What Is Health Plan Liability?

Health plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point-of-service (POS) plans, dominate the current American health care marketplace. The promise of this system of managed care is the delivery of comprehensive, quality care to enrollees and cost containment for plan purchasers. To control costs, health plans frequently conduct prospective utilization review, usually before patients are admitted to a hospital or before expensive services are delivered. Under this system, health plans can deny coverage of services before they are delivered, and thus enrollees might not receive services recommended by physicians if they have no other means to pay for them.

While patients can still hold individual physicians liable for medical malpractice in a managed care environment, there is currently little recourse for most patients who experience serious harm as a result of their health plan’s limitation or denial of payment for benefits. As shown by a survey conducted for Governor Wilson’s Managed Health Care Improvement Task Force in 1997, Californians’ experiences with managed care suggest that health plan denials, delays in getting needed care, difficulties in getting referrals to specialists and not receiving needed care all can have serious health consequences. These consequences include the worsening of existing health conditions, new conditions that were not previously present, and in some cases permanent disability.

For example, a jury recently awarded $116 million in punitive damages to a woman whose husband died of cancer after Aetna U.S. Healthcare of California refused to pay for a bone marrow transplant. The plaintiff was able to sue because her husband had been a government employee, and ERISA does not apply to government-sponsored health plans.

These experiences have led to proposals in Congress and in a number of states, including California, to expand the right of consumers to sue health plans for economic and punitive damages, analogous to allowing medical malpractice suits against physicians. However, Californians receiving coverage through private employee health plans currently cannot sue their plans for economic and punitive damages because of some federal and state barriers that preclude health plan liability.
Allowing patients to sue their health plans for the recovery of damages is now largely preempted for people in employer-sponsored plans by the federal Employee Retirement Income Security Act of 1974 (ERISA), because ERISA preempts state laws relating to employer health benefit plans. For the majority of insured Americans receiving coverage through an employer, ERISA provides the sole recourse for people who want to sue their health plan. The only remedy ERISA provides is recovery of the cost of providing the treatment that was denied. ERISA includes no remedy to compensate for economic or non-economic damages, such as lost wages, pain and suffering, or punitive damages.

Congress could amend ERISA in a number of ways to eliminate the conflict between ERISA and health plan liability legislation, by permitting liability suits against health plans under state law or altering ERISA’s remedy for patients who sue their health plans to allow compensation for economic and non-economic damages.

Currently, in about half the states, including California, health plans can use “corporate practice of medicine” laws as defense against liability. These laws prohibit those plans not owned by physicians from employing physicians. Thus, these plans can claim immunity from malpractice liability because they cannot “practice medicine.”

Health plan liability legislation has been proposed in Congress and many state legislatures, but as of 1998 only Texas and Missouri had enhanced the legal right of health plan members to sue their plans when they are injured by a denial of coverage. The Texas and Missouri laws eliminate the “corporate practice of medicine” defense used in suits against health plans. The Texas law also creates a new legal claim for health plan members that a plan failed to use “ordinary care” in denying or delaying payment for care recommended by a physician or other provider. A lawsuit contesting the Texas liability law was filed by Aetna U.S. Healthcare in federal court. Aetna has appealed the judge’s decision that the state’s liability law is not preempted by ERISA.

A survey conducted by the National Conference of State Legislatures at the end of 1998 found that 31 states intend to consider health plan liability legislation in 1999. Liability legislation could also resurface on the 1999 Congressional agenda.

According to some consumer and health care interest groups, the threat of a lawsuit may be the most effective way to hold health plans accountable for their decision-making behavior. Some claim that allowing patients to sue is the most appropriate means of redress for consumers who may have suffered physical harm as a result of treatment decisions made by their plans.

Health plans and business organizations argue that making plans liable for treatment decisions would raise costs significantly. They argue that utilization of services would increase because health plans would be less stringent in their benefit determinations to avoid the risk of patient lawsuits and jury verdicts with large damage awards. To the extent that health plans are less judicious in conducting utilization review, the cost-controlling aspect of this key feature of managed care could be eliminated. An increase in premiums could prompt some employers to increase their employee contribution for coverage, resulting in employees dropping coverage, and could induce some employers to drop coverage for their employees altogether.

Several proposals are already being considered in the 1999 session of the California Legislature to enhance health plan liability. SB 18 (Figueroa) would prohibit a health plan from refusing to authorize services determined to be medically appropriate and necessary by a patient’s physician or other provider who has a contractual relationship with the plan, except under certain conditions. SB 21 (Figueroa) would establish that a health plan has a duty of ordinary care to provide covered health care services to its members, subscribers, and enrollees, in a medically appropriate manner, and that a health plan shall be liable for any and all harm proximately caused by the failure to exercise the ordinary care required by this bill.

If the courts become an avenue through which conflicts between patients and their health plans are resolved, some have suggested California’s Medical Injury Compensation Reform Act of 1975 (MICRA) as an appropriate model for compensation. MICRA places a cap of $250,000 on non-economic physician malpractice damage settlements, and limits attorney contingency fees, though MICRA’s provisions are themselves a subject of intense debate in California. There may also be appropriate models for health plan liability that are used in other industries.