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An Overview of Managed Care Liability: Implications for Patient Rights and Federal and State Reform

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The Public Policy Institute, formed in 1985, is part of Public Affairs at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of AARP.

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Foreword

Health plan liability has been one of the most contentious issues in the congressional debate on managed care patient protection legislation, and the subject has figured prominently in state legislative debates as well. For consumers, the "right to sue" one's health plan appears, on the surface, to be an essential protection that can help ensure that managed care enrollees get the care they require in a timely and appropriate manner. However, in 2000, only 8 states had enacted insurer liability statutes. Why have legislative bodies been so slow to enact this type of legislation, and why has it been such a contentious issue?

One of the areas of disagreement in the federal managed care liability debate has been the proper "scope" of the legislation. Should all managed care enrollees be protected by the legislation, or should only those who are now covered by self-insured plans? The reach of federal legislation would be affected significantly by the answer to this question. Roughly 125 million workers have health insurance through their employers, of whom about half are in "self-insured" plans, and half are in insured plans regulated by the states. In most cases, those in self-insured plans are not now protected by state managed care protection laws because of the provisions of the Employees Retirement and Security Act (ERISA).

AARP commissioned Sara Rosenbaum, the Harold and Jane Hirsh Professor of Law at the George Washington University Medical Center, to help sort out this complicated subject to better enable policymakers and consumer advocates to evaluate the proposals that are currently being debated. We hope this Issue Brief will inform the debate by providing a non-technical discussion of the legal principles that govern managed care liability. The study addresses the ERISA preemption provisions and examines the key issues that must be taken into account to understand the implications of managed care liability laws. The author also examines the preemption implications of Medicare when a Medicare HMO enrollee alleges injuries arising from professional negligence in connection with coverage decisions.

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Executive Summary

Background

As legislative debate over consumer protections under managed care continues, the central issue to emerge is the extent to which persons enrolled in managed care under ERISA-covered employer-sponsored health plans should be able to recover damages for death and injury caused by substandard medical professional conduct by companies and their health care providers.

Managed care organizations (MCOs) are hybrid entities that combine features of both insurers and health care providers. As a result, courts have found MCOs liable for medical injuries under both professional medical liability law theory, as well as laws that make insurers liable for wrongful or negligent conduct related to the administration of their insurance contracts.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 in order to protect the federal pension system, but its requirements apply to all benefits offered by ERISA-covered employer-sponsored plans, including health benefits. ERISA contains one of the strongest preemption clauses ever written into federal law. While ERISA does not preempt state laws related to professional medical liability for the quality of care, ERISA has been held to preempt state laws that make remedies available for injuries arising from the negligent administration of insurance contracts. This distinction between coverage determination and health care quality injuries is extremely difficult to draw in the case of managed care, since managed care merges insurance and health care.

Purpose

This Issue Brief provides a foundation for understanding the legal principles that govern the liability of managed care organizations for injuries resulting from treatment decisions. It identifies the key issues that arise when considering the enactment of state legislation to establish expanded consumer rights against managed care plans for medical injuries. For selected states, it examines and compares the legislation expanding managed care liability that has been enacted to date. Finally, because, Medicare is, like ERISA, a comprehensive statutory scheme, the Medicare preemption is examined as well.

Methodology

The study involved analysis of key cases, and pertinent federal and state statutes, including the Employees Retirement and Securities Act (ERISA).

Findings and Conclusion

In *Pegram v Herdrich,* the Supreme Court suggested a new rule for determining when ERISA preempts state law claims, indicating that claims that allege negligent medical conduct by

MCOs and their physicians should be subject to state law, regardless of whether a case grows out of coverage decision-making or the quality of health care. The impact of the *Pegram* decision on the lower courts is as yet unclear.

Congress remains divided over the question of how to treat cases involving the negligent medical conduct on the part of managed care companies administering ERISA plans. Some lawmakers support the continuation of a quality/coverage distinction, while others would clarify that ERISA does not preempt claims that challenge professional medical conduct, whether in a coverage or quality context. In recent years states have attempted to legislate in the area of managed care liability. State laws may establish new rights and remedies for medical injuries by managed care organizations; at the same time, state laws may also narrow existing rights and remedies that courts have recognized under common law.

A similar preemption issue arises in Medicare when a beneficiary enrolled in a managed care plan alleges injuries arising from professional negligence in connection with coverage decisions. At the same time, where the claim relates to the quality of care, courts allow cases to proceed under state law.

Introduction

As legislative debate over consumer protections under managed care continues, probably the biggest issue to emerge is the circumstances under which individuals who are enrolled in managed care through employer-sponsored health plans should be able to recover monetary damages from companies for death and injuries caused by substandard medical professional conduct. In certain situations, managed care companies already can be found liable for injuries related to the provision of substandard quality care; this liability grows out of traditional principles of common law professional medical liability that have been applied over the years to both individual medical professionals and medical care corporations. But the question of liability for *treatment-related medical coverage decisions* is one that goes to the role of managed care companies as *insurers* rather than health care providers. It is this question of liability on the part of the managed care industry for injuries caused by *coverage*-related medical decision-making that has become the object of such intense focus.

As the managed care liability debate has moved into the federal and state legislative process, its resolution has become a highly visible political matter. At the heart of the debate lies one of the most complex of all federal laws, the Employee Retirement Income Security Act (ERISA) which affects the rights of more than 125 million Americans and whose impact on longstanding rights and remedies against insurers under state law is enormous. Because of ERISA's size and reach, the debate over the right to remedies for injuries caused by managed care organizations is of major consequence, and the matter was part of the Presidential election itself.

This Issue Paper examines the legal liability of managed care organizations (MCOs) for personal injuries caused by substandard professional medical conduct and the circumstances under which money damages can be available. It attempts to untangle the interaction between federal law and state laws that govern insurer and health provider liability and also seeks to shed light on the implications for consumers of the managed care legislative reform movement. The first portion presents a background and overview of the basic legal principles that govern liability of insurers and medical professionals for damages caused by substandard conduct. The second part discusses ERISA and attempts to explain how this federal law, whose original purpose was to ensure the integrity of the nation's employee pension system, has come to dominate legal discussions of managed care liability in the case of ERISA-covered employer sponsored health plans. The third portion of the paper examines recently enacted state reforms, as well as the key liability-related issues in pending federal legislation. The final portion of the brief concludes with a discussion of parallel liability questions that arise in the case of Medicare managed care.

In summary, an MCO's liability for damages resulting from the injuries it causes depends on (1) the nature of the legal claims raised; (2) the characteristics of the managed care group purchaser; and (3) the intersection between state law and the federal law in the case of particular group purchasers. Where a plaintiff's claim is linked to treatment-related coverage decisions, courts have held that ERISA precludes individuals' ability to recover under state law, even where recovery would otherwise be possible under state law in the case of non-ERISA plans. Similarly, recovery for injuries flowing from professionally substandard coverage decisions appears to be precluded in the case of Medicare. Where, however, a claim is characterized by a court as one that involves the *quality* of the care that has been furnished, recovery of damages is available if permitted under state law.

This complex quality/quantity distinction is a difficult one to draw in managed care, where the line between coverage and quality claims is often extremely blurred. This blurring of the line between coverage and quality arises from the impact of prospective coverage decision-making under managed care on subsequent access to care. In 2000, the Supreme Court in its decision in *Pegram v Herdrich*[1] attempted to achieve greater clarity regarding when medical conduct claims are preempted by ERISA. In its decision, the Court suggested that in injury cases, the distinction should shift away from "coverage versus quality" and toward one based on whether a case raises a challenge to the professional quality of the *medical judgment* that has been exercised. It is too early to know whether the *Pegram* decision will serve to clarify matters or whether this suggested new "medical judgment" principle will be applied to the parallel set of Medicare cases.

In the end, Congress has the power to determine the extent to which individuals covered by ERISA or Medicare plans will have the ability, if injured, to pursue the state law remedies that may be available, regardless of whether the facts of the case point to coverage or quality of care as the source of the allegation of injury. At this point, however, Congress remains divided over how this issue should be resolved.

[1] 530 U.S. 211, 120 S. Ct. 2143 (2000).

Background and Overview: Basic Principles of Liability Involving Health Care and Health Insurance and Their Application to Managed Care

Legal liability for injury or death caused by a defendant's negligent or wrongful conduct (in legal terms, a tort), is a question that historically has been the subject of state law, whether statutory (i.e., enacted by legislatures) or common law (i.e., judicial decisions in the absence of applicable statutory law). Where legal liability for medical injuries is concerned, different concepts of liability have emerged, depending on whether the entity that is sued is an *insurer* or a *health care provider*. Furthermore, over the past decade, a growing body of judicial decisions involving MCOs indicates that for legal liability purposes, courts view MCOs as *hybrid* entities that perform both functions and thus subject to liability under both bodies of state law.

a. Legal liability of health care professionals and institutions

Legal liability principles against health professionals are based on common law legal principles dating back more than 250 years. Under these principles, a physician could be held liable for damages when it was shown that an individual suffered death or injury as a result of care undertaken by the physician that fell below the "professional standard of care."[2] The professional standard has evolved considerably over the centuries;[3] in the modern era, it means care and services that are consistent with the actions of a reasonable and prudent health professional with similar skills and training.[4] A professional defendant may avoid liability if a plaintiff fails to prove the elements of a medical tort (breach of the professional standard of practice, causation, and injury),[5] or if the defendant is able to prove certain affirmative defenses, such as adherence to a relevant and accepted standard of practice, even if it is one that differs from the standard of care on which the plaintiff relied.[6]

Proving a case of professional medical liability is difficult. A plaintiff must be able to show through expert testimony a relevant professional standard of care, a breach of that standard by the defendant, and a link between the defendant's breach of duty and the plaintiff's injury. The plaintiff also must be able to show that the injury in fact entailed measurable damages (compensatory and additional damages such as pain and suffering). In most jurisdictions, where a plaintiff is able to show such gross misconduct

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[2] *Slater v Baker and Stapleton*, 95 Eng. Rep. 860 (King's Bench, 1767)
[3] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, 1997, 2000-01 Supplement, NY, NY). Ch. 3.
[4] *Shilkret v Annapolis Emergency Hospital* 349 A. 2d 245 (Md., 1975).
[5] *Law and the American Health Care System*, op. cit.
[6] This defense is known as the "two schools of thought" doctrine. See *Jones v Chidester,* 610 A. 2d 964 (Pa., 1992)

on the part of the defendant that the conduct can be characterized as willful or wanton, he or she also may be able to recover punitive damages. Studies of medical injuries caused by substandard practices suggest that many injuries in fact do not result in litigation and conversely, that many claims that actually are brought may entail conduct that was not negligent. [7]

As health care evolved from services furnished by individual professionals to care delivered in institutional settings (specifically in hospitals), courts, borrowing from the common law liability principles, developed new theories of *vicarious* and *corporate liability,* both of which have been applied to defendants that are health care corporations.[8] The law of corporate liability is actually relatively recent in the case of medical care, dating back less than 50 years. However, from the time that relevant concepts made their first appearance, the willingness on the part of courts to find liability in corporations has been evident.

Many courts have held that the concept of vicarious liability applies when a health professional who allegedly has negligently caused a medical injury is shown to be an *agent* of a health care corporation. Agency can exist either because the facts show that agency exists (i.e., that the health care corporation exercises control over the health professional) or because the facts suggest that the patient looked to the health care corporation rather than the particular physician for care.[9] Courts have been particularly willing to recognize this concept in cases in which the physician care in question involves a doctor supplied by the hospital (e.g., anesthesiologists). [10] Vicarious liability also has been found to exist in the case of certain "non-delegable" duties, such as hospitals' obligations to maintain control over the integrity of emergency room care, even when they furnish care through independent medical group contractors.[11]

Even more powerful perhaps has been the concept of *corporate liability*, which has been held to apply in cases in which negligent conduct on the part of the health care corporation (e.g., a hospital) is shown by the facts to have caused or contributed to the patient's injury.[12] The types of corporate misconduct that if proven can lead to corporate liability are negligence in the hiring and oversight of clinical staff, failure to maintain

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[7] Harvard Medical Practice Study Group, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).
[8] Id.
[9] *Coleman v McCurtain Memorial Medical Management Inc.* 771 F. Supp. 343 (E.D. Okla., 1991). See generally Law and the American Health Care System, op. cit., pp. 913-927.
[10] Id. See, e.g., *Mehlman v Powell* 378 A. 2d 1121 (Md. 1977) (vicarious liability exists in the case of hospital physicians not chosen by patients themselves).
[11] *Jackson v Power* 743 P. 2d 1376 (Alaska, 1987).
[12] *Law and the American Health Care System, op. cit.*, pp. 927-934.

practice standards of reasonable quality, failure to take prompt action against substandard practitioners, and failure to maintain proper equipment and supplies. [13]

Because professional and corporate medical liability are aspects of the law of *torts* (i.e., wrongful or negligent acts) certain damages principles apply. As noted, the common law permits the injured party to recover *compensatory damages* (e.g., lost wages, medical bills, etc.) and damages for *pain and suffering*. In addition, where the plaintiff is able to show particularly egregious conduct on the part of the defendant (e.g., the defendant acted with willful or wanton disregard for the plaintiff's health and well being), a plaintiff may be able to recover *punitive damages.* As with other torts, medical torts are heavily fact-driven and involve jury trials.

b. Liability of health insurers

Since the early 1970s, courts have applied tort liability principles to insurers.[14] Prior to this time an insurer that failed to pay claims covered under the contract could be liable for a breach of contract or in certain cases for violation of the concepts of good faith and fair dealing that underlie consumer laws.[15] The extension of tort liability principles to the insurance industry meant that insurers could be liable for the full range of tort damages (i.e., compensatory, pain and suffering, and punitive) if their coverage-related decisions were implicated in a plaintiff's death or injury. As *prospective* treatment-related coverage decision-making grew in popularity, the willingness to extend these common law principles also increased, since courts could readily see how a coverage decision when applied prospectively could actually affect access to appropriate care itself.

c. Efforts by state legislatures to reform common law liability principles through legislation

The common law of liability (especially professional liability) has been heavily criticized over the years, but it has never been replaced. Over the past generation however, as judicial intervention in the areas of professional and insurer liability increased, most legislatures have enacted statutory liability schemes that have modified common law concepts of liability and damages. Liability statutes are especially common in the case of medical liability, although many states also have codified insurance tort concepts.

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[13] Id. The leading case with respect to corporate liability is *Darling v Charleston Memorial Hospital* 211 N.E. 2d 253 (Ill., 1965).(Hospital liable for the loss of a boy's leg following its overall failure to monitor his recovery after the leg was set).
[14] *Law and the American Health Care System op. cit.*, Ch. 2, pp. 157-159. The leading case in the field is *Gruenberg v Aetna Insurance Co.*, 510 P. 2d 1032(Cal., 1973).
[15] *Law and the American Health Care System,* op. cit.*,* pp. 142-145.

Typically, state medical liability legislation has been enacted in the face of concerns over the cost of professional liability insurance. As such, the legislation has been designed to make it more difficult for injured persons to bring claims or recover large damages. For example, limits have been placed on the amount of time following an injury when a suit can be filed (statute of limitations laws). Legislatures also have sought to limit access to courts and juries in other ways (e.g., creation of mandatory arbitration procedures or other procedural limits on access to courts and juries, who are seen as sympathetic to plaintiffs). Legislatures also have sought to limit the amount of damages that injured persons can recover, particularly pain and suffering and punitive damages.

d. Applying professional medical liability and insurer liability concepts to managed care organizations

Just as courts led the way in the areas of medical and insurer liability, over the past decade or so, they have begun to apply principles of both medical and insurer liability to MCOS.[16] In examining these trends, it is evident that courts are of the view that MCOs are both insurers and health *care* corporations and that as a result, both bodies of liability law are relevant. In the absence of federal law preempting state law, MCOs thus can be (and indeed are being) found liable under various theories of state law, and can be subjected to damages remedies if their conduct is determined to cause injuries.

For purposes of applying state liability laws, courts (most recently the Supreme Court in *Pegram*) have held that MCOs have two different legal "personalities." When an MCO makes coverage decisions, it acts as an insurer and can be found liable for injuries flowing from negligent coverage decisions assuming that state common law or statutory law recognizes this form of liability. Furthermore, because a managed care agreement is in essence a contract for *prepaid health care* (to be furnished by a company through its medical staff or contracted health care providers), an MCO also has the attributes of a health care provider. As a result, it may be liable for injuries caused by the provision of care of substandard quality.[17]

This issue of managed care liability for both insurance-based coverage torts and health care-based quality-of-care torts constitutes a critical backdrop against which to study the intersection of ERISA and managed care. As is discussed at greater length below*, depending on the theory of liability that is advanced by a plaintiff* (i.e., coverage decision-making negligence versus health care negligence), ERISA may preempt state law remedies that otherwise would be available to the plaintiff.

The application of both insurance-related and professional medical care liability concepts to MCOs has evolved over the past three decades, much in the way that most

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[16] *Law and the American Health Care System, op. cit.* 1043-1071.
[17] Id.

liability law evolves over time. There are several key cases that illustrate this expanding concept of liability. In the seminal case *Wickline v State of California*,[18] in which a woman lost her leg following a premature discharge order by the California Medicaid program's utilization management reviewers, the Supreme Court of California, in a widely read opinion, wrote that health insurers that are negligent in the design or application of prospective utilization management procedures may face liability under state law. The *Wickline* principle was applied to private insurers in *Wilson v Blue Cross of Southern California.*[19]

Furthermore, courts have found MCOs liable like any insurer for a bad faith breach of contract where they negligently apply the terms of their own contracts in making coverage determinations.[20] This is particularly true in cases in which the care sought entails covered services that must be provided out-of-network because a company's own network lacks the necessary expertise. In this situation, at least some courts have taken the view that the company is making a simple coverage determination and thus is acting more as a traditional insurer would act.[21]

Similarly, the principles of corporate and vicarious liability that apply to hospitals have been extended to MCOs where the claim focuses on the quality of health care. Thus, where an MCO is alleged to control its network providers and its providers are alleged to have acted in a professionally negligent fashion in the delivery of covered care, a plaintiff may be able to hold the MCO liable on the basis of agency theory.[22] Where an MCO is alleged to have failed to select its health professionals with care, or failed to maintain professionally adequate practice standards, guidelines, and services, then courts have held that the defendant, like a hospital, may face liability under corporate liability theories, as well.[23]

It should be stressed that managed care liability in the courts is in an evolutionary stage, much as hospital liability theory (which is less than 40 years old) has taken decades to evolve. The cases cited here provide an indication of where courts are going, but the

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[18] 239 Cal. Rptr. 810 (Cal. App. 1986)

[19] 271 Cal. Rptr. (Cal. App. 1990) (ordinary tort and contract principles apply to private insurance utilization review and thus, utilization review company can be held liable for negligence in its utilization review design or operations).

[20] *McEvoy v Group Health Cooperative of Eau Claire* 570 N.W. 2d 397 (Wis., 1997).

[21] Id.

[22] *Boyd v Albert Einstein Medical Center* 547 A. 2d 1229 (Pa. Super., 1998);*Chase v Independent Practice Asso.,* 583 N.E. 2d 251 (Mass. App. 1991); *Petrovitch v Share Health Plan of Ill.* 719 N.E. 2d 756 (Ill., 1999). (In the Chase decision, the court found that the requisite relationship between the plaintiff and the named defendant (an IPA under contract to the HMO) did not exist to establish professional medical liability, since it was the HMO and not its subcontractor IPA that owed a duty of care to the plaintiff.)

[23] *Shannon v McNulty* 718 A. 2d 828 (Pa. Super., 1998); *Jones v Chicago HMO* 730 N.E. 2d 1199 (Ill, 2000).

law will vary from state to state, depending on the willingness of courts to recognize and extend insurance and hospital liability theory to new situations in the absence of express legislative direction under state statutes to do so (this is of course where state managed care quality reform legislation becomes crucial).

Just as with professional medical liability generally, state legislatures increasingly are engaged in legislating in the area of managed care liability for professionally substandard care. As discussed below, state legislation enacted to date addresses both sides of the managed care "personality" (i.e., negligent conduct in coverage decision-making and negligent conduct in the provision of care). In doing so, state laws also set forth the conditions under which MCOs can be sued, and the level of damages that can be recovered.

The Impact of ERISA on State Law Insurance and Medical Care Liability Concepts

a. ERISA

Enacted in 1974, ERISA has as its central purpose the protection of the nation's employee pension system. ERISA applies to all employers regardless of size, exempting only public employees and certain narrowly defined classes of employer-sponsored plans.[24] Thus virtually all privately employed Americans who receive health and welfare benefits as part of their employee compensation work for an ERISA-covered employer.

ERISA's purpose was to regulate the structure and operation of pension plans.[25] ERISA grants employers broad discretion over the design of their health plans, with very limited regulation of the benefits to be covered or the manner in which coverage will be obtained. Employers have the discretion to decide whether they will offer coverage through managed care companies and if so, whether their managed care arrangements will include physician incentive schemes.[26]

At the same time, ERISA grants covered individuals the right to bring individual lawsuits to enforce the benefits, to recover benefits due them under the terms of their plans and to enforce the fiduciary responsibilities incurred by ERISA plan administrators. Generally, while courts reserve the right to make an independent interpretation of the legal terms of an ERISA plan, they also grant a strong presumption toward coverage decisions made by ERISA fiduciaries. Courts permit recovery only if a plaintiff can

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[24] *Law and the American Health Care System*, op. cit., Ch. 2, pp. 159-195.
[25] *Law and the American Health Care System*, op. cit., Ch. 2(C), citing Langbein and Wolk, *Pension and Employee Benefit Law* (Foundation Press, NY, NY 2d. ed., 1996).
[26] *Pegram v Herdrich* 120 S. Ct. at 2152.

show that a plan administrator abused its fiduciary discretion by acting arbitrarily in denying a claim.[27]

ERISA precludes the payment of monetary damages even in cases in which benefits have been wrongfully or negligently denied, on the theory that such damages would drain the health and welfare plans that are held in trust for the members.[28] The law sets forth procedural remedies for enforcing individual rights, including a full and fair hearing by the ERISA plan and the right of judicial appeal. However, under traditional jurisprudential principles, courts will permit ERISA plan participants and beneficiaries to bypass the normal appeals process and obtain immediate injunctive relief in cases in which it appears that federal law is being violated and the beneficiary would suffer irreparable injury were routine appeals procedures to be followed.

In order to ensure the uniformity of federal pension laws and ease the application of nationally collectively bargained employee health and welfare benefit plans,[29] ERISA contains one of the strongest "preemption" provisions ever enacted by Congress. Under the concept of preemption, federal law supercedes state law. Customarily, and in keeping with judicial concern over the displacement of state law (particularly in the area of health insurance, where Congress specifically entrusted to states the authority to regulate insurers),[30] courts tend to find preemption only in those cases in which *specific provisions* of a federal law actually and directly conflicts with *specific* provisions of state law. This jurisprudential doctrine is known as "conflict preemption."

In the case of ERISA, however, courts have recognized the concept of *field preemption*, a more infrequently recognized doctrine. This judicial theory means that Congress has chosen to "occupy the field" of employee benefit law, regardless of whether a specific aspect of state law comes into conflict.[31] Thus, under the concept of field preemption, *even when there is no specific provision of federal law that conflicts with a specific state law*, ERISA has been held to preempt the application of any state laws that are found to fall within this ERISA "preemption vacuum."[32]

The ERISA preemption clause is very short, but has an extremely broad and complex impact. The law contains three major elements. First, ERISA preempts any

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[27] *Law and the American Health Care System*, op. cit., Ch. 2(D). For a discussion of the standard of review that applies when courts consider denials of benefit claims see *Firestone Tire and Rubber v Bruch* 489 U. S. 101.
[28] Id.
[29] See note 24, supra.
[30] This was accomplished by the McCarren Ferguson Act, enacted following the Supreme Court's decision in *Southeastern Underwriters' Ass'n v U.S.*322 U.S. 533 (1944), which extended federal antitrust law to insurance companies.
[31] Id.
[32] Id.

state law that *relates to* an *employee benefit plan*.[33] The term "relates to" has been defined broadly to include any state law that has "a connection with or reference to" an employee plan;[34] at the same time, state laws that have only a "remote and tenuous" relationship to plans and do not relate to benefit design or plan administration are considered *not* to relate to a plan and thus are not preempted.[35] State laws that regulate or apply to the quality of health care, as well as state laws that establish taxation schemes to support broader state health system goals (such as the establishment of an indigent care program), have been found to fall outside of the limits of preemption because they are too remote and tenuous to the design and administration of employee benefit plans.[36]

Second, even where a state law is held to relate to a plan, it may be saved from this broad preemption provision[37] if it is determined to *regulate insurance.* However, the Supreme Court has defined the ERISA concept of *"regulates insurance"* more narrowly than the entire body of state law that regulates *insurers*.[38] As a result, many types of state laws that apply to the insurance industry have been found to fall outside of the body of state law that regulates insurance and thus have not been "saved." The most important ruling in the context of this Issue Paper came in the case of *Pilot Life v Dedeaux*[39] in which the Supreme Court held that the common law of bad faith breach of contract, which tends to carry with it damages remedies, related to employee benefit plans and could not be saved as a law that "regulates insurance" because the law did not meet the "savings clause" test.

At least one U.S. Court of Appeals has held that state laws that establish external review procedures for individuals who are aggrieved by an insurer's coverage decision are preempted by ERISA.[40] This holding was based not on the application of an ERISA

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[33] ERISA 514(a); 29 U.S.C. §1144.
[34] *Shaw v Delta Airlines Inc.* 463 U.S. 85 (1983).
[35] Id. *New York State Conference of Blue Cross and Blue Shield Plans v Travelers Insurance Co.* 514 U.S. 645 (1995)
[36] *New York State Conference of Blue Cross and Blue Shield Plans v Travelers Insurance* note 33.
[37] *Metropolitan Life Insurance Co. v Massachusetts* 471 U.S. 724 (1985).
[38] Id. In discussing preemption, the Court, borrowing from the McCarren Ferguson Act's definition of insurance law, indicated that in order to be a law that regulates insurance, a state law must apply exclusively to the insurance industry, address the relationship between the insurer and the insured, and have the effect of transferring or spreading risk. Insurance content and solvency laws are examples of laws that "regulate insurance." In recent years the Court has clarified this test somewhat, but the reach of this relaxation is quite unclear. *Unum Life Insurance Co. of America v Ward*, 119 S. Ct., 1380 (1999). In *Unum Life* the Court took a broad view of what types of laws can fairly be said to spread risk, upholding California's notice prejudice law that prohibits insurers from denying claims that are filed late unless they can prove that the late filing creating a prejudicial injury.
[39] 481 U.S. 41 (1987).
[40] *Corporate Health Plan v Texas Department of Insurance* 215 F. 3d 526 (5th Cir., 2000); reh. den. 220 F. 3d 641.

field preemption analysis but instead on a finding that the state remedy provided was in direct conflict with the federal remedial scheme under ERISA, which provides participants with a full and fair review by the ERISA plan and an appeal to court.[41] However, the United States Court of Appeals for the Seventh Circuit has determined that state external review laws survive preemption in the case of fully insured plans, because the external appeal process is an integral part of the state insurance contract and is thus available to any member of an insured plan.[42] It is expected that the question of ERISA preemption of state external appeals laws will reach the Supreme Court, given this split in the circuits.

The third prong of the ERISA preemption analysis concerns the distinction between insured and self-insured plans. Based on the ERISA provision that prohibits states from deeming employee benefit plans to be insurers, the Supreme Court has held that state laws that are saved as laws that "regulate insurance" do *not* apply to employee health plans that *self-insure* as opposed to buying insurance.[43] Approximately 50 million of the 125 million individuals enrolled in ERISA plans are covered by self-insured plans. For these individuals, even state insurance laws would not apply to self-insured plans because the plans do not include the purchase of an insurance product. While an insurer may perform administration functions for the plan, no transfer of risk occurs and thus, the plan is exempt from state insurance law. Typically, persons covered by ERISA plans would have no way of knowing from the face of their insurance cards or their plan materials whether their plan is fully or self-insured.

Putting these elements of ERISA preemption theory together, and from a reading of the multitude of judicial decisions regarding managed care liability in the case of ERISA-sponsored plans,[44] it is possible to draw the following broad conclusions about damages litigation against managed care companies, regardless of whether the plan is fully insured or self-insured:

- Where an individual's claim is for damages arising from the wrongful *denial of covered benefits*, the claim is considered to be a claim for benefits that arises under ERISA,[45] and the state law that allows the awarding of damages remedies where such a claim is proven would be preempted under the rule of *Pilot Life*.

- However, where the individual claim for damages rests on allegations of *poor quality* medical care (including claims against individual health professionals

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[41] ERISA §§502 and 503.
[42] Moran v Rush Prudential HMO 2000 WL 1551659 (7th Cir., 2000).
[43] *Metropolitan Life, op. cit.*
[44] See cases cited in *Law and the American Health Care System*, op. cit. Ch. 3(E).
[45] *Corcoran v United Healthcare*, Inc. 965 F. 2d 1321 (5th Cir., 1992); cert. den., 506 U.S. 1033 (1992).

or the managed care company itself under theories of corporate or vicarious liability) the claim is considered to be one arising under state quality of care laws. These laws are considered too "remote and tenuous" to be considered as relating to an ERISA plan.[46]

- Finally, and as most recently suggested in the *Pegram* decision, a claim that challenges the reasonableness of a physician's professional medical conduct falls outside the scope of ERISA and amounts to a professional medical liability claim, since it goes to the question of professional medical judgment and is not one that challenges plan administration.[47] Moreover, managed care corporate practices that induce the exercise of substandard professional medical conduct (including both the use of incentive plans and practice guidelines) may be pursued under state concepts of direct and corporate professional medical liability and are not preempted by ERISA. [48]

Thus, the great controversy in ERISA in the context of the current managed care consumer protection debate arises from the application of ERISA to claims against managed care companies where the claim involves injuries that flow from treatment-related coverage decisions. In the case of managed care, the line between a *coverage* case and a *health care quality* case can be very blurry. For example, where the injury flows from the MCO's application of its practice guidelines to a specific case, the claim for damages might be framed as a denial of care claim, in which case it would be dismissed as a claim for benefits that arises under ERISA. Alternatively, the claim might be framed as a quality claim, under which the plaintiff would allege that, in managing its health care system, the MCO established practice standards for its network providers that were so defective as to result in substandard care. In this case the claim could survive ERISA as a quality of care case based on both corporate and vicarious liability theory.[49]

In recent months the Supreme Court has added to this confusion over which claims are preempted and which are not. As noted, *Pegram v Herdrich*,[50] which concerned the issue of whether managed care physician incentive arrangements constitute a breach of fiduciary liability under ERISA, the Court devoted an extensive discussion to the issue of "mixed" eligibility decisions, under which plan physicians both exercise medical judgment about the need for health care and in doing so, effectively make resource allocation decisions regarding the extent to which coverage should be furnished. The Court observed that for purposes of construing the scope of the meaning of "fiduciary" under ERISA (and thus the reach of ERISA itself, which applies its remedial

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[46] *Dukes v U.S. Healthcare Inc.,* 57 F. 3d 350 (3d Cir., 1995); cert. den. 116 S. Ct. 564 (1995)
[47] 120 S. Ct. pp. 2154-2158.
[48] *Lazorka v Penn. State Hospital,* 2000 WL 1886619 (3d Cir.)
[49] *In re U.S. Healthcare, Inc.* 193 F. 3d 151 (3d Cir., 1999); cert. den. 120 U.S. 2687 (2000).

provisions to fiduciary acts), such mixed decisions should be understood as falling outside of the limits of the term "fiduciary" as it is used in ERISA and within the scope of medical liability law.

The logical import of this lengthy discussion in *Pegram* regarding the limits of the ERISA fiduciary concept is that claims against managed care physicians for treatment decisions involving the exercise of medical judgment would be governed by state medical quality liability law and would fall outside of the remedial scheme of ERISA. But because much of this discussion did not relate to the court's holding in a case that primarily concerned the legality of physician incentive plans under ERISA, the ultimate application of this portion of the case to future medical injury cases brought by ERISA plan members remains to be seen. The decision is also unclear in that it does not address whether liability for mixed decisions applies only to *treating physicians* or also extends to the medical judgment of plan medical directors or other plan providers. The reach of this case is now the subject of intense debate among legal scholars.

Table 1, below compares the preemption-related outcomes of different types of claims brought against managed care organizations (i.e., insurance-based negligence claims versus health care based quality of care negligence claims), depending on the particular sponsor (e.g., an ERISA-covered employer, a public employer, Medicare, Medicaid) of the membership in the MCO.

How Coverage and Quality Claims Might Fare Against Managed Care Organizations, by Type of Group Sponsor

Group Sponsor	Coverage-related claims	Quality of care-related claims
Employers covered by ERISA (virtually all private employers)	Individual may recover only the value of the benefit that was denied, or alternatively may get an injunction against the denial of the benefit, in accordance with ERISA preemption theory	Individual may recover all damages permitted under state law against the MCO under either corporate or vicarious liability theory.
Non-ERISA Employers (public employers)	Individual may recover all damages permitted under state law for injuries.	Individual may recover all damages permitted under state law against the MCO under either corporate or vicarious liability theory
Medicare	Individual may recover only the value of the benefit that was denied, in accordance with Medicare preemption theory	Individual may recover all damages permitted under state law against the MCO under either corporate or vicarious liability theory
Other sponsors (individuals who buy coverage, Medicaid-insured enrollees	Individual may recover all damages permitted under state law for injuries caused by negligent coverage decision-making.	Individual may recover all damages permitted under state law against the MCO under either corporate or vicarious liability theory

An Overview of Recent State Managed Care Quality Reform Laws

As noted, it is customary for state legislatures to enact liability legislation with respect to both health care providers and insurers. States develop legislation either to fill a void created by the lack of judicial decisions or to adopt or modify the thrust of judicially created law. Thus, state legislatures might enact statutes that codify and adhere to judicial decisions recognizing damages remedies for both negligent coverage decisions as well as substandard health care. Alternatively, a legislature might enact legislation that limits the sweep of decisions with respect to who can be sued; the procedures that plaintiffs, defendants and courts themselves must adhere to during the course of litigating a damages action; the types of evidence that can be admitted during a case; or the types and amount of damages that can be awarded.

In other words, state statutes in the area of managed care liability law can either *expand or limit* patient rights and remedies for injuries.

It should not be assumed that managed care "reform" is always enacted to expand rights. Indeed, this type of legislation is extraordinarily complex, and as is the case with all laws regulating an industry, state statutes may reflect a series of pragmatic compromises. For example, a state legislature may decide to expressly recognize the right of a plan member to recover damages for injuries related to the wrongful denial of benefits. But the legislation also may contain provisions that establish procedural steps that plaintiffs must exhaust before filing suit. Certain evidence might be precluded from admissibility, while other evidence, such as the results of external appeals procedures, might be classified as automatically admissible. Certain types of damages might be limited or prohibited altogether in certain situations (e.g., no punitive damages where a defendant can affirmatively show a reasonable factual basis for a denial or alternatively no punitive damages unless a plaintiff can prove actual knowledge on the defendant's part that the denied care was covered). Attorney fees might be limited.

It is impossible to know with any assurance how the tradeoffs that are natural in this type of legislative process affect patients. Do legislative reforms permit patients to recover damages in appropriate circumstances (i.e., where independent assessment of the facts confirms the existence of errors in coverage or quality)? Does the quality of care or coverage decision-making change in measurable ways when patients have recourse to previously non-existent liability laws? Do certain types of statutory limits result in different outcomes for patients, members of the industry, or courts? There are no definitive answers to these questions; as a result, the ultimate impact of reform laws on care itself is not known, although the impact of laws on access to remedies can be gauged.

Table 2 summarizes six recently enacted state laws related to the ability of individuals to sue MCOs over coverage and/or health care quality matters. Recall that to the extent that the laws create rights in the area of health care coverage (either the right to sue or the right to external review of plan coverage decisions), the current trend among courts is to conclude that they would have no impact on ERISA plan members, although the effects of the *Pegram* case (which seems to create a new class of "mixed eligibility" claims that may be covered by state laws) have yet to be felt.

a. Conduct targeted by state statutes

All of the state statutes considered show the ongoing struggle to define the precise nature of the conduct that the law targets. In some cases the targeted conduct is clearly claims administration and benefit determination (GA). In other cases (TX, IL), the targeted conduct is expressed in much more sweeping terms (i.e., treatment decisions that affect the quality of care).

b. Preconditions to filing suit under state statutes

Virtually all of the laws establish the use of an external review process as a precondition to filing suit. Individuals are excused from using the process where exhaustion would be futile or where the injury already has occurred.

c. Defenses made available under state statutes

The statutes tend to permit defendants to raise a plaintiff's failure to exhaust his or her administrative remedies as a defense to a claim. Of far greater interest is the pattern in all of the statutes of potentially narrowing the concept of vicarious liability. This is done by setting stricter standards than the common law might require when the decision-maker is considered to be the agent of the HMO or carrier. Thus a state managed care liability law could in practice seriously limit the liability of a managed care organization, not merely the types of remedies that are available in cases in which negligent conduct is proven.

To the extent that the state law is limited to liability for *coverage* decisions, such a limiting provision would not alter the outcome of medical negligence cases. But to the extent that the state law is interpreted to also cover medical negligence cases (that is, it eliminates the distinction for managed care purposes between coverage and treatment decisions), then a legal provision that makes it harder for a plaintiff to prove agency also could actually limit the remedies available under common law. For example, much treatment decision-making is now done by network physicians who either are capitated or who act under physician incentive plans. If their participation in the network is not sufficient to create an agency, then a managed care company could defend a lawsuit on the grounds that it had nothing to do with the decision by the doctor and the doctor was not acting as an agent of the company.

d. Limitations on damages and attorneys fees under state statutes

With the exception of Georgia (whose law prohibits punitive damages), none of the statutes addresses damages or attorneys fees. It is important to stress, however, that these issues may be separately addressed in generally applicable tort reform laws.

e. Judicial Review of State Managed Care Liability Laws as Applied to ERISA Plans

At least one court has now passed on the legality of state managed care quality reform as applied to ERISA-covered employer-sponsored health plans. In *Corporate Health v*

State of Texas,[51] the United States Court of Appeals for the 5th Circuit held that, insofar as the Texas law imposes liability for poor quality care, the law is not preempted because state quality of care laws are not related to ERISA plan content or administration. The inverse, of course, would be that were the law to be applied as a liability statute for negligent *coverage* decision-making (i.e., an insurance based claim), then the statute would be considered preempted in the case of ERISA plans.

While *Corporate Health* is the only case to date that has considered the application of ERISA preemption theory to state managed care liability reform statutes, most observers believe that the liability aspects of the decision would be true in other states. That is, state laws that create *quality* liability would not be preempted, while laws creating *insurance* liability would be. Thus, to the extent that states have drafted their laws to reach *coverage* conduct, the laws would not apply to ERISA plans.

Federal Managed Care Consumer Protection Legislation

Given ERISA's preemption of state law related to the liability of insurers for negligent plan administration, the question becomes whether Congress will act to alter this picture.

The 106th Congress failed to complete action on managed care consumer protection legislation. The House and Senate bills address many issues beyond managed care liability, and to varying degrees establish certain coverage and content standards for employer-sponsored managed care plans.[52] Both bills also would establish external review procedures for plan beneficiaries.[53]

Where the bills differ profoundly is over the issue of liability. While the bills are extremely complex, the gist of the difference can be stated as follows:

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[51] 215 F. 3d 526 (5th Cir., 2000); pet. for reh. den. 220 F. 3d 641(2000).

[52] Phyllis Borzi and Sara Rosenbaum, A Comparison of House and Senate Managed Care Patient Protection Laws (Kaiser Family Foundation, Washington D.C., May, 2000). The biggest difference in the area of regulatory standards is whether the federal standards would apply to all plans (as in the case of the House) or only self-insured plans (in the case of the Senate). The Senate takes the position that states have the power to regulate insured plans; however, as discussed previously, many state laws that might regulate insurers, such as laws that establish the right to choose a network provider, might not be saved as laws that regulate insurance. This "scope" debate has been quite contentious with great concerns on the part of the Senate that legislation to cover all employer-sponsored plans would federalize regulation of the industry.

[53] Id. The procedures between the two measures differ significantly, although in recent months the Senate has moved closer to the House on a number of key matters.

- The House bill (H.R.2990) would permit plan members to bring both insurance and quality claims in state court and would effectively end ERISA preemption of claims based on MCOs' treatment-related coverage decisions. The House bill is predicated on the theory that in managed care, both coverage and actual care are inextricably intertwined and belong in state court, where traditional tort theory should be permitted to resolve the issue of liability. The managed care industry and employers object to the measure on the grounds that it would restore preempted remedies, and according to the employers and plans, expose employers to additional costs by restoring damages[54] (in the case of self-insured plans) for injuries flowing from coverage decisions.

- The Senate bill (a more recent version of which was included in the Senate appropriations bill and then dropped in conference) would create a new *federal* remedy for treatment-related coverage injuries (i.e., insurance-type claims). However, at least one analysis suggests that the Senate remedy is drafted sufficiently broadly to potentially sweep in existing quality claims, and places such restrictions on access to court as to make recovery nearly impossible.[55]

In recent months federal negotiators have discussed possible compromises in the area of health plan liability, but the two sides are philosophically far apart. Given this impasse, it is probably safe to say that the question of damages remedies for persons who are injured by managed care conduct will remain one to be sorted out by the courts on a case-by-case basis, with claims that are deemed to raise quality of care matters remanded to state court, and those that are deemed to be coverage decisions handled under existing federal ERISA limits that preclude damages.

Claims for Damages Brought by Medicare Managed Care Enrollees

The final section of this Issue Paper considers the problem of preemption in the case of Medicare. Unlike ERISA, the law of preemption has only begun to appear in the area of Medicare managed care; however, the issue can be expected to grow in importance as more beneficiaries enroll in managed care organizations.

Like ERISA, Medicare provides a federal remedy in the case of coverage disputes; under federal law, individuals who allege that they have been denied a benefit to which they are entitled have a right to both administrative and judicial review and provision of the benefit if they prevail. Thus, as with ERISA, the issue of preemption could arise, at least to the extent that a Medicare enrollee seeks to recover damages

[54] Long and Marquis
[55] Letter to Congressman John Dingell from Sara Rosenbaum, Rand Rosenblatt and David Frankford (July 7, 2000).

against an MCO for injuries allegedly caused by improper benefit denials (a claim that under state tort law would amount to a bad faith breach of contract or negligence in the administration of benefits). Finally, similar to ERISA, one would expect there to be no preemption where the claim against the HMO is pure quality (i.e., where it involves claims of medical malpractice and corporate and vicarious liability on the part of the MCO).

To date, there have been only a handful of decisions on Medicare preemption of insurance-like coverage claims. In *Ardary v Aetna Health Plans,*[56] the United States Court of Appeals for the Ninth Circuit held that federal Medicare law does not preclude beneficiaries from bringing state law claims for damages caused by the insurance decision-making process against a Medicare-participating MCO. In *Ardary* the plaintiff alleged that Aetna's failure to authorize emergency airlift transport to a specialty center following the decedent's heart attack, and that death resulted. The court determined that nothing in the Medicare statute indicated a similar desire on the part of Congress to preempt all state laws relating to a "private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA," [57] and dismissed the defendant's claim of Medicare preemption. A similar result was reached in in *McCall v Pacificare,*[58] in which the California Court of Appeals found that the facts of the case placed it within the special *Ardary* rule, because the injuries alleged went well beyond a dispute over payment and entailed injurious conduct on the part of an HMO and its physician group flowing from benefit denials. In *McCall*, the plaintiff was able to allege that treatment delays actually resulted in physical harm.

In *Redmond v Secure Horizons,*[59] a California appeals court found that an *Ardary*-type situation did not exist. Unlike *Ardary*, the plaintiff in *Redmond* suffered no actual injuries, and the only legal injury to which she could point was the delay in approval of a prior authorization request for surgery and a resulting bill for out-of-plan care (which the defendant ultimately paid). In rejecting plaintiff's claims that the case raised claims that could survive Medicare preemption, the court was careful to clarify that there is a class of "special" *Ardary* claims in which the facts show tortious conduct resulting in injury and death (rather than a mere payment dispute). In this special group of cases, an individual's claims "could not have been remediated by pursuit of the claim through the administrative review process." [60]But in *Redmond* the facts did not show the type of injury for which state tort statutes provide unique remedies other than the monetary injury of having to pay a bill that should have been covered to begin with. Because in the court's view the facts amounted to a dispute over a payment, the claims fell within the reach of Medicare's appeals provisions.

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[56] 98 F. 3d 496; cert. den. 520 U.S. 1251 (1997).
[57] Id. p. 501.
[58] 87 Cal. Rptr. 2d 784 (Ct. App. 4th Dist., Calif.) 1999.; app. den., 988 P. 2d 1083 (1999).
[59] 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 (Cal. App. 6th Dist.)
[60] Id at 103.

Similarly, in *Wilson v Chestnut Hill Health Care,*[61] the court found that the plaintiff (who broke her leg as she was departing a nursing home to live with her daughter at her own request) in fact raised no claims that truly amounted to injury claims related to the tortious conduct of the defendant. Instead, according to the court, she was merely alleging that she was entitled to more nursing facility care than she received.

Taken together, the Medicare preemption cases suggest that, depending on the facts, courts may be willing to save insurance tort cases from preemption, where the facts of the case confirm the potential existence of real injuries flowing from the alleged misconduct of the managed care entity in the denial of the claim. However, because of the existence of the Medicare appeals process, courts are careful to scrutinize the facts closely in order to assess whether a case is simply an attempt to "artfully plead" a tort case when in fact the only real injury is non-payment of a claim, for which a specific federal remedy is available.

The Medicare cases to date further suggest that even in states in which either statutory or common law provides remedies for negligence in coverage decision-making or bad faith breach of contract, the state remedy will be narrowly applied to Medicare beneficiaries, and the facts of their cases closely scrutinized, in order to determine whether the real issue as shown in the pleadings is the non-payment of a bill or the types of serious injuries for which negligence laws are designed to provide a remedy. To the extent that the state laws described in Table 2 focus on health care *quality* claims, they would be applicable to Medicare beneficiaries. To the extent that the laws focus on negligent coverage decision-making, their applicability to Medicare would probably be limited to the most factually clear cases of actual injury that raise the case above a simple claims denial.

It is probably also the case that state external review statutes would not apply to Medicare managed care claims, since federal Medicare law sets forth a comprehensive and exclusive appeals procedure for coverage and treatment disputes. The Balanced Budget Relief Act of 1999 specifically preempted state external appeals arrangements.

Conclusion

This review underscores the complex interaction between federal and state laws in a managed care era. Managed care represents a health care "hybrid," in which treatment and coverage are often inextricably linked and where the same set of circumstances can give rise to a host of federal and state law claims raising both coverage and quality matters. In the midst of this legal situation, both Congress and state legislatures are attempting to create new remedies for individuals who allege injury as a result of managed care decisions. In some cases, the statutory laws may broaden or codify pre-existing rights as articulated by courts. In others, the legislation may actually narrow the

[61] 2000 WL 204368 (E.D. Pa., 2000)

rights and remedies that courts have previously articulated. Whatever their direction, these laws, in their actual application, will continue to raise questions as courts grapple with whether the claims should be viewed as coverage or quality of care cases.

For consumers who are members of ERISA-sponsored or Medicare plans, it is probably fair to say that state laws that broaden or codify quality-related remedies are quite relevant, while those that establish liability for coverage denials, even when intimately bound up in access to treatment, may be preempted. Furthermore, the external review procedures set forth in state laws would not be relevant to Medicare plan members because they have exclusive federal procedures for recovery of their benefits. Whether state external appeals statutes apply to persons covered by ERISA plans depends on final resolution of the question by both Congress and the courts.

Ultimately, the interaction between state and federal law means that it is up to Congress to ensure a proper external review mechanism for ERISA-covered and Medicare plan members. It is also up to Congress to decide the circumstances under which the industry will face the prospect of financial damages for the consequences of substandard treatment-related coverage decision-making. In this area, Congress remains deeply divided (at least in the case of ERISA), as to whether the matter of liability should be returned to the state or retained as a federal matter and subject to federal limits. It is likely that the answer to this question will not come soon.

Overview and Comparison of Recently Enacted State Managed Care Liability Legislation

Issue Addressed	**Arizona HB 2600 (2000)**	**California S.B. 21 (1999)**	**Georgia H.B. 732 (1999)**	**Illinois H.B. 284 (1999)**	**Louisiana H.B. 2083 (1999)**	**Texas Civ. Prac. & Rem. 88.001 et. seq. (1997)**
Type of conduct for which entity may be liable	The failure by a health insurer to authorize coverage of medically necessary services or a bad faith denial of payment of benefits.	The failure to exercise ordinary care in the arranging for the provision of, or denial of, health care services in specified circumstances. Liability exists where both of the following apply: a failure to exercise ordinary care that resulted in the denial, delay or modification of health care service recommended for or furnished to an enrollee; and an enrollee suffered harm and injury. Special rules apply in cases of substantial harm, defined as loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss.	Injuries resulting from the failure of a claims administrator or benefits reviewer to exercise ordinary diligence.	Liability on the part of a health insurance carrier, HMO, or MCO for negligent "treatment decisions" made by employees or agents. A treatment decision is defined as a "determination made when medical services are actually provided by the health care plan and a decision that affects the quality of the diagnosis, care, or treatment provided to the plan's insured or enrollees."	Negligent medical necessity determinations by medical necessity review organizations which are insurance issuers or other entities authorized to make medical necessity review determinations. Determinations include decisions regarding medical necessity, appropriateness, health care setting, level of care, or effectiveness.	Treatment decisions by health insurance carriers, HMOs, and other managed care entities. Liability extends to employees and agents. A treatment decision is defined as a determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care or treatment provided to the plan's insured or enrollees.
Preconditions to suit	Enrollee must alternatively exhaust the external appeals process or provide written notice to the insurer at least 30 days prior to filing an action.	Enrollee must exhaust the independent review system, but no exhaustion is required where substantial harm has occurred or will imminently occur.	Enrollee must exhaust the external grievance procedure and agree to an independent review or must prove that the injury already has occurred and grievance process is not timely or available.	None	No private rights of action appear to be permitted. MNROs that violate the provisions of the act may be liable for civil money penalties and cease and desist orders.	Exhaustion of applicable appeals and review process under the law; 30 days' notice prior to filing; and submission of the claim to an independent review organization. Enrollees need not exhaust where the harm already has occurred and the review would not be beneficial or if exhaustion would place the individual's health in serious jeopardy.
Standard of proof required.	Not addressed.	Not addressed.	Not addressed.	Agency claims cannot turn solely on network membership where the claim is against an entity or practitioner alleged to be an agent of the carrier.	Not addressed; no apparent individual right of action.	Agency cannot turn solely on network membership where the claim is against an entity or practitioner alleged to be an agent of the carrier.

Issue Addressed	Arizona HB 2600 (2000)	California S.B. 21 (1999)	Georgia H.B. 732 (1999)	Illinois H.B. 284 (1999)	Louisiana H.B. 2083 (1999)	Texas Civ. Prac. & Rem. 88.001 et. seq. (1997)
Defenses specifically made available.	Not addressed.	Failure to exhaust where required. The treatment decision was not made by an entity or an agent of the entity, as the term is understood in light of the limitation on the meaning of agency.	Failure to exhaust where required.	The treatment decision was not made by an entity or an agent of the entity, as the term is understood in light of the limitation on the meaning of agency.	Not addressed.	Failure to exhaust where required. The treatment decision was not made by an agent of the entity, as the term is understood under the law in light of the limitation on the meaning of agency. The carrier or entity did not participate in, control, or influence the decision and did not deny or delay treatment recommended by a provider to the enrollee.
Limits on damages.	Not addressed.	Not addressed.	No punitive damages.	Not addressed.	Not addressed.	Not addressed
Attorney's fees.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed.	Not addressed
Effect of new law on other state rights and remedies.	Precludes insurer liability for harm caused by provider (may eliminate common law vicarious liability).	Specifically does not create any "new or additional liability on the part of a health care service plan or managed care entity for harm caused that is attributable to the medical negligence of a treating physician."	Does not appear to preclude medical negligence actions alleging poor quality care; confined to negligent administration and claims adjudication.	Unclear. The cause of action reaches treatment decisions that affect the quality of care and could potentially preclude other common law theories of liability for poor quality care.	To the extent that there would be other theories under which an individual could sue an MNRO under Louisiana law, nothing in the statute directly precludes such lawsuits.	Unclear. The cause of action appears to reach treatment decisions affecting quality, thereby foreclosing other claims based on common law vicarious or corporate theories of liability for poor quality care.