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INSURANCE Managed Health Plans: Provide Certain Enrollees of Managed Care Plans with an Independent Review of Plan Determination and Provide Standards, Conditions, and Procedures Relating Thereto; Provide for Duties, Powers, and Functions of the Health Planning Agency with Regard to Such Reviews and Provide for Certification of Independent Review Organizations; Provide for Expert Reviewers and Decisions Thereof; Provide for Costs and Expedited Reviews; Provide Immunity from Liability and Presumptions; Prohibit Certain

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INSURANCE

Managed Healthcare Plans: Provide Certain Enrollees of Managed Care Plans with an Independent Review of Plan Determination and Provide Standards, Conditions, and Procedures Relating Thereto; Provide for Duties, Powers, and Functions of the Health Planning Agency with Regard to Such Reviews and Provide for Certification of Independent Review Organizations; Provide for Expert Reviewers and Decisions Thereof; Provide for Costs and Expedited Reviews; Provide Immunity from Liability and Presumptions; Prohibit Certain Conflicts of Interest; Provide for Quality Assurance; and Provide for Applicability

CODE SECTIONS: O.C.G.A. §§33-20A-1 to -10 (amended), -30 to -41 (new), 51-1-48 to -49 (new)

BILL NUMBER: HB 732

ACT NUMBER: 281

GEORGIA LAWS: 1999 Ga. Laws 350

SUMMARY: The Act creates a tort with liability for Health Maintenance Organization (HMO) decisions concerning medical conditions that result in death or injury. A plaintiff may recover actual damages from an HMO or managed care provider if the plaintiff can prove he or she suffered from a poor decision made by an HMO. The Act excludes punitive damages. The purpose of the Act is to provide a remedy for patients whose HMOs refused medical services or denied them timely diagnostic procedures. The Act also creates an independent review panel to review claims before lawsuits proceed.

EFFECTIVE DATE: July 1, 1999

History

Governor Roy Barnes promised healthcare reform in his 1998 campaign.¹ With HB 732, he initiated legislation in an effort to hold HMOs liable for negligent acts such as “failing to provide coverage called for in their policies.”² Discussion surrounding the passage of the bill included impassioned pleas by patients and Representatives who shared such stories as that of a patient with a brain tumor who was forced out of a hospital only four days after surgery.³ In another example, a patient with a brain tumor was denied doctor referrals, subsequently causing a delay in treatment.⁴

The Act improves the current state of the law governing managed care by “lessening the chances of litigation over . . . covered services, while at the same time providing a cause of action for injury or death due to negligently failing to provide such services.”⁵

HB 732’s sponsors introduced it to protect the citizens of Georgia by giving those who have been refused medical treatment or have not received certain necessary procedures a remedy against their HMOs.⁶ The Act provides for an independent review board to hear appeals from denials of treatment and establishes a cause of action against the HMO.⁷ The Act was heralded as a “tremendous step forward for patient’s rights” and a political compromise between managed care, business lobbyists, and the Governor.⁸ The Georgia Trial Lawyers and the Georgia Chamber of Commerce opposed the bill when it was first introduced.⁹ After the Act’s passage, the Georgia Chamber of Commerce gave the Act its stamp of approval through a spokesperson who stated: “I don’t think this is onerous for business.”¹⁰ The Georgia

1. See Charles Walston, *'99 Georgia Legislature, Barnes Proposals to Take Spotlight*, ATLANTA J. & CONST., Jan. 4, 1999 at C1.

2. E-mail Interview with Rep. Charlie Smith, Jr., House District No. 175 (Apr. 25, 1999) [hereinafter Smith Interview].

3. See Records of Proceedings in the House Session (Mar. 9, 1999) (remarks by Rep. Everett) (available in Georgia State University College of Law Library).

4. See Kathy Pruitt, *HMO Hearing Gets Emotional*, ATLANTA J. & CONST., Mar. 2, 1999, at B1.

5. Smith Interview, *supra* note 2.

6. See Records of Proceedings in the House Session (Mar. 9, 1999) (remarks by Rep. Smith) (available in Georgia State University College of Law Library)

7. See O.C.G.A. § 51-1-48 (Supp. 1999).

8. Telephone Interview with Rep. Tom Bordeaux, House District 151 (July 29, 1999) [hereinafter Bordeaux interview].

9. See Records of Proceedings in the House Session (Mar. 9, 1999) (remarks by Rep. Bordeaux) (available in Georgia State University College of Law Library)

10. See Stephen Ursery, *New Laws Address Ambulance Chasers, HMO's, Vanishing*

Trial Lawyers Association predicted that the Act would not spark a flood of litigation.¹¹

During the 1998 legislative session, a similar bill introduced in the House failed.¹² During the 1999 legislative session, Representatives Charlie Smith, Jr. of the 175th, Henrietta Turnquest of the 73rd, Winifred Dukes of the 161st, Tom Bordeaux of the 151st, David B. Graves of the 125th, and Earl Ehrhart of the 136th sponsored HB 732.¹³ The Governor signed the Act into law on April 20, 1999.¹⁴

The Mechanics of HB 732

The Act affects both tort and insurance law in Georgia. The first part creates a new tort under which aggrieved HMO patients can sue HMOs for denial of treatment if the denial causes injury; the second part creates an independent review panel under the Insurance Code to review these claims before a plaintiff can file a lawsuit.¹⁵

Part I of the Act added a new tort to Title 51 of the Georgia Code in sections 51-1-48 and 51-1-49.¹⁶ Under this Code section, an enrollee of a healthcare plan has a cause of action if the healthcare provider does not provide care using "ordinary diligence . . . in a timely and appropriate manner in accordance with the practices and standards of the profession of the health care provider [that causes] any injury or death . . . resulting from a want of such ordinary diligence. . . ."¹⁷ The law does not provide for punitive damages.¹⁸ However, before filing a civil suit, the enrollee must exhaust the grievance procedure of Code section 33-20A-5 and submit the claim to an independent review panel.¹⁹

Venue, Other Issues, FULTON COUNTY DAILY REP., July 1, 1999, at 1-2 (quoting Earl V. Rogers).

11. *See id.* (quoting Nicholas C. Moraitakis).

12. *See* HB 1269, as introduced, Ga. Gen. Assem. 1998. Representative Bordeaux believes the reason HB 732 passed and HB 1269 did not pass was the strong support of Governor Barnes. *See* Bordeaux Interview, *supra* note 8. He also stated that the Governor made a smart tactical move by separating HB 732 from the "only willing provider" legislation (SB 210) to divide and conquer the opposition. *See id.*

13. *See* HB 732, as introduced, 1999 Ga. Gen. Assem.

14. *See* State of Georgia Final Composite Status Sheet, May 3, 1999.

15. *See* O.C.G.A. §§ 51-1-48, 33-20A-30 to -41 (Supp. 1999).

16. *See id.* §§ 51-1-48 to -49.

17. *Id.* § 51-1-48(a).

18. *See id.*

19. *See id.* § 51-1-49.

Managed care providers pay for the cost of the independent review, and Code section 51-1-48(b) prevents the companies from shifting this responsibility to physicians.²⁰ The Act does not allow managed care providers to contract with physicians or anyone else for indemnification.²¹ Code section 51-1-48(a) creates a standard for adjustors to follow when they decide whether to provide coverage for treatments. Adjustors must look at the standards of the doctors and nurses they review, not at whether other insurance companies would allow or deny coverage.²² Thus, in subsequent litigation, the expert witnesses are doctors and nurses, not insurance adjustors, which makes it easier to find experts.²³ The Act assures that the medical profession can protect itself against intrusions of the insurance industry.²⁴

The independent review process is described in the Insurance Title of the Code in new additions to chapter 20A, the "Patient Protection Act."²⁵ The new section, Article 2 (Code sections 33-20A-30 to 33-20A-41), is entitled the "Patient's Right to Independent Review Act."²⁶ The patients must submit their claim to an independent review panel, which determines if the treatment is "medically necessary."²⁷ Following an adverse outcome to a grievance procedure or denial of treatment as experimental, managed care enrollees may appeal to the independent review panel if they can meet five additional criteria.²⁸ If the panel decides in favor of the patient, the managed care company must provide the treatment, and the patient may sue for any injury caused by the HMO's denial of treatment.²⁹ However, if the panel rules against the patient, the Act creates a rebuttable presumption that the HMO acted properly for subsequent litigation.³⁰ Critics have noted that if the panel rules in favor of the HMO, patients may have a hard time finding an attorney to proceed with litigation because of the heavy burden created by this presumption.³¹

20. *See id.* §§ 33-20A-34(b), 51-1-48(b).

21. *See id.* § 51-1-48(b).

22. *See id.*

23. *See* Bordeaux Interview, *supra* note 8.

24. *See id.*

25. *See* O.C.G.A. §§ 33-20A-30 to -41 (Supp. 1999).

26. *See id.* § 33-20A-30.

27. *See id.* § 33-20A-40.

28. *See id.* § 33-20A-32.

29. *See id.* § 33-20A-37(a).

30. *See id.* § 33-20A-37(b).

31. *See* Dave Williams, *Liability Laws Getting Thumbs-Up*, AUGUSTA CHRON., Mar. 22,

The tort liability section of the Act closely parallels the medical malpractice statute.³² It is also structured similarly to HMO liability laws in Texas and Missouri, both of which have a two-tiered liability process, which includes independent review before litigation.³³ In Texas, out of over 450 complaints that went through independent review, only one HMO has been sued since September 1997.³⁴ No suits have been filed under the Missouri liability act, but the independent review board has reviewed twenty-six complaints.³⁵ Missouri officials view such a statute as a means “to generate a sense of accountability and avoid lawsuits.”³⁶ This Act differs from the Texas legislation in that it bans punitive damages and does not allow patients to sue without going through the independent review process.³⁷

House Judiciary Committee Changes from the Introduced Version

The House Judiciary Committee changed the bill to expand eligibility to sue under the tort and to participate in the independent review process.³⁸ As introduced, the bill defined “eligible enrollee” as a person who is enrolled in a healthcare plan who requests the service that is denied.³⁹ The House Judiciary Committee expanded this definition to include dependents of enrollees.⁴⁰

Another change altered the mechanics of the bill by disallowing the scenario in which potential litigants could sue without first participating in an external review process.⁴¹ Under the bill, as introduced, the enrollee would not have to submit the claim for independent review if the managed care company did not request review in a specific time period.⁴² The House Judiciary Committee

1999, at C1.

32. See Bordeaux Interview, *supra* note 8.

33. See Williams, *supra* note 31; see also TEX. [CIV. PRAC. & REM.] CODE ANN. §§ 88.001 to 88.003 (West 1998); TEX. INS. CODE ANN. art. 21.58A to 21.58C (West 1998).

34. See Williams, *supra* note 31.

35. See *id.*

36. *Id.*

37. See *id.*

38. See HB 732 (HCS), 1999 Ga. Gen. Assem.

39. See HB 732, as introduced, 1999 Ga. Gen. Assem.

40. See Smith Interview, *supra* note 2; compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem.

41. See Stephen Ursery, *House Makes HMO Bill More Patient-Friendly*, FULTON COUNTY DAILY REP., Mar. 11, 1999, at 1.

42. See HB 732, as introduced, 1999 Ga. Gen. Assem. The original version of the bill would have placed this provision in Code section 51-1-48(e). See *id.*

deleted this provision so that the enrollee must go through independent review before filing suit.⁴³ The House Judiciary Committee removed a section allowing a judge to send a claim to arbitration instead of dismissing it if the enrollee did not comply with the statutory requirements.⁴⁴

The Act gives the enrollee the right to appeal to the independent review panel when the HMO deems prescribed treatment medically unnecessary or experimental.⁴⁵ Much contention and debate surrounded the definition of "medical necessity."⁴⁶ The House Judiciary Committee amended the bill to narrow the definition of "medically necessary." The original language described treatment as "medically necessary" when, "after consultation with the patient or eligible enrollee, a treatment has been determined by the treating physician to be required for the diagnosis or direct care and treatment of an illness or injury of the patient, according to generally accepted principles of good medical practice."⁴⁷

The House Judiciary Committee changed this language to read, "care in light of conditions at the time of treatment" and added a five-prong test.⁴⁸ The heart of the definition read: "appropriate and consistent with the diagnosis and could not have been omitted without adversely affecting or failing to improve the eligible enrollee's condition."⁴⁹ Additional criteria include: a compatibility with acceptable United States medical standards, the nature of the injury and the appropriateness of the care, the factor of convenience, but not custodial care.⁵⁰ Some Representatives believed this standard placed an "unreasonably high burden of proof on the patient."⁵¹

Another change the House Judiciary Committee made involved the patient's right to independent review regarding experimental treatment, which was also narrowed in favor of managed care from the

43. Compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem.

44. Compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem. The original version of the bill would have placed this provision in Code section 51-1-48(f). See HB 732, as introduced, 1999 Ga. Gen. Assem.

45. See O.C.G.A. § 33-20A-32 (Supp. 1999).

46. See Ursery, *supra* note 41.

47. HB 732, as introduced, 1999 Ga. Gen. Assem.

48. HB 732 (HCS), 1999 Ga. Gen. Assem.

49. *Id.*

50. See *id.*

51. Ursery, *supra* note 41 (quoting Rep. Stephanie Stuckey, House District No. 67).

bill's original version.⁵² The bill, as introduced, only required that *one* condition on a six-part list be met.⁵³ The House Committee Substitute (and the version that passed) changed that criteria to require that *all* six conditions be met in order for the patient to receive independent review of an experimental treatment.⁵⁴ Additionally, some of the criteria were changed. For example, the introduced version required that the enrollee have a terminal condition with "a high probability of causing death within one year" from the date they request review.⁵⁵ The House Committee substitute changed the language to read "substantial probability of causing death within two years."⁵⁶ The House Committee removed one of the criteria that stated that independent review is appropriate when "any authorization" required by the HMO is denied.⁵⁷

The House Judiciary Committee also made additions to the bill. It added a Code section regarding the implications of the independent review organization's decision.⁵⁸ The decision is final and binding on the HMO when in favor of the enrollee and creates a rebuttable presumption that the HMO's decision was appropriate when in favor of managed care.⁵⁹ This presumption carries over to subsequent actions.⁶⁰ Members of the House Judiciary Committee questioned representatives from the Governor's office about how this presumption differs from a plaintiff's usual burden.⁶¹ Nonetheless, the language remained in the bill as passed.⁶²

The Committee also added a prescribed standard of review for the independent review organization, which provided that the standard of

52. Compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem.

53. See HB 732, as introduced, 1999 Ga. Gen. Assem.

54. Compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem., and O.C.G.A. § 33-20A-32(2) (Supp. 1999).

55. HB 732, as introduced, 1999 Ga. Gen. Assem.

56. Compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem.

57. Compare HB 732, as introduced, 1999 Ga. Gen. Assem., with HB 732 (HCS), 1999 Ga. Gen. Assem.

58. See HB 732 (HCS), 1999 Ga. Gen. Assem.

59. See *id.*

60. See *id.*

61. See Records of Proceedings in the House Session (Mar. 9, 1999) (available in Georgia State University College of Law Library).

62. See *id.*

review “shall be based upon generally accepted medical practices under like and similar circumstances.”⁶³

The Floor Amendment to Committee Substitute

The debate about the definition of medical necessity continued, and is reflected in a slight change, which makes the Act more favorable to patients.⁶⁴ The amendment changed the definition of “medically necessary” care to read, “based upon generally accepted medical practices in light of conditions at the time of treatment which is: (A) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee’s condition.”⁶⁵ The other four criteria remained the same.⁶⁶ This definition of “medical necessity” is the definition found in the final version of the Act.⁶⁷

The floor amendment deleted the text referring to the standard of review that the House Judiciary Committee added in proposed Code section 33-20A-36.⁶⁸ Representative Charlie Smith, Jr. stated that the provision was repetitive⁶⁹ because Code section 33-20A-40 already prescribed the standard of review as the definition of medical necessity.⁷⁰ The Committee made the deletion to mollify insurance and business interests who threatened to withdraw support.⁷¹

Senate Judiciary Committee Amendment

The Senate made minor changes to the bill. These included adding “or death” in Code section 51-1-48(a) to allow lawsuits on behalf of those who die or are injured due to HMO negligence.⁷² Moreover, the Amendment included a provision ensuring “liability will not be created on the part of an employee organization, [or] a voluntary employee beneficiary organization . . . unless such organization is the enrollee’s managed care entity and makes coverage determinations

63. HB 732 (HCS), 1999 Ga. Gen. Assem.

64. See HB 732 (CSFA), 1999 Ga. Gen. Assem.; Ursury, *supra* note 41.

65. See HB 732 (CSFA), 1999 Ga. Gen. Assem.

66. See *id.*

67. See O.C.G.A. § 33-20A-31(5) (Supp. 1999).

68. Compare HB 732 (HCS), 1999 Ga. Gen. Assem. with HB 732 (CSFA), 1999 Ga. Gen. Assem.

69. See Smith Interview, *supra* note 2.

70. See HB 732 (CSFA), 1999 Ga. Gen. Assem.

71. See Smith Interview, *supra* note 2.

72. See HB 732 (SCA), 1999 Ga. Gen. Assem.

under a managed care plan.”⁷³ Many business leaders’ concerns were allayed because the Act shields employers from lawsuits by employees who were denied coverage.⁷⁴

Definition of Medical Necessity

In HB 732, the definitions were truly the heart of the Act.⁷⁵ Representative Bordeaux stated that “[t]he definition of medical necessity was the core of the bill.”⁷⁶ For example, defining medical necessity as what a physician decides as necessary varies dramatically.⁷⁷ The original version was more favorable to the patient because it gave more power to the physician, but the final version narrowed the definition in favor of managed care.⁷⁸

The contention surrounding this definition of medical necessity stemmed from managed care’s fear that a broad definition could create too much litigation.⁷⁹ The final language was a compromise resulting from negotiations between the interested parties and strong lobbying on behalf of managed care.⁸⁰

Rebuttable Presumption

The rebuttable presumption created by the language the House Judiciary Committee added also generated debate.⁸¹ This language creates a presumption in favor of managed care organizations in subsequent litigation that their decision was appropriate.⁸² No presumption is created for the patient when the independent review process comes out in his or her favor.⁸³ Representative Charlie Smith, Jr. commented that the presumption works in favor of managed care

73. *Id.*

74. See Charles Walston, *Insurance Legislation Picks Up Steam*, ATLANTA J. & CONST., Mar. 3, 1999, at B4.

75. *See id.*

76. Bordeaux Interview, *supra* note 8.

77. *See id.*

78. *See id.*

79. *See id.*; Smith Interview, *supra* note 2.

80. *See* Bordeaux Interview, *supra* note 8.

81. *See* O.C.G.A. § 33-20A-37(b) (Supp. 1999); Bordeaux Interview, *supra* note 8; House Proceedings, *supra* note 3; Smith Interview, *supra* note 2.

82. *See* O.C.G.A. § 33-20A-37(b) (Supp. 1999).

83. *See* Bordeaux Interview, *supra* note 8.

because the HMO is obligated to give the treatment when the independent review is in the patient's favor.⁸⁴

However, Representative Tom Bordeaux still has concerns about the rebuttable presumption language.⁸⁵ His primary concern is that a scenario may occur when a patient is denied treatment and the window of opportunity for helpful treatment passes.⁸⁶ The patient must sue under Code sections 51-1-48 and 51-1-49.⁸⁷ In subsequent litigation, the decision of the independent review panel does not create any presumption and may not even be admissible.⁸⁸

Furthermore, use of the rebuttable presumption by managed care in subsequent proceedings creates an "irreconcilable inconsistency."⁸⁹ "It's like comparing apples to oranges, or like saying the outcome of a criminal proceeding should be a factor in a civil one."⁹⁰ No presumptions exist in medical malpractice statutes; if a doctor faces charges for criminal battery, the criminal determination does not carry over into a civil malpractice trial.⁹¹ Moreover, the independent review panel examines different evidence when it determines whether the HMO made the appropriate decision regarding care than a jury examines when it considers issues of negligence.⁹² It is hard to see how the rebuttable presumption in favor of managed care works in the judicial process.⁹³ Additionally, it is not clear from the Act whether the jury can consider information beyond what the HMO considered when it made its decision, such as subsequent death and injury.⁹⁴

Representative Smith was not concerned by the rebuttable presumption.⁹⁵ He commented, "[i]f you ever get up in front of a jury, you can read all the presumptions and definitions you want, but they're going to do what they think is right."⁹⁶

84. See Smith interview, *supra* note 2.

85. See Ursery, *supra* note 41.

86. See Bordeaux Interview, *supra* note 8.

87. See *id.*

88. See *id.*

89. *Id.*

90. *Id.*; Ursery, *supra* note 41.

91. See Bordeaux Interview, *supra* note 8.

92. See *id.*

93. See *id.*

94. See *id.* There may be some issues in the bill that the General Assembly was content to leave ambiguous to be hammered out by the courts. See Bordeaux Interview, *supra* note 8.

95. See Smith Interview, *supra* note 2.

96. Kathy Pruitt, *Two Managed Care Bills Advance*, ATLANTA J. & CONST., Mar. 4, 1999, at D3.

Criticism of the Act

The prohibition on punitive damages represented a big concession to managed care.⁹⁷ Some have criticized the procedures that the enrollee must follow, including the grievance procedure and independent review; they claim the procedures are so complicated that Georgians will not understand them and exercise their rights.⁹⁸

Another concern with the Act involves the guidelines for the independent review board to determine when treatment is experimental.⁹⁹ These criteria use Federal Drug Administration (FDA) approval as a benchmark.¹⁰⁰ However, some argue that “medicine moves like technology, and the FDA isn’t able to keep up.”¹⁰¹ Because of this language, patients face the possibility that HMOs can deny life-saving treatments based on lack of FDA approval or insufficient proof of effectiveness.¹⁰²

There was concern in the House Judiciary Committee that the two-step process of independent review before litigation creates more bureaucratic hoops for an enrollee, especially if the HMO’s negligence causes death.¹⁰³ “This issue of having a grievance process even after a person is dead is clearly beneficial to the managed care companies.”¹⁰⁴ Representative Smith responded to the criticism by denying it, claiming that it “save[s] both sides the protracted and expensive litigation that results from unfounded lawsuits.”¹⁰⁵

The strongest criticism of this Act is that the costs associated with liability and independent review will raise the costs of health insurance and cause some Georgians to lose coverage.¹⁰⁶ Advertisements sponsored by the Georgians for Affordable Healthcare

97. See Bordeaux Interview, *supra* note 8.

98. See *id.*

99. See Ursery, *supra* note 41.

100. See *id.*

101. *Id.* (quoting Thomas W. Malone, malpractice plaintiff’s lawyer).

102. See *id.*

103. See Records of Proceedings in the House Session (Mar. 9, 1999) (available in Georgia State University College of Law Library).

104. Pruitt, *supra* note 94 (quoting Rep. Jim Stokes, House District 92). The independent review determines whether treatment was necessary. See Bordeaux Interview, *supra* note 8. It is not clear, but Rep. Bordeaux believes that subsequent injury to the patient, such as death, may not even be considered by the independent review. See *id.* That is supported by the definition of medical necessity that states, “in light of conditions *at the time of treatment.*” *Id.* (emphasis added); see also O.C.G.A. § 33-20A-31(5) (Supp. 1999) (defining medical necessity).

105. Smith Interview, *supra* note 2.

106. See Pruitt, *supra* note 94.

ran on local radio stations; they included sound effects such as ringing cash registers and statements such as, “[w]hile your health costs skyrocket, trial lawyers will be laughing all the way to the bank.”¹⁰⁷ The ads were pulled by one station, WGST, in response to a letter from Governor Barnes’s office that broadcast law could have been violated because Georgians for Affordable Healthcare is not a corporation or political action committee.¹⁰⁸ Governor Barnes’s office alleged that the group sponsoring the advertisements was “a front for the HMO industry.”¹⁰⁹ The American Association of Health Plans (AAHP) opposes liability bills because of a fear that rising premiums will lead to more uninsured individuals.¹¹⁰ The AAHP believes that physicians will be put “into positions of recommending tests and procedures, not because the patient needs them, but because they’re worried about liability.”¹¹¹

Representative Charlie Smith, one of the bill’s sponsors, does not believe any evidence supports the fears of the AAHP, citing the Texas plan’s effects on insurance premiums.¹¹² In fact, healthcare costs have risen less than the national average in Texas since the state legislature enacted the HMO liability bill.¹¹³ Other proponents of the bill note that “it’s doubtful that top officers at CIGNA or any health care megacorporation relate to ‘affordable’ anything,” reporting that HMO executives earn two to three times more than executives in thirty-one other industries.¹¹⁴ Research has revealed that HMO liability reforms only increase costs by less than two dollars per month per Georgian.¹¹⁵

Even with these issues, the Act represents a tremendous step forward for patient’s rights.¹¹⁶ Georgia is one of the first states in the Nation to pass such legislation.¹¹⁷

Lisa Strauss

107. Charles Walston, *Ads Oppose Barnes’ Insurance Proposals*, ATLANTA J. & CONST., Mar. 2, 1999, at B4.

108. See Charles Walston, *WGST Pulls Ads Criticizing State Health Bill*, ATLANTA J. & CONST., Mar. 3, 1999, at B4.

109. *Id.*

110. See Williams, *supra* note 31.

111. *Id.*

112. See Smith Interview, *supra* note 2.

113. See Williams, *supra* note 31, at C1. Healthcare costs rose in the Dallas/Fort Worth only 2.8% and 2.4% in Houston. The national average rose 3.7%. See *id.*

114. Martha Ezzard, *Barnes’ Savvy Rules, Managed Care Meets Its Match*, ATLANTA J. & CONST., Mar. 8, 1999, at A6.

115. See *id.*

116. See Bordeaux Interview, *supra* note 8.

117. See *id.*