Health Plan Liability

This policy brief is the product of background research and the discussion at the California Health Policy Roundtable on Health Plan Liability held in Sacramento, California on February 25, 1999. The California Health Policy Roundtable is a nonpartisan education and information forum on health policy issues in California. It is directed by Helen Schauffler and staffed by Juliette Cubanski, Center for Health and Public Policy Studies, University of California, Berkeley, School of Public Health; cosponsored by the California Center for Health Improvement in Sacramento; and funded by the Kaiser Family Foundation.

The purpose of this Roundtable was to inform the policy debate in California about the issues involved in health plan liability. Speakers at the Roundtable included Patricia Butler, Attorney and Health Policy Consultant, Boulder, CO; David Druker, COO of the Palo Alto Medical Foundation, Palo Alto, CA; Mark Hiepler, Partner at the Law Firm of Hiepler & Hiepler, Oxnard, CA; J. Clark Kelso, Professor at the University of the Pacific McGeorge School of Law, Sacramento, CA; Peter Lee, Director of Consumer Protection Programs at the Center for Health Care Rights, Los Angeles, CA; Steve Thompson, Vice President of Government Relations at the California Medical Association, Sacramento, CA; and Walter Zelman, President and CEO of the California Association of Health Plans, Sacramento, CA. The Roundtable was moderated by Alan Weil, Director of the Assessing the New Federalism project at the Urban Institute in Washington, D.C.

Context for Reform

In 1997, an estimated 1.6 million adult insured Californians reported that they experienced delays in getting needed medical care and 480,000 reported that they were denied care or treatment by their health plan in the last year, according to a 1997 survey conducted for California’s Managed Health Care Improvement Task Force by researchers at the University of California, Berkeley and the Field Research Corporation (UC Berkeley/Field survey).1 Of those patients who reported that they had been denied care or treatment by their health plan, 50% reported that their health condition worsened, 41% reported the development of a new health problem not previously present, and 9% reported that the denial resulted in a permanent disability that negatively affected activities of daily living.

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According to the UC Berkeley/Field consumer survey, the methods consumers most commonly use in attempting to resolve their health plan problems include contacting a physician for help and calling or writing to their health plan. Less frequently used methods of problem resolution include: contacting an elected official, contacting a lawyer (5% of PPO enrollees and 3% of HMO enrollees) and contacting a state or local agency. Fifty-two percent of California consumers who experienced problems with their health plan reported that...
their problem was resolved; of this group, 45% reported that they were satisfied with the resolution, but 22% reported that they were not at all satisfied. People who contacted their health plan or physician were more likely to report satisfaction with the resolution than people who contacted a lawyer. While 44% of consumers were satisfied with how their health plan handled their complaint, 32% were not satisfied.

These data indicate that while most Californians’ problems with their health plans are resolved and that many consumers report satisfaction with the resolution, consumers experiencing health plan problems use a variety of methods to try to resolve their problems, with differing degrees of effectiveness. Furthermore, consumers may not have equal access to information about the methods of problem resolution available to them and many remain dissatisfied with the current system of health plan problem resolution.

One method proposed to increase health plan accountability for harm that results to patients from wrongful or inappropriate denials or delays of treatment is enhancing the legal liability of plans. This would allow patients to sue their plans and to receive awards for economic losses, pain and suffering, and punitive damages. Currently, most consumers who receive health insurance coverage through a private employer-sponsored plan cannot recover any compensatory or punitive damages if they sue their health plan.

Congress is now considering legislation that would expand consumers’ ability to sue their health plans. Health plan liability has also been proposed in many states, but as of 1998 only Texas and Missouri had established the legal right of all patients to sue their health plans for malpractice. Liability legislation, introduced but not passed in the 1998 session of the California Legislature, is once again being considered by the state’s policymakers.

In a 1998 Kaiser Family Foundation/Harvard University survey, 73% of Americans said they support a law to allow people to sue their health plans for malpractice, though support decreased to 54% when the possibility of increased health care costs was mentioned.²

Health Plan Liability and ERISA Preemption

The federal Employee Retirement Income Security Act of 1974 (ERISA) establishes the federal government as the regulator of private-sector employee benefit plans (ERISA plans), including health benefit plans, and thus preempts many state laws “relating to” private employer-sponsored health benefits even if there are no federal standards in place.³

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. However, 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.

ERISA’s preemption of state laws related to liability applies regardless of whether the plan is insured (i.e., the employer buys coverage from an insurer) or self-insured (i.e., the employer acts as the insurer). ERISA does permit states to regulate health insurance directly in some areas (e.g., by mandating coverage of certain benefits), but exempts self-insured plans from this regulation.

Previous court interpretations of whether suits against health plans and state health plan liability laws are preempted by ERISA could have implications for the fate of similar legislation if adopted in California. The Supreme Court held in Pilot Life (1987) that ERISA preempts state common law damages claims for injuries due to payment denial. According to this decision, such remedies are preempted by ERISA because they affect plan administration and also conflict with ERISA’s more limited remedies for health plan problem resolution.

More recently, courts have attempted to distinguish between disputes over a plan’s decision regarding whether to cover a service, in which case damages suits under state law are preempted by ERISA, and disputes over a plan’s direct involvement in care delivery, in which case damages
suits may not be preempted. These distinctions can be characterized as “coverage” vs. “quality” disputes.

Recent court decisions appear to have narrowed the extent of ERISA preemption, but ERISA still poses obstacles to state damages liability claims against health plans. The Congress is currently considering ERISA amendments to expand federal and/or state remedies with regard to health plan liability, but the outcome of these discussions is uncertain.

The law recently passed by the state of Texas sought to allow all consumers (including those covered by private sector employers, with the exception of people in self-insured plans) to sue their plans for damages caused by: 1) health plan treatment decisions; and 2) coverage denials or delays. A lower federal court upheld the part of the law that authorizes “quality”/malpractice suits but invalidated other provisions, including the state’s external review law; the case is now on appeal.

**Liability and Compensation in Other Industries**

Other industries have historically used a variety of different approaches to liability. These different approaches were explored at the Roundtable to provide policymakers with a broader context for continuing discussion of expanded liability for health plans.

**Contract vs. Tort Liability.** Liability in the U.S. generally follows one of two approaches: contract or tort.

**Contract law** is designed to facilitate private contracts between parties, and focuses on providing a high degree of certainty about the consequences if the contract is broken. Generally, damages are limited to what would have occurred if the contract had been kept. Punitive damages and damages for emotional distress are generally not recoverable. Remedies for breach of contract are designed to compensate the injured party by protecting his or her economic expectations, but are not intended to punish or deter parties from breaching contracts.

**Tort law** reflects societal judgments about how people should behave towards each other. The three main goals of tort law are deterrence, compensation for injuries, and minimizing society’s overall costs associated with accidents. Unlike contract law, remedies for breach under tort law include compensatory damages to ensure that the injured party is compensated for the defendant’s wrongful conduct, which in turn encourages the defendant to conform his or her conduct to society’s standards. In many cases, tort law remedies are limited to compensatory damages (i.e., do not include punitive damages) in order to avoid defensive behavior that might drive up costs without realizing equal gains to society. For those occasions where compensatory damages are insufficient to achieve a proper level of deterrence, punitive damages can be awarded to injured parties to punish malicious, oppressive or fraudulent conduct.

Some argue that the amount of punitive damages should be uncertain (e.g., not capped) in order to make it difficult for potential defendants to calculate in advance the liability cost of doing harm.

The current system of health plan liability under ERISA essentially follows a contract model of liability.

**History of Liability in Selected Industries and Contexts.** The concept of health plan liability can be informed by a consideration of liability in a few selected industries and contexts, including professional malpractice, workers compensation, product liability, insurance bad faith and wrongful termination.

**Professional malpractice** generally arises out of a contractual relationship between a member of a profession and a client. The law imposes independent duties upon the professional regarding his or her performance in the relationship, and the professional has a duty to exercise the ordinary skill and care of a competent member of the profession. Tort liability generally governs if this standard of care is breached, and the professional can be liable for economic, non-economic and punitive damages. For physician malpractice in California, non-economic awards (e.g., for pain and suffering or for punitive damages) are
limited to $250,000 under the Medical Injury Compensation Reform Act (MICRA).

**Workers compensation** exists to compensate all workplace injuries without establishing fault, but in this system damages are limited and workers are denied the opportunity to sue under tort law. Strict liability governs, meaning that any workplace injury can be compensated, not just those arising from employer negligence.

**Product liability** establishes that businesses can be held liable to consumers for product defects that result in personal injury to the consumer. Product liability is a tort cause of action.

**Insurance bad faith** involves claims by an insured party against his or her insurance company for failure to pay in accordance with the insurance contract. The California Supreme Court has ruled that tort liability applies to bad faith denials – meaning that punitive damages can be used to deter behavior – even though there is a contract that governs the relationship between the insurer and the insured. (Note that for people with employer-sponsored health coverage, ERISA’s remedies – which do not include tort damages – apply in many cases.)

**Wrongful termination** cases arose from a perceived breach of good faith and fair dealing by an employer in discharging an employee without cause. Such action, according to interpretation by the California Supreme Court in the early 1980s, might constitute a tort. However, in **Foley** (1988), the court emphasized the contractual nature of the relationship between employers and employees, and rejected tort liability in the employment context for breach of good faith and fair dealing.

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**Perspectives on Enhancing Health Plan Liability in California**

Speakers at the February Roundtable discussion offered a variety of perspectives on health plan liability.

**Mark Hiepler**, an attorney who represents health care consumers and physicians in California, argued that enhancing health plan liability is important because ERISA provides no mechanism for deterring health plans from breaching contracts. He further argued that the current system is inequitable in that those in ERISA plans are largely preempted from suing their health plan while those working for government employers or covered individually can sue for recovery of compensatory and punitive damages. Hiepler suggested that better disclosure laws could provide consumers with more complete information about their health plans and the methods of problem resolution available to them.

**Walter Zelman**, President and CEO of the California Association of Health Plans, suggested that the right to sue health plans for damages may have value, but that value should be weighed against the possible costs, which include higher premiums and more uninsured people. He argued that keeping overall health care costs down may be a more important goal than allowing large damage awards for a relatively small number of people.

Rather than enhancing health plan liability, Zelman pointed to a system of independent, external review of medical necessity determinations as a lower-cost alternative that could address consumer concerns that plans may inappropriately be denying care.

Zelman suggested three guiding principles if California does establish the right of patients to sue their health plans for damages:

1. There should be a limit on damages, similar to the cap placed on physician malpractice liability in MICRA;
2. Patients should be required to exhaust internal and external appeals prior to undertaking any legal action against the plan; and
3. Health plans should only be held responsible for decisions they make, and should not be vicariously liable for medical decisions made by medical groups or individual providers that contract with the health plan.

**Steve Thompson**, Vice President of Government Relations for the California Medical Association, suggested that ERISA issues could be avoided through an approach that requires treatment decisions – including a health plan’s determination of whether to deny or approve care – to be made by a California-licensed physician. This physician decision-maker, whether a health plan or medical group employee, should be liable for medical malpractice if patients are harmed by a treatment decision.
**David Druker**, COO of the Palo Alto Medical Foundation and representing the American Medical Group Association, pointed to the financial constraints of managed care. He argued that California has the lowest health plan premiums in the U.S. and that the state’s medical groups (and some health plans) are losing money. In this constrained financial environment, he cautioned against proposals such as expanded liability for which costs might outweigh the increase in health care quality that may result. He also expressed concern that under a system of enhanced health plan liability, health plans could seek greater control of and involvement in the health care decision-making process. This involvement would disrupt the relationships between patients and physicians and between physicians and health plans. Instead, he argued for a system in which physicians are the accountable decision-makers in the delivery of health care services, and where consumers have access to strong internal and external appeals.

**Peter Lee**, Director of Consumer Protection Programs at the Center for Health Care Rights, argued that compensating patients who are harmed is a matter of simple justice, but that expanded liability should be part of a broader effort to hold health plans accountable, including: greater oversight of the industry, ombuds programs to assist consumers, and external review of health plans decisions. He argued that consumers need better information about how to resolve problems with their health plans, pointing to the results of a survey of Sacramento-area consumers that found that 30% of consumers take no action when they experience a problem with their health plan.

**Would Expanded Liability Increase Health Plan Premiums?**

A key aspect of the debate over expanding health plan liability is the extent to which it would increase health care costs, leading health plans to increase premiums.

In a study commissioned by the American Association of Health Plans, the Barents Group estimated that the nationwide implementation of a liability law similar to the one passed in Texas would increase managed care plans’ costs by between 2.7% and 8.6%.

Other independent studies suggest a smaller cost effect. In an analysis of current legislation that would remove ERISA as a barrier to damage awards against health plans (S. 6), the Congressional Budget Office pegged the cost at 1.4% of premium. An analysis of California consumer protection legislation prepared for the Kaiser Family Foundation by Price Waterhouse estimated the cost of expanded liability at 0.1-0.4% of premium for Independent Practice Association model HMOs (and less for staff or group model plans).

In a related study prepared for the Kaiser Family Foundation, Coopers & Lybrand analyzed the liability experience of the California Public Employees’ Retirement System (CalPERS). Since CalPERS is a government-sponsored plan, ERISA’s preemption of damages does not apply.

The analysis found that of the 60 administrative appeals filed by CalPERS members from 1991 to 1997, between 15 and 20 appeals reached the level of civil litigation against the health plans, for a litigation rate of 0.3 cases per 100,000 enrollees. Coopers & Lybrand estimated the monthly cost per CalPERS enrollee related to litigation to be between $0.03 and $0.13, assuming an average cost per case for litigation of $100,000 and $10,000 for the cost of an administrative hearing.

However, as the Coopers & Lybrand study observed, the actual cost of expanding health plan liability on a widespread basis could be higher if health plans respond “defensively” by making their utilization review criteria less stringent. Large (and unpredictable) damages awarded by juries could further increase costs. For example, in a recent California case involving a public employee, a jury awarded $4.5 million in compensatory damages and $116 million in punitive damages to a woman whose husband died of cancer after Aetna U.S. Healthcare of California refused to pay for high-dose chemotherapy and a bone-marrow transplant. The suit contended that Aetna acted in bad faith when it denied treatment. Aetna’s motion for a retrial was denied.
Conclusion

The high volume of recently proposed health care consumer protection legislation – both in California and across the nation – is the response of policymakers to the perception that consumers are not adequately served by the current standards for patient protection in the health care industry. Because health plans are emerging as decision-makers about treatment delivery, many believe that plans should be held liable when those decisions result in harm to patients.

Moreover, critics of the current system of liability point to the inequity of allowing some consumers to sue for damages while most can only recover the cost of benefits they were denied under ERISA.

However, opponents of increased liability for health plans emphasize that increased costs might result, and instead argue for expanding consumer administrative appeal rights without compensatory or punitive damages. As previously mentioned, the percentage of Americans who favored health plan liability decreased from 73% to 54% when the possibility of increased health care costs was mentioned.

The premium effect of enhancing health plan liability in California may depend on the level of internal and external appeal processes available to consumers, whether limits are placed on the amount of damages that may be awarded, as well as modifications to health plan utilization review practices as a result of the risk of litigation.

Meanwhile, there is uncertainty regarding the extent to which California can expand health plan liability without its efforts getting preempted by ERISA. As federal courts work to interpret and re-interpret the reach of ERISA, Congress continues to debate proposals to eliminate the ERISA preemption of state lawsuits against health plans.
The California Health Policy Roundtable is funded by a grant from the Kaiser Family Foundation, Menlo Park, California.