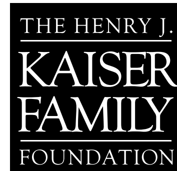


Comparison Of The Liability Provisions Of House And Senate Patients' Rights Bills

Prepared for the Kaiser Family Foundation by:

Gary Claxton
Institute for Health Care Research and Policy
Georgetown University

October 2002

The Kaiser Family Foundation is an independent, national health 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.

TABLE OF CONTENTS

INTRODUCTION……………………………………………………………………………1

ISSUE OF HEALTH PLAN LIABILITY…………………………………………………1

SENATE AND HOUSE LIABILITY PROPOSALS………………………………………3

Senate Bill……………………………………………………………………………3

Summary of Key Provisions in House and Senate Liability Bills………………………6

House Bill……………………………………………………………………………7

KEY DIFFERENCES BETWEEN THE SENATE AND HOUSE BILLS………………8

Source of Law: Federal versus State…………………………………………………9

Standard of Care Required of Health Plans……………………………………………9

Relationship of Liability to Appeals Process………………………………………10

Damages……………………………………………………………………………12

Proximate Cause: "The" versus "A"…………………………………………………13

Impact on State Law Actions Relating to the Delivery of Medical Care………………14

CONCLUSION………………………………………………………………………15

APPENDIX 1 – Scenario Exemplifying Differences Under the House and Senate Bills for Medically Reviewable Decisions……………………………………16

APPENDIX 2 – Scenario Exemplifying Differences Under the House and Senate Bills for State Law Cases Relating to the Delivery of Medical Care……………19

INTRODUCTION

The issue of when HMOs, health insurers and others administering health benefit plans should be financially liable to plan participants for harm caused by wrongful coverage denials is being hotly debated as Congress considers alternative patients' rights proposals. Under current law, private employment-based health plans are often shielded from liability for their coverage decisions by the Employee Retirement Income Security Act (ERISA). Differing patients' rights proposals passed in the U.S. Senate and in the U.S. House of Representatives would lift or modify this shield in certain instances.[1] This paper describes some of the key differences on the liability issue between the Senate and House legislative proposals. To keep the discussion simple, the paper will not address the issue of employer liability. The Senate and the House bills both have provisions that would permit employers and other plan sponsors to protect themselves from potential liability.[2] The discussion below will focus on disputes about coverage decisions made by HMOs or other health insurers (referred to collectively as health plans).

The paper will first briefly describe the liability issue that the legislative provisions are intended to address and will follow with a description of the liability provisions of the Senate and House proposals. The paper will then describe and discuss the key differences between the proposals. Two scenarios that exemplify some of these differences are appended to the paper.

ISSUE OF HEALTH PLAN LIABILITY

ERISA governs pension, health, or other benefits sponsored by private employers and other designated sponsors. These arrangements are referred to as employee benefit plans (referred to here as ERISA plans), and include plans where the benefits are funded through insurance (called insured plans) and plans where benefits are funded directly by the plan sponsor (called self-funded plans).

The Supreme Court in Pilot Life v. Dedeaux found that ERISA provides the exclusive remedy by which participants[3] in an ERISA plan may dispute a denial of benefits under the plan.[4] This means that ERISA plan participants are prevented from

---

[1] S. 1052 passed the Senate on June 29, 2001; H.R. 2563 passed the House of Representatives on August 2, 2001. These bills are awaiting conference committee action to resolve their differences.
[2] In some cases, when employers or others sponsor health plans, they reserve the right to be involved in benefit determinations. For example, they may reserve the right to review and overrule initial decisions of plan administrators. Both the Senate and House bills have protections from liability for employers and other plan sponsors. The Senate bill would shield plan sponsors from potential liability unless they actually made, or controlled the making of, the decision denying the benefit. The bill also specifies that a number of activities, such as offering or designing a benefit package or advocating for an employee during a claim dispute, would not give rise to liability. Both the Senate and House bills also have provisions that permit plan sponsors to designate other entities to make benefit determinations. Although the provisions differ significantly, under either bill a plan sponsor is shielded from liability if it has delegated benefit determinations to another entity.
[3] For simplicity, the term "participants" is used to refer to individuals who are covered under a health plan.
[4] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).

bringing a state law action[5] to dispute a denial of a claim for benefits or to recover damages for injuries that might result from such denials; such actions are preempted (i.e., federal law precludes that application of the state laws). The remedy provisions of ERISA permit participants to bring court actions[6] to obtain benefits due to them under their benefit plan, for redress of fiduciary breaches, to stop unlawful practices, and to obtain other appropriate equitable relief. ERISA does not, however, provide a remedy to plan participants for economic (e.g., lost wages) or non-economic (e.g., pain and suffering) damages that may result from improper claims denials.

In recent years, some courts have permitted participants to bring state law claims against health plans relating to the appropriateness of the medical care delivered by the health plan.[7] These cases look at the health plan not in its role as administrator of an ERISA plan, but in its role as a health care provider that arranges for and provides medical treatment.[8] This can be a difficult distinction to make. Health plans may be vicariously liable[9] for poor medical care provided by health care providers that contract with the health plan, or may be directly liable for failing to meet statutory or other legal duties to provide or arrange for quality health care.[10] In looking at these actions, the courts have had to determine whether ERISA would preempt the state law actions either because they relate to the administration of an ERISA plan or because ERISA provides the sole remedy for plan participants disputing a benefit denial.[11] The federal courts are divided on these issues. Some federal courts have found that state law vicarious liability cases against health plans for the negligence of their actual or ostensible agents (e.g., physicians or hospitals) are not preempted by ERISA, although other courts have found such cases to be preempted.[12] Courts in several federal circuits have permitted direct

---

[5] The terms "state law action" and "state law claim" refer to court actions brought by a person to adjudicate legal rights the person has under state law.

[6] ERISA permits participants to bring some claims in either state or federal courts, but defendant benefit plans often have the right to have the case moved to federal court (called removal).

[7] See for example, Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) cert. denied 516 U.S.1009 (1995); In re: U.S. Healthcare, Inc., 193 F. 3d 151, 162 (3d Cir. 1999) cert. denied 530 U.S. 1242 (2000); Rivers v. Health Options Connect, Inc., 96 F.Supp. 2d 1370 (S.D. Fla. 2000). See cases cited in Vicki Lawrence MacDougall, The "Shared Risk" of Potential Tort Liability of Health Maintenance Organizations and the Defense of ERISA Preemption, 32 Val. U. L. Rev. 855 (Summer 1998) (see cases cited at note 267).

[8] See In re: U.S. Healthcare, Inc., 193 F. 3d, at 162.

[9] Vicarious liability refers to situations where one party is legally responsible for the conduct of another party. Vicarious liability often occurs when one party is responsible for supervising the other party; for example, employers are sometimes responsible for the negligent conduct of their employees.

[10] For a good discussion of vicarious and direct liability theories as they may apply to health plans, see MacDougall, op. cit., and Sara Rosenbaum, "An Overview of Managed Care Liability: Implications for Patients Rights and Federal and State Tort Reform," American Association of Retired Persons, Washington D.C. (2001).

[11] The distinction between ERISA preemption flowing from the express preemption language of the statute [29 U.S.C.A. 1144] and from the complete preemption doctrine as applied in Pilot Life is important in several regards, including federal court jurisdiction. For good discussions of the these two bases for preemption, see Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995) or Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., 958 F. Supp. 1137 (E.D. Va. 1997).

[12] See Corporate Health Insurance, Inc. v. Texas Department of Insurance, 215 F. 3d 526, 535 (2000), reh. den. 220 F.3d. 641 (2000) for a recent discussion of vicarious liability and ERISA preemption. See also

liability claims based on state law against health plans, although again some courts have found such claims preempted by ERISA.[13] Where participants have won judgements in these actions, they have based their state law claims not on the health plan's coverage determination, but on the quality and appropriateness of the health care delivered or arranged for by the health plan.

The Senate and House bills each propose new remedies for participants in ERISA plans that would permit them to recover damages that result from wrongful denials of claims for benefits. The bills also address the viability of state law actions against health plans based on the delivery of medical care. These differences are discussed below.

SENATE AND HOUSE LIABILITY PROPOSALS

The patients' rights proposals passed by the Senate and House are similar in many respects.[14] One area where there are substantial differences, however, is in the area of liability. This section will describe each approach and then discuss the key differences.

Senate Bill

The Senate bill (S. 1052) contains two new liability provisions. The first creates a new federal cause of action for failure to exercise ordinary care in making non-medically reviewable decisions on a claim for benefits. The second lifts ERISA preemption of state law actions that are based on

> A medically reviewable decision under the Senate and House bills is a denial of a claim for benefits based on a determination that the proposed treatment (1) is not medical necessary or appropriate; (2) is experimental or investigational; or (3) is not a covered benefit where the determination requires an evaluation of medical facts by a health care professional in the specific case.

---

cases cited in MacDougall, op. cit. (cases finding vicarious liability preempted by ERISA at note 257; cases finding of vicarious liability claims not preempted by ERISA at note 267).

[13] For examples of cases finding direct liability claims not to be preempted, see In re: U.S. Healthcare, Inc., op. cit.; Lupo v. Human Affairs International, Inc., 28 F. 3d 269 (2d Cir. 1994); Rivers v. Health Options Connect, Inc., op. cit.; Crum v. Health Alliance-MidWest, Inc., 47 F.Supp. 2d 1013 (C.D. Ill 1999) and Stewart v. Berry Family Health Center, et al., 88 F. 3d. 1482, 105 F. Supp 2d 807 (S.D. Ohio 2000). For examples of cases finding ERISA preemption of direct liability claims, see Lancaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc., op. cit., and Garrison v. Northeast Georgia Medical Center, Inc., 66 F. Supp. 2d 1336 (N.D. Ga. 1999). See also Jass v. Prudential Health Care Plan, Inc., 88 F. 3d. 1482 (7th Cir. 1996) (vicarious liability claim against HMO for conduct of nurse employed by HMO as claims reviewer). These cases require courts to distinguish between a health plan's actions in providing or arranging for medical care and its actions in making coverage determinations and otherwise administering an employee benefit plan, which can be a hard distinction to make. Compare Lanchaster v. Kaiser Foundation Health Plan of Mid-Atlantic States, Inc. op. cit. (claim that health plan was negligent in establishing a physician incentive program was preempted) with Stewart v. Berry Family Health Center, et al., op. cit. (similar claim not preempted under complete preemption doctrine).

[14] Stephanie Lewis, *A Guide to the Federal Patients' Bill of Rights Debate,* prepared for the Henry J. Kaiser Family Foundation, (2001).

medically reviewable decisions. In addition, the bill seeks to clarify the treatment of state causes of action against health plans based on quality of care.

Federal Cause of Action for Decisions That Are Not Medically Reviewable

The first liability provision creates a new cause of action in federal law for participants or beneficiaries suffering personal injury or death resulting from a failure by their health plan to exercise ordinary care in making a decision on an initial claim for benefits or during an internal appeal regarding the following non-medically reviewable decisions: (1) whether an item or service is covered under the terms and conditions of the plan; (2) whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan; or (3) the application of cost-sharing, specific exclusions, or express limitations on the amount duration or scope of coverage. The failure to exercise ordinary care must be a proximate cause of the personal injury or death. Before bringing a cause of action under this new section, the bill requires the participant to exhaust administrative processes provided by the health plan for making an initial claim for benefits and for internal appeals.

As discussed above, the bill requires that the action must relate to a denial of a claim for benefits that is not medically reviewable. Claims that are denied because the participant had exceeded his or her annual benefit limit for prescription drugs or for mental health inpatient days, or because the participant had not been employed long enough to be eligible for health plan benefits are examples of decisions that are not medically reviewable.

This new cause of action would be exclusively federal and would be brought in federal court. Participants who prevailed in an action could recover both economic and non-economic damages, and the bill contains no limits on the amount of actual damages that may be recovered. The bill also permits the awarding of a civil penalty (payable to the participant) of up to $5 million if the participant shows by clear and convincing evidence that the health plan's conduct demonstrated bad faith and flagrant disregard to the rights or safety of the participant and was the proximate cause of the injury or death. This civil penalty is analogous to an award for punitive damages.

Lifting ERISA Preemption for State Medically Reviewable Decisions

The second liability provision in the Senate bill lifts ERISA's preemption for state causes of action for personal injury or wrongful death that arise from medically reviewable decisions by health plans. As discussed above, under current law, ERISA provides the exclusive remedy for participants in ERISA plans to dispute a denial of a benefit claim; state law actions based on a benefit denial are preempted. This Senate provision restores the applicability of state law claims where a participant in an ERISA plan suffers personal injury or death as the result of a medically reviewable decision by a health plan. As with the federal cause of action, the Senate bill requires participants to exhaust their administrative remedies (i.e., initial claims process, internal appeal, and external appeal) before bringing a state action under this new provision.

With one exception -- relating to punitive damages -- the types of damages available to prevailing participants, and any limits on damages, would be determined by state law. The bill continues federal preemption of state punitive damage claims where the health plan follows the legal requirements relating to the initial benefit decision, internal review, and external review, unless the participant establishes by clear and convincing evidence that the health plan's conduct was carried out with willful or wanton disregard to the rights or safety of others and was the proximate cause of the injury or death at issue.

State Law Actions Relating to the Delivery of Medical Care

As described above, some courts have permitted plan participants to bring actions against health plans relating to the quality and appropriateness of the medical care delivered under the plan. The Senate bill contains broad language that clarifies that these types of actions would not be preempted by ERISA.[15]

[15] In the section of the bill that creates the new federal cause of action for non-medically reviewable decisions, the bill provides that no state law should be treated as superceded or otherwise altered, amended, modified, invalidated, or impaired because of the new provisions. In the section of the bill that lifts ERISA preemption for state actions arising out of medically reviewable decisions, the bill provides that nothing in Title I of ERISA should be construed to affect any state law that relates to the practice of medicine or the provision of, or failure to provide, medical care, or to affect any action, whether for direct or vicarious liability, based on such a state law.

SUMMARY OF KEY PROVISIONS IN HOUSE AND SENATE LIABILITY BILLS

	House Bill (H.R. 2563)	Senate Bill (S. 1052)
Provision		
Source of Law	Basis and scope of liability established by federal law. Claims could be brought against health plans in either state or federal court. Claims brought in state court involving medically reviewable decisions could not be removed by the heath plan to federal court. Claims involving non-medically reviewable decisions could be removed by the health plan to federal court. .	Non-Medically Reviewable Claims: Basis and scope of liability established by federal law. Medically Reviewable Claims: Basis and scope of liability established by state law. Claims involving non-medically reviewable decisions would be brought in federal courts. Claims involving medically reviewable decisions would be brought under state law in state courts.
Standard of Care	Industry standard of care. Plan owes participant degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.	Non-Medically Reviewable Claims: Industry standard of care. Medically Reviewable Claims: Standard of care established by state law. Some states currently have an industry standard of care; a few hold plan to a medical professional standard of care.
Relation to Appeals Process	Participant must exhaust administrative remedies before bringing a liability claim against health plan. If plan's denial is upheld in external review, a presumption is created that the health plan exercised ordinary care in making its decision, and the participant must "rebut" the presumption by showing clear and convincing evidence of the health plan's failure to exercise ordinary care.	Non-Medically Reviewable Claims: Participant must exhaust administrative remedies before bringing a liability claim against health plan. Medically Reviewable Claims: Participant must exhaust administrative remedies before bringing a liability claim against health plan.
Damages Available to Participants	Participant can recover economic damages with no limits and up to $1.5 million for non-economic damages. Punitive damages of up to $1.5 million available if health plan fails to authorize coverage in compliance with an external review decision.	Non-Medically Reviewable Claims: Participant can recover economic and non-economic damages with no limits. New civil penalty (payable to the participant) of up to $5 million (comparable to punitive damages). Medically Reviewable Claims: Type and amount of damages established by state law. Punitive damages generally available only if plan fails to follow administrative processes or participant establishes by clear and convincing evidence that the health plan's conduct was carried out with willful or wanton disregard to the rights or safety of others.
Proximate Cause	Health plan's failure to exercise ordinary care must be "the" proximate cause of the personal injury or death of the participant.	Non-Medically Reviewable Claims: Health plan's failure to exercise ordinary care must be "a" proximate cause of the personal injury or death of the participant. Medically Reviewable Claims: Standard for proximate cause established by state law. State law generally permits recovery if there are multiple acts that proximately cause the injury or death.

House Bill

The House bill (H.R. 2563) contains one new liability provision that creates a federal cause of action for failure to exercise ordinary care in making certain decisions on a claim for benefits. Medically reviewable and non-medically reviewable decisions are handled similarly under the House bill in most regards, although there are some distinctions that are discussed below. The House bill also may preempt some state claims against health plans relating to quality of care that some federal courts are now permitting to go forward under ERISA.

Federal Cause of Action for Denials of Benefit Claims

The House bill creates a new cause of action in federal law for participants or beneficiaries suffering personal injury or death resulting from a failure by their health plan to exercise ordinary care in (1) making a determination denying an initial claim for benefits, (2) making a determination denying a claim for benefits on internal appeal, or (3) authorizing coverage in compliance with a written determination of an independent medical reviewer (as part of external review) that reverses the health plan's denial of benefits. The failure to exercise ordinary care must result in delay in receiving, or failure to receive, benefits and be the proximate cause of the personal injury or death of the participant.

Before bringing a cause of action under this new section, the bill requires the participant to exhaust administrative remedies. A cause of action cannot be brought unless the independent medical reviewer has reviewed the case and issued a written determination relating to the benefit denial, or the external review entity has determined that the medical review is not required because the benefit denial is not a medically reviewable decision.

Where an independent medical reviewer has reviewed the benefit denial and upheld the health plan's determination, the bill establishes a presumption that the health plan exercised ordinary care in making its determination. This presumption can be rebutted only if the participant shows by clear and convincing evidence that the health plan failed to exercise ordinary care.

This new cause of action would be established in federal law, but the bill authorizes actions to be brought against health plans in either state or federal court. The bill prohibits health plans that are sued in state court from removing[16] the case to federal court if the case involves a medically reviewable decision. Health plans would be free to seek removal to federal court of cases involving non-medically reviewable decisions.

---

[16] The law permits defendants sued in state courts under federal law claims to move their cases to federal court in certain circumstances.

The bill provides for participants who prevail in actions against their health plans to recover economic damages and non-economic damages, and, in limited circumstances, punitive damages. The bill does not place limits on economic damage awards, while awards for non-economic damages are capped at $1.5 million. Punitive damages of up to $1.5 million could be awarded in cases where the health plan fails to authorize coverage in compliance with the written determination of an independent medical review panel. States would be authorized to lower the damage limits but cannot raise them.

State Law Actions Relating to the Delivery of Medical Care

The House bill preserves some, but not all, state law claims that courts have permitted participants to bring against health plans relating to the delivery of medical care. The House bill provides that nothing in the new liability provision should be construed to preclude a state law action for liability or vicarious liability with respect to the delivery of medical care. However, the bill provides that a cause of action that is based on or otherwise relates to a health plan's determination on a claim for benefits is not the delivery of medical care under state law and that such actions must be maintained exclusively under the new liability provision of the bill. As discussed in greater detail in the next section, it appears that this provision would preempt some state law actions against health plans that currently are available in some jurisdictions. In some of these cases, the participant may be able to bring an action under the new federal cause of action created in the House bill. In other cases, such as a case where the health plan's activities contributed to poor medical care but where there was no explicit benefit denial, the participant may be left without an action against the health plan.[17]

KEY DIFFERENCES BETWEEN THE SENATE AND HOUSE BILLS

This section looks at the key differences for participants of the liability provisions of the two bills. To assist readers in seeing how these differences might play out, two scenarios are appended to the paper that discuss how the differences might affect participants in two hypothetical suits against their health plans, one involving a denial of a claim for benefits and the other involving a dispute over the inappropriate delivery of medical care.

---

[17] A participant might be left with no action because of the phrasing in the House bill which states that a cause of action that "otherwise relates to a determination on a claim for benefits" must be brought under the liability section of the bill. For example, if a health plan develops practice guidelines and strongly encourages its participating providers to follow them, that conduct might be found to relate to a determination on a claim for benefits because it is a guidepost for benefit determinations. However, if a provider follows the guideline and poor results, there would be no action available against the health plan under the House bill because an action can only be brought if there has been an explicit denial of a claim for benefits and where appeal rights have been exhausted.

Source of Law: Federal versus State

One key difference between the two bills is the source of the law that would govern causes of action involving medically reviewable decisions.[18] Under the Senate bill, ERISA preemption of state causes of action would be lifted. This would allow states to define the type of action that could be brought, the applicable standard of care, the defenses that health plans would have, and types of and limits on damages that would be available (subject to the federal provisions on punitive damages described above). States also could decide not to provide a cause of action for participants that want to sue their health plans over claims denials.

Under the House bill, actions over benefit denials involving medically reviewable decisions would be defined by federal law (although states could establish lower caps on damages), but could be brought in federal court or in state court.

Standard of Care Required of Health Plans

A second key difference between the bills involves the standard of care by which a health plan's conduct is judged in actions involving medically reviewable decisions. Several elements of the cause of action in the House bill are based on the failure of a health plan to exercise ordinary care when making certain determinations denying a claim for benefits, and ordinary care is defined as the ". . . degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved." This is considered an "industry" standard of care, which compares the conduct of the health plan to conduct that would be expected of a reasonable and prudent claims reviewer making a benefit determination for a health plan. The standard looks to what is common in the industry among claims reviewers.

Under the Senate bill, the standard of care expected of health plans making medically reviewable benefit determinations is established by state law.[19] States could choose to rely on existing law, or could enact new provisions to address the issue. Looking at the states that have enacted health plan liability laws, some have adopted an industry standard similar to that in the House bill. Others have adopted a "health professional" standard of care, which compares the health plan conduct to the conduct that would be expected of a reasonable and prudent health care provider. For example, the law in the State of Washington provides that a "health carrier shall adhere to the accepted standard of care for health care providers under [Washington malpractice law]

---

[18] Under both bills, causes of action involving non-medically reviewable decisions would be determined under new federal causes of action.

[19] The standard of care for non-medically reviewable claims under the Senate bill would be an industry standard.

when arranging for the provision of medically necessary health care services to its enrollees.[20]

Whether and how an industry standard of care would differ from a health care professional standard of care is something that courts would need to determine. The basic questions here are whether health plans typically employ the same degree of care, skill, and learning as health care providers when making benefit determinations, and, if not, whether they should.

Part of the answer to these questions might be provided by provisions in the Senate and the House bills which contain new requirements for utilization review activities and benefit determinations by health plans, including requirements that plans meet certain time limits for making decisions and use qualified health care professionals in establishing clinical review criteria and overseeing utilization review decisions. These provisions and others require health professional involvement in plan claims review activities, and may inform how courts apply the industry standard of care in the House bill.[21]

On the other hand, these new provisions are largely procedural and do not require that initial claim determinations be made by health care providers (although internal appeals must be decided by appropriate heath care providers). Courts might be unwilling to infer a health professional standard of care when the use of a health care professional is not required to make a benefit determination, particularly when the standard of care in the bill refers to an "individual . . . making a fair determination on a claim for benefits." Given the procedural nature of the new utilization review and benefit determination requirements, a court might focus on the process rather than the substance of the decisions and determine that a health plan has met its standard of care if it merely followed the new procedural requirements.[22]

Relationship of Liability to Appeals Process

The House and Senate bills each require participants to pursue and exhaust their right to an internal and external review before bringing a liability action against their

---

[20] Revised Code of Washington 48.43.545. In Washington, to bring an action against a health care provider for an injury resulting from health care, a patient must show that "the health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he belongs, in the state of Washington, acting in the same or similar circumstances." Revised Code of Washington 7.70.040.

[21] Discussions with the staff of Representative Norwood, lead sponsor of the amendment that contained the industry standard language, indicate that the provision is intended to establish a standard of care equivalent to a health professional standard of care.

[22] See for example Neal v. Superior Insurance Company, 432 S.E. 2d 253 (1993), finding in an action seeking a bad-faith penalty against an automobile insurer that the insurer's refusal to pay a claim based on the opinion of a licensed physician was reasonable unless the physician's opinion was patently erroneous based on facts timely brought to the attention of the insurer.

health plan.[23] Both of the bills also require a health plan to follow the decision of the medical reviewer if the reviewer overrules (or modifies in the case of the Senate bill) the plan denial. The bills differ, however, in how the outcome of external review affects the participant's liability action against the plan.

Under the House bill, if the health plan's denial is upheld, a presumption is created that the health plan exercised ordinary care in making its decision, and the participant must "rebut" the presumption in any subsequent liability action by showing "clear and convincing evidence" of the health plan's failure to exercise ordinary care.[24] Clear and convincing evidence is a legal standard that is generally interpreted to mean that a plaintiff must show that it is "highly probably" that what it is alleging is true. [25] This is a higher burden of proof than the "preponderance of the evidence" standard that is more typically applied in civil disputes, where the plaintiff must only show that what it is alleging is more likely true than not.

Under the Senate bill, state law determines how and when a participant could bring an action against a health plan, including determining how the results of the external appeal process would affect a participant's claim for damages.[26] States could choose to rely on existing law, or could enact new provisions to address the issue. Looking at the states that have enacted health plan liability laws, in most cases a participant's right of action is not altered by an external appeal decision that favors the health plan.[27] In one state, however, a participant has no right of action if the health plan prevails before the external appeal entity.[28] Another state has provisions similar to the House Bill: if the health plan prevails in the external appeal, a presumption is created in favor of the health plan that the participant must rebut by clear and convincing evidence.[29] There also are states in which a participant would be required to meet the higher "clear and convincing evidence" standard under existing state common law rights of action against health plans for improper claims denials.[30]

---

[23] The requirement to exhaust applies under both bills even if the participant no longer wants or could benefit from the medical treatment that was denied. For example, if a patient dies because of the alleged failure of a health plan to authorize emergency care, and the death occurs before an expedited review process can be completed, the participant's estate would need to proceed through the review process.

[24] If a health plan's claim denial is reversed by the external review entity, however, there is no presumption created in favor of the participant in any subsequent liability action.

[25] See Ninth Circuit Model Civil Jury Instructions, § 1.14 Burden of Proof – Clear and Convincing Evidence. See also State of New Jersey Judiciary Model Civil Charges, §1.19 Burden of Proof – Clear and Convincing Evidence ("Clear and convincing evidence is evidence that produces in your minds a firm belief or conviction that the allegations sought to be proved by the evidence are true. It is evidence so clear, direct, weighty in terms of quality, and convincing as to cause you to come to a clear conviction of the truth of the precise facts in issue.")

[26] The Senate bill does require that the results of an external appeal decision be admissible in any state liability action. This provision would presumably preempt any conflicting state law provision.

[27] See discussion in Butler, Patricia A., *Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience*, Menlo Park, CA; Kaiser Family Foundation, August 2001.

[28] Id, at 2-3.

[29] Id.

[30] See for example McEvoy v. Group Health Co-op, 570 N.W. 2d 397, 405 (1997).

Damages

One of the most visible differences between the House and Senate bills is the level of damages that could be awarded to participants.

Both the House and Senate bills generally permit prevailing participants to recover economic damages (e.g., lost wages and future medical costs) without any limit on the amount that can be awarded.[31] The House bill also permits prevailing plaintiffs to recover non-economic damages (e.g., pain and suffering, and severe disfigurement), but limits awards to $1.5 million (with states permitted to set lower, but not higher, limits).[32] The Senate bill generally permits recovery of non-economic damages without limit, although for claims involving medical reviewable decisions, state limits on non-economic damages would apply. A few states have non-economic damage caps in liability cases that are lower than the $1.5 million in the House bill.[33]

The difference between the two bills is largest in the area of punitive damages (i.e., awards intended to punish the defendant for egregious conduct). The House bill permits participants to recover punitive damages only in the presumably rare circumstances in which a health plan fails to authorize coverage in compliance with the written determination of an external review entity. Punitive damages are limited to $1.5 million in these situations, and states are permitted to set lower limits for these actions. The Senate bill has several provisions relating to punitive damage awards, but generally would permit recovery of greater amounts and in more situations than the House bill. For claims involving non-medically reviewable decisions, the Senate bill creates a new civil penalty of up to $5 million payable to the participant for conduct that demonstrates bad faith and flagrant disregard to the rights or safety of the participant. For claims involving medically reviewable decisions, the Senate bill permits the punitive damages available under state law to be awarded, provided that the participant establishes by clear and convincing evidence that the health plan's conduct was carried out with willful or wanton disregard to the rights or safety of others.[34] In states with a different standard or burden of proof for punitive damages, the participant presumably would have to meet both the state standard and the standard in the Senate bill before punitive damages could be awarded. A number of states place caps on the amount of punitive damages that may be

---

[31] As the Senate bill relies on state law for claims involving medically reviewable decisions, state law could limit economic damage awards.

[32] It appears from the language of the House bill that a state would need to enact a new law if it wished to limit non-economic or punitive damages under this new federal cause of action.

[33] Several states have enacted general limits on non-economic damage awards. For example, Alaska has a general limit that is the greater of $400,000 or $8000 times the life expectancy of the plaintiff. In cases of severe permanent physical impairment or severe disfigurement, the limit is the greater of $1 million or $25,000 times the life expectancy of the plaintiff. AS 09.17.010. The American Tort Reform Association has compiled a list of seven states (as of June 30, 2001) that have established general limits on non-economic damages. See http://www.atra.org/show/7340 visited on March 6, 2002.

[34] This special burden of proof is established only where the requirements of the bill relating to procedures for initial benefit determinations, internal appeals and external appeals have been met.

awarded, and under the Senate bill these caps would apply to punitive damage awards in actions against health plans.[35]

Proximate Cause: "The" versus "A"

Another potential difference between the bills involves how the concept of proximate cause is used. Proximate cause is used in the law to determine whether the acts of the defendant are sufficiently related to the injury of the plaintiff to hold the defendant legally responsible for the injury.

In most actions to recover damages, the plaintiff must show that his or her injuries were proximately caused by the act of the defendant. An act is considered a proximate cause of an injury if it sets off a natural and continuous sequence of events that produces injury, and without which the injury would not have occurred.[36] The plaintiff must show that the negligent act was a substantial (i.e., not remote, trivial or inconsequential) factor in bringing about the injury.[37] An act can be a proximate cause of an injury even if it is not the only cause of an injury, or even if it is not the most significant cause of the injury, provided it contributes materially to the production of the injury.[38]

Under the House bill, the health plan's failure to exercise ordinary care that results in delay in receiving, or failure to receive, benefits must be "the" proximate cause of the personal injury or death of the participant. The use of the word "the" before proximate cause may be read to imply that the health plan would not be responsible if there were any other people or entities whose acts contributed materially to the injury. In contrast, the federal liability provision in the Senate bill that applies to non-medically reviewable decisions requires that the failure of a health plan to exercise ordinary care in making certain decisions be "a" proximate cause of personal injury or death. For medically reviewable decisions, the Senate bill would rely on state law treatment of causation, which generally permits a defendant to be held responsible if its acts were a proximate cause of an injury, even if other parties' acts also contributed to the injury.

This small difference in language could have important implications for patients suing health plans. When a patient is wrongfully injured by a health plan decision, it would not be uncommon for the patient also to have a malpractice action against a medical provider who, for example, followed the wrong health plan decision or failed to notify the patient of additional treatment options. Under a literal reading of the House bill, a patient who has a valid cause of action against his or her medical provider could not succeed in a suit against his or health plan, even if the health plan's conduct was the primary cause of the harm.

---

[35] See list of states compiled by American Tort Reform Association at http://www.atra.org/show/7343, visited March 6, 2002.
[36] 57 Am. Jur. 2d Negligence § 428 (1989).
[37] Id. See also Restatement (Second) of Torts § 435 (1965).
[38] Restatement (Second) of Torts § 439 (1965).

It is unclear if the sponsors of the liability amendment to the House bill intended to restrict recoveries to cases in which the health plan's act was the only cause of the injury. The lead sponsor of the liability amendment to the House bill has questioned whether the House intended to limit rights of action in this way.[39]

Impact on State Law Actions Relating to the Delivery of Medical Care

Another key difference between the bills is how they address existing litigation involving the delivery of medical care. As discussed above, some courts in recent years have permitted participants to bring state law claims against health plans for the provision of inappropriate medical care.

Both bills contain language that preserves state law causes of action relating to the delivery of medical care. The Senate bill contains relatively broad language, stating that nothing in Title I of ERISA should be construed to affect or preempt state laws that relate to the practice of medicine or to the provision of, or failure to provide, medical care, or to affect any action (whether direct or vicarious) based on such a state law. The provision amends ERISA and applies the construction to the entire Title I of ERISA, and not merely to the new provisions contained in the bill. Title I of ERISA contains the general standards for conduct by ERISA plans and the basic rights and remedies of plan participants. As discussed above, courts reviewing suits against health plans relating to the provision of medical care have had to determine whether ERISA preempts these types of claims, with some courts finding that some types of these cases are preempted and others finding that they are not. The Senate bill, by extending the new construction provision to all of Title I, fairly clearly establishes that the existing provisions of ERISA should not be construed to preempt state actions relating to the practice of medicine or provision of medical care, and appears intended to end the dispute as to whether ERISA preempts these types of cases.

The House bill, in contrast, contains narrower language providing that nothing in the new liability provision should be construed to preclude a state law action with respect to the delivery of medical care. This provision, however, applies only to the new federal remedy for denials of claims for benefits, and therefore does not address itself to whether any existing parts of ERISA might be found to affect these actions, maintaining the ambiguity of current law.

The House bill further narrows the application of this provision by stating that a cause of action that is based on or otherwise relates to a health plan's determination on a claim for benefits should not be deemed to be the delivery of medical care, and that such actions must be brought exclusively under the new liability provision of the bill. This language raises some doubts about the future viability of many of the state law claims that have succeeded in the past against health plans relating to the quality of medical care. The phrasing "relates to a group health plan's determination on a claim for benefits" is potentially very broad, since many of the activities that health plans engage in could be

---

[39] Pear, Robert, "Matters of Law and Semantics," *New York Times*, August 4, 2001.

argued to relate to providing benefits for claims made under the plan. For example, if a health plan develops practice guidelines and instructs participating physicians that their performance (and continued affiliation with the plan) will be judged based on compliance with those guidelines, the intent of the activity is to influence the care that it delivered to participants seeking benefits under the plan and could be argued to relate to plan determinations for claims under the plan. The guidelines in such cases are in effect advance determinations of what care should be delivered.[40] If the "relates to" language in the House bill is broadly construed, suits seeking to hold health plans accountable for developing guidelines and imposing guidelines that fail to meet professional standards for the delivery of care – cases which today could be brought in some courts – may no longer be permissible.

CONCLUSION

The discussion above demonstrates that there are real differences between the liability provisions of the Senate and House bills and that these differences could have real consequences for participants and for health plans. These differences would affect when participants could sue their health plans, what their burden of proof might be in such a suit, the standard of care against which the health plan's conduct would be judged in the suit, and the damages that could be recovered if the participant were to prevail. Perhaps the biggest difference concerns future status of state lawsuits against health plans about the delivery of medical care, which have been permitted in some courts and denied in others. The Senate bill clarifies that ERISA is not a barrier to such actions while the House bill leaves the issue open to some doubt.

---

[40] It should be noted that if a health care provider denies to provide a service because a health plan's guidelines indicate that the service should not be provided, it is unlikely that the health plan would be considered to have denied a claim for benefits under either of the bills. Health plans are liable for their benefit determinations under the new liability sections of the bills only if they deny a benefit claim.

APPENDIX 1

Scenario Exemplifying Differences Under the House and Senate Bills for Medically Reviewable Decisions

The potential difference between the new liability provisions of the House and Senate bills for medically reviewable decisions may be seen through the following example.

> A woman is admitted to the hospital for back surgery. The woman has a history of hypertension, and the pre-operative examination shows elevated blood pressure. The surgery is performed despite the elevated blood pressure, which persists after her surgery, delaying her discharge. Three days after the surgery, the woman's blood pressure is lower, and she is scheduled to be discharged from the hospital. Her doctors, concerned that her blood pressure may become elevated again, request on the patient's behalf that the health plan approve her discharge to a skilled nursing home for medical management rather than to her home. The health plan disapproves the request for skilled nursing home care because it believes that the care is not medically necessary, and the woman is discharged to her home. The woman requests that the health plan review the denial. In the evening of the day of her discharge, the woman returns to the hospital with complaints of lethargy, right-sided weakness and inability to speak. Her blood pressure is elevated. The woman is readmitted to the hospital exhibiting generalized seizure activity and subsequently is diagnosed as having suffered a stroke. The woman is partially paralyzed, requiring substantial medical and personal care and rehabilitation.
>
> The health plan subsequently denies the woman's appeal of her benefit denial, finding that its original decision was correct. The woman asks for external review, and the external review upholds the health plan's decision. The woman brings an action against the hospital and her doctors for medical malpractice, alleging that they failed to adequately inform her of the risk of her discharge to home. The woman also brings an action against her health plan for failure to exercise ordinary care in reviewing her claim for benefits. The woman seeks economic damages for medical care, rehabilitation and personal care services. She also seeks non-economic damages for severe pain and suffering and punitive damages.

The woman's liability action would proceed somewhat differently under the two bills.

Applicable Law. Under both bills, the woman could bring her claims against the health plan in state court. Under the House bill, the claim would be brought pursuant to the new federal liability provision. Under the Senate bill, the woman's claim would be based in state law.

Standard of Care. Under the House bill, the question of whether the health plan used ordinary care would be reviewed under an industry standard, which would compare the health plan's conduct with the degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved. Under the Senate bill, the standard of care for evaluating the health plan's acts would be determined by state law. In some states, an industry standard would apply. In other states, the standard of care would be based on the standard care for health care providers.

Effect of Appeals Process. Under both bills, the woman would be required to go through the appeal process before bringing her action.[41] Under the House bill, because the external review upheld the health plan's denial, there would be a presumption created in the action that the health plan exercised ordinary care. To prevail, the woman would have to rebut that presumption by presenting clear and convincing evidence of the health plan's negligence. Under the Senate bill, state law would determine whether and how the outcome of the external review would affect the woman's right to sue the health plan. The Senate bill makes the external review decision admissible in any subsequent liability action.

Damages. Under the House bill, if the health plan were found to be negligent and to have caused the injury, the woman would be could recover her economic damages. Any award for non-economic damages would be capped at $1.5 million dollars. The woman could not recover punitive damages under the House bill because this is not a case where the health plan failed to authorize care in accord with the findings of external review.

Under the Senate bill, the remedies available to the woman for the most part would be determined under state law. Generally the woman would be able to recover her economic and non-economic damages, although in some states, non-economic damages are capped. She would be unable to recover punitive damages unless she met the state standard for such damages and showed that by clear and convincing evidence that the health plan's conduct was carried out with willful or wanton disregard to the rights or safety of others.

Proximate Cause. In this scenario, the woman is alleging that both the medical providers and the health plan were negligent and that each of their negligent acts contributed to her injuries. Under the House bill, one reading of the language would suggest that the woman could maintain the action against the health plan only if the health plan's conduct was the only cause of the injury. Under such a reading, in this

[41] It is interesting to note that in a scenario such as this, all of the medical facts that the external reviewer would need to render an opinion are in the possession of parties (e.g., the health plan, doctors and hospitals) whose interests are potentially adverse to the patient, because each would be concerned that they may be sued. Each of the parties also has an interest in having the external reviewer uphold the plan's decision, because that supports their conduct. The patient has no right to discovery (i.e., the right to compel others to produce evidence relevant to the proceedings) in external review, so he or she may not be able to supplement the record with facts that have not been provided to the reviewer.

scenario, if trial determines that any of the medical providers were negligent and that their negligence was a proximate cause of the woman's injury, the health plan would not be liable even if its own conduct was negligent and contributed to the injury. Under the Senate bill, the standard for causation would be determined under state law, but it is generally the case under state and federal law that more than one party can be held legally responsible for injuries that they proximately cause.

APPENDIX 2

Scenario Exemplifying Differences Under the House and Senate Bills for State Law Cases Relating to the Delivery of Medical Care

The potential difference between the House and Senate bills on actions relating to the delivery of medical care can be seen through the following example.

> A child seeks care from doctors affiliated with a health plan for nausea and severe headaches. The child sought treatment from the doctors over a period of time and is prescribed pain medication, but is not referred to a neurological specialist and no diagnostic testing is performed. Because the condition has persisted over a period of time, the psychologist at the child's school becomes concerned and contacts the child's doctors, urging diagnostic testing. An MRI finds right frontal tumor and cystic mass that had infiltrated a significant portion of the child's brain. The child needs surgery and intensive medical treatment that he alleges was brought about by the delay in diagnosing and treating his illness. The child brings an action against the doctors for medical malpractice. The child also brings an action against the health plan, alleging that the plan is vicariously liable for the malpractice of the doctors and directly liable for the injuries because the plan's guidelines discourage the use of diagnostic testing in cases similar to his and because the plan imposes financial disincentives on the doctors that discouraged them from recommending additional treatment and tests.

As discussed above, courts in some federal circuits have permitted participants to bring state law claims against health plans for the provision of inappropriate medical care. The child in this scenario could bring his vicarious and direct liability claims under current law in some courts but not in others. The House and Senate bills would affect the future viability of these claims differently.

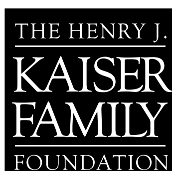
The Senate bill would appear to support the child's vicarious and direct liability actions in this scenario. The Senate bill has relatively broad language providing that nothing in Title I of ERISA is intended to preempt or interfere with state laws that relate to the practice of medicine or the provision of, or failure to provide, medical care, or to affect any action (whether direct or vicarious) based on such a state law. In the scenario above, all of the child's claims relate to the alleged improper provisions of medical care and not to the denial of a requested benefit. To the extent that courts have found that current provisions of ERISA preempt the types of claims discussed in the scenario, the Senate bill, by applying its non-preemption language to all of Title I, would appear to remove the basis overturn for those decisions.

It is less clear whether the child in this scenario would be able to bring all of his liability claims under the House bill. The House bill does contain language providing that nothing in the new liability provision should be construed to preclude a state law action with respect to the delivery of medical care. This language, by itself, neither

supports nor undercuts existing actions, and would have the effect of leaving the current diversity of law across different federal circuits in place.

The House bill, however, also contains limiting language that requires that claims that are based on or otherwise relate to a health plan's determination on a claim be brought exclusively under the new liability section of the law. This would add a new test for determining if these state liability claims would be preempted by ERISA. As discussed above, the term "relates to" is very broad, and it is difficult to predict the extent to which courts will determine that certain health plan actions "relate to" a benefit determination. In the scenario above, the child sought and received benefits under the plan. The financial incentives created by the plan certainly were intended to influence the decisions of medical providers, and may have affected the benefits that the child received under the plan. A court therefore might well find that the incentives "relate to" the benefit determinations that were made with respect to the child (e.g., the determinations to approve, or at least not to disapprove, the claims for the child's care over the long period that the child sought and received benefits under the plan). Such a finding by a court would mean that at least the direct liability claims must be brought exclusively under the new liability section. At the very least, the use of the broad "relates to" language in the House bill would lead to substantial litigation to determine the meaning of the provision.

It should be noted that if the language in the House bill were construed to preempt the child's direct state law negligence action against the health plan, the child would have no direct liability remedy against the health plan. In the scenario above, there was no denial of a claim for benefits (i.e., the child did not ask for anything that was denied), so the child would have no liability claim against the health plan under the new liability section in the House bill. It is interesting to note that the House bill preempts state law claims that relate to a health plan's determination on a claim for benefits, but provides a new remedy only when the health plan denies a claim for benefits.



The Henry J. Kaiser Family Foundation
2400 Sand Hill Road
Menlo Park, CA 94025
Phone: 650-854-9400   Fax: 650-854-4800

Washington Office:
1450 G Street N.W., Suite 250
Washington, DC 20005
Phone: 202-347-5270   Fax: 202-347-5274

www.kff.org

Additional copies of this publication (#3262) are available on the
Kaiser Family Foundation's website at www.kff.org or by
calling the Foundation's Publication Request Line at 1-800-656-4533.