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Federal and State Causes of Action Against Health Plans Under S. 1052 and S. 889

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Summary

One of the central issues in the debate over patient protection legislation is the jurisdiction in which suits against health plans may be brought. Both S. 1052 and S. 889 provide federal causes of action for certain types of suits against managed care plans, and to differing degrees, allow certain types of suits to be brought in state courts. However, each bill presents a different set of requirements for cases heard in either jurisdiction. This report discusses the provisions under each bill that would give a federal court jurisdiction over suits against managed care plans, and under what circumstances a state court would likely have jurisdiction.

S. 1052, Bipartisan Patient Protection Act

S. 1052,¹ introduced by Senator McCain and cosponsored by Senators Kennedy and Edwards, would amend ERISA to create a new federal cause of action against managed care plans and to exclude certain state causes of action from ERISA's preemption provisions, allowing participants and beneficiaries to bring these claims in state court.²

Federal Causes of Action

Federal causes of action would be allowed in situations where the health plan fails to exercise ordinary care in making decisions regarding the terms of the contract between the plan and the participant or beneficiary, including whether an item or service is covered under the plan, whether an individual is enrolled in the plan, and the application of specific exclusions and limitations under the plan, and such failure is the proximate cause of the

¹ S. 1052 is similar to S. 283 and S. 872, earlier bills introduced by Senator McCain and cosponsored by Senators Kennedy and Edwards. S. 872 was the subject of an earlier version of this report.

² Employee Retirement Income Security Act of 1974, 29 U.S.C. 1132, 1144.

participant's personal injury or wrongful death.³ Additionally, a cause of action could be brought in federal court where the plan fails to exercise ordinary care in the performance of any duty under the plan, which is the proximate cause of the participant's injury or wrongful death. Federal causes of action may not involve a "medically reviewable decision" and may not be brought if a cause of action may be brought in state court.⁴ All administrative remedies must be exhausted before a cause of action may be brought unless the personal injury is first known to the participant or beneficiary after the latest date by which the administrative remedy requirements could be met. Additionally, the exhaustion requirements do not apply in any case of immediate and irreparable harm or death occurring, as a result of the denial of a claim for benefits, prior to the completion of the administrative process.⁵

Examples of the types of cases brought in federal court, under S. 1052, would be a case in which a participant or beneficiary alleges that the plan has failed to exercise ordinary care in refusing to cover an item that is not specifically excluded from coverage under the terms of the plan, or a case in which a participant or beneficiary challenges the plan's allegation that a dependent child is not enrolled in the plan. These types of cases would not involve the quality of the care received or the plan's denial of a claim for benefits based upon a "medically reviewable decision," only the plan's interpretation of the health care contract or a failure to exercise ordinary care in the performance of a duty imposed under the terms of the plan.

State Causes of Action

ERISA's preemption clause would be amended by S. 1052 to allow a participant or beneficiary to recover damages resulting from personal injury or wrongful death in a cause of action against a managed care plan in state court, if the cause of action arises by reason of a "medically reviewable decision."⁶ Medically reviewable decisions involve the plan's denial of a claim for benefits based upon a determination that the item or service is not covered because it is not medically necessary and appropriate or that it is experimental or investigational, or a determination that an item or service is not covered on grounds that require an evaluation of the medical facts by a health care professional to determine the coverage and extent of coverage for an item or service.⁷ Medically reviewable decisions are those that are eligible for independent review, and such review must be exhausted

³ Liability as to employers or plan sponsors is limited to those who directly participate in the decision making process. For an analysis of the direct participation language see CRS Report RS20868, *Employer Liability Provisions in Selected Patient Protection Bills*, by Angie A. Welborn.

⁴ See *infra* for a discussion of what constitutes a "medically reviewable decision" and when a cause of action may be brought in state court.

⁵ Irreparable harm is defined in S. 1052 as "an injury or condition that, regardless of whether the individual receives the treatment that is the subject of the denial, cannot be repaired in a manner that would restore the individual to the individual's pre-injured condition."

⁶ See *supra* note 3.

⁷ Items or services denied coverage based upon one of the above stated determinations must be items or services that would otherwise be covered under the terms of the plan. The bill does not require coverage of items or services that are expressly excluded from plan coverage.

before these claims can be brought in state court, except under the special circumstances discussed above.

An example of the types of cases that would be allowed in state court under S. 1052 would be a case in which the plan has denied coverage of an experimental treatment for breast cancer when other breast cancer treatments are covered under the plan. Cases in which a participant or beneficiary has been denied a specific item or service, such as a wheelchair or extended physical therapy, based upon a medical necessity determination could also be brought in state court. These types of cases would not involve a interpretation of the plan's contract, only the plan's denial of a claim for benefits based upon a medically reviewable decision that has given rise to the participant's personal injury or wrongful death. Additionally, S. 1052 would not affect any state law relating to the practice of medicine or the provision of medical care, or a cause of action based upon any such law. Thus, state laws relating to medical malpractice or negligence would not be affected, and suits based upon the quality of care received could continue to be brought in state courts.

S. 889, Bipartisan Patients' Bill of Rights Act of 2001

S. 889 would amend ERISA to create a new federal cause of action against health plans, but would not amend the preemption provisions of ERISA to allow new causes of action to go forward in state courts.

Federal Causes of Action

Participants or beneficiaries would be allowed to bring a cause of action in federal court in situations where the plan failed to exercise ordinary care in approving coverage pursuant to the written determination of the independent medical reviewer, where the independent reviewer reversed the plan's denial of a claim for benefits, and such failure is the proximate cause of substantial harm to the participant or beneficiary.⁸ In addition, federal causes of action would be allowed where the plan failed to exercise ordinary care in making an initial denial of a claim for benefits or during the internal appeals process, that denial is subsequently reversed by the independent medical reviewer, and the delay in providing benefits resulting from the denial is the proximate cause of substantial harm to the participant or beneficiary. Administrative remedies must be exhausted prior to the commencement of a cause of action. However, a participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary.

The types of cases that would likely be brought in federal court under S. 889, include cases in which a plan refuses to cover an item or service, such as in-home nursing care, based upon a determination that such item or service is not medically necessary, the participant pursues administrative remedies through the independent review stage, and the

⁸ Liability is imposed on the plan's designated decision maker. See CRS Report RS20868, *Employer Liability Provisions in Selected Patient Protection Bills*, by Angie A. Welborn, for an analysis of the designated decision maker language.

independent reviewer reverses the plan's denial, but the plan fails to exercise ordinary care in approving coverage pursuant to the independent medical reviewer's reversal. Cases in which an item or service was denied coverage based upon a determination that the item or service was experimental or investigational, such as an experimental treatment for multiple sclerosis, and the denial was later reversed by the independent reviewer, could also be brought in federal court where the participant or beneficiary has suffered substantial harm as a result of the delay in providing care.

State Causes of Action

The preemption provisions of ERISA would not be amended under S. 889; therefore, S. 889 would not allow any new causes of action against health plans to be brought in state court. However, S. 889 would not preclude any action under state law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. The bill specifically excludes cases involving a health plan's administration or determination of a claim for benefits from the definition of state laws relating to the delivery of medical care.

The types of cases that would likely go forward in state courts would be those allowed under current law.⁹ The bill states that it would not preclude "any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care." Presumably, cases alleging medical malpractice or negligence on the part of a physician, as well as cases in which a health plan is held vicariously liable for a physician's alleged malpractice would be allowed. However, cases which involve the administration of the benefit plan or a determination of a claim for benefits would continue to be preempted by ERISA. For example, a participant or beneficiary could go forward with a claim against a physician for malpractice in performing knee replacement surgery, but could not bring a claim against a health plan in state court for failure to cover intensive physical therapy following the surgery.

⁹ Federal courts seem to be split on the issue of whether state causes of action for medical malpractice or vicarious liability against managed care plans are preempted by ERISA. Some federal courts have held that such causes of action may go forward as they relate to the quality of care received, and not the administration of the health plan. However, other federal courts have held that such causes of action inherently relate to the administration of the plan and should therefore be preempted by ERISA. For a discussion of ERISA preemption and state law claims for medical malpractice, see CRS Report 98-286, *ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans*, by Angie A. Welborn.