The Honorable John Dingell
United States House of Representatives
Rayburn House Office Building
Washington, D.C.

July 6, 2000

Dear Mr. Dingell;

At your request we have reviewed the Senate patients' bill of rights legislation that was inserted into the FY 2001 Labor/HHS legislation last week.

Rather than expanding individual protections, the measure would appear to undo state law remedies for medical injuries caused by managed care companies' treatment decisions and delays. In this regard, the bill runs directly contrary to United States Supreme Court's reasoning in its recent decision in *Pegram v. Herdrich,*[1] which seems to reaffirm the authority of states to determine medical liability policy, and underscores the appropriateness of state courts as the forum for medical liability cases.

The displacement of state medical liability law in favor of a new federal medical liability remedy might have some policy validity, were the new law fair and just. But the remedy set forth in the Senate bill is compromised by an unprecedented range of limitations, exceptions, and defenses and appears to leave injured persons with no remedy at all.

In sum, in the name of patient protection, the Senate legislation appears to eliminate virtually any meaningful remedy for most working Americans and their families against death and injury caused by managed care companies.

Conclusion

The central purpose underlying the enactment of federal patient protection legislation is to expand protections for the vast majority of insured Americans whose health benefits are derived from private, non-governmental employment, and who thus come within the ambit of ERISA. Not only would the Senate measure not accomplish this goal, but worse, it appears to be little more than a vehicle for protecting managed care companies from various forms of legal liability under current law. Viewed in this light, Congressional passage of the Senate bill would be far worse than were Congress to enact no measure at all.

Our detailed analysis is attached.

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[1] 120 S. Ct. 2143; 2000 WL 743301

Sincerely,

Sara Rosenbaum
Harold and Jane Hirsh Professor, Health Law and Policy
George Washington University
(202)530-2343
ihosxr@gwumc.edu

David M. Frankford
Professor of Law
Rutgers University School of Law - Camden
(610)-642-0400
frankfor@crab.rutgers.edu

Rand E. Rosenblatt
Professor of Law
Rutgers University School of Law – Camden
(856)225-6379
rrosenbl@crab.rutgers.edu

By classifying medical treatment injuries as claims denials and coverage decisions governed by ERISA, the Senate bill insulates managed care companies from medical liability under state law.

Section 231 of the Senate bill amends ERISA §502 to create a new federal cause of action relating to a "denial of a claim for benefits" in the context of prior authorization. The bill defines the term "claim for benefits" as a "request *** for benefits (including requests for benefits that are subject to authorization of coverage or utilization review) *** or for payment in whole or in part for an item or service under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan." ERISA §503B, as added. Thus, the bill would classify prior authorization denials as "claims for benefits" that are in turn covered by the new federal remedy. Federal remedies under ERISA §502 preempt all state law remedies.[2]

This classification would have profound effects, particularly in light of the Supreme Court's recent decision in *Pegram v. Herdrich.* As drafted, the Senate bill arguably would preempt state medical liability law as applied to medical injuries caused by the wrongful or negligent withholding of necessary treatment by managed care companies. The bill thus would reverse the trend in state law, which has been to hold managed care companies accountable for the medical injuries they cause, just as would be the case for any other health provider.

In recent years courts that have considered the issue of managed care-related injuries have applied medical liability theory and law to managed care companies in a manner similar to the approach taken in the case of hospitals. Thus, like hospitals, managed care companies can be both directly and vicariously liability for medical injuries attributable to their conduct.[3] In a managed care context, the most common type of situation in which medical liability arises tends to involve injuries caused by the wrongful or negligent withholding of necessary medical treatment (i.e., denials of requests for care).

State legislatures also have begun to enact legislation to expressly permit medical liability actions against managed care companies. The best known of these laws is medical liability legislation enacted in 1997 by the state of Texas and recently upheld in relevant part against an ERISA challenge by the United States Court of Appeals for the Fifth Circuit.[4]

In *Pegram v. Herdrich*, the Supreme Court implicitly addressed this question of whether managed care state liability law should cover companies for the medical injuries

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[2] *Pilot Life v. Dedeaux* 481 U.S. 41 (1987)
[3] *Boyd v. Albert Einstein Medical Center* 547 A. 2d 1229 (Pa. Super., 1988); *Petrovitch v. Share Health Plan* 719 N.E. 756 (Ill., 1999); *Jones v. Chicago HMO* 2000 WL 637290(Ill.); *Dukes v. U.S. Healthcare* 57 F. 3d 350 (1995); *In re U.S. Healthcare* 193 F. 3d 151 (3d Cir., 1999)
[4] *Corporate Health Insurance v. Texas Department of Insurance* 2000 WL 792435 (5th Cir.)

they cause. The Court decided that liability issues do not belong in federal courts and strongly indicated its view that in its current form ERISA does not preclude state law actions. It is this decision that the Senate bill would appear to overturn.

In *Pegram*, the Court set up a new classification system for the types of decisions made by managed care organizations contracting with ERISA plans. The first type of decision according to the Court is a "pure" eligibility decision that, in an ERISA context, constitutes an act of plan administration and thus represents an exercise of ERISA fiduciary responsibilities. Remedies for injuries caused by this type of determination would be addressed under ERISA §502 (which of course currently provides for no remedy other than the benefit itself).

The second type of decision is a "mixed" eligibility decision. While the Court's classification system contains a number of ambiguities, it appears that in the Court's view, this second class of decision effectively occurs any time that a managed care company, acting through its physicians, exercises medical judgment regarding the appropriateness of treatment. Such decisions, as medical decisions rather than pure eligibility decisions, are not part of the administration of an ERISA plan and thus not part of ERISA's remedial scheme because, according to the Court, in enacting ERISA, Congress did not intend to displace state medical liability laws. The Court thus strongly indicated that these claims are not preempted by ERISA and may be brought in state court. In the Court's view, these mixed decisions represent a "great many, if not most"[5] of the coverage decisions that managed care companies make.

The Senate bill would appear to reverse *Pegram* by effectively classifying all prior authorization determinations as §502 decisions, without any regard to whether they are "pure" or "mixed". As a result, state medical liability laws that arguably now reach mixed decisions apparently would be preempted, leaving individual physicians, hospitals, and other health providers as the sole defendants in state court. Under the complete preemption theory of §502,[6] remedies against managed care companies would be governed by the new federal remedy, which would effectively shield the industry from accountability under state law.

The federal "remedy" in the Senate bill would leave Americans with no remedy.

Upon close examination, the new federal remedy simply creates the illusion of relief while at the same time foreclosing other more meaningful approaches to holding managed care accountable:

- The provision is unclear on the meaning of the term "denial" in the context of claims that are actionable under the new federal remedy. Were the remedy to be interpreted by the courts to encompass only outright denials, many of the worst types of treatment delays would go unaddressed. In a recent decision from New York, for example, Aetna U.S. Healthcare used a series of appalling tactics to delay making

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[5] 2000 WL 743301, 9.
[6] *Dukes v. U.S. Healthcare* 57 F. 3d 350, 354.

any decision regarding treatment for an individual with profound mental illness-related problems for over seven months. When the New York State Department of Insurance finally ordered coverage it was too late; the patient died eight days before Aetna finally entered a favorable initial determination.[7]

By focusing only on denials and not covering delays, the provision effectively incentivizes the industry to put patients through delay after delay as a strategy for avoiding liability.

- The provision bars any actions that challenge the company's denial of treatment that it asserts to be "excluded," rather than not medically necessary. This loophole would encourage companies to classify denials as exclusions rather than as denials of claims based on lack of medical necessity. The irony is that the external review provisions of the bill seem to permit review of decisions involving analysis of medical facts, a broader standard of review than a strict medical necessity standard. Despite this, the remedy would bar any relief for an individual whose denial is couched in exclusion terms rather than medical necessity terms. Any good insurance lawyer would advise his or her client to draft all denial letters in a manner that conforms to this limitation on remedies.

- In order to successfully prove a claim, a plaintiff would have to prove not only a negligent denial (i.e., a denial that was made by incompetent staff or using incompetent standards or insufficient evidence) but that the denial was made in *bad faith.* This is a virtually impossible standard to prove and particularly egregious in light of the fact that plaintiffs cannot even bring such an action unless they have gotten a reversal of the denial at the external review stage. Even where they have proven that a company wrongfully withheld treatment, plaintiffs can recover nothing for their injuries without taking the level of proof far beyond what is needed to win at the external review stage. Virtually all injuries would go uncompensated.

- A plaintiff will be forced to show "substantial harm", defined in the law as loss of life, significant loss of limb or bodily function, significant disfigurement or severe and chronic pain. This definition arguably would exclude some of the most insidious injuries, such as degeneration in health and functional status, or loss of the possibility of improvement, that a patient could face as a result of delayed care, particularly a child with special health needs. In *Bedrick v. Travelers Insurance Co.,*[8] the managed care company cut off almost all physical and speech therapy for a toddler with profound cerebral palsy. The Court of Appeals, in one of the most searing decisions ever entered in a managed care reversal case, found that the company had acted on the basis of *no* evidence and with what could only be described as outright prejudice against children with disabilities (the managed care company's medical director concluded that care for the baby never could be

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[7] BNA Health Law Reporter, "New York Judge Allows Negligence Case Against Health Plan's Coverage Denials" (9:13, March 30, 2000), p. 467.
[8] 93 F. 3d 459 (4th Cir., 1996).

medically necessary because children with cerebral palsy had no chance of being normal).

The consequences of facing years without therapy were potentially profound for this child: the failure to develop mobility, the loss of the small amount of motion that the child might have had, and the enormous costs (both actual and emotional) suffered by the parents. Arguably, however, none of these injuries falls into any of the categories identified in the Senate bill as constituting "substantial harm."

- The maximum award permitted is $350,000, and even this amount is subject to various types of reductions and offsets. This limitation on recovery will make securing representation extremely difficult.

- No express provision is made for attorneys fees. Were the new right of action to be interpreted not to include attorneys fees this would be a radical change in the ERISA statute, and one that would create a massive barrier to use of the new purported ERISA remedy. To mount a case proving bad faith denial of treatment that caused substantial injury is an enormously expensive proposition. The limitations on recovery are in addition to the fact that the bill gives federal courts exclusive jurisdiction over cases brought under the new provision. The cost and difficulties associated with litigating a personal injury claim requiring proof of bad faith would thus be exponentially increased, and would make it virtually impossible for injured persons to find lawyers to represent them.

- The provision gives the company as an affirmative defense the claim that it did not receive sufficient information to make a decision. How this can be a plausible or fair defense when the individual is the *company's own patient* completely eludes us, as does the existence of any reasonable nexus between the existence of such a defense and the bad faith standard that the bill requires (a standard that implies a deliberate failure to act *despite* knowledge). In our view, allowing such a defense under these circumstances would be irrational and grievously unfair.

- The provision insulates any group health plan that offers its members the choice of either an insured benefit or an individual benefit payment to be used by the member to buy an individual insurance policy. Every group health plan thus could shield itself from liability, even where its own selected group health insurer was grossly negligent, by offering this option, a choice which in many states is useless because individual employees are unable to secure coverage on an individual basis in the open market. We presume that many plans would begin to offer this meaningless type of benefit simply to shield their group health plans from even the minimal liability allowed under the law.

- Finally, it should be noted that the measure would preclude class actions under the new ERISA remedy, no matter how widespread the misconduct of the defendant. For example, a defendant might engage in a practice of systematically denying every request for treatment in order to push individuals into external review and delay

treatment. Under this provision, even were the defendant pursuing such a strategy as a matter of "design," no class could seek relief.

- In a similar vein, the legislation would prohibit any class action "alleging any violation of section 1962 [of RICO]" "where the action seeks relief for which a remedy may be provided under Section 502" of ERISA. This provision has, to the best of our knowledge, received no public attention by Congress, and it most certainly has not been debated. Its effects are utterly unknown but its potential to shield managed care companies from civil prosecution for corrupt practices is enormous. In *Humana v Forsythe*[9] the United States Supreme Court held RICO applicable to a managed care company that had systematically defrauded thousands of health plan members out of millions of dollars in benefits by systematically lying to members about the proportional cost of the treatment they were being required to bear (the policy was a typical 80/20 payment policy, but because of secret discounts that were not disclosed to members, group policy holders in many cases were paying for the majority of their care). This is racketeering, pure and simple, and thus represents a classic type of RICO claim. To use a patient protection bill potentially to insulate managed care companies against these types of practices is unwise at best.

Conclusion

The central purpose underlying the enactment of federal patient protection legislation is to expand protections for the vast majority of insured Americans whose health benefits are derived from private, non-governmental employment, and who thus come within the ambit of ERISA. Not only would the Senate measure not accomplish this goal, but worse, it appears to be little more than a vehicle for protecting managed care companies from various forms of legal liability under current law. Viewed in this light, Congressional passage of the Senate bill would be far worse than were Congress to enact no measure at all.

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[9] 119 S. Ct. 710(1999)