National Center for Policy Analysis

BRIEF ANALYSIS
No. 307
For immediate release:
Friday, December 3, 1999

Patients' Rights: A Double Standard

As everyone "knows," the Patients' Bill of Rights that recently passed the House of Representatives would allow members of Health Maintenance Organizations to sue their plans. What most people probably don't know is that members *already* can sue their HMOs under current law. So what's going on?

What the bill would really do is encourage trial lawyers to flood the courts with malpractice-like suits over what are essentially contract disputes. These tort lawsuits would allege noneconomic damages (such as pain and suffering) and seek punitive damages. Given the willingness of juries to award multimillion-dollar judgments, the liability for health plans and employers could be huge. Health insurance premiums would soar as a result, pricing even more Americans out of the market and leaving them uninsured.

Ironically, although the bill would allow people to bring tort lawsuits against private-sector plans, it does not grant similar rights to Medicare beneficiaries or to those participating in the government's health plan for federal workers. If it's good for private plans, why isn't the right to litigate in this way also good for government-sponsored insurance?

The bill would allow people to bring tort lawsuits against private plans for coverage disputes but not against Medicare or any other government health care plan.

The Right to Sue an HMO. Ordinarily, insurance is regulated by the state in which it is bought and sold. However, in 1974 Congress imposed federal regulation on health plans sponsored by employers through the Employee Retirement Income Security Act (ERISA). ERISA preempts — that is, takes precedence over — state laws that relate to employer plans under most circumstances. However, ERISA makes an exception regarding insurance, in recognition of the states' traditional role in insurance. Many employers' health plans, instead of being traditional insurance, are "self-funded" and thus do not fall within ERISA's exception for insurance. (In a self-funded plan, the employer assumes the risk for claims. The employer may administer the plan itself, or it may hire a third-party administrator.) In these cases, ERISA preempts the states' laws.

ERISA does not preempt state laws relating to an HMO that is not an employer's self-funded plan. Nor does ERISA prevent members, even of a self-funded plan, from suing their doctor or hospital for malpractice under state law. Further, self-funded plans can be held liable under current law for their own malpractice as providers of care or the malpractice of their doctors where state law provides vicarious liability — i.e., recovery against plans for the actions of employed doctors.

It is also possible to sue for wrongful denial of coverage, asking the court to rule that the insurer must provide the coverage under its contract. For ordinary insurance, the suit can be brought under state law. For self-funded plans, ERISA rules permit a case to be brought under federal law to recover the cost of the denied treatment plus attorneys' fee, and to obtain appropriate equitable relief.

What patients cannot do now is sue a self-funded plan for malpractice-type damages relating to denial of coverage. This means they cannot seek compensation for such noneconomic damages as mental distress, pain and suffering, loss of consortium, etc. Nor can they sue for punitive damages. By contrast, ordinary insurance plans can be sued for all these things under state law, depending on the law of the particular state. Where such suits are allowed, lawyers use state law to turn the disputes over what services health plans should cover into personal injury suits. ERISA, on the other hand, provides only a contract remedy against self-funded employer plans. It avoids turning a dispute over what in many cases is a relatively small sum into a lawsuit for millions of dollars.

Turning Contract Disputes into Tort Suits. The Patients' Bill of Rights would change things. It would legitimize and encourage the temptation to turn contract disputes into tort suits. It would enable plan members to recover large judgments (and their lawyers to take at least one-third of the recovery) for pain and suffering and other noneconomic damages — all of which are necessarily subjective and give juries great license. It would also allow the award of punitive damages. The bill lets state law govern lawsuits. But this is not a neutral stance. Passage of the legislation would signal the federal government's support for such suits. Some state legislatures can be expected to enact laws permitting patients to

Dallas Headquarters: 12655 N. Central Expy., Suite 720 • Dallas, TX 75243-1739 • 972-386-6272 • Fax: 972-386-0924 • E-Mail: ncpa@public-policy.org
Washington Office: Metropolitan Square • 655 15th Street N.W., Suite 375 • Washington, D.C. 20005 • 202-628-6671 • Fax 202-628-6474 • E-Mail: ncpa@his.com
For more information: Julie Hillrichs in Dallas at 972/386-6272 or Joan Kirby in Washington at 202/628-6671

recover on these extended theories of damage for coverage denials. Even in states whose legislatures do not act, many state courts would make law to allow these large recoveries.

The bill does not limit the amount of noneconomic damages that can be recovered, with one exception. In a suit over wrongful denial of coverage, the bill prohibits the award of punitive damages if the plan follows the ruling of an outside review panel that a treatment is covered. But this apparent protection is of no value. A plan is not likely to be sued if it complies with the determination of the panel that a treatment is covered because, if it does, the patient would then have no complaint. Moreover, this "protection" does not apply to the multitude of *other* theories on which noneconomic damages can be awarded — pain and suffering, mental distress, etc.

The bill also provides that a plan's outside review panel (which would be regulated by and answerable to the federal government) would *not* be bound by provisions of the plan defining what is medically necessary and is thus covered.

New Risks for Employers. The fear induced by exposure to large judgments will make administrators of self-funded plans reluctant to deny coverage — which, of course, is the intent of the legislation. The result will be fewer denials — or potentially large judgments for noneconomic damages if the health plan administrator persists in interpreting and applying the employer's plan as originally intended. In either event, employers that sponsor health coverage for their employees will face higher costs.

Employers will also face more direct risks. A part of the legislation states that an employer cannot be sued unless the lawsuit is based on the employer's "exercise of discretionary authority to make a decision on a claim for benefits" under the plan. It is not clear, however, how much protection this would provide after the courts are finished interpreting it. The courts might, for instance, interpret it to mean that if an employer exercised discretionary authority in one instance it could be sued even where it did not make a decision in another case, the absence of a decision where it could act itself being held to be the exercise of discretionary authority. It is equally possible that actions of the plan administrator will be attributed to the employer through a theory of agency and consequently that the exercise of discretion by the plan administrator will support lawsuits against the employer.

Even if it were successful in avoiding direct liability, the employer would be dragged through litigation. Litigation entails extensive "discovery." Communications between the employer's human resources department and the plan administrator would be scrutinized by plaintiffs' lawyers seeking to prove that the employer made claims decisions and to establish an agency relationship. Employees' records maintained by the employer or the administrator would be at risk of public disclosure.

Imposing a Double Standard. It is noteworthy that the Patients' Bill of Rights would impose these new costs on private-sector employers only, while exempting the federal government itself.

If Medicare determines that a treatment is not medically necessary, the beneficiary can go though an appeals process and seek judicial review. But if he wins, he collects only the cost of the treatment, as is now the law under ERISA. A beneficiary covered by traditional Medicare cannot recover noneconomic damages under state law if Medicare wrongfully denies a claim.

To the same effect, the law setting up the Federal Employees Health Benefit Program tracks ERISA in barring lawsuits under state law against insurers who cover federal government employees. The federal worker who is denied coverage can collect the cost of the denied treatment, but not the consequential damages that the Patients' Bill of Rights would allow to be assessed against the plans of private employers.

Medicare and plans providing coverage to federal workers have the same incentive to deny claims as self-funded employer plans. If it is good policy to give private workers the chance to recover noneconomic damages from their employers (directly or indirectly), why shouldn't individuals covered under these federal programs have the same rights? The answer, of course, is that the federal government is not prepared to try to persuade taxpayers that the increased cost this would entail is a good use of their tax money or to persuade the beneficiaries to accept reduced benefits to offset these additional litigation costs. It is easier for the government to force private employers (and their employees, stockholders and customers) to bear them.

If Medicare beneficiaries and federal employees demanded rights equal to those extended in the Patients' Bill of Rights, the cost of the new legislation would be better appreciated.

This Brief Analysis was prepared by John Hoff, a health care lawyer in Washington, D.C.