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States restrain HMO abuses

by Marianna Wertz

A report issued in mid-March by the Inspector General of the U.S. Department of Health and Human Services, found that a majority of Medicare beneficiaries in managed-care programs cannot obtain the medical services they need, because Health Maintenance Organizations (HMOs) limit their ability to appeal adverse decisions on treatment. Inspector June Gibbs Brown also found that more than half of the HMOs examined did not fully comply with Federal rules for handling appeals and grievances.

In response to this and similar abuses by managed-care companies nationwide, several state legislatures are crafting legislation to subject managed-care practices to strong state regulation. Some recent bills are summarized here:

New Jersey: The New Jersey "Health Care Quality Act"—the toughest managed-care regulatory bill in the nation to date—was unanimously approved on March 10 by the State Assembly and Senate Health Committees. The major force behind the bill is Patients First, a coalition of trade unions in the health-care field, which organized two days of intense testimony by victims of managed care.

The legislation now awaits a vote by the full state legislature, which could come as early as May, according to the chief Senate sponsor, Jack G. Sinagra (R-Edison). The legislation puts muscle into the new regulations for health maintenance organizations which went into effect March 15, and extends those regulations to all other forms of managed-care plans. The regulations include:

- Only a doctor, not a nurse or a clerk, can decide to deny or limit coverage.
- Consumers have a right to a choice of specialists, following a referral.
- An appeals process is available for patients or doctors who disagree with an HMO decision. That process is run through an independent panel set up by the State Department of Health.
- "Gag" rules—prohibiting a doctor from discussing with a patient all treatment options, including those the HMO won't pay for—are forbidden.
- HMOs must disclose the type of compensation arrangement they have with their physicians, and "shall not provide financial incentives to the health care provider for withholding covered health care services that are medically necessary. . . ."
- The Department of Health will produce a series of HMO "report cards" every six months, to inform the legislature of each HMO's performance.

The legislation also authorizes fines for HMOs which don't follow the new regulations, ranging from not less than $250 to not more than $10,000 for each day that the carrier is in violation of the Act.

Texas: The Texas Senate passed a bill March 17 that will be the toughest HMO liability law in the nation, if it also passes the House. Sponsored by Sen. David Sibley (R-Waco), the bill would hold managed health care organizations liable for the medical treatment they approve for, or deny to, their clients. Under current law nationwide, HMOs have been able to wriggle out of liability for the malpractice which was clearly caused by their practices, using an arcane precedent, under which the federal government is exempted for liability for those insured under the Employee Retirement Income and Security Act.

The proposed legislation, S.B. 386, stipulates that "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." It also states that managed-care entities may not remove a physician or health care provider from its plan or refuse to renew the provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

Maryland: At last count, 61 bills have been introduced in the Maryland General Assembly seeking to correct the abuses of the HMOs. The bill judged most likely to pass this session would give patients an avenue outside the insurer's internal appeals process to challenge decisions denying them coverage for medical procedures. The bill has HMO support, because it is the least restrictive of all the proposals. Under the legislation, an HMO member who was denied coverage for a procedure or hospital stay would have to be told that the Health Advocacy Unit of the Attorney General's Office was available to help file the complaint under the insurer's internal grievance procedure.

California: In California, the most aggressive move against managed care is coming from the California Nurses Association. Nurse negotiators representing some 7,500 registered nurses at 45 Kaiser Permanente hospitals and clinics throughout northern California voted March 6 to strike beginning April 16, to protest escalating patient care abuses and massive concessions demanded by Kaiser, the state's leading health maintenance organization. Options for the strike include a one-day strike April 16 at all Kaiser facilities, or rolling strikes by region or facility beginning April 16. In addition, the nurses are stepping up other public activities. Those actions have included mass picketing at Kaiser facilities in Santa Teresa on March 14 and Walnut Creek on March 21.

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