

Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience

Prepared by

Patricia Butler, J.D., Dr.Ph.

for

The Henry J. Kaiser Family Foundation



August 2001

The Henry J. Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit independent national health care philanthropy dedicated to providing information and analysis on health issues to policymakers, the media and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

State Managed Care Organization Liability Laws:
Current Status and Experience

I. Introduction

Since Texas enacted the first law explicitly authorizing suits by enrollees of health plans offered by managed care organizations (MCOs) and other insurers, eight additional states (Arizona, California, Georgia, Maine, Oklahoma, Washington, West Virginia, and most recently New Jersey) have adopted similar legislation. This paper briefly describes: 1) the key features of these state laws, 2) legal challenges that have been raised to some of them, and 3) early experience in states whose laws are in effect. Sources include the laws enacted in each state, relevant court decisions, and contacts with over two dozen people, including state insurance and HMO regulators, representatives of individual MCOs and their trade associations, plaintiffs' lawyers, and consumer advocates.

MCOs can be liable for damages resulting from various functions in their roles as employers, payers, and health care providers or arrangers. Although courts in several states have previously permitted health plan enrollees to sue MCOs for actions or failures to act that result in injury,¹ some state legislatures have enacted laws authorizing such suits in order to: avoid any uncertainty about the availability of these types of cases under common law, overcome potential obstacles to litigation such as the "corporate practice of medicine" doctrine (discussed below), and impose conditions on the right to sue (such as limiting the time to file suits or damages awards).

A major uncertainty for these state laws is the impact of ERISA, the federal Employee Retirement Income Security Act of 1974, which governs health plans offered by private employers that currently cover about 137 million Americans.² As discussed more fully below, courts hold that ERISA preempts many types of enrollee lawsuits against MCOs -- and such preemption occurs regardless of whether the employer's plan is covered through an insurance plan or is "self-funded." A matter of intense dispute in the current congressional debate over MCO patients' rights legislation is whether ERISA should be amended to permit more of these types of suits to proceed in state or federal court.

II. Characteristics of State MCO Liability Laws

The key features of the laws in eight states (not including the recently enacted law in New Jersey) are outlined in the table. Most of these laws share similar characteristics but some differ in important respects.

Entities that may be sued. State laws impose liability on managed care organizations (defined somewhat differently across states and often including other insurers), but all eight statutes explicitly exclude employers and employer purchasing groups from suits.

Conduct for which entity may be liable. While the definitions of conduct that may result in MCO liability differ somewhat across states, most appear designed to impose liability for MCO actions that directly affect enrollee health care or its quality, at least in part as an attempt to overcome potential ERISA preemption challenges. Georgia's statute is unique in creating

liability only for failing to pay claims in a “timely and appropriate manner” rather than for injuries due to MCO care decisions. West Virginia’s law allows suits only if the MCO fails to comply with an external review organization decision favorable to the enrollee.³

Laws in five other states focus on MCO actions related to authorizing, arranging for, or providing health care services. For example, the Texas law creates a statutory right to sue for injuries due to the failure of a plan or its employees and agents to use care in making “treatment decisions” (decisions that involve the actual delivery of health care and affect the quality of diagnosis or treatment). The Texas law is generally understood to impose liability for both a plan’s actions involving its own decisions about care and those of employees or others over whom the plan exercises control -- so-called “vicarious liability” similar to that available under common law principles.⁴ Statutes in Maine and Oklahoma also define liability based on an MCO’s failure to use care in making treatment decisions but explicitly provide that they do not impose on plans any new vicarious liability beyond that available under common law principles for physician or hospital malpractice. Oklahoma’s law also provides that liability occurs only if the plan’s action results in denial, significant delay, or modification of the prescribed health care service.

California and Washington State laws use a slightly different liability definition, imposing responsibility for failure to use care in arranging for provision of medically necessary services, which results in denial, delay, or modification of the recommended service. The Washington law also holds MCOs responsible for decisions by its employees and agents under its control that do not follow accepted standards. While this appears to provide vicarious liability for plan employees’ malpractice, the Washington statute explicitly states that it does not create new vicarious liability.

The laws in these five states define liability in term of “negligence,” a failure to act as would a prudent organization under similar circumstances.⁵ Arizona’s law sets a higher standard of liability but one that applies more broadly to various types of insurer administrative actions. It imposes liability for an MCO’s delay or denial in authorizing care *or* denial of payment without a reasonable basis, where the MCO either knew it was acting unreasonably or failed to investigate to determine whether its action was reasonable. This law embodies the common law claim of “insurance bad faith”-- knowingly acting without a reasonable basis -- a higher standard than ordinary negligence.⁶ But it applies not only to treatment decisions (like the other state liability laws) but also to other types of insurer decisions, such as whether a condition was pre-existing.

Relationship to external review. Over three-quarters of states now require “external” review under which MCO enrollees can appeal a denial of coverage on grounds of medical necessity (or sometimes other grounds) to an organization outside of the MCO, which is either a state agency or an organization certified by the state as meeting specified criteria. All state laws except that in Arizona⁷ require enrollees to complete the state’s external review process before filing suit. Statutes in California, Georgia, and Texas, however, provide exceptions for situations where the enrollee has already been harmed or would be harmed before the outside review could be completed,⁸ and Washington’s law allows enrollees to seek other remedies if their health is in jeopardy. Only three laws indicate how an external review decision would be used in a liability

lawsuit. In Georgia, an external review decision favoring the plan provides a rebuttable presumption that the MCO acted correctly. The Maine statute authorizes the external review decision to be introduced into evidence at trial. And West Virginia's law allows a suit only if a plan fails to comply with the external review decision.

Corporate practice of medicine. The "corporate practice of medicine" doctrine evolved under state law as a way to protect physician medical decision-making from control by lay persons. About half the states prohibit the corporate practice of medicine, usually defined as corporations controlled by non-physicians employing physicians. Exceptions in these states are often made for HMOs and organizations operated by physicians or nonprofit hospitals. It is unclear in many states whether limits on the corporate practice of medicine bars medical malpractice suits or other lawsuits against MCOs, but courts in a few states (including Missouri and Texas) have applied this doctrine to bar medical malpractice suits against HMOs.⁹ Laws in Maine, Oklahoma, Texas, and Washington provide that the corporate practice of medicine defense¹⁰ is not a bar to liability actions, permitting suits involving medical malpractice to be brought against MCOs.

Damages limits. Personal injury lawsuits can bring several types of money damages: "economic" (actual cost incurred such as medical expenses or lost wages), "non-economic" (for "pain and suffering"), and punitive (to punish a defendant found to have engaged in "outrageous" conduct). California's law explicitly permits compensation for all of the injuries caused by the plan's actions. Laws in Georgia and Maine prohibit punitive damages, and Maine's law also limits non-economic damages to no more than \$400,000. Other laws leave damages up to juries to award under normal common law tort principles.¹¹

Indemnity clauses and enrollee waivers All but Arizona's law prohibit MCO's from imposing on physicians and other health care providers the requirement to "indemnify" (pay damages assessed against) the plan for its vicarious liability. Several laws also prohibit requiring enrollees to waive their right to sue.¹²

Other state laws: Four other states have enacted laws related to MCO enrollees' ability to sue their health plans but these laws do not prescribe a broad statutory right to sue for MCO treatment or payment activities. In 1997 Missouri followed Texas in repealing the corporate practice of medicine defense that had previously been applied to prevent a suit against an HMO.¹³ In 1998 New Mexico authorized a limited opportunity for health plan enrollees to enforce their statutory and contractual rights.¹⁴ The state law authorizes plan enrollees to sue to recover actual damages (but no less than \$100) for violations of rights under the state's "Patient Protection Act" and its implementing regulations¹⁵ and also makes enrollees third-party beneficiaries of the contract between the MCO and purchasers (such as employers).¹⁶ In 1999 Louisiana adopted a procedure for independent external review of MCO decisions about medical necessity, which includes the right of a plan enrollee to sue an organization (such as HMOs or other health insurers) for injuries due to a medical necessity decision involving bad faith, negligence, gross negligence, or intentional misrepresentation of factual information about the enrollee's medical condition.¹⁷ The purpose of this provision was to authorize a right to sue for errors in the process of determining whether a service was medically necessary, not for disputes over the substance of the medical review decision. In 2001, Oregon enacted MCO enrollee

protections, including external review of MCO coverage decisions and a right to sue to enforce the external review determination.¹⁸

III. Legal Challenges to State MCO Liability Laws

Two of the state MCO liability laws have been challenged as conflicting with various provisions of federal law. The suit in Oklahoma has not been resolved. Portions of the Texas law have been invalidated as preempted by ERISA.

ERISA has been held to preempt certain types of state court damages lawsuits by enrollees in private sector employer health plans.¹⁹ In many recent ERISA cases, federal courts have created a distinction between: 1) traditional malpractice-type actions where MCOs can be held responsible for the negligence of a physician or other practitioner the MCO employs or whose practice it substantially controls and 2) disputes over the interpretation of what benefits the health plan will cover. All courts hold that ERISA preempts the latter types of “coverage” cases, but most courts hold that ERISA does not preempt the former, involving professional malpractice or health care quality, which can proceed in state courts.

An HMO operated by Aetna U.S. Health Care challenged the Texas liability law before it went into effect. The federal Court of Appeals for the Fifth Circuit affirmed the lower court’s decision that ERISA does not preempt portions of the statute that authorize lawsuits against MCOs for negligent delivery of care by their network physicians.²⁰ At the same time, the Court of Appeals noted, consistent with other courts that have addressed this issue, that ERISA would preempt state court lawsuits against MCOs for inappropriate coverage or payment decisions.²¹ The Court of Appeals also held, however, that ERISA preempts the Texas law allowing health plan enrollees to seek “independent review” of MCO coverage decisions. This part of the decision is inconsistent with one out of the Seventh Circuit Court of Appeals upholding the Illinois external review law.²² The U.S. Supreme Court recently agreed to hear the appeal of the Illinois case in its fall 2001 term, and the Court’s decision should have an impact on the validity of the Texas law, as well.

The first case filed under the Texas MCO liability law in late 1998 was brought by the widow of an MCO plan enrollee who committed suicide after being discharged from a hospital, allegedly as a result of the MCO’s refusal to authorize additional hospitalization at the request of the decedent’s physician. A federal district court held that the suit was not preempted by federal law and the widow could sue the plan in state court for a negligent treatment decision.²³ The case was settled for undisclosed terms in July 2000. Federal district courts in two other cases filed under the Texas law have held that ERISA preempts certain liability claims. One case challenged an HMO’s cost-containment incentives that allegedly discouraged the plaintiff’s physician from ordering needed tests.²⁴ The other case involved delay in authorizing treatment that allegedly resulted in amputation of the enrollee’s leg.²⁵

In July 2000, just as the Oklahoma MCO liability law was taking effect, it was challenged by the Oklahoma Health Plan Association on the grounds of federal preemption.²⁶ The case is still pending.

Other state liability laws may face preemption challenges under ERISA and other federal laws. To the extent that they are drafted similar to the Texas statute, the Fifth Circuit decision may be helpful in defending them. But the preemptive effect of ERISA and other federal laws is likely to depend very much on the precise nature of the facts of each case and how they are presented.

IV. Experience with State MCO Liability Laws

According to knowledgeable people contacted in preparing this report, relatively few lawsuits have been filed under the state laws in effect as of spring 2001.²⁷ In Texas, with the longest-lived law, it is estimated that between 17 and 25 cases have been filed since the law became effective in September 1997, five of which have been settled (for undisclosed terms but reportedly for a total of under \$5 million). None of the others has yet gone to trial. Several of these cases involved death or serious injury that could not have been remedied by appeal to an independent review organization. Two or three suits have been filed in Oklahoma, although they may involve conduct that occurred before the state's law became effective and could be challenged on this basis. It was reported that one case has been filed in Maine. Respondents from California, Arizona, and Georgia indicated no knowledge of any suits filed in those states.

None of the individuals contacted in preparing this paper reported that the existence of the laws, suits filed, or cases settled have yet resulted in any impacts on MCO premiums. Several respondents observed, however, that liability laws were enacted simultaneously with other managed care requirements, which could collectively raise MCO costs. Others noted that recent premium increases in some states are probably attributable primarily to rising medical costs and recent MCO losses. Some health plan representatives worry that the threat of litigation will cause MCOs to approve marginally appropriate care. A recent report of the Texas legislature's House Research Organization identified no evidence that the state's law has thus far led to more "defensive medicine" (unnecessary tests or procedures to avoid potential malpractice claims),²⁸ but little research on this issue has been undertaken. Several representatives of the managed care industry expressed concern that liability laws may contribute to (rather than respond to or assuage) public distrust of managed care, making it more difficult to operate health plans effectively.

Independent review processes operate in all eight states and were generally considered effective mechanisms for addressing most disputes over MCO coverage before injuries occur, limiting the need for litigation.²⁹ At least half the independent review decisions in most of these states favor enrollees. Because relatively few people have sought external review, it is not clear whether these review systems satisfy enrollee concerns about unfair or financially-driven coverage and treatment decisions.

V. Conclusion

Most of the state laws are drafted to provide liability for MCO actions involving health care treatment (though some also attempt to provide recovery for disputes over MCO coverage

decisions). Consequently they seem likely to overcome challenges under ERISA and other federal laws. To the extent that plan enrollees attempt to sue for damages resulting from MCO coverage or payment decisions, however, they face a more difficult ERISA obstacle unless Congress amends federal law to allow more state or federal court lawsuits. And beyond ERISA implications, the meaning of these laws will evolve over time courts interpret what MCO conduct is negligent or reckless.

Drawing the line between cases involving actual care delivery and coverage can be difficult. For example, a dispute over whether a service is “medically necessary” can involve both an interpretation of the MCO’s benefits contract (subject to only ERISA remedies) and what is appropriate medical practice (subject to state court medical malpractice litigation). A few recent cases suggest that the federal courts may be more willing to categorize a dispute over a mixed coverage and medical decision as a malpractice action that can proceed in a state court.³⁰ And this trend may be spurred by a recent U.S. Supreme Court decision that held an MCO’s financial incentives for its contracting physicians to save money was not a breach of the fiduciary duty owed to ERISA plan participants.³¹ Although the case did not involve state liability litigation directly, Justice Souter’s comment that enrollees can generally sue MCOs under state law for injuries resulting from physicians’ mixed coverage/treatment decisions has led analysts to predict that (were it presented with such a case) the Supreme Court would hold that ERISA does not preempt these types of suits. Furthermore, the Supreme Court’s language may prompt more federal courts to hold that ERISA does not preempt cases where treatment and coverage decisions intermingle, making it easier to bring suits under state MCO liability laws.

Long before states enacted specific MCO liability laws, courts in some states had held that enrollees could sue their HMOs and other insurers for the negligence of their physicians and for negligent coverage decisions.³² Consequently, it is unclear whether the MCO liability laws extend legal rights beyond those already likely to be available under common law principles in some of these states.

It is premature to assess the impacts of state liability laws on overall health care spending, MCO premiums, or the satisfaction of health plan enrollees or providers. The adequacy of damages suits to remedy medical malpractice and health plan misconduct remains subject to debate because damages suits have not been either a particularly efficient means to compensate victims of medical negligence or an effective malpractice deterrent. Policymakers need to strike a balance between providing a fair enrollee grievance resolution process that can deter injuries or compensate injured victims without increasing the costs of both litigation and excess medical care that may result from greater access to the courts. In view of the mixed record of the tort system to accomplish these goals, it is hoped that independent review systems will provide quick relief from inappropriate MCO decisions. Because independent review is unlikely to prevent all injuries, however, pressure will remain to adopt a system to compensate for harms that do occur.

Endnotes

¹ For a discussion of these different bases of MCO liability, see, Butler, Patricia A. *Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation*, Menlo Park, CA: Kaiser Family Foundation, November 1997.

² The number of persons covered by private sector employer plans (not those employed by local, state, or federal government, but including employed persons over 65) is calculated as 80% of the 172 million Americans covered by employer health insurance reported by the U.S. Census Bureau (www.census.gov/hhes/hlthins).

³ Presumably this law would limit evidence introduced at trial to the external review decision and damages resulting from the MCO's failure to comply with it; that is, the trial court would not appear authorized to decide on its own whether the requested care was medically necessary or experimental.

⁴ Vicarious liability is the responsibility of an organization for the negligence of people: 1) it employs, 2) over whom it exercises substantial control, or 3) who an MCO plan enrollee reasonably believes are under the control of the organization.

⁵ This standard involves a factual decision (typically made by a jury) about how a prudent entity would act and whether the organization in question met this duty.

⁶ *Sarchett v. Blue Shield of California*, 729 P. 2d 267 (Cal. 1987); *McEvoy v. Group Health Co-op*, 570 N.W. 2d (Wis. 1997).

⁷ Arizona's law (along with those in Georgia, Oklahoma, and Texas) does require written notice to the MCO at least 30 days before filing suit, a time period that could allow insurers to remedy some coverage mistakes.

⁸ Most of the suits filed in Texas involved death or serious injuries, which external review could not have remedied, so these plaintiffs did not seek external review of their disputes.

⁹ *Harrel v. Total Health Care*, 781 S. W. 2d 58 (Mo. 1989), *Williams v. Good Health Plus*, 743 S. W. 2d 373 (Tex. App. Ct. 1988).

¹⁰ The corporate practice of medicine doctrine as a defense to MCO lawsuits is discussed in endnote 2.

¹¹ In Texas, suits against MCOs are subject to the cap on punitive damages applicable to other malpractice awards: the higher of: 1) the sum of economic damages plus non-economic damages awarded by the jury up to \$750,000 or 2) \$200,000 (Texas Civil Practice and Remedies Code section 41.008).

¹² In states that do not prohibit waivers, courts might decide that an insurance contract's waiver of the right to sue was void as "unconscionable" due to unequal bargaining power between the insured and insurer or a violation of general state insurance law standards for fair contracts.

¹³ Missouri H.B. 335 (1997) repealed former Missouri statute section 345.505(3), that had provided that HMOs were not to be deemed to be practicing medicine.

¹⁴ New Mexico Insurance Code section 59A-57-9.

¹⁵ These rights include, for example, access to information, accessible services, a grievance process, and a continuous quality improvement program.

¹⁶ This doctrine allows people (third parties) who are determined to be intentional beneficiaries of a contract between two other parties (because of either state law or the contract's terms) to sue to enforce the terms of the contract. It is frequently invoked as a common law concept in construction disputes involving multiple parties.

¹⁷ Louisiana Revised Statutes Section 22:3085(D).

¹⁸ Under Oregon House Bill 3040 (signed May 31, 2001) this right exists only if the MCO states in its health plan description that it is not bound by independent review and the MCO does not comply with an independent review decision.

¹⁹ ERISA raises two types of preemption problems for state MCO liability and external review laws: the potential that these lawsuits "relate to" ERISA plans but are not "saved" as insurance regulation and the assertion that a suit for damages or the external review process conflicts with ERISA's limited remedy allowing a federal court suit for only the cost of disputed benefits. For more analysis of ERISA and its affect on state MCO liability laws, see, Patricia Butler, *ERISA Preemption Manual for State Health Policymakers*, Washington, D.C.: Alpha Center, January 2000 (www.statecoverage.org) and *Update - January 2001: ERISA Preemption Manual*, Portland, ME: National Academy for State Health Policy (www.NASHP.org).

²⁰ *Corporate Health Ins., Inc. v. Texas Dept. of Ins.*, 215 F. 3d 626 (5th Cir. 2000), affirming 215 F. Supp. 526 (S. D. Tex. 1998). The Court of Appeals reversed one portion of the district court's decision, which had held that ERISA preempted the Texas statute's prohibition on MCO contract clauses requiring physicians to indemnify MCOs for their own negligence.

²¹ This line of reasoning derives from a U.S. Supreme Court opinion, *Pilot Life v. Dedeaux* (481 U.S. 41 (1987)), holding that ERISA preempted a state punitive damages lawsuit against a disability insurer because Congress intended ERISA's limited remedies (the right to enforce a plan term or to obtain payment for denied benefits) to be exclusive.

²² *Moran v. State of Illinois*, 230 F. 3d 959 (7th Cir. 2000).

²³ *Plocica v. NYLCare of Texas, Inc.*, 43 F. Supp. 2d 659 (N.D. Tex. 1999). The deceased person was a Medicare beneficiary so the preemption decision involved Medicare, not ERISA.

²⁴ *Cristiantielli v. Kaiser Foundation Health Plan*, 113 F. Supp. 2d 1055 (N.D. Tex. 2000).

²⁵ *Roark v. Humana, Inc.*, N.D. Tex, No. 3:00-CV-2368-D, May 25, 2001.

²⁶ *Oklahoma Association of Health Plans v. Regier*, Case No. VIV-00-1160-M (Amended complaint filed march 30, 2001).

²⁷ Although court records are generally public, there is no repository of categories of civil cases filed in state or federal courts. Information about MCO liability cases can come definitively only from the lawyers representing plaintiffs or defendants. A few cases (like the *Plocica* case in Texas) receive press attention when they are filed, but many do not. State court opinions are typically published only from appellate courts. Neither trial court opinions nor data on settlements are systematically reported.

²⁸ Zamrazil, Kristie. 2000 (December). *Managed Care Debates: Texas, Congress and the Courts*. Austin: Texas House of Representatives, House Research Organization.

²⁹ Most of the cases filed in Texas involved serious injuries or death, however, which are exempt from external review requirements, but these 15 to 25 suits represent a small fraction of the over 1200 independent review cases completed in Texas since the appeals process was initiated in November 1997.

³⁰ So far, these cases have arisen in states under the jurisdiction of the federal Third Circuit Court of Appeals (Pennsylvania, New Jersey, and Delaware). See, for example, *Lazorko v. Pennsylvania Hospital*, 237 F. 3d 242 (3d Cir. 2000), holding that ERISA does not preempt a state court suit against an MCO whose financial incentives allegedly led a decedent's physician to deny hospital readmission, after which she committed suicide, and *In Re U.S. Healthcare, Inc.* 193 F. 3d 151 (3rd Cir. 1999), *cert. denied*, 120 S. Ct. 2687, holding that the MCO's maternity length of stay policy (whose objective was to change physician practice) was a medical treatment decision, so that ERISA did not preempt a suit for injuries due to premature discharge.

³¹ *Pegram v. Herdrich*, 530 U. S. 211 (2000). The Court held that managed care plan physicians' decisions about how to diagnose or treat a patient involves both "treatment" and "eligibility" decisions and that "mixed" decisions are not fiduciary decisions under ERISA. The Court noted that such mixed decisions might be the basis for a malpractice claim that is already currently available in many states.

³² Such cases often avoided ERISA preemption issues because they involved people covered by state or local government plans not governed by ERISA.

State Managed Care Organization Liability Laws:

Tables

Key Characteristics of State Managed Care Organization Liability Laws

	Arizona (2000) [AZ Rev. Stat. 20-3153 et seq.]	California (1999) [CA Civil Code 3428]	Georgia (1999) [GA Code ann. 51-1-48 et seq.]	Maine (1999) [Title 24-A M.R.S.A. sec. 4313]
Effective date	7/18/00	1/01/01	7/1/99	8/11/00
Entities that may be sued	health insurers, health care service organizations, Blue Cross/BlueShield plans	health care service plans, managed care entities	managed care entities (insurers, PHO, HMO, BlueCross/BlueShield plans)	carriers (insurers, HMOs, MEWAs, self-insured employers BlueCross/BlueShield plans)
Conduct for which entity may be liable	damages to enrollee caused by entity's delay in authorizing, failure to authorize or denial of payment for medically necessary care if delay, failure or denial was without reasonable basis and entity knew or should have known its action was without reasonable basis	substantial harm ¹ to enrollee caused by plan failure to use ordinary care to arrange for provision of medically necessary care resulting in denial, delay or modification of health care service	injury or death to enrollee resulting from entity's claims administrator's or health care advisor's failure to use ordinary diligence in adjusting claims in a timely & appropriate manner in conformity with standards of the health care provider	harm to enrollee caused by failure of carrier (or its agents over which it exercised control or influence) to use ordinary care ² when making health care treatment decisions affecting quality of diagnosis, care or treatment
Preconditions to suit - relationship to external review	either: complete external review process or provide written notice at least 30 days before filing suit	exhaustion of independent review process unless substantial harm has occurred or will occur before independent review completed	-written notice at least 30 days before filing suit -exhaustion of grievance and independent review processes, unless enrollee is already harmed and appeal process could not remedy injury	-exhaustion of all levels of carrier's internal grievance procedures and independent review process -3 year statute of limitations
Defenses	plan conduct was inadvertent or unintentional	no provision	-plan not liable for following independent review decision favoring enrollee -independent review decision supporting plan's action is a rebuttable presumption that plan's action was correct [GA Code sec. 33-20A-37]	neither carrier (nor any agent for whose conduct it is sued) controlled, influenced, or participated in health care treatment decision
Damages limits	none	none ³ (permits compensation for all of the detriment caused by plan's conduct)	no punitive damages	-no punitive damages -non-economic damages may not exceed \$400,000

Indemnity clauses	no provision	plan contract terms to impose liability for its conduct onto providers are prohibited	prohibited	plan contract terms to impose liability for its conduct onto providers are prohibited
Vicarious liability	does not create new plan vicarious liability for professionals' medical malpractice	does not create new plan vicarious liability for professionals' medical malpractice	no provision	does not create new plan vicarious liability for professionals' medical malpractice
Enrollee waivers	prohibited	prohibited	prohibited	no provision
Effect on employers	imposes no liability on employer or employer group purchasing organization that purchases coverage or assumes risk	imposes no liability on employer or employer group purchasing organization that purchases coverage or assumes risk	imposes no liability on employer or employer organization (unless employer or organization is managed care entity)	imposes no liability on employer that assumes risk or employer group purchasing organization
Relationship to other remedies	does not limit other theories of liability available at law but enrollee cannot file both under this law and common law insurer bad faith claim	does not limit other theories of liability available at law	no provision	enrollee may bring wrongful death action or sue under this law, but not both
Other	external review is NOT prerequisite to suit but any external review decision or fact that enrollee did not participate in external review can be introduced as evidence in trial	no provision	no provision	-no "corporate practice of medicine" defense -external review decision can be introduced as evidence at trial -carrier need not provide services not covered by enrollee's health plan

	Oklahoma (2000) [OK. Stat. Title 36 sec. 6593 et seq.]	Texas (1997) [TX Civil Practice & Remedies Code, Title 4 sec 88.001 et seq.]	Washington (2000) [48.43.545 Rev. Code WA]	West Virginia (2001) [33-25C7 Code of W Va]
Effective date	7/1/00	9/1/97	7/01/01	7/01/02
Entities that may be sued	health insurer, HMO, or other managed care entity	health insurance carriers, HMOs & other managed care entities	carriers (health insurers, HMOs, BlueCross/BlueShield plans)	HMOs
Conduct for which entity may be liable	harm to enrollee caused by failure to use ordinary care in making health care treatment decisions resulting in denial, significant delay or modification of the service	harm to enrollee caused by failure of entity (or any employees, agents or representatives over which it has influence and control) to use ordinary care ² in making health care treatment decisions ⁴	substantial harm ¹ to enrollees caused by 1) failure of carrier to follow health care provider ⁵ standard of care when arranging for medically necessary health care resulting in denial, delay or modification of the service 2) health care treatment decisions by employees and agents it controls that don't follow accepted care standard	damage caused by failure to comply with decision from an external review (regarding whether desired care is medically necessary or experimental)
Preconditions to suit - relationship to external review	-exhaustion of plan appeals processes and external review -written notice at least 30 days before filing suit	-written notice at least 30 days before filing suit -exhaustion of plan's appeal procedures and independent review process ⁶ (unless harm has occurred or review would not benefit enrollee)	-exhausted independent review process -3 year statute of limitations	-exhaust all appeals processes, including external review -external review decisions favored enrollee -HMO failed to comply with external review decision - 2 year statute of limitations
Defenses	no provision	neither entity nor its employees, agents or representatives controlled, influenced or participated in health care treatment decision and entity did not deny or delay payment for treatment	-service in question is not a benefit under the plan -neither carrier, employee nor agent controlled, influenced or participated in the health care treatment decision -carrier did not deny or unreasonably delay payment for recommended treatment	-coverage was provided in compliance with external review decision -neither HMO nor its employees or agents participated or influenced decision
Damages limits	related law does not apply ⁷	limits on punitive damages ⁸	no provision	no provision

Indemnity clauses	plan contract terms to impose liability for its conduct onto providers are prohibited	plan contract terms to impose liability for its conduct onto providers are prohibited	plan contract terms to impose liability for its conduct onto providers are prohibited	plan contract terms to impose liability for its conduct onto providers are prohibited
Vicarious liability	does not create new plan vicarious liability for professionals' medical malpractice	liable for actions of agents and persons whom it can influence or control	does not create new plan vicarious liability for professionals' medical malpractice or eliminate current malpractice cause of action	liable for actions of employees, agents and others whom it can influence or control
Enrollee waivers	no provision	no provision	prohibited	no provision
Effect on employers	imposes no liability on employer or employer group purchasing organizations that purchase coverage or assume risk	imposes no liability on employer, employer group purchasing organizations that purchase coverage or assume risk or pharmacies	imposes no liability on employer, employer group purchasing organizations that purchase coverage or assume risk (other than state employee purchasing group)	imposes no liability on employer or employer group purchasing organizations that purchase coverage or assume risk, including government purchasers
Relationship to other remedies	no provision	enrollees may pursue other remedies if their health is in jeopardy	enrollees may pursue other remedies if their health is in jeopardy	no provision
Other	-no corporate practice of medicine defense -no class actions may be brought under the act -no obligation to cover treatment not covered by plan -plan may not retaliate against provider for advocating on behalf of enrollee	-no corporate practice of medicine defense -no obligation to cover treatment not covered by plan -enrollee must comply with requirements of TX medical malpractice reform law relating to cost bonds, deposits and expert reports -plan may not retaliate against provider for advocating on behalf of enrollee	no corporate practice of medicine defense	does not create new cause of action or eliminate any presently existing cause of action

¹ Substantial harm = loss of life, significant impairment of limb or function, significant disfigurement, severe & chronic pain or significant financial loss.

² Ordinary care = degree of care that carrier (or individual in the case of employee or agent) of ordinary prudence would use in same or similar circumstances.

³ Managed care plans are not “providers” and therefore not subject to state’s medical malpractice tort reforms (such as limits on damages and attorneys’ fees).

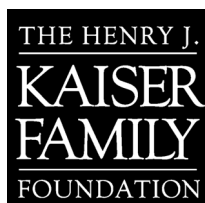
⁴ Health care treatment decision = determination made when medical services are actually provided by the plan and a decision that affects the quality of diagnosis, care or treatment provided to plan enrollees.

⁵ As defined in Under Washington's medical malpractice statute, 7.70 Rev. Code of WA.

⁶ Texas independent review process was held invalid as preempted by ERISA (*Corporate Health Ins. v. Texas Dept. of Ins.*, 215 F. 3d 626 (5th Cir. 2000)), but the court's order was stayed while the case is on appeal to the U.S. Supreme Court.

⁷ The liability law provides that damages limits in another part of state law (limits on disgorgement of profits for selected types of insurance bad faith claims) do not apply to liability suits under this law.

⁸ Suits against MCOs are subject to the cap on punitive damages applicable to other malpractice awards: the higher of: 1) the sum of economic damages plus non-economic damages awarded by the jury up to \$750,000 or 2) \$200,000 (Texas Civil Practice and Remedies Code section 41.008).



The Henry J. Kaiser Family Foundation

2400 Sand Hill Road
Menlo Park, CA 94025
650-854-9400 Fax: 650-854-4800

Washington Office:

1450 G Street NW, Suite 250
Washington, DC 20005
202-347-5270 Fax: 202-347-5274

www.kff.org

Additional copies of this publication (#3155) are available on the Kaiser Family Foundation's web site at www.kff.org or by calling the Foundation's Publication Request Line at 1-800-656-4533.