lawsuits against MCO's. The spirit in which I – and many of you – offered legislation was to wedge a strong doorstop beneath that open door, ensuring that Connecticut patients could sue for malpractice in appropriate circumstances.

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In my opinion, HB 7032 would actually swing that door closed, or so near to closed that almost no one seeking to sue a malpracticing MCO could actually pass through.

Some examples:

1. Section 1, Subsection 4 of the bill states, "Health care treatment decision' means a determination made when medical services are actually provided by the managed care plan . . ." *What if medical services were not provided by the plan, but ought to have been?* The language of the bill does not seem to cover that circumstance.
2. Section 1, Subsection 6 of the bill exempts "self-insured employee welfare plans established pursuant to the Federal Employee Retirement Income Security Act (ERISA) of 1974" from the definition of MCO's. *Recent court rulings have indicated that plaintiffs may sue ERISA plans that commit malpractice. Why should the General Assembly pass a measure that carves out these plans from liability, preventing approximately 50% of Connecticut's insured population from suing under appropriate circumstances?* I encourage you to eliminate this exemption. The courts may or may not continue to permit individuals belonging to ERISA plans to sue; we should not preemptively take away that right.
3. Section 1, Subsection 8 of the bill reads, "'Ordinary care' means . . . in the case of a person who is an employee, agent, ostensible agent or representative of a managed care organizations, that degree of care that a person of ordinary prudence in the same profession, specialty or area of practice as such person would use under similar circumstances." *What if the MCO has the wrong type of employee making key medical decisions? An LPN, for example, telling a doctor what type of procedure is permissible?* This circumstance appears to fall outside the bill's definition of "ordinary care."
4. Section 2, subsection (c) of the bill indicates that it shall be a defense to any action asserted against a managed care organization that "the managed care organization did not deny or delay payment for any treatment prescribed or recommended by a health care provider to the enrollee." *What if the MCO has practice guidelines or formularies that direct physicians and other providers not to prescribe or recommend certain treatments?* It appears that malpractice claims resulting from such circumstances would be disallowed under this bill.
5. Section 3 of the bill says that no person may sue an MCO "unless the enrollee has exhausted the appeals and review applicable under the utilization review requirements. *This provision gives managed care companies an incentive to stretch out their appeals processes, preventing potential plaintiffs from going to court.* When we passed managed care reforms two years ago, we set no time limit for internal or external appeals. This legislation would encourage companies to take advantage of that omission.

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In conclusion, the legislation before you today seems to create more new defenses against malpractice suits than grounds for action. I ask you to consider the following changes:

- Eliminate the ERISA exemption in Section 1 of the bill.
- Establish a strong right to sue that is not encumbered by narrow definitions and provisos – or else take no action on this bill.
- Set up a time limit for internal appeals processes of MCO's, so that they cannot stretch out such processes indefinitely. I also encourage you to consider a time limit for the state's external appeals process.
- Create a consumer hotline for people who have questions about their rights under state and/or federal law. Many patients are unsure of their rights, and therefore fail to take advantage of the mechanisms we have set up to help them.
- Establish an Office of Consumer Advocate for Health Care. Such an advocate could help educate citizens about their rights; he or she could also help ensure that patients are treated according to the dictates of our state statutes and regulations.

I thank you for considering these recommendations, and would be happy to answer any questions or concerns that you may have.

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**Testimony of Norman Coutu
CT State Employees Association Council 400 Retirees
for Public Health, Judiciary and Insurance and Real Estate Committees
An Act Concerning the Liability of Managed Care Organizations
March 23, 1999**

My name is Norman Coutu, and I am a member of CSEA Council 400 Retirees. We represent approximately 14,000 state employee retirees. CSEA is a member of the Health Care for All Coalition.

I would like to testify today on the "right to sue" legislation. CSEA has been a strong supporter of this kind of legislation since the Managed Care Reform Bill of 1997. However, it has come to our attention that we need to be very careful what kind of language we put in any bill that allows the right to sue. You may need to study the issue more closely.

We are not experts in this legislation, but we do know one thing. We want to give people the right to sue an HMO for decisions that harm people. We don't care how you do it - through the courts or through the legislature. Just do it right. If in the end, you aren't careful and people don't have that right, you will not have accomplished what many of you promised in your election campaigns.

There are several things that you should do in addition to considering the "right to sue" legislation. The most important right you can give people is to establish a State Consumer Advocate program for health care. This office should be independent and could help people who are having problems with their HMO. It could especially be of benefit to seniors who are having difficulty with their Medicare HMO plans. It could be one office where anyone could call that needs help with their current coverage or if they have no coverage at all. It could especially assist the State to document what kinds of problems people are having, and help legislators better understand what kind of legislation on health care would be most helpful.

Most importantly, this office should have the ability to advocate for people in need - no matter who you are and how old you are.

Thank you.

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In conclusion, the legislation before you today seems to create more new defenses against malpractice suits than grounds for action. I ask you to consider the following changes:

- Eliminate the ERISA exemption in Section 1 of the bill.
- Establish a strong right to sue that is not encumbered by narrow definitions and provisos – or else take no action on this bill.
- Set up a time limit for internal appeals processes of MCO's, so that they cannot stretch out such processes indefinitely. I also encourage you to consider a time limit for the state's external appeals process.
- Create a consumer hotline for people who have questions about their rights under state and/or federal law. Many patients are unsure of their rights, and therefore fail to take advantage of the mechanisms we have set up to help them.
- Establish an Office of Consumer Advocate for Health Care. Such an advocate could help educate citizens about their rights; he or she could also help ensure that patients are treated according to the dictates of our state statutes and regulations.

I thank you for considering these recommendations, and would be happy to answer any questions or concerns that you may have.

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☆ HEALTH CARE FOR ALL COALITION ☆

Testimony of Suzanne Haviland, Director, Health Care for All Coalition
for Public Health, Judiciary and Insurance and Real Estate Committees
Regarding An Act Concerning the Liability of Managed Care Organizations, 7032
March 23, 1999

My name is Suzanne Haviland, and I am the director of the Health Care for All Coalition, a coalition of more than 40 consumer, community, labor, senior, women's and provider groups working together to reform the health care system and to increase access for everyone.

Over the past year, Health Care for All members have been vocal in our support for giving consumers the right to sue managed care companies for malpractice, and we included it in a checklist we developed of 15 key consumer protections we felt should be included in a Patients' Bill of Rights.

We supported the "right to sue" because it is clearly a right that individuals should have. Managed care companies say they don't practice medicine and shouldn't be liable like doctors. We say they do practice medicine, and we know from countless hours of speaking to the public in the past few months, canvassing literally to thousands of households, that the average person is with us.

However, given the experience of other states and the court decisions in this state, we urge the legislature to take a second and third look at this language. We believe that there may be benefit to forming a study commission to analyze this issue more closely, unless we can be absolutely sure that the bill we pass does not actually limit people's existing rights. The court decisions leave the right to sue open for discussion. The wrong legislation could limit the court's interpretation of people's rights.

It is certainly not the intention of legislator-advocates to limit the rights of consumers, we know. That is why we say that we need to have a broader discussion about this bill, before we act.

I cannot tell you today what the perfect language would be for this bill to avoid hurting people. I don't believe it exists now. We should work together to find that language. A study commission or a legislative task force could help. Bill 7032 is not it. There is no reason why someone should have to exhaust all their appeals before they can sue. And, who is going to decide if "medical services are actually provided by the managed care plan" as is stated in section four? Section four is of serious concern to us, because again, managed care companies say they don't provide medical services. They simply issue policies and statements and opinions and mandates that have the power to heal or to hurt us.

This year, we suggest you put the real focus on two other appeal rights that currently do not exist in our law. Every month, we get many phone calls from consumers who need help with obtaining coverage or understanding their rights or current coverage, and there is nowhere they can turn. We ask that you:

Regulate and improve the internal appeals system of HMOs. Less than 50 people in one year used the state's external appeal program when they had a problem with denial of care by their insurer. You can't use the external appeal unless you have exhausted your internal appeal. Obviously, people are getting lost for months in the system, and give up. We believe that health companies should allow consumers to formally file a complaint over the telephone, other than only in writing. This process should take no more than 30 days. All correspondence should clearly state the reasons that care has been denied, and the criteria used to determine "medical necessity" should be fully outlined.

Establish an Office of Consumer Advocate for Health Care: This office would be modeled on the Office of Child Advocate and the Office of Protection and Advocacy, assist consumers with their problems and questions. It would provide information to people about health care insurance and obtaining health care coverage, and it would be given the authority to advocate on behalf of patients who are denied care. Vermont currently has such a program. This office could also be of great assistance to the approximate 40% of people in HMOs who currently are in self-insured plans and are not allowed to go through the "external appeal". (end)

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Checklist for Patients' Rights Legislation

Health Care For All Coalition supports these Managed Care Reforms for 1999. Please give this list to your legislators to fill out, or call them to discuss. Send copy to HCFA, Suite 305, 45 S. Main St., West Hartford, CT 06107 or call (860) 561-6060.

| | |
|---|--|
| Name of Person Requesting Information: _____ | Tel #: _____ |
| Address to Mail Response: _____ | |
| Full Name of Lawmaker: _____ | Date sent to lawmaker or filled out: _____ |
| Check: <input type="checkbox"/> State Senator <input type="checkbox"/> State Representative OR <input type="checkbox"/> U.S. Congressperson <input type="checkbox"/> U.S. Senator | |

Consumer Rights

| | yes | no | Needs more info - use back side for comment |
|---|--------------------------|--------------------------|---|
| 1. Establish a State consumer advocate program to assist the public with health care concerns | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Require uniform "internal appeal" standards for managed care companies to follow when dealing with patient grievances. Set specific time limits for action by the company, allow telephone appeals, and provide clear reasons for denials in all correspondence. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Provide parity in patient reimbursement rates for certain illnesses and medications, such as non-biological and biological mental illness, and prescription contraception. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Accountability

| | | | |
|--|--------------------------|--------------------------|--------------------------|
| 4. Allow patients to hold health insurers liable for malpractice, just as doctors can be held liable, if they wrongfully deny care. This right should be <i>without</i> limitation, or must be reconsidered. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|

Access

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| 5. Allow patients to use out-of-network health providers, medications, treatments, and equipment that are not on the health plan's approved lists when recommended by their doctor. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Allow patients to continue to receive care from their doctor or other health provider for a period of time if he/she leaves the health plan or if a patient involuntarily leaves a plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Allow direct access to specialists if it is medically appropriate. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Medical Decision-Making

| | | | |
|--|--------------------------|--------------------------|--------------------------|
| 8. Ensure that doctors and nurses determine standards of care and medical necessity. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Protect caregivers from being penalized by health plans for reporting quality concerns | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Patient protections and reforms should be available to every consumer receiving health care benefits, regardless of the plan used, including individual plans, Medicare, Medicaid, Workers' Compensation and ERISA covered plans. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Empower the State Department of Health (DOH) or agency outside of the Insurance Department to oversee all aspects of rationing of health care, including consumer grievances and appeals. Allow patients to "externally" appeal directly to an independent panel at DOH and bypass the company "internal appeal" when appropriate. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Quality

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| 12. Establish minimum standards of care to ensure caregivers are qualified medical professionals. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Set and maintain standards of responsible staffing at health care institutions. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Corporate Responsibility

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| 14. Pass legislation to ensure that health plans, such as Medicare HMOs, make long-term commitments to customers in all areas of Connecticut in which they serve. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Enact community benefits legislation for health plans and managed care companies. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Note: Public Act 97-99, An Act Concerning Managed Care, became law in 1997. This act contains other important patient protections. (HCFA 3-18-99)
Please use back side of this form for comment on other reforms supported.

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NASW

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Stephen A. Karp, MSW, Executive Director

Proposed Language for a Standardized Internal Appeal Process under Managed Care

"Within five business days of receipt of an oral or written initial appeal of an adverse determination, a notice of acknowledgement shall be sent by the managed care organization to the enrollee or person representing the enrollee, with the name and telephone number of the individual responsible for resolution of such initial appeal. If the person responsible for resolution of the initial appeal changes, the enrollee or person representing the enrollee will be notified in writing within five business days of such change and the name and phone number of the new person responsible for resolution of the initial appeal.

All initial appeals shall be resolved in the most expeditious manner possible, but in any event 1) no more than 24 hours after the initial appeal has been filed where the enrollee's health or well being is in jeopardy or 2) no more than thirty days after the initial appeal is filed in all other instances.

The enrollee or their representative shall be notified by the managed care organization in writing, within five business days of the decision on the initial appeal, except where the enrollee's health is in jeopardy the managed care organization will immediately notify the enrollee or their representative. If the initial appeal is denied, the notice of denial shall state the specific justification for denial, include supporting documentation, indicate in clear language the right to a second appeal and an explanation of how to file a second appeal. The enrollee or their representative may request a second internal appeal, for which the managed care organization must have a person licensed to treat the condition under appeal who has expertise in the treatment of the condition under appeal and who has not taken part in the denial of the initial appeal, act upon the second appeal. Such second appeal shall be made within sixty days of receipt of written notification of the denial of the initial appeal. All internal second appeals shall be resolved in the most expeditious manner possible, but in any event 1) no more than 24 hours after the second appeal has been filed where the enrollee's health or well being is in jeopardy or 2) no more than thirty days after the second appeal is filed in all other instances, except that the second appeal process may be extended up to an additional thirty days if agreed upon by the enrollees or their representative.

At any point during the initial appeal or internal second appeal process, should the enrollee or their representative believe the managed care organization is not acting in good faith, they may file a request with the Commissioner to have the appeal immediately handled by the independent external appeal process as provided for in the

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general statutes section _____. The Commissioner shall rule on such request within fifteen working days of receipt of the request. Refusal by the Commissioner shall not affect the right to file an external appeal following completion of the second internal appeal process.

The managed care organization shall not require more than an initial appeal and a second appeal prior to the enrollee or representative of the enrollee being eligible to file with the Commissioner a request for an external appeal as provided for in the general statutes section _____.

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TESTIMONY OF
JOHN RATHGEBER
CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION and
TIMOTHY MOYNIHAN
METRO HARTFORD CHAMBER OF COMMERCE
BEFORE THE
PUBLIC HEALTH COMMITTEE
JUDICIARY COMMITTEE and the
INSURANCE & REAL ESTATE COMMITTEE
LEGISLATIVE OFFICE BUILDING
MARCH 23, 1999

My name is John Rathgeber. I am the executive vice president of the Connecticut Business & Industry Association (CBIA). With me is Timothy Moynihan, president of the Metro Hartford Chamber of Commerce.

We are here to speak in opposition to HB 7032, which relies on state-court lawsuits and expanded litigation as the means of resolving disputes with health care plans. The business community acknowledges that there are ongoing frustrations with health plans among providers and among some employers and employees. However, we believe that expanding litigation will only further escalate the high cost of health insurance, which is the single greatest impediment to individual and group health insurance coverage.

We urge you, instead, to concentrate on the goal of access to affordable, quality health care. The small-employer insurance reforms enacted by the General Assembly in the early 1990s have been essential steps toward this goal. In contrast, expanded litigation would divert needed resources away from health care services and ultimately result in reduced access to care for Connecticut citizens.

In examining proposals to expand tort liability, we are not venturing into uncharted waters. We don't need to speculate about how tort liability *will* work; we already know from experience. This experience tells us that the system is extremely costly:

- The *direct* cost of the medical malpractice system – where “health care treatment decisions” of the kind envisioned in HB 7032 are at issue – is estimated at nearly \$13 billion annually. (*Tort Cost Trends: An International Perspective*, 1995 update of previous studies published in 1985, 1989, and 1992, Tillinghast – Towers Perrin, hereinafter referred to as “Tillinghast”)
- The *indirect* cost of medical malpractice – i.e., the costs of defensive medicine, where services without benefit to patients that are provided to avoid malpractice claims – are estimated by various sources at between \$10 and \$20 billion a year.
- The average, direct cost of defending a medical malpractice action was \$19,300 in 1995 – nearly a *threefold* increase from 1985. And the average cost of defense in cases that actually went to trial was nearly \$95,000.
(Study by Physician Insurers Association of America, released August 21, 1997, hereinafter referred to as “PIAA.” Figures are from the PIAA database of more than 150,000 malpractice actions, representing approximately one-quarter of the physician population practicing in the U.S.)
- Costs for medical expert witnesses in medical malpractice cases increased *over fourfold* from 1985 to 1995. (PIAA)

Our experience also tells us that claimant’s receive only a fraction of the dollars spent in the tort system and wait years before they’re compensated:

- Only 25 cents on the dollar goes to the claimant as compensation for economic damages. When combined with compensation for pain and suffering, the system still returns only 46 cents on the dollar to the claimant. (Tillinghast)
- 30 cents on the dollar goes to attorneys and defense costs (16 cents to claimants’ attorneys; 14 cents in defense costs). (Tillinghast)
- Claimants win only 49 percent of all tort cases that go to trial, and only 30 percent of malpractice lawsuits. (Civil Trial Court Network, National Center for State Courts)
- It takes, on average, 5 years and 4 months from the time of an incident until a claimant receives payment on a malpractice claim in Connecticut. (National Practitioner Data Base, 1997 Annual Report, U.S. Department of Health & Human Services.)

Medical malpractice liability is costly, inefficient, and time-consuming. It provides minimal benefits for claimants, while driving up the cost of health care for all. Recognizing this, in 1986 and 1987, CBIA, the Greater Hartford Chamber of Commerce and Connecticut's medical community all participated in the coalition that worked to reform aspects of Connecticut's tort liability system, including the medical malpractice system. In testimony before the Judiciary Committee in 1986, a representative from the medical society testified, "Because of the very real threats and pressures of our civil justice system, as it is presently structured, doctors are practicing expensive defensive medicine techniques. . . . these defensive medicine measures increase the cost of patient care to the consumer."

If the direct and indirect costs of the medical malpractice system are already driving up the price health care, expanding liability against health plans will make matters worse. Various studies at the national level have estimated that expanding liability would increase health care premiums by anywhere from 6 to 12 percent (Barents Group, KPMG, Inc.). When applied to the average Connecticut health care premium per employee, this translates into increased costs of anywhere from \$260 to \$519 per employee – this, at a time when we're already experiencing annual premium increases in excess of 10 percent. (NOTE: Connecticut employers spent an *average* of \$4,323 per active employee for health care benefits in 1998. William M. Mercer, Inc. annual survey.)

What are the consequences of substantial increases in the cost of providing health care benefits? When CBIA asked this question in our annual membership survey, 5 percent of respondents indicated they would be forced to drop benefits; 14 percent indicated they would have to reduce health care coverage, and nearly 59 percent responded that employees would have to contribute a larger share to the cost of their benefits.

The consequences of major cost increases fall on employers and employees alike. And low-wage workers feel the most devastating effects. There is a direct relationship

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between increases in health care costs and increases in the percentage of uninsured. ("The Decline in Insurance Coverage," Kronick & Gilmer, Health Affairs March/April 1999) To the extent that prices are moderated, "this has had real benefits for low-wage workers, more of whom are able to afford insurance than would have been the case if prices had continued on their prior path of rapid increases." On the otherhand, "if health care spending continues to rise more rapidly than income, . . . then more workers will lack insurance."

With health-care-benefit cost increases beginning to accelerate in 1998, health care coverage has eroded in businesses of all sizes. The most severe erosion has occurred in the small-business community, where the percentage of employers offering health insurance coverage has declined. ("Changes in "Employee Health Coverage by Small Businesses, Henry J. Kaiser Foundation, Feb. 1999) But even where employers continue to offer health care benefits, workers aren't enrolling. And they're not enrolling because they can't afford the price. (UCLA Center for Health Policy Research, June 1998; "Report on Connecticut's Insured and Uninsured," OHCA, April 1998; "Private Health Insurance, Continued Erosion of Coverage Linked to Cost Pressures," GAO Report, 1997)

Increasing the ranks of uninsured workers is too high a price to pay for increasing the opportunities to sue. But there is also a high price to pay in terms of health care quality. Connecticut employers are deeply committed to improving the quality of health care by increasing the capacity of plans and providers to measure and account for health care outcomes and improve these outcomes. Some of Connecticut's major employers have been national leaders in the move for health care quality. They've been driving forces in the creation of HEDIS data and the National Council for Quality Assurance (NCQA), the national health care plan certification agency; they've led in the development of health plan report cards; and they've been key participants on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

However, by punishing errors after the fact, health plan liability is reactive and interferes with proactive approaches that emphasize continuing quality improvement and greater accountability of all health care providers. And, just as malpractice liability drives defensive medicine, health plan liability will drive defensive reimbursements, increasing the incidents of unnecessary and inappropriate treatments and services. If one objective of proposals to expand health plan liability is to improve quality and accountability, this mechanism is counterproductive.

So, what is the solution to provider and consumer frustration? How can accountability be improved? The work begun through the 1997 Managed Care Legislation to issue health plan report cards and provide an external review process provide opportunities for further improvement. The Health Plan Report Card developed by the Department of Insurance is a good mechanism to help consumers and employers compare health plans. However, while the Report Card can be helpful, few consumers or employers have seen it because there has been no means of distributing it. Every health plan enrollee should have a copy. And the Report Card should be expanded to include patient-satisfaction information, more comparative information on plans' internal-review processes and processing time, and more information on their external-review experiences.

The state's current external review process, which has been operational since January 1998, provides a fast, fair, and efficient forum for independent medical examiners to review, investigate and resolve complaints against managed care plans concerning issues of "medical necessity." However, like the Report Card, the availability of the state's new external-review process is not widely known. Mechanisms need to be developed for alerting all health plan enrollees and all health care providers of the process and how to use it. And ways need to be developed to make the process more accessible and to make it work faster and better under a variety of patient health care scenarios. The goal must be to address conflicts early and effectively to prevent further health problems – not react after the fact through lengthy and expensive litigation.

We urge you to reject proposals to expand health plan liability, and thank you for your consideration.

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Testimony of the Connecticut State Medical Society

In Support of

House Bill 7032, An Act Concerning the Liability of Managed Care Organizations

Presented by Margaret Morelli

March 23, 1999

Good morning members of the Public Health Committee, Insurance Committee, and Judiciary Committee, my name is Margaret Morelli and I am the Director of Government Relations for the Connecticut State Medical Society. I am here on behalf of the Connecticut State Medical Society, which represents over 7,000 physicians in this state. I am pleased to speak today in support of Raised House Bill 7032, An Act Concerning the Liability of Managed Care Organizations.

House Bill 7032, the managed care accountability bill you are considering, is designed to hold health maintenance organizations and other managed care entities appropriately responsible for their actions that result in injury to patients.

Managed care organizations are increasingly encroaching on the medical treatment decisions historically made by physicians and other health care providers. When health care providers are negligent in making health care treatment decisions, they are held accountable through the legal system.

Under House Bill 7032, managed care organizations would be required to exercise ordinary care when making health care treatment decisions and would be held responsible for their failure to do so. We strongly believe that Connecticut patients deserve no less.

The managed care industry will argue that health maintenance organizations and other managed care entities do not practice medicine. However, when they deny payment for a covered benefit or perform utilization review procedures negligently and thus delay needed care or substitute

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inferior care, their actions impact the quality of medical care delivered to patients. Should they not be held accountable for those actions?

Meaningful legal remedies, such as those provided in this bill, are critical when grievance and other appeal procedures fail. The managed care industry will argue that this bill relieves physicians and other health care providers of their responsibility. Nothing could be further from the truth. Physicians have been and, after this bill's enactment, will continue to be legally and ethically responsible for practicing medicine in accordance with accepted standards of care. This bill simply clarifies the accountability of managed care organizations for the decision they make, holding only those defendants who are responsible for a negligent injury appropriately liable.

Health maintenance organizations and other managed care entities also try to hide behind ERISA preemption. They tell courts that they cannot be held responsible for medical malpractice in cases involving patients who receive care through an employer-sponsored health plan because state law malpractice claims are preempted by ERISA. Courts, however, have started to view things differently, holding that ERISA does not preempt certain types of malpractice actions against health maintenance organizations and other managed care entities. This was the decision of the U. S. District Court in *Moscovitch v. Danbury Hospital*. This bill should be amended to clarify that patients who are harmed by their managed care organizations' negligent decisions have recourse, regardless of whether or not their coverage is provided through an employer-sponsored plan.

Health maintenance and other managed care organizations also attempt to hide behind the unpopularity of the trial lawyers by claiming that this legislation is designed to benefit them. It is not. The legislation will benefit the patients of this state. Nor will this reform lead to an explosion in litigation. These lawsuits are already being brought. . .but physicians, hospitals and other health care providers are the only defendants, even when the harmful decision is made by a managed care organization. This legislation would simply allow patients to hold managed care decision-makers appropriately responsible for their actions.

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Another argument advanced by the insurance industry is that health care costs will increase significantly if this bill is enacted. In Texas, the first state to adopt managed care accountability legislation, this issue was hotly debated. Milliman and Robertson completed an actuarial determination of the cost of the Texas liability legislation to a Texas-based HMO and set the cost at only 34 cents per member per month. Nor should the costs of care increase significantly, as these costs are already covered by premiums. Care is being paid for, but not provided. Managed care organizations recognize these "savings" as profits. While profit margins may narrow, the care that patients are already paying for will be provided.

The managed care industry also asserts that defensive medicine will return as a result of this bill. We believe that *necessary* medicine will return. If the care covered by the health plan is properly and promptly provided, it is more likely to save money in the long run.

I would like to close today by emphasizing that with the power to make decisions affecting peoples' lives should come the responsibility for making those decisions. Physicians and other health care providers accept that responsibility. For the sake of the patient, shouldn't we require health maintenance organizations and other managed care entities to do the same?

On behalf of the Connecticut State Medical Society, I appreciate your time today and your thoughtful consideration of this testimony. I will be happy to take any questions.

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Molly Rees Gavin, LCSW, ACSW, President
Stephen A. Karp, MSW, Executive Director

**TESTIMONY ON
H.B. 7032: AAC THE LIABILITY OF MANAGED CARE
ORGANIZATIONS
PUBLIC HEALTH, JUDICIARY & INSURANCE COMMITTEES
March 23, 1999
Presented By: Stephen A. Karp, Executive Director**

H.B. 7032 calls for the right to sue a managed care organization. NASW/CT is one of the organizations that supported such a right, and we still do. However, we have come to question whether the right to sue should be put into statute in Connecticut at this time. There have been several Connecticut Supreme Court cases where the Court found ways around the ERISA exemption and permitted lawsuits to proceed in state court (Napoletano, et al vs. CIGNA Healthcare of Connecticut, Inc, / Hollis, et al vs. CIGNA Healthcare of Connecticut, Inc. / Moscovitch vs. Danbury Hospital, et al). Given these cases NASW/CT believes that consumers may be better off leaving the right to sue to the courts rather than enacting legislation that may inadvertently or purposefully limit that right to sue due to the language of the legislation. Additionally, we are concerned that as we near the end of the session a high profile liability law may become a trade off between the Legislature and the HMO's, whereby other managed care bills that would potentially affect far more persons (and in some cases alleviate the need to sue), such as the ombudsman, continuity of care, internal appeals, and community benefits, would not be passed in return for the right to sue.

NASW/CT urges you to either construct a liability bill that has no restrictions on the right to sue or recommends changing H.B. 7032 to a study bill so that the question of whether or not a liability bill would in fact restrict consumer rights to sue be answered prior to enacting such legislation.

There are other avenues for addressing consumer concerns that may alleviate the need for legal action in most cases. One is creating a HMO Consumer Ombudsman Office to assist patients in receiving their rights as managed care enrollees. Such an office is proposed in S.B. 1355: AAC An HMO Ombudsman which is currently before the Judiciary Committee. An Ombudsman will greatly assist managed care enrollees and their family members who are struggling to understand and navigate the complexities of managed care. Since patients do not know how their health insurance coverage works until they need to use it, and since at the point you need coverage and run into problems with your managed care insurer you are often ill and least able to deal with an intransigent managed care company, an ombudsman is critical to assuring that patients

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and their families receive all of their rights under the laws affecting managed care, without necessarily resorting to the filing of a lawsuit.

Another way to address problems with managed care organizations, which may also reduce the need to sue, is to regulate the entire internal appeals process of managed care organizations. Currently only the initial appeal is covered by statute, which calls for a timely decision on the appeal. However managed care organizations have added second, third, fourth, etc. levels of appeal which are not covered by statute. For example, a representative of CIGNA testified before the Public Health Committee on March 18, 1999 that CIGNA has at least four levels of internal appeal. Patient's, their family, or their representative must wade through these bureaucratic mazes in an attempt to resolve their complaint and since there is no requirement as to how quickly the managed care organization must make a decision, or how few levels of appeals can be required, the patient's condition can dramatically worsen, leading to a greater likelihood of a lawsuit being filed. The other consideration in regards to internal appeals is that unless we regulate the entire internal appeals process the patient may remain stuck in the internal appeal process for months and months, or even over a year, which delays the patient's right to file for an external appeal, which in turn delays the right to file a lawsuit. It seems to us that the regulation of internal appeals is critical both to resolving issues prior to necessitating a lawsuit and to ever reaching the point of having the right to sue. Proposed language on regulating the entire internal appeal process is attached.

The issue as to the right to sue managed care organizations is directly affected by the kinds of regulations that exist to moderate the excesses of managed care. Passage of legislation on continuity of care (S.B. 336) and internal appeals, as well as an ombudsman program, will no doubt reduce the need of ultimately having to go to court. Regardless of the outcome of legislation on liability we urge you to pass legislation that deals with the problems that lead up to the need to sue

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The Moscovitch case has been returned by the federal circuit for trial in the state court and the Plocica case has been ruled worthy of civil action according to a law passed in Texas in 1997. The Supreme Court of Pennsylvania has recently ruled that the ERISA preemption does not apply to a negligence claim against US Healthcare.

A proliferation of initiatives has developed in state legislatures throughout the country the aim of which is to circumvent the ERISA preemption. These initiatives involve voiding so-called "hold harmless" clauses and allowing claims to be brought for medical malpractice. The "hold harmless" clause in contracts between a managed care company and a provider enables the latter to indemnify the former when an action is brought by an enrollee. Connecticut was among the earliest states to prohibit such clauses in 1995. Malpractice claims are based on the theory that a managed care company is effectively practicing medicine when it makes treatment decisions and thus is liable when injury results to an enrollee as a result of those decisions.

In a substantial number of cases before the courts the plaintiff is left with no remedy as a result of the continued existence of the ERISA preemption. Increasingly the courts claim that they are powerless to change ERISA and that this is the province of the Congress. It is hoped and expected that this year the Congress will enact measures to enable the injured or harmed enrollees of self insured health plans to obtain proper consideration for their claims.

The Connecticut Psychological Association takes the position that the consumer of health care services is best protected by a combination of a secure and comprehensive external appeal mechanism and a firm liability law such as HB 7032. Such instruments will allow for unfettered access to consistently high quality treatment.

We also applaud the language in Section one, (1), which sets forth the definition of "appropriate and necessary care" as "determined by health care providers in accordance with the prevailing practices and standards of the medical profession and community".

In conclusion, as providers of behavioral health services and consumers of health care, we strongly urge you to vote for HB7032 so that Connecticut will take a major step forward to protect the consumers of health care.

I thank you for your time,

A. Richard Tomanelli, Ph.D.

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I believe that we in Connecticut are in a very unique position on the issue of managed care litigation. In the case that I was counsel to ***Napoletano, et al vs. CIGNA Healthcare of Connecticut, Inc.*** (Doctors' case) and it's companion case ***R. Barrett Hollis, et al vs. CIGNA Healthcare of Connecticut, Inc.*** (Patients' case) coupled with a decision by Judge Christopher Droney in the United States District Court entitled, ***Moscovitch vs. Danbury Hospital***, Docket #CV3:97-CV-1654 ample room to litigate HMO claims exists in both the State and Federal Courts in Connecticut. I believe that if Raised Bills 7032 and/or 1195 are passed as currently written that the only guarantee that will arise from the passage of such legislation will be a challenge in the Federal Court on ERISA pre-emption issues and thus my concern that in attempting to expand patient rights, we will really be running a high risk of restricting them.

First of all, a basic understanding of what ERISA Preemption is all about is important. ERISA stands for the Employer Retirement Income Security Act, 29 U.S.C. Section 1144 which says in effect that the Federal ERISA Statute will preempt any state law that may "now or hereafter relate to any employee benefit plan". Significant language in that clause, "relate to" has caused much litigation and is the essential thing to understand with regard to the whole question of ERISA preemption. Effectively, if ERISA preempts a

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WATERBURY MEDICAL ASSOCIATION

Statement in Support of House Bill 7032 –

An Act Concerning the Liability of Health Maintenance Organizations

**Public Health, Judiciary, and Insurance and Real Estate Committees
March 23, 1999**

This statement is being submitted on behalf the Waterbury Medical Association in strong support of House Bill 7032 – An Act Concerning the Liability of Health Maintenance Organizations.

House Bill 7032 would allow individuals to sue their managed care companies when that managed care company does not exercise ordinary care in making health care treatment decisions. With the advent of managed care, the amount of medical decisions actually made by doctors has decreased. Instead, it is the HMOs who decide which medications will be authorized for a patient, which treatments a patient may use, and how long a patient may stay in the hospital. This is incredibly frustrating since the HMO never has actually physically seen the patient before. It is then the physician who is held liable. It has gotten to the point that HMOs are now providing direct medical advice over the phone on 800 numbers.

HMOs will claim that that they do not make “health care treatment decisions” and that denial of care is not a medical decision but rather a payment decision. However, denying payment and denying care are

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inextricably linked. House Bill 7032, will, for the first time in Connecticut, give the patient some recourse when that patient is injured when a managed care company fails to exercise due care.

It seems only fair that after living up to their part of the bargain by paying all of the premiums, a patient should have some recourse when an HMO does not live up to their end of the bargain. We hope that you will encourage HMOs to play by the rules by holding them responsible for their decisions.

If managed care companies want to make medical decisions they must live up to the consequences of those decisions. We urge the committees to support House Bill 7032.

**For more information, please contact the
Waterbury Medical Association
Arthur Schuman, Executive Director
Melissa Dempsey, Government Relations
(860) 447-9408**

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Statement in Support of House Bill 7032 –

An Act Concerning the Liability of Health Maintenance Organizations

**Public Health, Judiciary and Insurance and Real Estate Committees
March 23, 1999**

This statement is being submitted on behalf of the New London County Medical Association in strong support of House Bill 7032 – An Act Concerning the Liability of Health Maintenance Organizations.

House Bill 7032 would allow injured individuals to sue their insurers when the insurer fails to exercise ordinary care in making health care treatment decisions. It has become common place that managed care organizations, not the patients' doctors, are making health care treatment decisions. Frequently, it is the managed care organization that decides which medications patients may use, which treatments patients may get, and how long patients may stay in the hospital. Patients are forced to receive inferior medical tests, medication, and treatment.

Currently, patients are allowed to sue their doctors, but not their managed care companies. There is no justification for treating managed care companies differently under the law than other businesses, which can be held accountable for conduct that injures customers. Further, we believe that the threat of litigation will encourage appropriate managed care decisions and encourage better health care for patients.

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NEW LONDON
COUNTY MEDICAL
ASSOCIATION

Statement in Support of House Bill 7032 –

An Act Concerning the Liability of Health Maintenance Organizations

**Public Health, Judiciary and Insurance and Real Estate Committees
March 23, 1999**

This statement is being submitted on behalf of the New London County Medical Association in strong support of House Bill 7032 – An Act Concerning the Liability of Health Maintenance Organizations.

House Bill 7032 would allow injured individuals to sue their insurers when the insurer fails to exercise ordinary care in making health care treatment decisions. It has become common place that managed care organizations, not the patients' doctors, are making health care treatment decisions. Frequently, it is the managed care organization that decides which medications patients may use, which treatments patients may get, and how long patients may stay in the hospital. Patients are forced to receive inferior medical tests, medication, and treatment.

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While opponents of this legislation state that it will result in an explosion of litigation, that is untrue. When there is a bad health care outcome – the lawsuits are already there. This bill would simply allow all involved parties to be named in the suit. If the managed care organization is responsible, it must be held accountable.

HMOs' are making life and death decisions. With the power to make decisions affecting people's lives, comes the responsibility to be held accountable for those decisions. We urge the committees to support House Bill 7032.

**For more information, please contact the
New London County Medical Association
Arthur Schuman, Executive Director
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The introduction of this bill acknowledges that patients deserve the right to sue their HMO when they are proximately injured by a decision made by the HMO. This is especially important since more and more often the managed care company is making the decisions about treatment, medications, and length of hospital stays rather than the physician.

We have heard the argument that this bill will hurt employers and will cause health care costs to skyrocket. This is simply untrue. In fact, in setting costs for one major Texas HMO after a similar law passed in Texas, the actuarial firm of Milliman & Robertson, working on behalf of the HMO, stated that the cost would be a mere 34 cents more per member per month. A study by Kaiser Family Foundation found similar cost factors. We have also heard that this legislation will lead to increased amounts of litigation. This too, is untrue. When there are bad healthcare outcomes, doctors are already sued. This bill would simply allow a patient to name the HMO as a party.

HMOs are making life and death decisions. With the power to affect people's lives, comes the responsibility to be held accountable for those decisions. There is no justification for treating managed care companies differently under the law than other businesses, which can be held accountable for conduct that injures customers. We urge this committee to support House Bill 7032.

**For more information, please contact the
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Statement in Support of House Bill 7032 –

An Act Concerning the Liability of Health Maintenance Organizations

Public Health, Judiciary, and Insurance and Real Estate Committee

March 23, 1999

Good morning, Chairs of the Public Health, Insurance, and Judiciary Committees and committee members. I am Adam Seidner, a family physician practicing in Middletown and the president of the Connecticut Academy of Family Physicians. I am here today on behalf of the family physicians to testify in support of House Bill 7032 – An Act Concerning the Liability of Health Maintenance Organizations.

We applaud the General Assembly for the comprehensive managed care reform package that it passed in 1997. That reform increased patients' rights in the health care industry by creating an outside independent appeals process. This process demonstrated that the legislature recognizes that when making medical treatment decisions, it is possible that managed care organizations may be WRONG. House Bill 7032 takes that point one step further by saying that when a managed care organization does not exercise due care in a making health treatment decision, that managed care organization can be held liable for that decision.



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**Statement of William J. Sweeney, Jr. on behalf of Connecticut Trial Lawyers
and in consultation with Connecticut Citizens Action Group concerning Raised Bills
7032 and 1195, before the Public Health, Judiciary, Insurance and Real Estate
Committees of the Connecticut General Assembly March 23, 1999**

Good Morning:

My name is Bill Sweeney, I am a practicing attorney in New Britain, Connecticut and I was counsel to the Plaintiff doctors and Plaintiff patients in the cases of *Napoletano, et al vs. CIGNA Healthcare of Connecticut, Inc.* and *R. Barrett Hollis, et al vs. CIGNA Healthcare of Connecticut, Inc.* consolidated appeals, 238 Conn. 216, (1996) cert. denied 117 S. Ct 1106 (1997).

I testify in opposition to Raised Bill 7032 (and the identical Raised Bill 1195).

I testify in opposition to these Bills based on the age old legal maxim, "If it ain't broke, don't fix it". I believe that in an attempt to be responsive to constituents' concerns this legislation will not expand patient rights but will in fact restrict them which I do not believe is the desired effect that the legislature intends.

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state action it prevents the action from proceeding in state court where damages are possible and forces the matter into federal court under ERISA which does not permit the award of damages, effectively, denying the litigant its claim for damages for wrongful care or wrongful treatment with regard to health plans. The significance of *Napoletano* and *Moscovitch* is that in both cases the Connecticut Supreme Court in *Napoletano* and the United States District Court by Judge Dronev in *Moscovitch* found ways around the "relates to" language and permitted lawsuits to proceed in the state court.

Napoletano was a case that arose out of physician termination from the CIGNA Healthcare of Connecticut provider list and the resulting suit by *Hollis*, the patients of those doctors. The actions were brought by the doctors and the patients against CIGNA Healthcare of Connecticut alleging state causes of action as a result of CIGNA's unilateral conduct. CIGNA moved to strike the complaint from state court alleging that ERISA preemption.

In permitting the Plaintiff's case to proceed in *Napoletano* and *Hollis* the Court held that:

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The essence of the plaintiffs' claims do not relate to the administration of employee benefit plans. The claims and relief sought do not impermissibly affect the plans--they do not attempt to prescribe the substantive administrative aspects of a plan, such as a determination of an employee's eligibility, the nature and amount of employee benefits, the amount of an employer's contribution to a plan, and the rules and regulations under which the plan operates. The plaintiffs' claims do not require the administrators to operate the plans differently, they do not force a plan to adopt a certain scheme of substantive coverage, they do not tell CIGNA what type of plan to adopt, what coverage to offer, or whom to cover.

Rather than affecting or prescribing the establishment, administration, regulation or maintenance of an employee benefit plan, the plaintiffs' claims merely turn on requiring CIGNA to enforce the benefit plan that it has already established and is maintaining. The Hollis plaintiffs' statutory and common law claims are based on CIGNA's alleged misrepresentations that their physicians chose not to continue as plan providers and that the physicians did not meet the requisite criteria. One of the alleged reasons that the Hollis plaintiffs became or remained members of this plan was because CIGNA had contracted with certain physicians, whose identities they knew based upon the filing that CIGNA was required to make under P.A. 94-235. The Hollis plaintiffs, therefore, could reasonably presume that as long as their physicians continued to meet the credentialing criteria and did not meet any of the reasons for discharge, that they would continue to be providers under the plan. Furthermore, even if P.A. 94-235 did not exist, the Hollis plaintiffs could reasonably expect that their physicians would continue to be providers under the plan for the duration of the physicians' contracts with CIGNA and would not be unilaterally terminated. Similarly, the Napoletano plaintiffs' claims simply assert that CIGNA has failed to enforce the employee benefit plan that it administers.

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The Napoletano plaintiffs reasonably believed that they would continue to be providers under the plan as long as they met the criteria that P.A. 94-235 required that CIGNA provide or for the duration of their contracts. The Napoletano plaintiffs are merely asking that their relationship with CIGNA be managed in accordance with a specific filing that CIGNA has made with the state in which CIGNA was required to indicate the criteria by which it would select and could discharge providers, as well as in accordance with their one year contracts with CIGNA. This is not a case in which the Napoletano plaintiffs seek to force themselves into CIGNA's plan. CIGNA removed the physicians from its list of providers before their contracts had expired and without following the requirements of P.A. 94-235—it did not inform the plaintiff physicians of its criteria for discharge and did not give alternate reasons for discharging them. Neither class of plaintiffs is requesting that CIGNA change the method by which it determines which physicians will be providers under its plan—in other words, the plaintiffs are not claiming that CIGNA should change its list of criteria. Instead, the plaintiffs are merely asking that CIGNA disclose its criteria and, subsequently, adhere to them.

Napoletano at page 244 through page 246.

The language in *Napoletano* is extremely broad and certainly provides a broad berth in which to litigate against HMO's in the State of Connecticut.

In *Moscovitch*, a medical malpractice claim, a case was filed in the state court, it was then removed under 28 United States Code 1441(a) and (b) (1994) to the Federal Court. It was removed to Federal Court where it was alleged that Federal Court had

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exclusive jurisdiction over this case because the claim arose under ERISA (which is as I said earlier provides no monetary relief). The decision that Judge Droney faced was whether or not to remand the case back to the Connecticut Superior Court, the standard being whether or not there was an independent state action which was not preempted by ERISA. Judge Droney ruled that the allegations were of medical negligence and not claims for improper denial of plan benefits and remanded the case back to state court and held that a claim about the quality of a better benefit received under a health plan is not a claim to recover benefits it is due under the terms of a plan. This fine distinction is most important because it provides a basis upon which other Courts can find that medical malpractice cases are not properly removed from Federal Court which is a common tactic of Defendants.

The affect of these two rulings is that in Connecticut State Court and in the Federal District Court we are the recipients of decisions that have very broad consequences and benefit medical consumers.

My review of Raised Bills 7032 and 1195 would indicate that they are mere images

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of Texas Senate Bill 386 the Healthcare Liability Act codified as Tex.Civ.Prac. & Rem. Code Annotated Section 88.00.1 - 88.003 a copy of which is attached as Exhibit A.

The Texas statute was subsequently attacked in the United States District Court for the Southern District of Texas, Houston Division in the case of **Corporate Health Insurance et al vs. The Texas Department of Insurance**, a case where Aetna Health Plans of Texas, Aetna Life Insurance Company joined with Corporate Health Insurance, Inc. to bring a declaratory and injunctive relief requesting that the Texas statute be preempted by ERISA. In that decision (a copy of which is also attached as Exhibit B) the Court discussed the legislation in great lengths in respect with its conflict with ERISA. (The Corporate Health Insurance decision was appealed by the Plaintiffs **Corporate Health and Aetna** to the United States Court of Appeals for the Fifth Circuit. Briefs are due on April 1, 1999, with oral argument yet to be scheduled). It is I believe a pretty good indication of what would happen if in fact the present statute was passed in Connecticut.

In **Corporate Health Insurance**, Judge Vanessa Gilmore found that while the act did not constitute an improper imposition of state law liability it did find certain provisions

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to be preempted by ERISA. The Court preempted Section 88.002(f), Section 88.002(g), Section 88.003(a)(2), Section 88.003(b), Section 88.003(c), Sections of 88.003(d), Sections of 88.003(e)(f and (g) as well as other provisions of Texas state law.

The significance of this ruling is that it shows the uncertainty that faces whatever is done by the Connecticut legislation. If the Texas Court is to be followed verbatim, it would strike Section 2(e), furthermore it would appear also that Sections 3 or 4 would also be subject to be stricken under the Texas ruling. Furthermore, the Texas Court struck 88.002(f) which was one of the primary holdings in *Napoletano*.

I would point you to this uncertainty because I believe it is at the heart of what I said earlier in my remarks that "If it ain't broke, don't fix it". I believe that if in fact legislation is passed without further study, it undoubtedly will be attacked in Federal Court and the results of which are unknown and will likely end up back here for further review. Why leave the safe harbor of *Napoletano*, *Hollis* and *Moscovitch* in exchange for uncertainty of a legal assault on whatever you do.

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As someone who has fought very hard to establish and to protect the rights of providers and consumers of healthcare in the age of managed care I would urge to not act hastily. Your action could very well restrict the rights already achieved in Connecticut.

Accordingly, I would suggest that legislation of this magnitude should properly be referred to a Study Commission or like body in which representative of the various consumer, medical, hospital and insurance interests be assigned representatives with the hope of resolving some of the obvious issues that arise from this legislation. This will also allow us to see what the Fifth Circuit does with *Corporate Health Insurance* as well as what Congress does with ERISA Preemption.

I would be happy to answer any questions from either any of the Senators or Representatives or their staff in public or private if you so desire.

Thank you for your attention.

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Appendix A

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§ 88.001 CIV. PRAC. & REM.. Definitions

In this chapter:

(1) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession and community.

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care plan" means any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services.

(4) "Health care provider" means a person or entity as defined in Section 1.03(a)(3), Medical Liability and Insurance Improvement Act of Texas (Article _____, Vernon's Texas Civil Statutes).

(5) "Health care treatment decision" means 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.

(6) "Health insurance carrier" means an authorized insurance company that issues policies of accident and sickness insurance under Section 1, Chapter 397, Acts of the 54th Legislature, 1955 (Article _____, Vernon's Texas Insurance Code).

(7) "Health maintenance organization" means an organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(8) "Managed care entity" means 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.

(9) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article _____, Vernon's Texas

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Civil Statutes) or a nonprofit health corporation certified under Section 5.01, Medical Practice Act (Article 4400c, Texas Civil Statutes, Vernon's Texas Civil Statutes); or

(C) another person wholly owned by physicians.

(10) "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or **managed care** entity, that degree of care that a health insurance carrier, health maintenance organization, or **managed care** entity of ordinary prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or **managed care** entity, "ordinary care" means 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.

Added by Acts 1997, 75th Leg., ch. 163, § 1, eff. Sept. 1, 1997.

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§ 88.002 CIV. PRAC. & REM.. Application

(a) A health insurance carrier, health maintenance organization, or other **managed care** entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise such ordinary care.

(b) A health insurance carrier, health maintenance organization, or other **managed care** entity for a health care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

- (1) employees;
- (2) agents;
- (3) ostensible agents; or
- (4) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other **managed care** entity for a health care plan that:

(1) neither the health insurance carrier, health maintenance organization, or other **managed care** entity, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurance carrier, health maintenance organization, or other **managed care** entity is liable under Subsection (b), controlled, influenced, or participated in the health care treatment decision; and

(2) the health insurance carrier, health maintenance organization, or other **managed care** entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other **managed care** entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity.

(e) This chapter does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by the State Board of Pharmacy that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurance carrier, health maintenance organization, or **managed care** entity may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurance carrier, health maintenance organization, or other **managed care** entity may not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other **managed care** entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

(h) Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other **managed care** entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurance carrier, health maintenance organization, or other **managed care** entity in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurance carrier, health maintenance organization, or **managed care** entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of such health insurance carrier, health maintenance organization, or **managed care** entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

(j) This chapter does not apply to workers' compensation insurance coverage as defined in Section 401.011 CIV. PRAC. & REM., Labor Code.

(k) An enrollee who files an action under this chapter shall comply with the requirements of Section 13.01, Medical Liability and Insurance Improvement Act of Texas (Article Vernon's Texas Civil Statutes), as it relates to cost bonds, deposits, and expert reports.

Added by Acts 1997, 75th Leg., ch. 163, § 1, eff. Sept. 1, 1997.

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§ 88.003 CIV. PRAC. & REM.. Limitations on Cause of Action

(a) A person may not maintain a cause of action under this chapter against a health insurance carrier, health maintenance organization, or other **managed care** entity that is required to comply with the utilization review requirements of Article 21.58A, Insurance Code, or the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by Subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under Article _____, Insurance Code, as required by Subsection (c).

(b) The notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or **managed care** entity against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or **managed care** entity against whom the claim is made requests the review not later than the 14th day after the date notice under Subsection (a)(2)(A) is received by the health insurance carrier, health maintenance organization, or **managed care** entity. If the health insurance carrier, health maintenance organization, or **managed care** entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (a).

(e) The enrollee is not required to comply with Subsection (c) and no abatement or other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or **managed care** entity or because of an act or omission of an employee, agent, ostensible agent, or representative of such carrier, organization, or entity for whose conduct it is liable under Section (b); and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant carrier, organization, or entity finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by Subsection (a), before the statute of limitations applicable to a claim against a **managed care** entity has expired, the limitations period is tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a) (2) (A).

(g) This section does not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

Added by Acts 1997, 75th Leg., ch. 163, § 1, eff. Sept. 1, 1997.

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Appendix B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

CORPORATE HEALTH INSURANCE
INC., ET AL.

versus CIVIL ACTION NO. H-97-2072

THE TEXAS DEPARTMENT OF
INSURANCE, ET AL.

ORDER

Pending before the Court are Defendants' motion to dismiss, which has been converted into a motion for summary judgment, (Instrument No. 10), and Plaintiffs' motion for judgment, (Instrument No. 20). Based on the parties' submissions and the applicable law, the Court finds that Defendants' and Plaintiffs' motions should be GRANTED in PART and DENIED in PART.

I. Background

Plaintiffs Corporate Health Insurance, Inc., Aetna Health Plans of Texas, Inc., Health Plans of North Texas, Inc., and Aetna Life Insurance Company bring this action against Defendants Texas Department of Insurance (the "Department") and Elton Bomer ("Bomer"), Commissioner of the Texas Department of Insurance, and Dan Morales ("Morales"), Attorney General of the state of Texas, in their official capacities, seeking declaratory relief. Plaintiffs request a declaration that Texas Senate Bill 386, the Health Care Liability Reform Act ("Act"), codified as Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-88.003 (West 1998), which adds or amends Tex. Ins. Code Ann. arts. 20A.09, 20A.12, 20A.12A, 21.58A, and 21.58C (West 1998), is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.A. § 1001 et seq. (West 1985 & Supp. 1998), and by the Federal Employees Health Benefit Act ("FEHBA"), 5 U.S.C.A. § 8901 et seq. (West 1967 & Supp. 1996). Plaintiffs also seek, if necessary, to enjoin the enforcement of the Act as applied to employee benefit plans covered by ERISA and FEHBA.

The Act allows an individual to sue a health insurance carrier, health maintenance organization, or other managed care entity for damages proximately caused by the entity's failure to exercise ordinary care when making a health care treatment decision. Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (West 1998). In addition, under the Act, these entities may be liable for substandard health care treatment decisions made by their employees, agents, or representatives. Id. § 88.002(b). The Act also establishes an independent review process for adverse benefit determinations and requires an insured or enrollee to submit his or her claim to the independent review organization if such a review is requested by the managed care entity. Id. § 88.003(c). Additional responsibilities for HMOs and further requirements concerning the review of an adverse benefit determination by an independent review organization are also addressed by the Act. Tex. Civ. Prac. & Rem. Code Ann. arts. 20A.09, 20A.12, 20A.12A, 21.58A, and 21.58C (West 1998).

On July 21, 1997, Defendants filed a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim and to dismiss Plaintiffs' suit against the Department and Bomer as improper parties. Defendants argue that dismissal is appropriate for the following reasons:

Senate Bill 386 regulates the quality of care provided by the HMO(s) operating under ERISA and FEHBA, in contrast, govern what types of regulations may be placed on an employer's employee benefit plan. The plain meaning of the statute shows that the purpose of Senate Bill 386 is to prevent health plans from escaping liability for the medical decisions they "make," "control" or "influence." Senate Bill 386 does not seek to regulate the structure of a benefit plan. Accordingly, the ERISA and FEHBA preemption clauses do not apply to Senate Bill 386.

(Defendants' Summary of Argument, Instrument No. 25 at 1). If the Court were to determine that certain provisions of the Act relate to employee welfare benefit plans, Defendants would seek to sever any "non-liability" provisions of the Act that it finds to be preempted, and to preserve the quality of care liability provisions. (Defendants' Reply, Instrument No. 24 at 8 n. 1). Defendants also contend that the Eleventh Amendment bars suit against both the Texas Department

Insurance and Bomer because the state of Texas is immune from suit. Furthermore, as to Defendants, there is "a real question" as to whether Elton Bomer is a proper party to Plaintiffs' allegations in their complaint. (Defendants' Brief, Instrument No. 11)

On July 29, 1997, Plaintiffs filed a motion for summary judgment, contending that "impermissibly interferes with the purpose, structure and balance of ERISA and FEHA by injecting state law into an area exclusively reserved for Congress." (Plaintiffs' Argument, Instrument No. 21 at 1). Plaintiffs contend that the language in the Act "refers to" ERISA plans, and that the Act has a connection with ERISA plans because it imposes state law liability on ERISA entities and to mandate the structure of their administration. Plaintiffs also maintain that the Act wrongfully binds employer administrators to particular choices and impermissibly creates an alternate enforcement mechanism.

On April 24, 1998, the Court held a hearing on Defendants' motion to dismiss a Plaintiffs' motion for summary judgment. At the hearing, the Court informed the parties that Defendants' motion to dismiss would be converted into a motion for summary judgment. On May 15, 1998, Plaintiffs filed their First Amended Complaint for Declaratory Judgment and Permanent Injunction, adding Morales as a defendant in this case.

II. 12(b)(6) Motion to Dismiss Standard of Review

Rule 12(b)(6) allows for dismissal if a plaintiff fails "to state a claim upon which relief may be granted[.]" Fed. R. Civ. P. 12(b)(6). Such dismissals, however, are rare, *Amoco Prod. Co.*, 794 F.2d 967, 970 (5th Cir. 1986), and only granted where "it appears to the court that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-6, 78 S. Ct. 99, 102 (1957). Dismissal is based either on a lack of a cognizable legal theory or the absence of sufficient facts to support a cognizable legal theory. *Balistreri v. Pacifica Police Dept.*, 901 F.2d 696, 699 (5th Cir. 1994); *Vines v. City of Dallas, Texas*, 851 F. Supp. 254, 259 (N.D. Tex. 1994).

In determining whether a dismissal is warranted pursuant to Rule 12(b)(6), the court must accept as true all allegations contained in the plaintiff's complaint. *Gargiul v. Kaiser Aluminum & Chem. Sales, Inc. v. Avondale Shipyards, Inc.*, 677 F.2d 1045, 1050 (5th Cir. 1982). In addition, all reasonable inferences are to be drawn in favor of the plaintiff. *Kaiser Aluminum*, 677 F.2d at 1050. "To qualify for dismissal under Rule 12(b)(6), a complaint must on its face show a bar to relief." *Clark*, 794 F.2d at 970.

If the court, in its discretion, accepts for consideration matters that are beyond the pleadings then the motion to dismiss is converted into a motion for summary judgment. Rule 12(b) states, in pertinent part, that:

[i]f, on a motion asserting the defense numbered (6) to dismiss for failure to state a claim upon which relief can be granted, matters outside the pleadings are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56 Fed. R. Civ. P. 12(b). A court is more likely to consider matters outside the pleadings if "extra-pleading material is comprehensive and will enable a rational determination of the motion." *Isquith ex rel. Isquith v. Middle South Utilities, Inc.*, 847 F.2d 1366 (5th Cir. 1988) (quoting 5 C. Wright & A. Miller, *Federal Practice and Procedure* §36:1366 (1969)). However, the Court is unlikely to do so when it is scanty, incomplete and inconclusive. *Id.*

The court must give all parties notice of such a conversion and provide them with an opportunity both to be heard and to present further materials in support of their motion. *Nowlin v. Resolution Trust Corp.*, 33 F.3d 498, 504 (5th Cir. 1994). Following conversion, the court should permit the parties to engage in discovery as appropriate on the converted motion. *Washington v. Allstate Ins. Co.*, 901 F.2d 1281 (5th Cir. 1994).

In this case, having received for consideration matters that are beyond the pleadings such as affidavits, contracts for health benefit plans, and statistical data, the court converted Defendants' motion to dismiss into a motion for summary judgment. Given that Plaintiffs subsequently filed a motion for summary judgment on the same issues, Plaintiffs had ample notice that the case may be decided at this stage on the merits. Furthermore, at the hearing held on April 24, 1998, the Court informed the parties of its intention to convert Defendants' motion into a motion for summary judgment. The parties also had an opportunity to be heard at the hearing and to present any additional evidence. They had sufficient notice of the conversion.

III. Summary Judgment Standard

Summary judgment is appropriate if no genuine issue of material fact exists and a party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56. A fact is "

resolution in favor of one party might affect the outcome of the suit under governi Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247, 106 S. Ct. 2505, 2510 (1986). "genuine" if the evidence is sufficient for a reasonable jury to return a verdict f party. Id. If the evidence rebutting the motion for summary judgment is only colc significantly probative, summary judgment should be granted. Id. at 249-50, 106 S. see Lewis v. Glendel Drilling Co., 898 F.2d 1083, 1088 (5th Cir. 1990).

Under Rule 56(c) of the Federal Rules of Civil Procedure, the moving party bea initial burden of informing the district court of the basis for its belief that the a genuine issue for trial and for identifying those portions of the record that dem absence. Matsushita Elec. Ind. Co. v. Zenith Radio Corp., 475 U.S. 574, 586-87, 10 1348, 1355-56 (1986); Leonard v. Dixie Well Serv. & Supply, Inc., 828 F.2d 291, 294 1987).

Where the moving party has met its Rule 56(c) burden, the nonmovant "must do n simply show that there is some metaphysical doubt as to the material facts . . . [T party must come forward with 'specific facts showing that there is a genuine issue Matsushita, 475 U.S. at 586-87, 106 S. Ct. at 1356 (quoting Fed. R. Civ. P. 56(e)) original); Celotex Corp. v. Catrett, 477 U.S. 317, 322-23, 106 S. Ct. 2548, 2552 (1 Leonard, 828 F.2d at 294. To sustain the burden, the nonmoving party must produce admissible at trial. Anderson, 477 U.S. at 255, 106 S. Ct. at 2514; Thomas v. Pric 231, 235 (5th Cir. 1992) ("To avoid a summary judgment, the nonmoving party must ac admissible evidence which creates a fact issue. . . .").

IV. Improper Parties

Defendants argue that the Department and Bomer are improper parties to this su (Defendants' Motion, Instrument No. 10 at 10; Defendants' Reply, Instrument No. 24 First, Defendants contend that the Eleventh Amendment bars suit against both partie Eleventh Amendment provides that "[t]he judicial power of the United States shall r construed to extend to any suit in law or equity, commenced or prosecuted against c United States by citizens of another state or by citizens or subject of any foreign Const. amend. XI. In addition, the Eleventh Amendment "bars suit against a state e regardless of whether money damages or injunctive relief is sought. In determining entity is entitled to . . . immunity, [the court] . . . 'must examine the particula and its powers and characteristics as created by state law. . . .'" Voisin's Oyster Guidry, 799 F.2d 183, 186 (5th Cir. 1986) (quoting Laje v. R.E. Thomason Gen. Hosp. 724, 272 (5th Cir. 1982)).

Several factors are considered in determining whether an agency is an arm of t including: (1) whether state statutes and case law view the agency as an arm of the source of the entity's funding; (3) whether the entity is concerned with local or s problems; (4) the degree of the agency's authority which is independent from the st whether the entity can sue and be sued in its own name; and (6) whether it has the and use property. Guidry, 799 F.2d at 186-87. "Positive answers to the latter two mitigate against an entity's being an alter ego of the State and thus against Eleve immunity." Correa v. City of Bay City, 981 F. Supp. 477, 479 (S.D. Tex. 1997).

The Department is clearly a state agency, created by the laws of the state of Tex. Ins. Code Ann. art. 1.01 et. seq. (West 1998); El Paso Elec. Co. v. Texas Dep' 937 S.W.2d 432, 434 (Tex. 1996). Its primary responsibility is "to regulate the bu insurance in this state." Tex. Ins. Code Ann. art. 1.01A (West 1998). The Departr executive branch of the state government, and is controlled by an executive officer Commissioner, who is appointed by the Department with the advice and consent of the Texas. Id. art. 1.09. Several members of the Department, such as deputies, assist personnel, are appointed by the Commissioner. Id. art. 1.02. All of the above fac finding that the Department is an arm of the State of Texas and therefore entitled Amendment immunity. See Correa, 981 F. Supp. at 479. Consequently, the Court DISM the Department from this lawsuit.

With respect to state officials, "'a gaping hole in the shield of sovereign in by the [E]leventh [A]mendment and the Supreme Court' is the doctrine" of Ex Parte Y U.S. 123, 28 S. Ct. 441 (1908). Saitz v. Tennessee Dep't of Employment Sec., 976 F (5th Cir. 1992) (quoting Brennan v. Stewart, 834 F.2d 1248, 1252 (1988)). Under th Young doctrine, "a federal court, consistent with the Eleventh Amendment, may enjo officials to conform their future conduct to the requirements of federal law, even injunction may have an ancillary effect on the state treasury." Quern v. Jordan, 4 337, 99 S. Ct. 1139, 1143 (1979). "The essential ingredients of the Ex Parte Young that a suit must be brought against individual persons in their official capacities state and the relief sought must be declaratory or injunctive in nature and prospec

Saltz, 976 F.2d at 968 (footnote omitted); see also *Cigna Healthplan of La. v. Loui* 642, 644 n.1 (5th Cir. 1996) (recognizing "the federal courts have jurisdiction to state officials where, as here, the plaintiffs seek only prospective declaratory or to prevent a continuing violation of federal law").

In this case, Plaintiffs have sued Bomer in his official capacity and also seek injunctive relief, not monetary damages. Therefore, Defendants' argument that suit is barred by the Eleventh Amendment fails.

Second, Defendants argue that "[t]here may be a real question whether Commissioner Bomer is a proper party" based on the Plaintiffs' allegations in their complaint. Brief, Instrument No. 11 at 38 n.37). According to Defendants, Plaintiffs' "only a . . . [regarding Bomer's] official administrative capacity . . . [concerns] his response enforcing state insurance law. The only role for the Commissioner in Senate Bill 3 approve IROs (independent review organization) and it is very unclear whether . . . alleging [that] the IRO procedures are preempted." (Id. at 38 n.37). In response, maintain that Bomer is a proper party to this suit because as the Commissioner, Bomer responsible for ensuring compliance with . . . the establishment and supervision of review organizations." (Plaintiffs' Motion, Instrument No. 20 at 5). The Court agrees with Plaintiffs' contention.

Clearly, Plaintiffs contest the inclusion of the IRO provisions in the Act. Plaintiffs state that the "IRO procedure improperly affects the administration of health plans, and is therefore an unwarranted extension into an area governed by ERISA. . . either directly or indirectly, HMOs and PPOs will incur costs in connection with the use of IROs under the Act, thereby also supporting a finding of preemption." (Plaintiff Instrument No. 20 at 17 n.17). Plaintiffs elaborated on this position at the hearing on 24, 1998. (Transcript, Instrument No. 60 at 21). Furthermore, Defendants concede that the Commissioner, is responsible for approving the IRO procedure. (Defendants' Instrument No. 11 at 38 n.37).

Moreover, Defendants do not provide the Court with any authority for their position that Bomer is an improper party to this suit. On the contrary, the Commissioner of Insurance has been named as a defendant in other cases similar to the instant case: *NGS Am., Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993) (enjoining the Commissioner of Insurance for the state of Texas from enforcing a Texas statute that was preempted by ERISA); *Inc. v. Pogue*, 929 F.2d 1100 (5th Cir. 1991) (holding that the Texas Administrative Code was preempted by ERISA and enjoining the Commissioner of Insurance from collecting tax); *Texas Commerce Bancshares, Inc. v. Barnes*, 798 F. Supp. 1286 (W.D. Tex. 1992) (examining plaintiff's award of attorney fees and costs in ERISA preemption action against the Commissioner of Insurance). Consequently, given Bomer's role with the IRO procedure in other cases where the Commissioner has been named as a defendant, the Court finds that Bomer is a proper party to this suit.

V. Insurance Savings Clause

Plaintiffs claim that the Act is preempted by ERISA. Thus, as an initial matter, the Court will examine whether the Act is saved from preemption by ERISA's insurance savings clause.

ERISA provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities." ERISA § 1144(b)(2)(a) (West 1985) (emphasis added). The Supreme Court "delineated the test that a state statute must meet in order to come within the insurance facet of the savings clause in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 741-47, 105 S. Ct. 2333 (1985). The Supreme Court in *Metropolitan Life* took the following conjunctive two-step approach:

First, the [C]ourt determined whether the statute in question fitted the definition of insurance regulation. Second, it looked at three factors: (1) whether the practice (the statute) has the effect of spreading policyholders' risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. If the statute fitted the common sense definition of insurance regulation and the court answered "yes" to each of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.

In *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 107 (5th Cir. 1993) (footnote omitted), the court applied the test and found that the statute fit the common sense definition of insurance regulation or to satisfy any one element of the three-factor *Metropolitan Life* test is not exempt from preemption by the ERISA insurance savings clause." *Cigna*, 82 F.3d 1038, 1044 (5th Cir. 1994).

When the Court begins to apply this test to the Act, it can both start and finish with the third factor of the *Metropolitan Life* test: on its face, the Act is obvious

to entities within the insurance industry." Even though the Act lists health insurance one group covered by its terms, it also specifies that it applies to health maintenance or other managed care entities for a health care plan. Tex. Civ. Prac. & Rem. Code § 88.002(a) (West 1998). As the Act fails to meet the third factor of the Metropolitan the Court finds that the statute is not saved from preemption by the insurance exception 514(b) of ERISA. See *Cigna*, 82 F.3d at 650 (holding that Louisiana's Any Willing F statute was not exempt from preemption by ERISA's savings clause because the statute limited to entities within the insurance industry).

VI. ERISA Preemption

Having determined that the Act is not saved by the insurance savings clause, must next examine whether the Act is preempted by Section 514(a) of ERISA.

Section 514(a) governs the preemption of state laws by ERISA. More specifically 514(a) provides that ERISA "shall supersede any and all State laws insofar as they any employee benefit plan" 29 U.S.C.A. § 1144(a) (West 1985) (emphasis added). ERISA preemption analysis, a state law relates to an ERISA plan if it has a connection reference to such a plan. *Cigna*, 82 F.3d at 647.

If the Court determines that certain portions of a state statute are preempted therefore, contravene federal law, then the Court may sever those portions from the provided that their invalidity does not affect the remainder of the statute. *Texas v. Prudential Ins. Co. of Am.*, 105 F.3d 1035, 1039 (5th Cir. 1997). The Court's decision to sever a statute is also based on whether or not that state statute has a provision nonseverability. *Id.*

Since pre-emption turns on Congress's intent, the court must begin "with the text provision in question, and move on, as need be, to the structure and purpose of the it occurs." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers* 514 U.S. 645, 655, 115 S. Ct. 1671, 1676 (1995). "A facial challenge to a legislative course, the most difficult challenge to mount successfully, since the challenger must no set of circumstances exists under which the Act would be valid." *U.S. v. Salerno* 739, 745, 107 S. Ct. 2095, 2100 (1987). Thus, in this case, the Court must determine any claims brought under the Act would relate to an employee benefit plan and would be preempted by Section 514(a) of ERISA.

A. What is an ERISA Plan?

First, the Court must examine what constitutes an ERISA plan. An employee welfare benefit plan (which includes health benefits plans), is defined as:

any plan, fund, or program which was heretofore or is hereafter established by an employer or by an employee organization, or by both to the extent that a fund, or program was established or is maintained for the purpose of providing participants or their beneficiaries, through the purchase of insurance or other medical, surgical, or hospital care or benefits, or benefits in the event of an accident, disability

29 U.S.C.A. § 1002(1) (West Supp. 1998) (emphasis added). The first phrase plan, if program has been interpreted as requiring an "ongoing administrative program" on the part of the employer. See *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11, 107 S. Ct. 22 (1987). A "plan, fund, or program" under ERISA is established if "from the surrounding circumstances a reasonable person can ascertain the intended benefits, class of beneficiaries, source of financing, and the procedures for receiving benefits." *Donovan v. Dillier* 1367, 1371, 1373 (11th Cir. 1982); see *Peckham v. Gem State Mut. of Utah*, 964 F.2d 1047-48 (7th Cir. 1992). The administrative program, however, need not be elaborated 964 F.2d at 1048.

The second phrase of the definition established or maintained by an employer is designed to distinguish situations in which the employer merely acts as a marketer of an insurance policy to individual employees (in which case no ERISA exists), from the situation in which the employer financially pays for some or plan and/or otherwise is involved in its administration (e.g. defining and administering employee eligibility, or listing the plan as a benefit of employment).

Rand Rosenblatt, Law and the American Health Care System 190 (Supp. 1998). In particular, this second phrase is designed to "ensure that the plan is part of an employment relationship. . . . [This] requirement seeks to ascertain whether the plan is part of an employment relationship by looking at the degree of participation by the employer in the establishment and maintenance of the plan." *Peckham*, 964 F.2d at 1049.

In *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993), the Fifth Circuit

its "comprehensive test for determining whether a particular plan qualifies as an 'welfare benefit plan'" under ERISA. Under Meredith, the test requires the full analysis of whether a plan: (1) exists; (2) falls within the safe-harbor provision of the Department of Labor; and (3) satisfies the primary elements of an ERISA "employee benefit plan" establishment or maintenance by an employer intending to benefit employees. If any part of the inquiry is answered in the negative, the submission is not an ERISA plan. . . . [The Court's] analysis is informed by reference to ERISA including germane indications of congressional intent, and to the extent Congress failed to state its intention on the precise issue in question, we refer to the interpretations by the agency charged with administering the statute the Department of Labor.

Id. Furthermore, ERISA does not regulate "bare purchases of health insurance where the purchasing employer neither directly or indirectly owns, controls, administers or has a responsibility for the policy or its benefits." *Taggart Corp. v. Life & Health Ben. Inc.*, 617 F.2d 1208, 1211 (5th Cir. 1980). Thus, in this case, the Court must determine whether the provisions of the Act relate to any employee benefit plan as defined by Meredith.

In this case, Defendants make the following argument:

[Plaintiff] Aetna blurs the distinction between an ERISA plan (established by an employer to provide benefits to an employee) and a health plan (established by health insurance entities as a vehicle for bearing the risks of health insurance and providing health insurance to those employees). Aetna admits plaintiffs offer products in the form of managed health care coverage to employees who are enrolled in ERISA and FEHBA in Texas. Aetna may operate as a 'health plan,' but Aetna is not an ERISA plan established by an employer.

(Defendants' Reply, Instrument No. 24 at 1). In essence, Defendants argue that plaintiffs are operating health plans, but that they are not operating ERISA plans that would be protected by ERISA. The Court agrees.

The Act expressly regulates health insurance carriers, health maintenance organizations and managed care entities by specifically addressing their health plans and not the health plans of employers. Under the Act, "[a] health insurance carrier, health maintenance organization or other managed care entity for a health care plan has the duty to exercise ordinary care in making health care treatment decisions and is liable for harm to an insured or enrollee caused by its failure to exercise such ordinary care." *Tex. Civ. Prac. & Rem. Code* § 88.002(a) (West 1998). A health insurance carrier "means an authorized insurance company that issues policies of accident and sickness" under Article 3.70-1 of the Texas Insurance Code. *Tex. Civ. Prac. & Rem. Code Ann.* § 88.001(6) (West 1998). A health maintenance organization includes "organization[s] licensed under the Texas Health Maintenance Act[.]" *Id.* § 88.001(7). A managed care entity under the Act is defined as

any entity which delivers, administers, or assumes risk for health care services through systems or techniques to control or influence the quality, accessibility, utilization 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 employer or more subsidiaries or affiliated corporations of the employer or a pharmacy or the State Board of Pharmacy.

Id. § 88.001(8) (emphasis added).

The health plans provided by health insurance carriers, health maintenance organizations or managed care entities, as previously defined, and the health care entities themselves constitute ERISA plans because the third inquiry under the Fifth Circuit's test whether the plan satisfies the primary elements of an ERISA "employee benefit plan" must be answered negatively. Plaintiffs admit that they "offer products in the form of managed health care to employees who are enrolled in ERISA and FEHBA plans in Texas." (Plaintiffs' Motion Instrument No. 20 at 3). Plaintiffs and the coverage provided by them, however, are not established or maintained by an employer.

Plaintiffs concede that they fall "within the term 'managed care entity' as defined in the Act[.]" (*Id.* at 4). A managed care entity does not include "an employer purchasing coverage on behalf of its employees[.]" *Tex. Civ. Prac. & Rem. Code Ann.* § 88.001(8) (1998). Therefore, by definition, plaintiffs and the managed health care plans that they provide would not satisfy the primary elements of an ERISA employee benefit plan because they are not established or maintained by an employer. Rather, plaintiffs are medical service providers for ERISA plans and their members. Plaintiffs operate health plans rather than ERISA employee benefit plans. Consequently, the Court finds that plaintiffs and the particular arrangements for services provided by them, that are addressed under the Act, are not ERISA employee benefit plans since the coverage is not established or maintained by an employer. See *Cigr*

648 (recognizing that Plaintiffs, an HMO and a health insurer, were not ERISA plans Washington Physicians Serv. Ass'n v. Gregoire, No. 97-35536, 1998 WL 318759, *3 (9th Cir. 1998) (stating that the statute makes it clear that the term "health plans" "refers by the health carrier (e.g., an HMO), not the benefit plan offered by the employer" U.S. Healthcare, 57 F.3d 350, 356 (3d Cir. 1995) (noting the Department of Labor's that plaintiff's claims merely attacked "the behavior of an entity completely external to the plan") [the HMO]).

Nonetheless, Plaintiffs argue that the fact that Aetna is not an ERISA health plan is of no significance to the preemption analysis." (Plaintiffs' Surreply, Instrument No. 33) Plaintiffs rely on Cigna Healthplan of La., Inc. v. Louisiana, 82 F.3d 642 (5th Cir. 1996), for their argument.

In Cigna, CIGNA Healthplan of Louisiana ("CIGNA"), a licensed HMO, and Connect General Life Insurance Company ("CGLIC"), a licensed health insurer, filed suit against Ieyoub, the Attorney General of the state of Louisiana, seeking a declaratory judgment that Louisiana's Any Willing Provider statute was preempted by ERISA. 82 F.3d at 644. The court held that the Any Willing Provider statute . . . mandate[d] that '[n]o licensed provider . . . who agrees to terms and conditions of the preferred provider contract . . . [could] be denied the status of a preferred provider.'" Id. at 645 (quoting La. Rev. Stat. Ann. § 40:2202(5)(c)). The Fifth Circuit concluded that the statute was preempted by ERISA both because it excluded ERISA-qualified plans by including certain enumerated entities, and because it had the effect of interfering with such plans by mandating that "certain benefits available to ERISA plans . . . be provided in a particular manner." Id. at 648-49.

Since the Court found that the statute in Cigna directly affected benefits provided under the plan, the Court did not have to examine whether or not CIGNA or CGLIC was an ERISA plan. Rather, the Court based its decision on the substantial effect that the statute had on insured plans. Id. at 648. The Court, however, did remark that the fact that CIGNA and CGLIC were not themselves ERISA plans was inconsequential. Id. at 648. It made this statement while discussing the statute's "connection with" ERISA plans. Id. The Court further explained that CIGNA's and CGLIC's status was inconsequential because:

[b]y denying insurers, employer, and HMOs the right to structure their benefits in a particular manner, the statute [wa]s effectively requiring ERISA plans to purchase a particular structure when they contract with organizations like CIGNA and CGLIC. In that regard, the statute "b[ore] indirectly but substantially on all insured plans" [wa]s accordingly preempted by ERISA.

Id. at 648-49 (quoting Metropolitan Life, 471 U.S. at 739, 105 S. Ct. at 2389).

In accordance with Cigna, the Court finds that whether or not Plaintiffs in this case are ERISA plans is inconsequential because, under current Fifth Circuit law, certain sections of the Act, as discussed below, "relate to" ERISA employee benefit plans.

B. "Relates To" Analysis

A state law relates to an ERISA plan "in the normal sense of the phrase if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 289, 299-300 (1983) (emphasis added). The Supreme Court has given the phrase "relates to" a "broad common-sense meaning." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 107, 117 (1987). Under this definition,

A state law can relate to an ERISA plan even if that law was not specifically designed to affect such plans, and even if its effect is only indirect. If a state law does concern employee benefit plans, it will be preempted insofar as it applies to ERISA plans in particular cases. . . .

Cigna, 82 F.3d at 647. "The most obvious class of pre-empted state laws are those specifically designed to affect ERISA-governed employee benefits plans." Corcoran v. HealthCare, Inc., 965 F.2d 1321, 1328 (5th Cir. 1992).

In determining whether a state law "relate[s] to" an ERISA plan, the Supreme Court has adopted a pragmatic approach. See Travelers, 514 U.S. 645 at 654-57, 115 S. Ct. at 1677. In Travelers, the Court stated that it "must go beyond the unhelpful text [of Section 514] and look to the frustrating difficulty of defining its key term ['relates to'], and look instead to the ERISA statute as a guide to the scope of the state law that Congress intended to survive [preemption]." 514 U.S. at 656, 115 S. Ct. at 1677.

As stated by the Court in New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., in passing Section 514,

Congress intended 'to ensure that plans and plan sponsors would be subject to the body of benefits law; the goal was to minimize the administrative and financial burdens on the

of complying with conflicting directives among States or between States and the Government . . . , [and to prevent] the potential for conflict in substantive

requiring the tailoring of plans and employer conduct to the peculiarities of state jurisdiction.'

514 U.S. at 656, 115 S. Ct. at 1677 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 142, 111 S. Ct. 478, 484 (1990)). Therefore, "[t]he basic thrust of . . . [ERISA] clause . . . was to avoid a multiplicity of regulation in order to permit the national administration of employee benefit plans." *Travelers*, 514 U.S. at 657, 115 S. Ct.

Although the text of Section 514(a) is clearly expansive, in so far as it affects that relate to ERISA plans, the phrase "relate[s] to" does not "extend to the further indeterminacy[.]" *Id.* at 655, 115 S. Ct. at 1677. If that were the case, "then for purposes pre-emption would never run its course" and courts would be required "to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption of the law whenever Congress speaks to the matter with generality." *Id.* Thus, in ERISA's "relate[s] to" language was not "intended to modify 'the starting presumption that Congress does not intend to supplant state law'" which falls within areas of traditional state regulation. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 117 S. Ct. 1747, 1751-52 (1997) (quoting *Travelers*, 514 U.S. at 654-55, 115 S. Ct. at 1676).

"The historic powers of the State include the regulation of matters of health care. *De Buono*, 520 U.S. at 806, 117 S. Ct. at 1751-52 (citing *Hillsborough County v. Auton. Lab., Inc.*, 471 U.S. 707, 716, 105 S. Ct. 2371, 2376 (1985)). The Act, in this case, regulates the medical decisions of health insurance carriers, health maintenance organizations, and managed care entities, see *Tex. Civ. Prac. & Rem. Code Ann.* § 88.002 (West 1998), and therefore, clearly operates in a field that has been traditionally occupied by the States. The federal law is said to bar state action in fields of traditional state regulation, "work on the 'assumption that the historic police powers of the States were not to be displaced by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Travelers*, 514 U.S. at 654-55, 115 S. Ct. at 1676 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 67, 69, 67 S. Ct. 1146, 1152 (1947)). Consequently, Plaintiffs "bear the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 520 U.S. at 806, 117 S. Ct. at 1752.

1. "Reference To"

Under the "reference to" inquiry, the Supreme Court has "held preempted a law that imposed requirements by reference to [ERISA] covered programs, . . . a law that exempted ERISA plans from an otherwise generally applicable garnishment provision, a common-law cause of action premised on the existence of an ERISA plan." *California Labor Standards Enforcement, N.A., Inc. v. Dillingham Constr.*, 519 U.S. 316, 117 S. Ct. 832, 837-38 (1997) (citations omitted) (quoting *District of Columbia v. Greater Wash. of Trade*, 506 U.S. 125, 131, 113 S. Ct. 580, 584 (1992)). Thus, "[w]here a State's law is essential to the law's operation . . . that 'reference' will result in pre-emption." *De Buono*, 520 U.S. at 806, 117 S. Ct. at 838.

In *Travelers*, the Supreme Court examined New York statutes that imposed "surcharges on bills of patients whose commercial insurance coverage [wa]s purchased by employee health care plans governed by ERISA and . . . on HMOs insofar as their membership fees . . . were paid by an ERISA plan." 514 U.S. at 649, 115 S. Ct. at 1673-74. Notably, the surcharge on HMOs was "not an increase in the rates to be paid by an HMO to a hospital, but a direct charge by the HMO to the State's general fund." *Id.* at 650, 115 S. Ct. at 1674. The Court held that the "surcharge statutes . . . [could not] be said to make 'reference to' ERISA plans in part because the surcharges were 'imposed upon patients and HMOs, regardless of whether the coverage was commercial or membership, respectively, [wa]s ultimately secured by an ERISA plan, private purchase, or otherwise[.]'" *Id.* at 656, 115 S. Ct. at 1677.

Similarly, in this case, the Act imposes a standard of ordinary care directly on health insurance carriers and health maintenance organizations when making health care treatment decisions, regardless of whether the commercial coverage or membership therein is secured by an ERISA plan. See *Tex. Civ. Prac. & Rem. Code* § 88.001-88.002 (West 1998). The Act also requires managed care entities to exercise ordinary care when making treatment decisions. *Id.* § 88.002(a). However, as already mentioned, the Act specifically excludes ERISA plans from the definition of a "managed care entity." See *id.* § 88.001(8). Section

the Texas Civil Practice and Remedies Code, as added by the Act, provides that a "n entity" does not include "an employer purchasing coverage or acting on behalf of it Id. Consequently, as in Travelers, the Act cannot be said to make any reference to Plaintiffs, however, maintain that preemption is mandated because the Act has reference to ERISA plans in several other provisions. (Plaintiffs' Motion, Instrum 7). In particular, Plaintiffs seem to argue that the mere inclusion of certain ter refer to ERISA plans, such as "plan," "health care plan," "health maintenance organ "managed care entity," warrants preemption. (Plaintiffs' Motion, Instrument No. 20 Plaintiffs rely on District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. S. Ct. 580 (1992), and Cigna for this proposition.

In Greater Washington, 506 U.S. at 130, 113 S. Ct. at 583, the Supreme Court c that "Section 2(c)(2) of the District's Equity Amendment Act specifically refer[re]d benefit plans regulated by ERISA and on that basis alone [wa]s pre-empted." Sectic the Equity Amendment Act provided the following: "Any employer who provides health coverage for an employee shall provide health insurance equivalent to the existing insurance coverage of the employee while the employee receives or is eligible to re compensation benefits under this chapter." Id. at 128, 113 S. Ct. at 582 (quoting Ann. § 36-307(a-1)(1) (Supp. 1992) (emphasis added)). Furthermore, the employer ha provide this health insurance coverage for a maximum of 52 weeks "at the same benef the employee had at the time the employee received or was eligible to receive worke compensation benefits." Id. (quoting D.C. Code Ann. § 36-307 (a-1) (3) (Supp. 1992 the health insurance coverage required of employers was "measured by reference to ' health insurance coverage' provided by the employer" and had to be maintained at th benefit level. Id. at 130, 113 S. Ct. at 583-84 (emphasis added) (quoting D.C. Cod 307(a-1)(1) and (3) (Supp. 1992)).

The Court then determined that "[t]he employee's 'existing health insurance cc turn, [wa]s a welfare benefit plan under ERISA . . . because it involv[ed] a fund c maintained by an employer for the purpose of providing health benefits for the empl the purchase of insurance or otherwise.'" Id. at 130, 113 S. Ct. at 584 (quoting 2 1002(1)). Thus, since the Equity Amendment Act imposed requirements by reference t employer-sponsored health insurance programs that were subject to ERISA regulation, concluded that the Act was preempted by ERISA. Id. at 130-31, 113 S. Ct. at 584.

Contrary to Plaintiffs' contention, in Greater Washington, the Supreme Court c conclude that the statute referred to ERISA plans simply because it contained certa Rather, as explained in California Div. of Labor Standards Enforcement, N.A., Inc. Constr., 519 U.S. at , 117 S. Ct. at 838, the Court reasoned that the reference to resulted in preemption because the existence of ERISA plans was essential to the st operation. Unlike the statute in Greater Washington, the Act is not premised on th of an ERISA plan. It merely requires health insurance carriers, HMOs, and other ma entities to exercise ordinary care when making medical decisions. The Act imposes on these entities without any reference to or reliance on an ERISA plan.

In Cigna, 82 F.3d at 645-47, the Fifth Circuit held that Louisiana's Any Willi statute was preempted by ERISA because it referred to ERISA-qualified plans. The s required all licensed providers "who agre[ed] to the terms and conditions of the pr contract" to be accepted as providers in the preferred provider organization ("PPO" Stat. Ann. § 40:2202(5)(c) (West 1992) (emphasis added). Under the Health Care Cos Act, a "preferred provider contract" was defined as "an agreement 'between a provic providers and a group purchaser or purchasers to provide for alternative rates of p specified in advance for a defined period of time.'" Cigna, 82 F.3d at 647-48 (quc Stat. Ann. § 40:2022(5)(a) (emphasis added)).

The Fifth Circuit then examined the definition of "group purchasers." Under t group purchasers may have included entities "such as 'Taft-Hartley trusts or employ establish or participate in self funded trusts or programs,' which 'contract [with providers] for the benefit of their . . . employees.'" Cigna, 82 F.2d at 648 (quot Stat. Ann. § 40:2022(5)(a) (emphasis added)). Since the entities encompassed by th "group purchasers" included ERISA plans, the Court determined that Louisiana's Heal Cost Control Act, "and through it the Any Willing Provider statute, expressly refer plans." Id.

Unlike the statute in Cigna, the requirement imposed by the Act does not conta reference to ERISA plans. The Act states that health insurance carriers, HMOs, anc managed care entities have a duty to exercise ordinary care when making health care decisions. Tex. Civ. Prac. & Rem. Code Ann. § 88.002 (West 1998). None of these enumerated entities constitute ERISA plans since, by definition, they are not "esta

maintained by an employer or by an employee organization . . . for the purpose of health care benefits for employees. 29 U.S.C.A. § 1002(1) (West Supp. 1998); see T Prac. & Rem. Code Ann. § 88.001 (West 1998).

In this case, the Court finds that, as in *Travelers*, the existence of an ERISA essential to the operation of the Act. Furthermore, the Act does not work "immediately exclusively upon ERISA plans." *Dillingham*, 514 U.S. at , 117 S. Ct. at 838. Cons the Court concludes that the Act "cannot be said to make a 'reference to' ERISA plan manner." *Travelers*, 514 U.S. at 656, 115 S. Ct. at 1677.

Plaintiffs also suggest that the Act explicitly refers to ERISA plans by its "health care plan" and "managed care entity." (Plaintiff's Motion, Instrument No. Act defines "health care plan" as "any plan whereby a person undertakes to provide, pay for, or reimburse any part of the cost of any health care services." Tex. Civ. Code Ann. § 88.001(3) (West 1998). The Act then states that a "managed care entity care plan" must exercise ordinary care when making medical decisions. Id. § 88.002 (emphasis added). The phrase "health care plan" cannot be isolated from the term "entity" simply to create a reference to an ERISA plan. In this context, "health care constitute an ERISA plan because a "managed care entity . . . does not include an purchasing coverage or acting on behalf of its employees[.]" Id. § 88.001(8).

2. "Connection With"

"A law that does not refer to ERISA plans may yet be pre-empted if it has a 'connection with' ERISA plans." *Dillingham*, 519 U.S. at , 117 S. Ct. at 838. "To determine whether state law has the forbidden connection, [the court looks] . . . both to 'the object statute as a guide to the scope of the state law that Congress understood would survive as to the nature of the effect of the state law on ERISA plans." Id. (quoting *Travelers* at 656, 115 S. Ct. at 1677); see *De Buono*, 520 U.S. at , 117 S. Ct. at 1750 (noting rejection of a strictly literal reading of Section 514(a) and emphasis on the object ERISA statute).

Here, Plaintiffs contend that the Act has a "connection with" ERISA plans in that Plaintiffs claim that the Act improperly imposes state law liability on ERISA entities impermissibly mandates the structure of plan benefits and their administration, and plan administrators to particular choices, and wrongfully creates an alternate enforcement mechanism. (Plaintiffs' Motion, Instrument No. 20 at 9-18).

i. Imposition of State Law Liability

According to Plaintiffs, the "Fifth Circuit has twice held that attempts to impose liability on managed care entities in 'connection with' their 'health care treatment within the scope of the preemption clause." (Plaintiffs' Response, Instrument No. particular, Plaintiffs rely on the Fifth Circuit's decisions in *Corcoran v. United* 965 F.2d 1321 (5th Cir. 1992), and *Rodriguez v. Pacificare of Tex., Inc.*, 980 F.2d 1993) for this argument.

In *Corcoran*, 965 F.2d at 1331, the Fifth Circuit held that a Louisiana tort action for wrongful death of an unborn child was preempted by ERISA. In that case, United Health ("United"), the provider of utilization review services to an employee benefit plan that Mrs. Corcoran's hospitalization during the final months of her pregnancy was not despite her doctors' repeated recommendations for complete bed rest. Id. at 1322-2 contract between United and Mrs. Corcoran's employer provided that United would "conduct Participant's physician and based upon the medical evidence and normative data determine whether the Participant should be eligible to receive full plan benefits for the hospitalization and the duration of benefits." Id. at 1331 (quotation omitted). Corcoran's doctor's requests, United only authorized ten hours per day of home nursing care for Corcoran. Id. at 1324.

While the nurse was off-duty, the fetus went into distress and died. Id. Subsequently, Corcorans brought suit against United for wrongful death, alleging "that their unborn child as a result of various acts of negligence committed by" the mother's health plan administrator at 1324.

United argued that the Corcorans' claims were preempted by ERISA because its "conduct [was] made in its capacity as a plan fiduciary [and was] about what benefits were available under the [p]lan." Id. at 1329. According to United, the company simply applied previous eligibility criteria in order to determine whether Mrs. Corcoran was qualified for benefits provided by the plan. Id. Thus, United maintained that, under prevailing ERISA principles, the Corcorans could not "sue in tort to redress injuries flowing from decisions about benefits that are to be paid under a plan." Id. at 1330.

The Corcorans, on the other hand, contended that their cause of action sought damages for benefits solely for United's erroneous medical decision that Mrs. Corcoran did not

hospitalization during the last month of her pregnancy." Id. at 1330. Therefore, continued, United's exercise of medical judgment fell "outside the purview of ERISA preemption." Id.

Unable to agree with either characterization, the Fifth Circuit concluded that "medical decisions . . . in the context of making a determination about the availability under the plan." Id. at 1331. The Court reasoned that "United decide[d] 'what the . . . [would] pay for.' When United's actions [we]re viewed from this perspective, [became] apparent that the Corcorans [we]re attempting to recover for a tort alleged in the course of handling a benefit determination." Id. at 1332 (quoting the Quality ("QCP") booklet which contains a description of the QCP, a cost-containment service the services provided by United). Since United made the erroneous medical decision and parcel of its mandate to decide what benefits [we]re available under the . . . concluded that ERISA's preemption of "state-law claims alleging improper handling of claims [wa]s broad enough to cover the cause of action asserted here." Id. "Although liability on United . . . [may] have the salutary effect of deterring poor quality . . . [the Court found there was] a significant risk that state liability rules would differently to the conduct of utilization review companies in different states." Id.

Despite its finding of preemption, the Court acknowledged "the fact that . . . interpretation of the preemption clause . . . [left] a gap in remedies within a state protect participants in employee benefit plans" and suggested a reevaluation of ERISA 1333, 1338-39. Indeed, the Fifth Circuit recognized that:

[t]he result ERISA compels us to reach means that the Corcorans have no state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules inapplicable, there is theoretically less deterrence of substandard medical decisions. Moreover, if the cost of compliance with a standard of care . . . need not be borne by utilization review companies' cost of doing business, bad medical judgments will be cost-free to the plans that rely on these companies to contain medical costs. Plans, in turn, will have one less incentive to seek companies that can deliver quality services and reasonable prices.

Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest in preserving the pool of funds available to compensate all beneficiaries. . .

Finally, cost containment features such as the one at issue in this case were not when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of actions against employee benefit plans nor to provide beneficiaries in the Corcoran's position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its purpose of safeguarding the interests of employees. Our system, of course, is not the task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

Id. at 1338 (emphasis added). Since Corcoran, the Supreme Court has reevaluated the "potentially infinite reach of 'relations' and 'connections'" under ERISA preemption. It has rendered three decisions, namely *Travelers*, *Dillingham*, and *De Buono v. NYSA-ILA Medical and Clinical Services*, 520 U.S. 806, 117 S. Ct. 1747 (1997), that "reveal the proper approach to analyze[] ERISA preemption." *American Drug Stores, Inc. v. Harvard Pilgrim Health Care Inc.*, 973 F. Supp. 60, 64-65 (D. Mass. 1997) (quoting *Travelers*, 514 U.S. at 656, 117 S. Ct. at 1677).

Without the benefit of these recent opinions, the Court in *Corcoran* stated that "states traditionally have regulated in a particular area is no impediment to ERISA preemption." 965 F.2d at 1334. As such, the Court did not begin, as the recent Supreme cases did, with the presumption against preemption where the statute at issue addresses a matter of health and safety. See *Dillingham*, 514 U.S. at 117 S. Ct. at 838; *De Buono*, 520 U.S. at 117 S. Ct. at 1751-52; *Travelers*, 514 U.S. at 653-55, 115 S. Ct. at 1676-77. Instead, the Court in *Corcoran* reasoned that "Congress could not have predicted the interjection into the ERISA 'system' of the medical utilization review process[,] and therefore, concluded that "Congress enacted a preemption clause so broad and so comprehensive that it would be incompatible with the language, structure, and purpose of the statute to allow tort suits against entities so integrally connected with a

965 F.2d at 1334 (emphasis added). Although the fact that "the States traditionally . . . [certain] areas would not immunize their efforts[,]" since Corcoran, it is clear to be an "indication in ERISA . . . [or] its legislative history of any intent on the part of Congress to preempt" a traditionally state-regulated substantive law. Dillingham, 519 U.S. at 840-41 (emphasis added).

Furthermore, in Corcoran, the Court noted that:

[t]he cost of complying with varying substantive standards would increase providing utilization review services, thereby increasing the cost to health care of including cost containment features such as the Quality Care Program (or cost containment) to eliminate this sort of cost containment program altogether) and ultimately the pool of plan funds available to reimburse participants.

965 F.2d at 1333. However, the Supreme Court in Travelers emphasized that an "indirect economic influence . . . does not bind a plan administrator to any particular choice of function as a regulation of an ERISA plan itself." 514 U.S. at 659, 115 S. Ct. at 1177. Moreover,

if ERISA were concerned with any state action such as quality of care standards or hospital workplace regulations that increased the cost of providing certain benefits, thereby, potentially affected the choices made by ERISA plans, [then] we could see the end of ERISA's pre-emptive reach, and the words 'relate to' would limit

Dillingham, 519 U.S. at 840, 117 S. Ct. at 840 (citing Travelers, 514 U.S. at 663-64, 115 S. Ct. at 1681).

In light of the Supreme Court's recent mandate regarding ERISA preemption analysis, perhaps the Fifth Circuit would reach a different decision in Corcoran today. Even if the facts in Corcoran are distinguishable from the conduct covered by the Act,

The plaintiffs in Corcoran filed suit against their HMO regarding a medical denial in relation to the denial of certain plan benefits. In this case, a suit brought under the Act relate to the quality of benefits received from a managed care entity when benefits were provided, not denied. The Act imposes a duty of ordinary care upon certain entities making health care treatment decisions and holds those entities liable for damages proximately caused by a failure to exercise that duty. Tex. Civ. Prac. & Rem. Code Ann. § 88.002(a) (West 1996). Furthermore, the Act clearly states that a "health care treatment decision" is "a decision 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 insured enrollees." Id. § 88.001(5) (emphasis added). Thus, Corcoran is factually distinguishable from the instant case.

The facts in Rodriguez v. Pacificare of Tex., Inc., the other case cited by Plaintiff in their argument that the Act wrongfully imposes state law liability on managed care entities, can be distinguished for the same reason. In Rodriguez, David Rodriguez ("Rodriguez") brought a negligence action against his HMO and his primary care physician. 980 F.2d at 1016. Rodriguez attempted to seek medical attention for himself and his children after they were injured in an automobile accident. Id. Rodriguez believed that he and his children needed to see a surgeon, but he was unable to obtain the requisite referral letter from their primary care physician or his HMO. Id. Without obtaining the needed letter, Rodriguez and his family were treated by an orthopedic surgeon who placed Rodriguez on a therapy program. Id. Rodriguez's HMO refused to cover the expenses because Rodriguez had not first obtained approval for such expenses as required by his plan. Id. Rodriguez thereafter filed suit against his HMO and primary care physician "for failing to 'provide prompt and adequate medical care and coverage.'" Rodriguez's complaint filed in Texas state court).

The Fifth Circuit determined that Rodriguez's state law claims were sufficient to state a claim "because his 'claims, at bottom, result[ed] from dissatisfaction with . . . [his HMO's] handling of his medical claim.'" Id. at 1017. Unlike Rodriguez's claims against his HMO and primary care physician, a suit brought under the Act may challenge the quality of benefits actually received without challenging a denial of benefits or a denial of a medical claim. A suit addressing the quality of care actually received is more akin to the claims asserted by plaintiffs in Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995).

In Dukes, the Third Circuit examined two separate claims. The first claim involved the death of Darryl Dukes ("Dukes"). Dukes had several ailments which prompted him to see his primary care physician who identified a problem with his ear. Dukes, 57 F.3d at 35. For some unknown reason, when Dukes presented the prescription to the laboratory, the laboratory refused to perform the blood tests. Id. On the next day, Dukes went to see a third doctor who also ordered blood tests. Id. The hospital performed the tests. Id. However, by

Dukes's condition had worsened and he subsequently died. At the time of his death, blood sugar level was extremely high a condition that allegedly could have been detected by a timely blood test. *Id.*

The other claim, examined in *Dukes*, concerned Ronald and Linda Visconti and their stillborn child. *Id.* at 353. The Viscontis maintained that Linda's obstetrician noted symptoms that Linda exhibited during the third trimester of her pregnancy that were preeclampsia. *Id.*

"[T]he plaintiffs in these two cases filed suit in state court against health organizations ("HMOs") organized by U.S. Healthcare, Inc., claiming damages, under theories, for injuries arising from the medical malpractice of the HMO-affiliated health care personnel." *Id.* at 351. The defendant HMOs removed both cases to federal court on the "complete preemption doctrine." *Id.* at 351. The Court held that since plaintiffs fell outside the scope of the ERISA provision granting the right to recover benefit rights due under terms of the plan or to clarify rights to future benefits then the preemption doctrine did not permit removal. *Id.* In particular, the Court held that the control of benefits, such as health care benefits provided here, is a field traditionally regulated by state regulation. *Id.* at 357 (emphasis added) (citing *Travelers*, 514 U.S. at 657-58 at 1678-79). The Court then "interpret[ed] the silence of Congress as reflecting a desire to remain as such." *Id.*

This Court finds the discussion in *Dukes* to be applicable here. The Court, in *Dukes*, made a distinction between a claim for the withholding of benefits and a claim about the quality of benefits received. The Court reasoned that "[i]nstead of claiming that the welfare of the plaintiff was withheld some quantum of plan benefits due, the plaintiffs in both cases complained of the low quality of the medical treatment that they actually received" *Id.* (emphasis added). In particular, "*Dukes* did not allege . . . that the Germantown Hospital refused to perform blood studies on Darryl because the ERISA plan refused to pay for those studies. Similarly, the Viscontis did not contend that Serena's death was due to their well-known refusal to pay for or otherwise provide for medical services." *Id.* at 356-57. In *Dukes*, the claim may be brought under the Act that simply challenges the quality of the benefits received. *Id.*

Also in *Dukes*, the Court distinguished the *Corcoran* case based on the dual role assumed by an HMO. *Dukes*, 57 F.3d at 360-61. The Court emphasized that in *Corcoran v. United HealthCare, Inc.* the defendant HMOs in *Dukes* played two roles: the utilization review role and the arranger for the actual medical treatment for plan participants. *Id.* at 361. "[U]nder the Act, [in *Dukes*] there . . . [was] no allegation . . . that the HMOs denied anyone any benefits that were due under the plan. Instead, the plaintiffs [in *Dukes*] . . . attempted to hold the HMOs liable for their role as the arrangers of their decedents' medical treatment." *Id.* The plaintiff bringing suit under the Act may seek to hold a HMO liable in its position of poor quality medical treatment, thereby, avoiding any allegation that the HMO wrongfully denied benefits under the plan and therefore, any connection with ERISA.

Thus, the distinction can be summarized as follows:

Claims challenging the quality of a benefit, as in *Dukes*, are not preempted by ERISA. See *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 154 (10th Cir. 1995) (ERISA preemption does not apply to a claim of medical malpractice or negligence or giving professional advice. Claims based upon a failure to treat where the failure was the result of a determination that the requested treatment wasn't covered by the plan, however, are preempted by ERISA. See *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1312, 1331 (5th Cir.), cert. den. 514 U.S. 1033, 113 S. Ct. 812, 121 L. Ed. 2d 684 (1992) (medical determinations made by an HMO preempted by ERISA because made in context of benefits determination under the plan).

Schmid v. Kaiser Found. Health Plan of Northwest, 963 F. Supp. 942, 944 (D. Or. 1999)

In this case, the Act addresses the quality of benefits actually provided. ERISA says nothing about the quality of benefits received." *Dukes*, 57 F.3d at 357. "A rule . . . [Section] 514(a) resulting in the preemption of traditionally state-regulated areas . . . [an] area[] where ERISA has nothing to say would be 'unsettling.'" *Dillier v. Kaiser Found. Health Plan of Northwest*, 117 S. Ct. at 840 (quoting *Travelers*, 514 U.S. at 664-65, 115 S. Ct. at 1681)

Furthermore, "the Supreme Court has cautioned that '[s]ome state actions may be so tenuous, remote, or peripheral a manner to warrant a claim that the law 'relates to' the plan.'" *Cigna*, 82 F.3d at 647 (quoting *Shaw*, 463 U.S. at 477, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000)

Corcoran, 965 F.2d at 1329 (quoting Mackey v. Lanier Collection Agency & Serv., Inc 825, 833, 108 S. Ct. 2182, 2187 (discussing these types of claims in dicta)). In a does not preempt state laws that have 'only an indirect economic effect on the rela various health insurance packages' available to ERISA-qualified plans" such as qual Cigna, 82 F.3d at 647 (quoting Travelers, 514 U.S. at 659-60, 115 S. Ct. at 1680); Dillingham, 519 U.S. at , 117 S. Ct. at 840 (noting that if ERISA were concerned w action, such as medical care quality standards, that increased costs of providing c then courts could scarcely see the end of ERISA's preemptive reach); Pacificare, 59 ("As long as a state law does not affect the structure, the administration, or type provided by an ERISA plan, the mere fact that the [law] has some economic impact or does not require that the [law] be invalidated."). As such, the Court finds that " of benefits, such as the health care benefits provided [by HMOs and other managed c is a field traditionally occupied by state regulation and . . . interprets the sile reflecting an intent that it remain such." Dukes, 57 F.3d at 357 (emphasis added).

Accordingly, the Court concludes that the Act does not constitute an improper of state law liability on the enumerated entities.

ii. Mandating the Structure and Administration of Plan Benefits

Next, the Court will examine Plaintiffs' argument that the Act has a connectic ERISA plans because it improperly mandates the structure of plan benefits and their in violation of clear Supreme Court authority. In Travelers, the Court noted that, objectives of ERISA and its preemption clause, Congress intended for ERISA to preer laws that mandate[] employee benefit structures or their administration." 514 U.S. S. Ct. at 1678. For example, in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97, 10 2900 (1983), the Court held that a New York statute "which prohibit[ed] employers f structuring their employee benefit plans in a particular manner that discriminate[c of pregnancy . . . [and another statute] which require[d] employers to pay employee benefits . . . clearly 'relate[d] to' benefit plans." ERISA preempted these New Yc because their "mandates affecting coverage could have been honored only by varying of a plan's benefits whenever New York law might have applied, or by requiring ever provide all beneficiaries with a benefit demanded by New York law if New York law c been said to require it for any one beneficiary." Travelers, 514 U.S. at 657, 115 Therefore, "absent preemption, benefit plans would have been subjected to conflicti from one state to the next." Coyne & Delany Co. v. Selman, 98 F.3d 1457, 1468 (4th (citing Shaw, 463 U.S. at 99, 103 S. Ct. at 2901).

Plaintiffs claim that the Act "imposes a 'negligence' standard of review on HV PPOs . . . in contravention of the federally mandated abuse of discretion standard a factual benefit determination under ERISA[," and "purports to re-define the star 'appropriate and medically necessary' as it pertains to ERISA plans." (Plaintiffs' Instrument No. 20 at 15).

With respect to Plaintiffs' first contention, the Court reiterates its conclus may only be brought under the Act that challenges the quality of care received, not determination. Such a claim would not implicate the abuse of discretion standard r ERISA for factual benefit determinations. See Pierre v. Connecticut Gen. Life Ins. 1552, 1562 (5th Cir. 1991) (holding that "for factual determinations under ERISA pl of discretion standard of review is the appropriate standard"). Whether a claim br Act seeks a review of a plan administrator's factual benefit determination rather t a medical decision should be examined by the Court on a case-by-case basis. At tha Court could determine whether or not the particular claim conflicts with the standa provided under ERISA.

Plaintiffs also claim that the Act wrongfully purports to redefine the standar "appropriate and medically necessary" as it pertains to ERISA plans. (Plaintiffs' Instrument No. 20 at 15). Section 88.001(1) of the Texas Civil Practice and Remedi which was added by the Act, defines "appropriate and medically necessary" as "the s health care services as determined by physicians and health care providers in accor prevailing practices and standards of the medical profession and community. Tex. C & Rem. Code Ann. § 88.001(1) (West 1998). Plaintiffs contend that "[t]his imposed of medical necessity is different from that contained in many ERISA plans." (Plair Instrument No. 20 at 15). Since Plaintiffs' health care plans purportedly confer a the plan administrator to make coverage determinations in accordance with the terms Plaintiffs argue that the Act's definition of "appropriate and medically necessary" terms of employee benefit plans and restrict[s] the ability of plans to deny claims medical necessity or other terms defined in the plan." (Id. at 16).

With respect to the Act's definition of when a health care benefit is "appropri

medically necessary," the Court must examine this term in conjunction with the process provided by the Act for the review of claims relating to an adverse benefit determination by an independent review organization ("IRO"). Section 88.003 of the Texas Civil Practice Remedies Code, as added by the Act, provides the following:

(a) A person may not maintain a cause of action under this chapter against an insurance carrier, health maintenance organization, or other managed care entity required to comply with the utilization review requirements of Article 21.58A, Code, or the Texas Health Maintenance Organization Act (Chapter 20A Vernon's Insurance Code), unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) has exhausted the appeals and review applicable under the requirements; or

(2) before instituting the action:

(A) gives written notice of the claim as provided by

(B) agrees to submit the claim to a review by an independent review organization under Article 21.58A, Insurance Code, as required by Subsection (c).

(b) the notice required by Subsection (a)(2)(A) must be delivered or mailed to the health insurance carrier, health maintenance organization, or other managed care entity against whom the action is made not later than the 30th day before the date the action is filed.

(c) The insured or enrollee or the insured's or enrollee's representative must submit the claim to a review by an independent review organization if the health insurance carrier, health maintenance organization, or managed care entity against whom the action is made requests the review not later than the 14th day after the date notice of the claim is received by the health insurance carrier, health maintenance organization, or other managed care entity. If the health insurance carrier, health maintenance organization, or other managed care entity does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to an independent review organization to maintain the action.

(d) Subject to Subsection (e), if the enrollee has not complied with Subsection (c), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation nonbinding alternative dispute resolution and may abate the action for a period not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with Subsection (c).

(e) The enrollee is not required to comply with Subsection (c) and no other order pursuant to Subsection (d) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) harm to the enrollee has already occurred because of the conduct of the health insurance carrier, health maintenance organization, or managed care entity or because of an act or omission of an employee, agent, ostensible agent, representative of such carrier, organization, or entity for whose conduct the enrollee is liable under Section 88.002(b); and

(2) the review would not be beneficial to the enrollee, unless the court, on motion by a defendant carrier, organization, or entity finds after that a hearing was not made in good faith, in which case the court may enter an order pursuant to Subsection (d).

(f) If the insured or enrollee or the insured's or enrollee's representative exhausts the appeals and review or provides notice, as required by Subsection (c), the statute of limitations applicable to a claim against a managed care entity shall be tolled until the later of:

(1) the 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under Subsection (a)(2)(A).

(g) This section does not prohibit an insured or enrollee from pursuing appropriate remedies, including injunctive relief, a declaratory judgment, or other remedies available under law, if the requirement of exhausting the process for appeal places the insured's or enrollee's health in serious jeopardy.

Tex. Civ. Prac. & Rem. Code Ann. § 88.003 (West 1998) (emphasis added).

In addition, the Act amended and added several provisions to the Texas Insurance Code that address specific responsibilities of an HMO and further explain and define the independent review of an adverse benefit determination by an IRO. See Tex. Ins. Code arts. 20A.09, 20A.12, 20A.12A, 21.58A, and 21.58C (West 1998). Article 20A.09, which was amended by the Act, now requires an HMO to issue evidence of coverage to an enrollee who describes "the enrollee's right to appeal denials of an adverse determination . . . by an independent review organization." Tex. Ins. Code Ann. art. 20A.09(e)(4) (West 1998).

Under the amendments to Article 20A.12 of the Texas Insurance Code, every HMO must establish a complaint system that provides for the "resolution of oral and written complaints initiated by enrollees concerning health care services." Id. art. 20A.12(a). The system mandated by Article 20A.12 has several requirements that reference the IRO procedure. Specifically, Article 20A.12A, which was also added by the Act, states that the complaint must include:

- (1) notification to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization;
- (2) notification to the enrollee of the procedures for appealing an adverse determination to an independent review organization; and
- (3) notification to an enrollee who has a life-threatening condition of the enrollee's right to immediate review by an independent review organization and the procedure to obtain that review.

Id. arts. 20A.12A(a) and (b). Article 20A.12A then defines "adverse determination," "independent review organization," and "life-threatening condition." Id. art. 20A.12A(b).

The Act also amends Article 21.58A Section 6 of the Texas Insurance Code. If an adverse determination is denied, Section 6 now requires the utilization review agent to submit a clear and concise statement to the appealing party informing him of his "right to a review of the denial by an independent review organization under Section 6A . . . and the procedures for obtaining that review." Id. art. 21.58A(6)(b)(5)(C). Furthermore, if an enrollee is faced with a life-threatening condition then he "is entitled to an immediate appeal to an independent review organization as provided by Section 6A[.]" Id. art. 21.58A(6)(c).

Furthermore, the Act adds a new section 6A to Article 21.58A of the Texas Insurance Code which outlines the utilization review agent's responsibilities with respect to the review of adverse determinations. Id. art. 21.58A(6A). In particular, Section 6A(1) of Article 21.58A provides that:

A utilization review agent shall:

- (1) permit any party whose appeal of an adverse determination is denied by the utilization review agent to seek review of that determination by an independent review organization assigned to the appeal in accordance with Article 21.58C of this code;
- (2) provide to the appropriate independent review organization not later than the next business day after the date that the utilization review agent receives a request for a copy of:
 - (A) any medical records of the enrollee that are relevant to the determination;
 - (B) any documents used by the plan in making the determination by the organization;
 - (C) the written notification described in Section 6(b)(5) of this code;
 - (D) any documentation and written information submitted to the utilization review agent in support of the appeal; and
 - (E) a list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal;
- (3) comply with the independent review organization's determination with respect to the medical necessity or appropriateness of health care items and services for the enrollee; and
- (4) pay for the independent review.

Id. art. 21.58A(6A). Notably, under Article 20A.12A, the provisions in Article 21.58A(6) that relate to independent review, namely Section 6A, apply to an HMO as if the HMO were a utilization review agent. Id. art. 20A.12A(b). Moreover, given the addition of the independent review procedure by the Act, Section 8 of Article 21.58A now provides that "[c]onfidential information in the hands of a utilization review agent may be provided to an independent review organization subject to the rules and standards already in effect under the Texas Insurance Code." Id. art. 21.58A(8)(f).

Lastly, the Act added Article 21.58C to the Texas Insurance Code. This section sets the standards for independent review organizations, such as certification requirements under Article 21.58C. For example, Article 21.58C explains the Commissioner of the Texas Insurance Code's responsibilities for the certification and designation of independent review organizations. An entity may be certified as an independent review organization. *Id.*

Plaintiffs argue that an administrator's determination as to "whether a claim is covered under the medical necessity definition contained in the plan implicates the terms of a plan's term." (Plaintiffs' Motion, Instrument No. 20 at 16). Therefore, Plaintiffs argue that the Act which contains these procedures for an independent review of a benefit determination is preempted because it mandates the structure and administration of benefits.

In response, Defendants maintain that "the IRO is geared solely to corporate determinations of 'medical necessity,' the practice of medicine admittedly being a traditional area of state regulation." (Defendants' Response, Instrument No. 46 at 16). Defendants also explain, and Plaintiffs do not dispute, that "[o]nly when Aetna, or another managed care entity, makes adverse determinations that benefits are not medically necessary, the IRO provisions [become applicable]." (*Id.* at 14). According to Defendants, "the possible HMO action that could be called a 'benefit determination' which could ever be taken for action under the IRO provisions of . . . [the Act] are 'adverse determinations.' Adverse determinations are necessarily limited to 'medical necessity' decisions[.]" (*Id.* at 14).

In *Travelers*, the Supreme Court provided guidance as to the scope of plan administration that Congress intended to protect from state interference. 514 U.S. at 657-68, 115 S.Ct. 1684. The Court discussed

earlier decisions which held various state statutes preempted for "mandated benefit structures or their administration." . . . The Court [also] explained that the state statutes at issue in *Shaw* because they imposed "mandates affecting benefit coverage" which directly affected the benefit structures which ERISA plans cover. . . . The law at issue in *FMC Corp. v. Holliday* interfered with benefit calculations by prohibiting plans from obtaining subrogation, the law frustrated any attempt at a uniform national benefits. . . . In *Alessi v. Raybestos-Manhattan, Inc.*, . . . the Court preempted a statute which prohibited plans from using a method of calculating benefits not permitted by federal law. . . . In each of these cases, the [Supreme] Court was concerned with administrative and structural matters central to the administration of ERISA plans themselves.

American Drug, 973 F. Supp. at 68 (emphasis added) (quoting *Travelers*, 514 U.S. at 677-78). The Act's use of independent review process implicates the "liability of administrative functions which are part of operating an employee benefit plan[,] determining the eligibility of claimants. *American Drug*, 973 F. Supp. at 66; see also *Shaw*, 482 U.S. at 8-9, 107 S. Ct. 2211, 2216 (1987).

Furthermore, the Act's definition of "appropriate and medically necessary" adverse determinations under Section 88.003 for reviewing an adverse determination by an IRO is a clarification of the IRO procedure and requirements in Articles 20A.09(4), 20A.12A, 20A.12B, 20A.12C, 20A.12D, 20A.12E, 20A.12F, 20A.12G, 20A.12H, 20A.12I, 20A.12J, 20A.12K, 20A.12L, 20A.12M, 20A.12N, 20A.12O, 20A.12P, 20A.12Q, 20A.12R, 20A.12S, 20A.12T, 20A.12U, 20A.12V, 20A.12W, 20A.12X, 20A.12Y, 20A.12Z, 20A.12AA, 20A.12AB, 20A.12AC, 20A.12AD, 20A.12AE, 20A.12AF, 20A.12AG, 20A.12AH, 20A.12AI, 20A.12AJ, 20A.12AK, 20A.12AL, 20A.12AM, 20A.12AN, 20A.12AO, 20A.12AP, 20A.12AQ, 20A.12AR, 20A.12AS, 20A.12AT, 20A.12AU, 20A.12AV, 20A.12AW, 20A.12AX, 20A.12AY, 20A.12AZ, 20A.12BA, 20A.12BB, 20A.12BC, 20A.12BD, 20A.12BE, 20A.12BF, 20A.12BG, 20A.12BH, 20A.12BI, 20A.12BJ, 20A.12BK, 20A.12BL, 20A.12BM, 20A.12BN, 20A.12BO, 20A.12BP, 20A.12BQ, 20A.12BR, 20A.12BS, 20A.12BT, 20A.12BU, 20A.12BV, 20A.12BW, 20A.12BX, 20A.12BY, 20A.12BZ, 20A.12CA, 20A.12CB, 20A.12CC, 20A.12CD, 20A.12CE, 20A.12CF, 20A.12CG, 20A.12CH, 20A.12CI, 20A.12CJ, 20A.12CK, 20A.12CL, 20A.12CM, 20A.12CN, 20A.12CO, 20A.12CP, 20A.12CQ, 20A.12CR, 20A.12CS, 20A.12CT, 20A.12CU, 20A.12CV, 20A.12CW, 20A.12CX, 20A.12CY, 20A.12CZ, 20A.12DA, 20A.12DB, 20A.12DC, 20A.12DD, 20A.12DE, 20A.12DF, 20A.12DG, 20A.12DH, 20A.12DI, 20A.12DJ, 20A.12DK, 20A.12DL, 20A.12DM, 20A.12DN, 20A.12DO, 20A.12DP, 20A.12DQ, 20A.12DR, 20A.12DS, 20A.12DT, 20A.12DU, 20A.12DV, 20A.12DW, 20A.12DX, 20A.12DY, 20A.12DZ, 20A.12EA, 20A.12EB, 20A.12EC, 20A.12ED, 20A.12EE, 20A.12EF, 20A.12EG, 20A.12EH, 20A.12EI, 20A.12EJ, 20A.12EK, 20A.12EL, 20A.12EM, 20A.12EN, 20A.12EO, 20A.12EP, 20A.12EQ, 20A.12ER, 20A.12ES, 20A.12ET, 20A.12EU, 20A.12EV, 20A.12EW, 20A.12EX, 20A.12EY, 20A.12EZ, 20A.12FA, 20A.12FB, 20A.12FC, 20A.12FD, 20A.12FE, 20A.12FF, 20A.12FG, 20A.12FH, 20A.12FI, 20A.12FJ, 20A.12FK, 20A.12FL, 20A.12FM, 20A.12FN, 20A.12FO, 20A.12FP, 20A.12FQ, 20A.12FR, 20A.12FS, 20A.12FT, 20A.12FU, 20A.12FV, 20A.12FW, 20A.12FX, 20A.12FY, 20A.12FZ, 20A.12GA, 20A.12GB, 20A.12GC, 20A.12GD, 20A.12GE, 20A.12GF, 20A.12GG, 20A.12GH, 20A.12GI, 20A.12GJ, 20A.12GK, 20A.12GL, 20A.12GM, 20A.12GN, 20A.12GO, 20A.12GP, 20A.12GQ, 20A.12GR, 20A.12GS, 20A.12GT, 20A.12GU, 20A.12GV, 20A.12GW, 20A.12GX, 20A.12GY, 20A.12GZ, 20A.12HA, 20A.12HB, 20A.12HC, 20A.12HD, 20A.12HE, 20A.12HF, 20A.12HG, 20A.12HH, 20A.12HI, 20A.12HJ, 20A.12HK, 20A.12HL, 20A.12HM, 20A.12HN, 20A.12HO, 20A.12HP, 20A.12HQ, 20A.12HR, 20A.12HS, 20A.12HT, 20A.12HU, 20A.12HV, 20A.12HW, 20A.12HX, 20A.12HY, 20A.12HZ, 20A.12IA, 20A.12IB, 20A.12IC, 20A.12ID, 20A.12IE, 20A.12IF, 20A.12IG, 20A.12IH, 20A.12II, 20A.12IJ, 20A.12IK, 20A.12IL, 20A.12IM, 20A.12IN, 20A.12IO, 20A.12IP, 20A.12IQ, 20A.12IR, 20A.12IS, 20A.12IT, 20A.12IU, 20A.12IV, 20A.12IW, 20A.12IX, 20A.12IY, 20A.12IZ, 20A.12JA, 20A.12JB, 20A.12JC, 20A.12JD, 20A.12JE, 20A.12JF, 20A.12JG, 20A.12JH, 20A.12JI, 20A.12JJ, 20A.12JK, 20A.12JL, 20A.12JM, 20A.12JN, 20A.12JO, 20A.12JP, 20A.12JQ, 20A.12JR, 20A.12JS, 20A.12JT, 20A.12JU, 20A.12JV, 20A.12JW, 20A.12JX, 20A.12JY, 20A.12JZ, 20A.12KA, 20A.12KB, 20A.12KC, 20A.12KD, 20A.12KE, 20A.12KF, 20A.12KG, 20A.12KH, 20A.12KI, 20A.12KJ, 20A.12KK, 20A.12KL, 20A.12KM, 20A.12KN, 20A.12KO, 20A.12KP, 20A.12KQ, 20A.12KR, 20A.12KS, 20A.12KT, 20A.12KU, 20A.12KV, 20A.12KW, 20A.12KX, 20A.12KY, 20A.12KZ, 20A.12LA, 20A.12LB, 20A.12LC, 20A.12LD, 20A.12LE, 20A.12LF, 20A.12LG, 20A.12LH, 20A.12LI, 20A.12LJ, 20A.12LK, 20A.12LL, 20A.12LM, 20A.12LN, 20A.12LO, 20A.12LP, 20A.12LQ, 20A.12LR, 20A.12LS, 20A.12LT, 20A.12LU, 20A.12LV, 20A.12LW, 20A.12LX, 20A.12LY, 20A.12LZ, 20A.12MA, 20A.12MB, 20A.12MC, 20A.12MD, 20A.12ME, 20A.12MF, 20A.12MG, 20A.12MH, 20A.12MI, 20A.12MJ, 20A.12MK, 20A.12ML, 20A.12MN, 20A.12MO, 20A.12MP, 20A.12MQ, 20A.12MR, 20A.12MS, 20A.12MT, 20A.12MU, 20A.12MV, 20A.12MW, 20A.12MX, 20A.12MY, 20A.12MZ, 20A.12NA, 20A.12NB, 20A.12NC, 20A.12ND, 20A.12NE, 20A.12NF, 20A.12NG, 20A.12NH, 20A.12NI, 20A.12NJ, 20A.12NK, 20A.12NL, 20A.12NM, 20A.12NN, 20A.12NO, 20A.12NP, 20A.12NQ, 20A.12NR, 20A.12NS, 20A.12NT, 20A.12NU, 20A.12NV, 20A.12NW, 20A.12NX, 20A.12NY, 20A.12NZ, 20A.12OA, 20A.12OB, 20A.12OC, 20A.12OD, 20A.12OE, 20A.12OF, 20A.12OG, 20A.12OH, 20A.12OI, 20A.12OJ, 20A.12OK, 20A.12OL, 20A.12OM, 20A.12ON, 20A.12OO, 20A.12OP, 20A.12OQ, 20A.12OR, 20A.12OS, 20A.12OT, 20A.12OU, 20A.12OV, 20A.12OW, 20A.12OX, 20A.12OY, 20A.12OZ, 20A.12PA, 20A.12PB, 20A.12PC, 20A.12PD, 20A.12PE, 20A.12PF, 20A.12PG, 20A.12PH, 20A.12PI, 20A.12PJ, 20A.12PK, 20A.12PL, 20A.12PM, 20A.12PN, 20A.12PO, 20A.12PP, 20A.12PQ, 20A.12PR, 20A.12PS, 20A.12PT, 20A.12PU, 20A.12PV, 20A.12PW, 20A.12PX, 20A.12PY, 20A.12PZ, 20A.12QA, 20A.12QB, 20A.12QC, 20A.12QD, 20A.12QE, 20A.12QF, 20A.12QG, 20A.12QH, 20A.12QI, 20A.12QJ, 20A.12QK, 20A.12QL, 20A.12QM, 20A.12QN, 20A.12QO, 20A.12QP, 20A.12QQ, 20A.12QR, 20A.12QS, 20A.12QT, 20A.12QU, 20A.12QV, 20A.12QW, 20A.12QX, 20A.12QY, 20A.12QZ, 20A.12RA, 20A.12RB, 20A.12RC, 20A.12RD, 20A.12RE, 20A.12RF, 20A.12RG, 20A.12RH, 20A.12RI, 20A.12RJ, 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Allowing state based procedures for independent review of an adverse benefit determination, like the one at issue here, "would subject plans and plan sponsors to unlike those that Congress sought to foreclose through . . . [Section] 514(a). Paralytic is the potential for conflict in state law. . . . Such an outcome is fun with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand*, 49 U.S. Ct. at 484.

Consequently, as explained by the Supreme Court in *Travelers*, 514 U.S. at 657 U.S. Ct. at 1677-78, the Court finds that the provisions for an independent review impair the administration of employee benefits and therefore, have a connection with ERISA. *Coyne*, 98 F.3d at 1468 (indicating that state laws which mandate employee benefit administration have a connection with ERISA plans). "Congress intended ERISA to preempt state laws[,] [such as the IRO provisions in the Act,] that 'mandate[] employee ben-

or their administration." *Id.* (quoting *Travelers*, 514 U.S. at 658, 115 S. Ct. at 115). The Court finds that the relevant language in Section 88.003 of the Texas Civil Practice and Remedies Code, the relevant language added by the Act in Articles 20A.09(e)(4), 21.58A(6)(b)(5), and 21.58A(6)(c) of the Texas Insurance Code, and that Articles 20A.12A, 21.58A(6A), 21.58A(8)(f), and 21.58C of the Texas Insurance Code, all addressing the procedure, can be severed from the Act without affecting the other provisions or the legislative intent.

"Whether portions of a state statute found to contravene federal law are severable is a question of state law." *Texas Pharmacy*, 105 F.3d at 1039. The Texas Code Construction Act provides that:

[i]n a statute that does not contain a provision for severability or nonseverability, the invalidity of a provision of the statute or its application to any person or circumstance is not a ground for invalidity does not affect other provisions or applications of the statute that would have the effect without the invalid provision or application, and to this end the provisions of the statute are severable.

Tex. Gov't Code Ann. § 311.032(c) (West 1988); see also Tex. Gov't Code Ann. § 312.001(a) (West 1988) (providing the same standard). Thus, "[u]nder the Texas Code Construction Act, a Texas statute should be deemed severable if the invalidity of one provision does not affect other provisions, unless it has an express provision for severability or nonseverability." *Pharmacy*, 105 F.3d at 1039; see *In re Johnson*, 554 S.W.2d 775, 787 (Tex. Civ. App. Christi, 1977, writ ref'd n.r.e.) (noting that where invalid sections on an act may be severed, the court "must do so and not permit the invalid part to destroy the whole law"). The court should "sustain the remainder only if the result is consistent with the original intent." *Black v. Dallas County Bail Bond Bd.*, 882 S.W.2d 434, 437 (Tex. Civ. App. Dallas, 1994, no writ); see *Anderson v. Wood*, 152 S.W.2d 1084, 1087 (Tex. 1941) (concluding that a whole statute was void because the remainder, by reason of its generality, would have acted a broader scope than was intended by the legislature).

In this case, the Act does not have an express provision for severability or nonseverability of the statute. Furthermore, an examination of the legislative history of the Act shows a purpose that the legislature sought to achieve with the passage of the Act. Specifically, the legislature sought to address two distinct issues: quality of care and denial of care. To address quality of care, the Act establishes a standard of care for HMOs and other managed care entities and allows participants to sue an HMO or a managed care entity for negligent decisions. (Index of Legislative History-Testimony of Rep. Smithee, Instrument No. 17, Exh. A at AG01585 and Exh. B at AG01607). With regard to denial of care, the Act creates an independent review process that reviews adverse benefit determinations by an HMO or other managed care entity. (*Id.*) In particular, as a prerequisite to filing a lawsuit under the Act, a participant would "be able to get an independent review [of his or her HMO's denial of coverage] in order to try and get the care" that he or she needs. (Index of Legislative History-Testimony of Rep. Smithee, Instrument No. 17, Exh. B at AG01607). Thus, the Court finds that clearly the intent of the legislature to address both the quality of care issue and the denial of care issue under the Act.

The Court has already determined that the IRO provisions concern the review of adverse benefit determinations and are therefore, an improper mandate of benefit administration. As such, the IRO provisions and, in particular, the relevant language in Section 88.003 of the Texas Civil Practice and Remedies Code, the relevant language added by the Act in Articles 20A.09(e)(4), 21.58A(6)(b)(5), and 21.58A(6)(c) of the Texas Insurance Code, and Articles 20A.12A, 21.58A(6A), 21.58A(8)(f), and 21.58C of the Texas Insurance Code would have no effect on lawsuits that may be brought under the Act challenging the quality of care that an individual has actually received. The Court can still give effect to the provisions of the Act that address quality of care. In other words, even without these sections which address the procedure, suits addressing the quality of a benefit may still be brought under the Act by an HMO or other managed care entity. This goal under the Act is separate and distinct from the independent review process which solely addresses adverse benefit determinations by a plan administrator or utilization review agent. Thus, upholding the provisions of the Act is consistent with the legislative intent. Moreover, where the provisions of an act may be separated, the Court "must do so and not permit the invalid part to destroy the whole." *In re Johnson*, 554 S.W.2d at 787. Therefore, since the Act can be given effect without these sections, the Court finds that they may be severed from the Act.

iii. Binding Employers or Plan Administrators to Particular Choices

The Court agrees with Plaintiffs' next argument that, under existing Fifth Circuit precedent, certain provisions in the Act bind employers or plan administrators to particular choices.

Cigna, the Fifth Circuit held that the statute had a connection with ERISA plans be required "ERISA plans to purchase benefits of a particular structure when they contract with organizations like CIGNA and CGLIC." 82 F.3d at 648. The Court reasoned that:

ERISA plans that choose to offer coverage by PPOs are limited by the statute to PPOs of a certain structure i.e., a structure that includes every willing, licensed provider. Stated another way, the statute prohibits those ERISA plans which elect to use a PPO that does not include any willing, licensed provider. As such, the statute connects with ERISA plans.

Id. Furthermore, the Court found that it was "sufficient for preemption purposes to eliminate[d] the choice of one method of structuring benefits." Id.; cf. Dillingham, 117 S. Ct. at 842 (holding that prevailing wage statute is not preempted by ERISA statute merely "alters the incentives . . . but does not dictate the choices, facing employers").

Later, in Texas Pharmacy Ass'n v. Prudential Ins. Co. of Am., the Fifth Circuit affirmed its opinion in Cigna and determined that Texas's Any Willing Provider statute was preempted by ERISA. 105 F.3d at 1037. The Court explained that "[a]s with the Louisiana statute in Cigna, the Texas statute relates to ERISA plans because it 'eliminates the choice of structuring benefits,' by prohibiting plans from contracting with pharmacy networks that would exclude any willing provider." Id. (citing Cigna, 82 F.3d at 648).

Based on the Fifth Circuit's holding in Cigna and Texas Pharmacy, the Court finds that the Act creates two provisions that bind employers or plan administrators to particular choices Sections 88.002(f) and (g) of the Texas Civil Practice and Remedies Code. Section 88.002(f) provides that:

[a] health insurance carrier, health maintenance organization, or managed care entity shall not remove a physician or health care provider from its plan or refuse to renew a contract with a physician or health care provider with its plan for advocating on behalf of the enrollee appropriate and medically necessary health care for the enrollee.

Tex. Civ. Prac. & Rem. Code Ann. § 88.002(f) (West 1998) (emphasis added). Section 88.002(g) states that:

[a] health insurance carrier, health maintenance organization, or managed care entity shall not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause that acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any such indemnification or hold harmless clause in an existing contract is hereby declared void.

Id. § 88.002(g) (emphasis added).

Thus, in the instant case, ERISA plans that choose to offer coverage by either a health insurance carrier, HMO, or other managed care entity are limited by the Act to using a particular structure i.e., a structure that does not remove a physician or health care provider from its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care and a structure that does not include a prohibited indemnification or hold harmless clause. In other words, the Act prohibits ERISA plans from using a managed care entity that does not conform to the requirements in these provisions. By denying health insurance carriers, HMOs, and other managed care entities the right to structure their benefits in a particular way, the Act effectively requires ERISA plans to purchase benefits of a particular structure through a contract with organizations like Plaintiffs. See Cigna, 82 F.3d at 648.

Since these provisions require ERISA plans to purchase benefits of a particular structure, they essentially cause the Act to have a "connection with" such plans. However, that these provisions may be severed from the remainder of the statute.

Although these provisions at issue would clearly serve to enhance the quality of care that could be provided, the absence of these sections from the Act does not affect the constitutionality of the provisions concerning quality of care. A suit may still be brought under the Act concerning the quality of a benefit actually received. Moreover, upholding the validity of the relevant provisions of the Act is in accord with the legislative intent. The floor debates as well as the testimony of the Act, given before the Senate Interim Committee on Managed Care and Consumer Protections and the Senate Economic Development Committee reveal the proponents' and the legislature's concern over managed care entities and the lack of quality care. (In History, Instrument Nos. 14, 16). Even though these provisions clearly were designed to ensure quality medical care, this goal can be given effect without these invalid provisions accordingly, the Court finds that they may be severed from the Act.

iv. Alternate Enforcement Mechanism

Lastly, Plaintiffs argue that the liability sections created by the Act, Sections (a) and (b) of the Texas Civil Practice and Remedies Code, purport to create an alternate

mechanism. (Plaintiffs' Surreply, Instrument No. 53 at 6).

State laws that provide "alternate enforcement mechanisms [for employees to obtain plan benefits] also relate to ERISA plans, triggering pre-emption." *Travelers*, 514 U.S. 645, 115 S. Ct. at 1678; *Coyne*, 98 F.3d at 1468 (noting Congress' intent to preempt state laws that provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits). In *Travelers*, the Court has already determined that the liability sections of the Act, namely 29 U.S.C. §§ 1102(a) and (b) of the Texas Civil Practice and Remedies Code, provide a cause of action for challenging the quality of benefits received. Such a lawsuit would not create an alternate enforcement mechanism for employees to obtain ERISA benefits. See *Dukes*, 57 F.3d at 1104 (distinguishing between an HMO's denial of plan benefits and an HMO's role as the provider of a participant's medical treatment which implicates the quality of care that a participant actually receives). Rather, it would ensure the quality of care that employees actually receive. Whether a review of an adverse benefit determination or to secure quality coverage should be conducted by the Court on a case-by-case basis. See *Schmid*, 963 F. Supp. at 945 n.1 (noting "determination of whether or not a particular claim is preempted by ERISA must be made on a case-by-case basis"). It is not apparent to the Court that every claim that may be brought under the Act would establish an alternate enforcement mechanism for benefit determination.

Based on the foregoing analysis, the Court holds that Plaintiffs have not met their burden of proving that every claim brought under the Act would be preempted by ERISA. Even if some economic impact may result, a claim concerning the quality of a benefit actually received would remain valid.

VII. FEHBA Preemption

Plaintiffs finally argue that the Act is preempted by FEHBA. In response, Defendants maintain that "FEHBA preemption applies only when there exists a conflict between a state law being relied upon in litigation and contractual provisions in a FEHBA policy that relate to the nature or extent of coverage of benefits." (Defendants' Brief, Instrument No. 36). According to Defendants, Plaintiffs fail "to set forth any facts alleging any FEHBA policy or contract language conflicting with" the Act. (Id.).

Conversely, Plaintiffs argue that FEHBA preemption is required given the Fifth Circuit decision in *Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656 (5th Cir. 1993). Plaintiffs contend that Defendants' argument, raised by the plaintiffs in *Burkey*, was clearly rejected by the Fifth Circuit.

As with ERISA, FEHBA provides that state law may be preempted. However, "FEHBA preemption is far more narrow than that of ERISA." *Arnold v. Blue Cross & Blue Shield of Texas, Inc.*, 973 F. Supp. 726, 732 (S.D. Tex. 1997). Congress expressed its intent to preempt state law under FEHBA in 5 U.S.C.A. § 8902(m)(1) (West Supp. 1996), which states that

[t]he provisions of any contract under this chapter which relate to the nature, extent, or coverage of benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or regulation issued thereunder, to the extent that such law or regulation is inconsistent with such contractual provisions.

This language makes it clear "that Congress did not intend for state law to be entirely preempted." *Arnold*, 973 F. Supp. at 731.

By expressly limiting the FEHBA's preemptive effect to those laws or regulations that are inconsistent with insurance carrier (or health plan) contracts, Congress indicated that courts may not assume that the FEHBA preempts all related state law claims but instead conduct a case-by-case analysis to determine whether a plaintiff's state law claim conflicts with a contractual provision.

Id. at 732 (citing *Transitional Hosps. Corp. v. Blue Cross & Blue Shield of Texas*, 973 F. Supp. 67, 70 (W.D. Tex. 1996)): "The policy underlying § 8902(m)(1) is to ensure the uniformity of the administration of FEHBA benefits." *Burkey*, 983 F.2d at 660.

In *Burkey*, a federal employee and her son brought an action against the Government Employees Hospital Association ("GEHA") under Louisiana law "which authorize[d] damages attorneys' fees for unreasonable delay in paying health and accident insurance claims." *Burkey*, 983 F.2d at 657. The Burkeys claimed that GEHA breached its contractual obligation to pay their medical bills.

The Fifth Circuit held that "Louisiana's penalty provision [wa]s inconsistent with the federal law regulating federal employee health benefits and therefore preempted by the federal law regulating federal employee health benefits." *Burkey*, 983 F.2d at 658. Although the Burkeys argued that their state law claim related to remedies, nature, or extent of coverage or benefits[,] the Court reasoned that "tort claims arising in which a benefit claim is handled are not separable from the terms of the contract providing the benefits. . . . [Therefore,] such claims 'relate to' the plan under § 8902(m)(1) as a connection with or refer to the plan." *Id.* at 660. "Insofar as the Burkeys' claim

delay damages necessarily refer[red] to GEHA's plan to determine coverage and whether proper claims handling process was followed, it refer[red] to the plan, 'relate[d] therefore preempted." Id.

Unlike the claim asserted by the Burkeys, an individual may file suit under the damages for the substandard quality of care actually received. As articulated by the ERISA preemption analysis, such a suit would not arise out of the manner in which claim was handled and would not refer to Plaintiffs' plan to determine coverage or proper claims handling process was followed. Therefore, even under Burkey, a claim the quality of a benefit received would not "relate to" a FEHBA plan. Moreover, with other claims that one may bring under the Act, a court should conduct a case-by-case to determine whether that claim conflicts with a contractual provision. See Arnold at 732.

VIII. Conclusion

Accordingly, the Court finds that Defendants' and Plaintiffs' motions for summary judgment are GRANTED in part and DENIED in part. (Instrument Nos. 10 and 20).

The Court ORDERS that the Department is dismissed from the lawsuit.

The Court also finds that the following provisions are preempted by ERISA and accordingly, the Court ORDERS them to be severed: Section 88.002(f), Section 88.003(a)(2), Section 88.003(b), Section 88.003(c), the relevant language in 88.003(d), Section 88.003(e), and the relevant language in Sections 88.003(f) and the Civil Practice and Remedies Code, the language added by the Act in Article 20A.09(e), 20A.12A, the amendments to Articles 21.58A(6)(b)(5) and 21.58A(6)(c), Article 21.58A(8)(f), and Article 21.58C of the Texas Insurance Code.

The Court finds that the remaining provisions of the Texas Civil Practice and Remedies Code and the Texas Insurance Code, as added and amended by the Act, are not preempted by ERISA.

The Clerk shall enter this Order and provide a copy to all parties.

SIGNED this 18th day of September, 1998, at Houston, Texas.

VANESSA D. GILMORE
UNITED STATES DISTRICT JUDGE

002810

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Testimony of the Fairfield County Medical Association

in Support of

House Bill 7032 – An Act Concerning the Liability of Managed Care Organizations

Presented by Edward J. Volpintesta, MD

to the

Public Health Committee,

Judiciary Committee,

and

Insurance and Real Estate Committee

March 23, 1999

Good day, honorable chairpersons and members of the Public Health, Judiciary, and Insurance and Real Estate Committees. My name is Edward Volpintesta. I am a family physician from Bethel. I am the chairman of the Board of Trustees of the Fairfield County Medical Association (FCMA). I am here today to testify in support of House Bill 7032 – An Act Concerning Liability of Managed Care Organizations.

We have all heard the many horror stories about the harmful, and even fatal, outcomes that can occur when managed care organizations deny medical care that physicians deem necessary for their patients. In fact, giving patients the right to sue their HMOs was at the center of many political campaigns last fall. Since October 1998, there have been two major court rulings concerning the liability of managed care organizations – one in Houston, Texas by U.S. District Court Judge Vanessa Gilmore, who ruled to uphold the state's law that holds HMOs liable for denying medically necessary care, and the other right here in Connecticut by U.S. District Court Judge Christopher Droney, who ruled that a lawsuit brought against PHS can proceed in Danbury Superior Court.

In Texas, Aetna filed a suit arguing that the state's Health Care Liability Act is preempted by federal law. Judge Gilmore dismissed the suit declaring that the law addresses quality of care issues rather than federally protected benefits administration. Similarly, in the suit filed against PHS in Connecticut, PHS had argued that the suit should be dismissed because federal law bars claims based on denial of insurance benefits. However, Judge Dronney ruled that the suit against PHS concerned the quality of care dictated by the HMO rather than denial of benefits.

We support legislation that enables physicians, not health insurance company bureaucrats, to determine what is medically necessary for their patients. Currently, many managed care contracts attempt to contractually define "medical necessity" and, in these definitions, impose "lowest cost" criteria. The use of "lowest cost" language in contractual definitions clearly suggests that some health insurers are focusing their medical necessity determinations solely on cost. We need to prohibit health insurers from continuing this practice of placing their financial bottom lines ahead of appropriate medical care for their enrollees, our patients. We need to impose the following principles:

- **Physicians must be able to make decisions regarding medical necessity for their patients without unreasonable interference from health insurers.** Our patients need to be able to trust that we are making medical decisions and recommendations for them based solely on their medical needs. If a health insurance company wishes to exclude coverage for specific services, it must explicitly identify those non-covered services prior to a patient's enrollment in a health plan.
- **"Medical necessity" must be defined as follows:** *Health care services that a physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.*

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- Patients should not be treated unfairly by health insurers denying coverage for medically necessary treatment, based on information the insurer obtains only later in the course of treatment. Any review of a medical necessity decision must be based solely on the information that the physician had at the time the medical services were rendered.
- “Medical necessity” must be determined according to a “prudent physician standard” – which legally and medically is an objective standard – and not be subject to the abuses alleged by health insurers.

As physicians, we are held accountable for decisions that affect medical care and patient outcomes. If a health insurer wants to tell us that, under managed care plan, we cannot offer our patients services for which they have paid premiums, then that insurer must be held to the same high standard of patient care as we are.

Therefore, as a group whose members are dedicated to improving the health of all area citizens, the Fairfield County Medical Association *SUPPORTS* HB 7032 because it establishes a system through which managed care organizations *must* assume responsibility for their actions. We urge your favorable report of this bill. Thank you for your attention. I will be glad to answer any questions.

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**TESTIMONY OF MELISSIA PETRO
AMERICAN CANCER SOCIETY
BEFORE THE PUBLIC HEALTH, JUDICIARY AND REAL ESTATE COMMITTEES**

HB 7032: An Act Concerning the Liability of Managed Care Organizations

Distinguished members of the Public Health and Judiciary and Real Estate Committees. My name is Melissia Petro and I am submitting testimony regarding HB 7032: An Act Concerning the Liability of Managed Care Organizations.

Just as any doctor is liable for damages when they fail to exercise ordinary care when dealing with their patients, we believe that managed care companies and other insurance providers should be held to the same standard of accountability. With the power of making medical decisions regarding the health and treatment of cancer patients, also comes the responsibility resulting from these decisions.

On behalf of the American Cancer Society, cancer patients and their families in the state of Connecticut, thank you for raising this bill and starting a necessary dialogue.

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**Connecticut
Psychiatric
Society**

*District Branch
American Psychiatric
Association, Inc.*

Statement in Support of House Bill 7032 –

An Act Concerning the Liability of Health Maintenance Organizations

Public Health, Judiciary, and Insurance and Real Estate Committees

March 23, 1999

Good morning, Chairs of the Public Health, Judiciary, and Insurance Committees and committee members. My name is Brian Benton. I am a psychiatrist and the Medical Director of the Psychiatry Department at Backus Hospital, and Chairman of the Pharmacy and Therapeutics Committee also at Backus Hospital. I am here today as the nominated president-elect of the Connecticut Psychiatric Society to represent the 1050 members of the Society in testifying in support of House Bill 7032 – An Act Concerning the Liability of Health Maintenance Organizations.

House Bill 7032 would allow injured individuals to sue their managed care companies if a health treatment decision made by the managed care company is the proximate cause of their injury. We cannot stress enough the necessity for this type of legislation. As it currently stands, it is the physician who is held liable for a health treatment decision or denial of care.

However, with the advent of managed care, fewer and fewer medical decisions are actually being made by the physician. It is the managed care companies who are deciding which medications will be authorized for a patient, which treatments a patient may use, and how long a patient may stay in the hospital. This is especially true in the area of mental health where the

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most fragile of patients are treated. Psychiatrists and their patients are often at the mercy of managed care companies who either deny or severely limit the treatment available to a patient.

We have heard the argument that decisions on health care treatments and/or denials of care are not medical decisions but rather they are payment decisions. When denying the payment for the care that a physician says is medically necessary or refusing to allow a medication because it is not on formulary, the managed care company is effectively denying medical treatment. Very few people can actually afford to pay out-of-pocket, and besides they have already been paying premiums that should be going towards their care.

This is incredibly frustrating for psychiatric doctors since the HMO has never actually seen the patient before denying care.

House Bill 7032 will, for the first time in Connecticut, give the patient some recourse when he or she is injured by a health treatment decision made by an HMO. Traditional managed care reform legislation is not sufficient to rein in the egregious behavior of managed care organizations. We believe that this is the only way to force managed care companies to carefully consider health treatment decisions. This type of legislation will not result in an explosion of litigation. When there is a bad health care outcome – the lawsuits are already there. This bill would simply allow all involved parties to bear the appropriate responsibility.

If managed care companies want to make medical decisions they must live up to the consequences of those decisions. We urge this committee to support House Bill 7032.

**For more information, please contact the
Connecticut Psychiatric Society
Jacquelyn T. Coleman, Executive Director
Robert D. Houley and Melissa Dempsey, Government Relations
(860) 243-3977**

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STATE OF CONNECTICUT

INSURANCE DEPARTMENT

**Written Statement of George M. Reider, Jr., Insurance Commissioner
To Public Health, Judiciary and Insurance and Real Estate Committees
Regarding Raised Bill 1195, An Act Concerning the Liability of Health
Maintenance Organizations and H.B. 7032, An Act Concerning the Liability
of Managed Care Organizations**

March 23, 1999

Health care continues to be a topic of great concern. As you are aware, the Insurance Department has been extremely active in the implementation of Public Act 97-99, An Act Concerning Managed Care. I thought I would detail some of the consumer protections that are currently administered by the Insurance Department to provide you further insight regarding the existing managed care environment as you contemplate further legislation in this area.

External Appeals Process

One of the highlights of Public Act 97-99 was the creation of an external appeals process for managed care denials. This process provides an independent review to enrollees of managed care plans after they have exhausted all of the internal appeals processes of their managed care organization or utilization review company. A review is conducted by one of the three entities contracted by the Insurance Department to perform such services. These entities were selected through a RFP process by a committee of representatives of the Insurance Department, Department of Public Health, Office of Policy and Management and the Office of Health Care Access.

The external appeal entity conducts a preliminary review within five (5) business days from receipt of the appeal from the Department and informs the Commissioner and the enrollee/provider if the appeal is accepted for full review. If accepted, the utilization review company is also notified and both parties are given the opportunity to provide additional pertinent information for consideration. The appeal will be accepted for full review if the external appeals entity determines that:

- the individual was or is a member of a managed care plan;
- the benefit or service under appeal reasonably appears to be a covered service and benefit limitations have not been reached;
- the enrollee has exhausted all internal appeals mechanisms; and
- the enrollee has submitted all required information, including completed application, a copy of final denial and fully executed medical release form.

A decision on the full review must be completed and forwarded to the Insurance Commissioner within thirty (30) business days of completion of the preliminary

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review. The Commissioner must accept the decision and notifies the parties involved. The decision is binding.

Notification of the appeals process must be provided in every denial letter sent by a utilization review company. In addition, each letter must include the address and telephone number of the Insurance Department for further information. Copies of the external appeals brochure and application are available on the Department's web site and are also distributed at all public meetings the Commissioner attends throughout the state.

Expedited Review Process

Section 18e of Public Act 97-99 required the establishment of an expedited review process for utilization review requests when an enrollee has been admitted to an acute care hospital. In cases where the attending physician determines that the enrollee's life will be endangered or serious injury could occur if the patient is discharged or treatment is delayed, the attending physician may transmit a request for an expedited review. If the attending physician does not receive a response within three (3) hours of his request, the request is deemed approved. Each utilization review company must have review staff available from 8:00 a.m. - 9:00 p.m. to process these requests.

In accordance with §22 of PA 97-99, this process was developed by a committee made up of representatives of the Insurance Department, Connecticut State Medical Society, Connecticut Hospital Association, Connecticut HMO Association and Anthem Blue Cross and Blue Shield. The process was implemented on November 1, 1997.

The Insurance Department maintains a directory of two methods of communication to the utilization review company and distributes it to all acute care hospitals in Connecticut on a monthly basis.

Utilization Review

The Insurance Department is responsible for the licensing of all utilization review companies in accordance with §38a-226 et al of the Connecticut General Statutes, as amended by PA 97-99. In addition, each utilization review license is renewed annually on October 1st. As part of the Department's renewal requirements, each utilization review company is required to demonstrate compliance with the new requirements of PA 97-99. This includes submitting copies of denial letters at all stages (first denial through final appeal) advising the enrollee of his right to an external appeal through the Insurance Department.

The companies are also required to certify that on appeal, all decisions not to certify an admission, procedure, service or extension of stay must be reviewed by a physician who is a specialist in the field related to the condition whenever

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the reason for the decision is based on medical necessity, including whether a treatment is experimental or investigational.

As of December 31, 1998, there were 123 utilization review companies licensed in Connecticut. 1998 activities regarding utilization review in Connecticut, as reported to the Department, are as follows:

| | # of UR requests | # of UR denials | % of UR denials | # of appeals | # of denials reversed on appeal | % of denials reversed on appeal |
|-------------------------|------------------|-----------------|-----------------|--------------|---------------------------------|---------------------------------|
| Connecticut only | 813,965 | 28,172 | 3.46% | 5,246 | 1,840 | 35.07% |

During calendar year 1998, the Insurance Department's Market Conduct Division was active in conducting compliance reviews of utilization review companies. The on-site examination determines if the utilization review company is operating in compliance with all statutory requirements, including timeliness of decisions and notification requirements, adherence to confidentiality laws, and use of appropriate medical personnel.

As part of the on-site market conduct examination program, the Department reviews company protocols and procedures used to render utilization review decisions. The examination verifies that the protocols are in written form, periodically updated to reflect changes in medicine, developed with local input from appropriately licensed medical professionals and are made available to providers upon request. In addition, the Department verifies, through review of sample case files, that specialists in the relevant medical fields are involved in utilization review determinations. If a utilization review company is found not to be in compliance, the Department has the ability to levy fines or take other actions as appropriate.

Consumer Complaints and Outreach Programs

The Insurance Department's Consumer Affairs Division is always available to assist consumers with any complaints against managed care organizations. When a complaint is received, the Department acts as an intermediary to try to achieve resolution. Department staff participates in numerous outreach activities in an effort to educate both the public and private sectors regarding Public Act 97-99 and other matters relating to health insurance.

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Consumer Report Card

In October, 1998, the Insurance Department published the first edition of "A Comparison of Managed Care Organizations in Connecticut", a comparison of all health maintenance organizations and the fifteen largest insurers that offer managed care plans in the state. This guide is designed to be used by consumers when choosing a managed care plan for themselves and their families. The Department continues to receive feedback from the public in an attempt to be responsive to the changing managed care environment.

As always, my staff and I are available to provide technical assistance to the committees and to answer any questions.

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Office of the Attorney General
State of Connecticut

TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL
BEFORE THE PUBLIC HEALTH AND
INSURANCE AND REAL ESTATE COMMITTEES

MARCH 23, 1999

I appreciate the opportunity to support House Bill 7032, An Act Concerning The Liability of Managed Care Organizations.

This proposal aims at elemental fairness, so that the managed care industry will be held accountable for negligent acts, and potential devastating damage. One of the basic tenets of American law is that a victim of negligence should be able to recover for the harm proximately caused by a tortious act. Rarely is it good policy to deny a victim this recovery, since private suits are likely to make everyone more careful. Unfortunately, many victims have discovered that HMO's are virtually exempt from such accountability.

I received a letter from a mother of two children. She related her experience when her managed care company overruled her physician and determined that she was in sufficiently good condition to leave the hospital. A massive infection developed, causing her to require a colostomy bag for the rest of her life. Had she been in the hospital, the infection would have been diagnosed and proper treatment applied in a timely fashion. Despite the evidence that the HMO decision significantly contributed to the harm she suffered and will continue to suffer, she will never have a fair day in court to prove her case because current law does not allow effective lawsuits against HMO's.

Our law has failed to keep pace with the real world of health care and the changing legal landscape. Prior to the era of managed care, insurance companies merely decided whether to pay a claim. Exercise of this authority rarely, if ever, threatened the individual. Now, in the new HMO era, insurers have become active participants in the diagnosis and treatment of patients. The managed care companies review physician decisions primarily to reduce costs of coverage. For the past two years, the General Assembly has heard the horror stories of bad managed care company decisions, but the law still does not address the victim's rights in these instances. Although there is a provision in state by which HMOs cannot enter into hold harmless agreements with physicians in their organization, that law does not provide a sound legal basis for authorizing a patient to recover damages caused by a health insurer.

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House Bill 7032 is a common-sense approach that balances the rights of victims to recover for damages with the need to protect managed care companies from unfounded lawsuits. House Bill 7032 carefully establishes a negligence standard for managed care decisions based on well-established common law principles. The proposal specifies that managed care companies do not need to pay for treatment excluded by the health care plan of the company. Finally, the proposal prohibits managed care companies from requiring physicians to indemnify the company's losses as a result of its negligence.

This proposal is modeled after a Texas law except that the proposal exempts ERISA plans from its liability provisions. The Employee Retirement Income Security Act (ERISA) has been used as a defense by HMO's in a number of medical malpractice claims. Currently, federal case law is unclear as to whether ERISA preempts state laws authorizing lawsuits against HMO ERISA plans. However, there is some room for hope. The Texas law was partially upheld against this challenge, holding in part that an HMO could be liable for arranging inadequate health care as part of their coverage services.

In Connecticut, a recent very significant federal district court decision rejected an HMO request to dismiss a suit brought against it for ordering a patient with psychiatric problems to be discharged from Danbury Hospital. The HMO had referred to him to another facility with inadequate services, the patient then committed suicide after his discharge from the hospital. I urge the committee to consider providing ERISA plan enrollees with the same protection as non-ERISA plan enrollees. Since ERISA's preemption scope is uncertain, the Committee should provide as much protection for consumers as possible.

I urge your support for this legislation.

Thank you.