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Wisconsin Supreme Court Rules "Bad Faith Applies to HMOs"

Editorial Staff

On September 9, 1991, Susan McEvoy brought her 13-year-old daughter, Angela, to see Lawrence MacFarlane, MD, a primary-care physician of the Group Health Cooperative (GHC) HMO of Eau Claire, Wisconsin.

GHC, lacking the expertise to handle Angela's problem, anorexia nervosa, sent her to the University of Minnesota Hospital. Angela's stay at the hospital was approved for two weeks by Stuart Lancer, MD, GHC's medical director. Because of the seriousness of her condition, her hospital care was extended another week, and then another three weeks. After six weeks of in-patient care for Angela, Dr. Lancer denied additional treatment, as noted in the following notation in GHC's records:

> "12/27/91 [Lancer] OK'ed [coverage] thru Wed. Jan 1st 1992 will be Angela's last day. ... NO MORE EXTENSIONS. [Lancer] doesn't want to talk to them anymore. No excuses. Discharge, or no payment."

Both Dr. MacFarlane and the hospital psychiatrist opposed the decision to deny additional care. Under the terms of the HMO benefits agreement, Angela had 70 days of insurance coverage remaining for inpatient care.

When she was discharged from the hospital, Angela weighed 95 pounds, but over the next two months of her outpatient treatment at Systems Counseling, her situation deteriorated. GHC then approved coverage for Angela to see an eating disorder specialist who recommended inpatient treatment. With her weight down to 74 pounds, Angela was re-admitted by Dr. Lancer to the University of Minnesota Hospital. She was released after eight days into the Midelfort Clinic's eating disorders program.

Shortly after that, Angela and her mother filed a bad faith claim against GHC in the circuit court of Eau Claire County for discontinuing her inpatient hospital care. According to the legal review:

> "The rationale underlying a bad faith cause of action is to encourage fair treatment of the insured and penalize unfair and corrupt insurance practices. By ensuring that the policyholder achieves the benefits of his or her bargain with the insurer, a bad faith cause of action helps to redress a bargaining power imbalance between parties to an insurance contract."

GHC argued that the bad faith claim was being used to "circumvent the prohibition of punitive damages in medical malpractice actions," citing that the medical director was in fact a medical doctor. The circuit court judge agreed with GHC and denied the claim of bad faith in summary judgment.

Angela and her mother appealed the case, seeking a review of the application of bad faith to

HMOs.

On December 17, 1996, the appellate court reversed the lower-court decision, finding that:

> "Although Lancer is a medical doctor, and Group Health does employ a staff of physicians, the decisions Lancer made with regard to Angela's treatment were administrative insurance coverage decisions, rather than medical decisions.
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> "We interpret these remarks as those of an HMO administrator, rather than a treating physician. Lancer acted in a purely administrative or case-management capacity for Group Health when he decided to deny insurance coverage to Angela for further inpatient treatment at the University of Minnesota Hospital."

GHC in turn appealed the appellate decision to the Wisconsin Supreme Court. In a precedent-setting case, the supreme court had much to say about the application of the tort of bad faith to HMOs:

> "The question of whether HMOs can be sued by subscribers under the common-law tort of bad faith traditionally applied to insurance companies is a question of first impression for this court, and one that has not received significant discussion in other jurisdictions. To properly resolve this issue, we must consider the rationale underlying our previous adoption of the common-law tort of bad faith, the nature and purpose of HMOs, the legislature's pronouncements concerning the regulation and organization of HMOs, and the policy implications behind labeling HMOs as insurers under bad-faith tort. These considerations convince us that for purposes of the application of the common-law doctrine of bad faith, HMOs making out-of-network benefit decisions are insurers.
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> "In the course of the contractual relationship between the HMO and subscriber, a power imbalance similar to that between a classical insurer and policyholder exists. An HMO subscriber has little effective negotiating power since policy terms, like those in insurance contracts, are usually prepackaged and subject to a significant number of regulations and rules. When faced with a problem, HMO subscribers, like many insurance policyholders, may encounter bureaucratic or procedural hurdles in asserting their contractual health care rights. As a practical matter, HMO subscribers are similarly situated vis-a-vis their HMOs as insurance policyholders are to their more traditional insurance companies.
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> "Accordingly, based on the practical and legal similarities of HMOs and traditional insurance companies, we determine that the common-law tort of bad faith applies to HMOs making out-of-network benefit decisions.
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> "Public policy also supports our decision to equate HMOs and insurers for purposes of applying bad-faith tort to HMOs.
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> "Through contractual arrangements with physicians and patients, HMOs are able to exert significant influence on, if not outright control over, the costs of treatment regimens administered to patients, thereby limiting waste. The fears attendant with such arrangements, however, revolve around the economic model of health care financiers focusing on reducing aggregate costs while failing to recognize and protect adequately the medical needs of individual subscribers.

"This fear is particularly acute in the present high-cost medical economy where an adverse benefits ruling means not just that the financier will not provide payment, but also that the medical care itself is effectively denied. The tort of bad faith was created to protect the insured from such harm.

"Because HMO subscribers are in an inferior position for enforcing their contractual health care rights, application of the tort of bad faith is an additional means of ensuring that HMOs do not give cost containment and utilization review such significant weight so as to disregard the legitimate medical needs of subscribers.

"Because HMOs by their nature are an amalgamation of characteristics from health care providers and insurers designed to reduce medical costs, this inquiry does not adhere well to bright line rules, particularly since cases will exist where a particular HMO action or omission may constitute both bad faith and malpractice. However, despite this difficulty, several boundaries can be applied to the inquiry.

"First, we emphasize that it is not the case that all malpractice cases against HMO physicians may also be pursued under the guise of the tort of bad faith. The tort of bad faith is not designed to apply to classic malpractice cases arising from mistakes made by a health care provider in diagnosis or treatment.

"Second, the bad-faith cause of action is not limited to decisions made by an HMO's medical director. The official capacity of the decision maker is not the touchstone of our bad-faith inquiry. Rather, we are concerned with the underlying basis for a decision made by an HMO employee that effectively denies coverage for out-of-network care under a subscriber's contract where the weight of internal financial considerations overcomes concern for the subscriber's reasonably necessary medical care.

"Third, the facts as alleged in this case present an excellent example of where a bad-faith claim should survive a summary judgment motion. Where a staff model HMO refers a subscriber of an out-of-network provider pursuant to that subscriber's needs and contract with the HMO, and it is alleged that the HMO then denies reimbursement for that out-of-network care without an established reasonable basis (i.e., due to internal financial considerations), the HMO is acting purely as an insurer.

"Fourth, bad-faith tort claims cannot arise in out-of-network provider situations unless an HMO unreasonably refuses to provide a service or cover payments to outside providers for which it is contractually obligated. Thus, an HMO insurer that denies payment for care because contractual coverage for such care is reasonably debatable cannot be held liable for bad-faith tort."

Now that this case has been established in Wisconsin, it will be important to see if the claim of bad faith is levied against other managed care organizations that deny care inappropriately. It is quite possible that the specter of bad faith will force medical directors to reconsider their decisions to terminate care just to save money.

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