The tragic events of 9/11 have diverted attention from the public debate in Washington about a national patients' bill of rights. The idea behind such legislation is that patients should have the right to sue their HMO or managed care insurer for money damages if their coverage is wrongfully denied, treatment is delayed or withheld, and their health is seriously damaged as a result. This kind of legislation is generally supported by patients, trial lawyers, and consumer advocates. It is opposed by advocates of tort reform, big business, and the insurance industry.

Last fall, buoyed by a popular consensus that a national patient's bill of rights was long overdue, conflicting House and Senate versions were going to a conference committee for resolution and submission to the President. Then came 9/11, and terrorism issues eclipsed health care from the legislative agenda. In the aftermath, partisan bickering began anew, and special interests enjoy another opportunity to forestall enactment indefinitely.

In the meantime, a few state legislatures have created their own Patients' Bill of Rights, and Arizona is one of them. Our law, enacted 2 years ago, can be found in the Arizona Revised Statutes, Title 20, number 3153. Although it is the right idea, giving a covered person the right to sue an insurer in state court, the injured party must prove that the insurer acted unreasonably and intentionally to delay or deny a service that was medically necessary. This is a greater burden of proof than an injured party has in an ordinary negligence case, such as medical malpractice, where it is not necessary to prove that the party causing the harm acted intentionally. Negligence means acting carelessly, or failing to satisfy a reasonable "standard of care" to keep from injuring others. It does not matter whether the negligent party intended to cause the injury or not. Under the Arizona law, the health care insurer must know that it is acting unreasonably. The conduct cannot be inadvertent, it must be deliberate.

Not surprisingly then, only the worst cases of abuse by an HMO or health insurance company could be brought under the Arizona Patients' Bill of Rights. Other legal theories, called causes of action, may be better suited in many cases. The most conventional cause of action against an insurance company is called bad faith. Any type of insurance claim, including a health insurance claim, that is wrongfully denied by the company is bad faith. That is because an insurance policy is a contract between the policyholder and the company. The law of contracts imposes a duty on the insurance company to act in good faith, which means they must act fairly and reasonably, and not put their own financial interests above the interests of those they insure. Bad faith claims may also include charges of fraud, false advertising, corporate liability, and breach of fiduciary duty.

The trouble with bad faith claims against health insurance companies is that they may fall under a Federal law called ERISA. This stands for the Employee Retirement Income Security Act, a mammoth piece of federal legislation enacted in 1974 to guarantee the well being and security of private sector employee benefit plans. ERISA thus impacts on health care plans which are offered by private employers as benefits to their employees, and this is how most people get their health insurance coverage. Until recently, ERISA has provided a nearly impenetrable shield for managed care organizations against liability for bad decisions about benefits which result in bad outcomes for patients. That is because ERISA has been found to pre-empt, or supercede any state law which might allow such an action. The practical effect of this pre-emption is to remove a lawsuit brought in state court to federal court where relief is limited to the recovery of benefits due, enforcement of rights under the plan, or clarification of future benefits. Any fines which may be levied are payable to the government, and complaining parties may or may not be awarded their attorney's fees. There is no remedy to compensate for such losses as physical
injury, pain and suffering, emotional distress, lost wages, or disability. The cost of pursuing the remedies under ERISA may be greater than the relief which is available.

Courts have ruled differently, and sometimes inconsistently, on ERISA pre-emption. The outcome depends greatly on the unique facts and circumstances of each individual case. As a general rule, if the issues in the case have to do with the quality of the care, which are medical issues, rather than the quantity of care, which are commercial or business issues, it is less likely that ERISA will apply. At the present time, most claims which only allege bad faith are found to be pre-empted by ERISA, with a very limited recovery at best. That was one of the main reasons that the Arizona legislature decided to enact its patients' bill of rights. When and if Congress passes a national patients' bill of rights, it may pre-empt the Arizona law, and make it easier to prevail against an HMO or managed care organization than it would be under the present state law.

There is, however, another legal theory under which HMO's and managed care organizations may be held accountable for bad decisions which damage their patients' health. That is to make them liable for ordinary medical malpractice, just as doctors and hospitals are now. Such a claim would remain in the state court system, where ERISA does not apply, and there are no limits on recovering for all kinds of damages. The theory is that managed care presents patients with a package, limiting their choices about doctors and hospitals, location of ancillary services, primary or specialty care, and even the very necessity of treatment itself. They compete for business, often marketing and advertising better services and lower costs. This makes them vicariously liable for their provider's mistakes, in much the same way employers are liable for the mistakes of their employees. In many cases, decisions about coverage are made by licensed physicians working for the company as medical directors. Such physicians may be liable for negligent decisions, just as any doctor would be, but the company employing the director is liable as well.

In other cases, the company may be liable under a legal theory called ostensible agency. This theory applies when it reasonably appears to the public that the company, doctors, and hospitals are all working together as a single unit. Managed care policies and procedures limit patients' choices of doctors and hospitals to those they select and contract with. They credential their doctors just as a hospital would, and they set standards of care for the hospitals they use as well. The providers are said to be acting as "agents" of the insurance company, and the company is regarded as the "principal". Under agency theory, the doctors and hospitals are said to be working for the principal in much the same way that employees work for employers. The company vouches for the competence of its providers, and is liable like an employer for their mistakes. For obvious reasons, claims like this are usually brought as part of ordinary medical malpractice claims against doctors and hospitals. Arizona courts have applied this kind of reasoning in several cases over the last decade.

Managed healthcare is here to stay. The need to control the ever increasing cost of healthcare in this country makes certain that decisions about benefits will continue to be made with the bottom line in mind. Sometimes these decisions will be wrong, and patients' health will suffer as a result. When that happens, HMO's and insurance companies must be held accountable, just as anyone in a position of power and authority would be, for negligent injury to others who depend on them. In the past, patients had little or no recourse for such injuries. Whether by relying on a patients' bill of rights, or on other more conventional remedies, the scales of justice will be better balanced in favor of patients one day soon.