The Bipartisan Patient Protection Act: Greater Liability on Managed Care Plans

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I. INTRODUCTION

Recently, both the Senate and House of Representatives passed bills that comprise the Bipartisan Patient Protection Act of 2001. The ability for either bill to go into effect depends largely on its ability to endure House-Senate conference committee discussions, as well as President George W. Bush’s staunch refusal to place his signature on a bill that would ultimately serve as a boon for trial lawyers.

Proponents of the Senate bill are considered to be in favor of consumer protection, while proponents of the House bill seem willing to limit such protection. The House bill is more favored by President George W. Bush because it negates advantageous opportunities for trial lawyers, but a conference committee will work to develop a compromise bill that can be sent to the President. If this compromise bill is passed, it will serve generally as the Patients’ Bill of Rights. Even though a compromise bill is essentially a settlement of differences by mutual concessions, there will always be a feeling that one side’s views are more incorporated than the other’s.

This Article will provide a look into the remedies made available under...
both the House and Senate bills to participants, beneficiaries, and enrollees. This Article will also discuss the development of managed care entities, particularly health maintenance organizations ("HMOs"), and liabilities that have been assessed against these organizations in terms of state claims filed under state tort law. A general overview of the Employee Retirement Income Security Act ("ERISA") and recent actions fostered to amend it will be addressed due to its preemptive power.

II. MANAGED CARE PROGRESSION

Traditionally, medical care services in America have been provided on a "fee-for-service" basis. Under this type of arrangement, a patient makes a payment to the provider selected for the services provided. Likewise, if the patient had insurance and the provider was willing, the provider submitted the patient's bill to the insurance plan for reimbursement subject to the terms of the insurance agreement. Therefore, under "a fee-for-service [arrangement], a [provider's] financial incentive is to provide more care, not less, so long as payment is forthcoming." "The check on this incentive is a [provider's] obligation to exercise reasonable medical skill and judgment in the patient's interest."6

"Beginning in the late 1960's, insurers and others developed new models for health-care delivery, including HMOs."7 In turn, HMOs developed from managed care, theories of "[reducing] costs and [providing] the best value for both the [provider] and the patient."8 Generally, an HMO is "any of a variety of types of health plans that contract with a defined group of providers (usually on a capitated basis) to provide health care to a defined population."9

Capitation involves providing "a monthly payment per enrollee regardless of what care the individual actually receives."10 "The HMO thus

3. This preemptive power operates generally against health care plans that are provided through an employer, or that are self-insured.
5. Id.
6. Id. at 215.
7. Id. at 218.
8. Managed Care Organization ("MCO") is a broad category of health plans, ranging from simple preauthorization plans to HMOs. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 308 (3d ed. 1997).
10. Id. (discussing the different types of managed care plans, including the definition of capitated price).
assumes the financial risk of providing the benefits promised: if a participant [or] [enrollee] never gets sick, the HMO keeps the money regardless, and if a participant [or] [enrollee] becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant’s [or] [enrollee’s] premiums."11 "Hence, in an HMO system, a [provider’s] financial interest lies in providing less care, not more."12 "The check on this influence (like that on the converse, fee-for-service incentive) is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient’s interest."13

An HMO may act as both the provider and the insurer.14 There are two main types of HMOs.15 The first type, the staff model, hires providers directly to work out of its facilities.16 The second type, the group model, contracts with provider groups to provide health care at discounted rates.17

In order to encourage the development of HMOs as an alternative to traditional methods of health care delivery, Congress enacted the Health Maintenance Organization Act of 1973 ("HMOA").18 The law fostered the development of HMOs by offering loans and loan guarantees to those wishing to establish and operate federally qualified HMOs, and for grants for such things as the training of HMO administrators.19 The law further provided for the preemption of restrictive state laws that might frustrate the operation of federally qualified HMOs.20

There were other managed care entities established as substitutions to conventional systems of health care to reorganize risk assumption and medical decision-making.21 Two of the managed care models that evolved included preferred provider organizations ("PPOs") and point-of-service ("POS") plans.22 PPOs are "health plan[s] that offer full or high coverage

12. Id. at 219.
13. Id.
15. Id.
16. Id.
17. Id.
22. Christine Lockhart, The Safest Care is to Deny Care: Implications of Corporate Health Insurance, Inc. v. Texas Department of Insurance on HMO Liability in Texas, 41 S. TEX. L. REV. 621, 626 (2000).
for a defined panel of providers (who accept discounted fees) and more limited coverage for care outside of the plan."

A POS, on the other hand, is a "hybrid plan with features of managed care and insurance [...] [thereby making it a] [t]raditional HMO that also partially reimburses care received outside the plan."

Although utilization review is a driving force, HMOs and other managed care organizations ("MCOs") primarily use two ways to encourage providers to engage in "cost-conscious decision making." One way is through capitation. The second way is by salary.

Salary exists when an HMO hires a group of providers as employees or contracts with a provider group, and each provider receives a salary for providing health care to a group of individuals in a particular health plan. Both of these payment plans discourage providers from spending more time with their patients, because there is no additional compensation available for doing so. Further, use of ancillary health care services like experimental treatments, diagnostic test, and referrals are not encouraged. This is because there is often a certain amount of money set aside for these services, and anything remaining goes to the provider as a bonus.

These payment arrangements have, therefore, either directly or indirectly impacted providers' decision-making regarding their patients and their patients' medical care needs. A great deal of patients are enrolled in health plans where providers have limited, denied, or prolonged access to necessary treatment and/or provided substandard treatment. Many of these patients were injured and sought recourse in state courts. Nevertheless, almost all of the plaintiffs' complaints have been removed to district courts because defendant-HMOs realize that ERISA preemption has the effect of reducing liability that could be imposed on them.

23. See National Conference of State Legislatures, supra note 9.
24. Lockhart, supra note 22.
27. Id.
29. Id. at 718.
30. Id.
31. Id. at 718-719. This type of incentive system was the issue at stake in Pegram, 530 U.S. at 211.
32. See generally Herrington, supra note 25.
35. See Zaremski & Nelson, supra note 33, at 572.
III. ERISA OVERVIEW OPERATION

Almost simultaneously with the HMOA, Congress enacted ERISA.\(^3\)\(^6\) It was effectuated in response to growing concern that employers who sponsored pension and welfare programs were not supervising plan assets accordingly, thereby threatening the availability of those assets for plan beneficiaries, enrollees, and participants when needed.\(^3\)\(^7\) Since Congress has blotted out almost all state law on the subject of pensions, a complaint about pensions rests on federal law no matter what label is attached by its author.\(^3\)\(^8\) Therefore, this ERISA overview will concern the employee welfare-benefit plan portion of such programs. An employee welfare-benefit plan or welfare plan is defined as one that provides to employees "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or] death" whenever these benefits are provided "through the purchase of insurance or otherwise."\(^3\)\(^9\)

One of the principal purposes of ERISA is to standardize the administration of plans subject to the law, regardless of the diversity of health care delivery systems.\(^4\)\(^0\) By enacting ERISA, Congress hoped to simplify employee benefit administration by preventing plan administrators from working with numerous types of state laws.\(^4\)\(^1\) In this respect, employers and other plan sponsors, acting under ERISA, have greater flexibility to determine plan provisions.\(^4\)\(^2\) By enacting ERISA, Congress shielded qualifying ERISA plans from inconsistent state regulatory schemes that could increase inefficiency and potentially cause benefit levels to be reduced because benefit dollars would have had to be diverted.\(^4\)\(^3\) In order to advance standardization in plan administration and available remedies, Congress drafted the ERISA preemption clause in extremely expansive...
A literal interpretation of the "relates to" language was advanced by almost all of the earlier case law, including Supreme Court decisions. For instance, the U.S. Supreme Court held that a "state law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan." The Supreme Court repeatedly indicated that the "relates to" clause should be interpreted broadly.

The Supreme Court, while giving great deference to the statutory language "relates to," has failed to indicate that all state law actions are preempted under ERISA. Consequently, in Shaw v. Delta Airlines, the Court reasoned "[s]ome state actions may affect an employee benefit plan in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." The Supreme Court, in 1995, began to define parameters for what laws "relate to" a benefit plan in the case of Travelers. The Court observed that "if 'relates to' were taken to extend the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course, for really, universally, relations stop no where." Thus, the ERISA preemption issue becomes a question of where to draw the line. The Court stated that in order to draw that line and determine whether a law has a connection with an ERISA plan, it must look

45. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983) (finding that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan").
46. Id.
47. See, e.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (holding that state lawsuit asserting improper processing of claim for benefits under ERISA-regulated plan was preempted by federal law where state common-law cause of action did not regulate insurance, within meaning of saving clause in ERISA preemption provision, and there was clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive); FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990) (finding that ERISA preempted application of Pennsylvania Motor Vehicle Financial Responsibility Law to self-funded health care plan); Ingersoll-Rand, Co. v. McClendon, 498 U.S. 133, 138 (1990) (reasoning that ERISA preempted the employee's state law wrongful discharge claim because of an allegation that his discharge was based on his employer's desire to avoid making contributions to his pension fund).
48. Shaw, 463 U.S. at 100 n.21.
49. N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 649 (1995) (holding that a New York state law requiring hospitals to collect surcharges from certain health maintenance organizations as well as from patients whose commercial insurance coverage was purchased by an employee health care plan was not preempted since the statute did not affect the administration of the benefit or bear the requisite "connection with" an ERISA plan so as to trigger preemption).
50. Id. at 655.
to the objectives of the ERISA statute "as a guide to the scope of the state law that Congress" intended to preempt. 52

The ERISA preemption provision, therefore, is not absolute. Coverage is not to be construed "to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 53 Thus, the insurance industry, traditionally regulated by the states, is not preempted by ERISA. 54 The insurance savings clause language provides an exception to ERISA's expansive preemption.55 Specifically, ERISA does not preempt state laws that regulate insurance even if those laws otherwise "relate to" an ERISA plan. 56

The exception for insurance regulation is itself limited by the provision that an employee welfare-benefit plan may not "be deemed to be an insurance company or other insurer ... or be engaged in the business of insurance ... ." 57 Therefore, states may not impose insurance regulation on ERISA self-funded benefit programs by cloaking it as insurance. 58 Companies may choose to self-insure themselves, rather than seek out other health insurance coverage. 59 These employers are regulated by ERISA and are not deemed insurance companies under ERISA, so state law remains inapplicable to these plans. 60

Just as states cannot regulate an employee benefit plan by labeling it insurance, neither can an insurance program avoid state regulation by calling itself an employee benefit plan. 61 The common elements of an ERISA self-funded program that distinguish it from an insured program include: 1) the existence of an ERISA-qualified employer who promises to provide to employees a benefit defined in the plan, 2) the employer retaining ultimate liability for the "losses" covered under the plan—this employer specifically retains liability even if the employer transfers some financial risk to another party, 3) no direct contract between the employee and any other person other than the employer relative to the securing of covered benefits; in other words, there is no privity of contract between the employee and any third party who may have agreed, on behalf of an

52. Travelers, 514 U.S. at 656.
54. Bridget S. Kenney, Comment, Chipping Away at the ERISA Shield: Managed Care Accountability and the Fifth Circuit’s Decision in Corporate Health Ins., Inc. v. Texas Dep’t of Ins., 85 MARQ. L. REV. 481, 485 (2001).
56. See id.
58. Kenney, supra note 54.
59. Id.
60. Id.
employer, to assume certain risk of loss, and 4) a benefit program not marketed to the general public. 62

Therefore, generally, whether a state law is preempted by ERISA typically involves a three-step inquiry. 63 First, does the law "relate to" an ERISA plan? 64 Second, is it protected from preemption by existing as a law that regulates insurance, banking, or securities? 65 Finally, is the particular plan at issue self-insured and thereby excluded from state insurance laws? 66 The preemption issue hinges upon whether the state law involved "relates to" the ERISA plan.

AVAILABLE REMEDIES

ERISA creates not only uniformity of operation, but also uniformity with respect to the remedies available to persons denied health insurance or certain benefits associated with the plan. ERISA contains sections that outline both civil and criminal penalties for violating the law's provisions. 67 Civil sanctions include injunctive and equitable relief, including the right to specific performance, as well as other relief, specifically enumerated in the statute. 68 Criminal sanctions include fines of up to five thousand dollars or a year in jail for individuals, and up to one hundred thousand dollars in all other cases. 69

Under section 502(a)(1)(B) of ERISA, 70 an individual may assert a civil claim to recover benefits under the plan, enforce rights under the plan, or clarify rights for future benefits under the plan. 71 Thus, ERISA plan participants can sue their plan in state courts of competent jurisdiction and district courts of the United States, since these courts have concurrent jurisdiction with the state courts, if there is a dispute over benefits. 72 Further, the participant may obtain an injunction against the plan and

63. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 418, 421 (3d ed. 1997) (discussing how the three-step inquiry is used in varying degrees by most, but not all, courts).
64. Roth, supra note 41, at 3.
65. Id.
67. Megna, supra note 19, at 35.
69. Id. § 1131.
70. Id. § 1132.
71. Id. § 1132 (a)(1)(B).
72. Id. § 1132(c).
ERISA imposes minimal conditions on employees' benefit plans, and thus, provides few remedies for employees who are ill served by their health plans. Further, ERISA preempts a wide range of state laws and remedies intended to protect health plan beneficiaries, often leaving beneficiaries without legal protection from health plan abuses. Once in federal court, the most plaintiffs can recover is the cost of the care denied to them.

As a result, individuals under an ERISA plan are limited to the remedies, benefits, and enforcement of rights outlined in that specific plan. Hence, no punitive or extra contractual damages are allowed, and suits for wrongful death, personal injury, or other claims for consequential damages caused by improper refusal of care or coverage by an insurer or utilization reviewer are preempted. This is because they pray for relief not enumerated in the statute. As case law on this subject continues to evolve, many courts, both state and federal, have taken the position that, as to traditional areas of state concern (like tort actions for malpractice), damage actions still are permissible.

IV. HMO LIABILITY PREDICATED ON STATE LAW TORT CLAIMS

Were it not for ERISA preemption, the choice of tort or contract would be significant primarily with respect to the cause of action, remedy available, proof required, statute of limitations, and similar practical considerations. Without ERISA preemption, it is fair to say that all managed care organizations would be subject to state common law liability to their patients, as are other insurers and corporations. Today's debate over managed care liability arises because of ERISA's preemption of state

73. Id.
74. Furrow, supra note 63, at 419.
75. Id.
78. See Megna, supra note 19, at 36.
80. Megna, supra note 19, at 36.
common law actions in certain cases.  

One of the pioneering cases that attempted to impose liability by asserting common-law breach of contract and tort claims against an insurance company that issued an employer's group insurance policy was *Pilot Life Insurance Co. v. Dedeaux*.  

In *Pilot Life*, the plaintiff, Dedeaux, injured his back in an employment-related accident. His employer, Entex, had a long-term disability employee benefit plan established by purchasing a group insurance policy from the defendant, Pilot Life Insurance Co. Although the plaintiff sought permanent disability benefits, the defendant terminated his benefits after two years. Three years thereafter, the plaintiff's benefits were reinstated and terminated by defendant several times. In reaching its holding, the Court conducted a detailed ERISA analysis of the savings clause and the deemer clause.

Furthermore, the Court opined, "[t]he question whether a certain state action is preempted by federal law is one of congressional intent." The purpose of Congress is the ultimate touchstone." The Court, therefore, held that since there was no dispute that the common law causes of action asserted in the plaintiff's complaint "relate[d] to" an employee benefit plan, the causes fell under ERISA's express preemption clause.

Since *Pilot Life*, the Supreme Court has limited the wide scope of preemption. The Court's reaction, in this respect, along with creative lawyering by attorneys has allowed some state law tort claims to prevail on their merits and avoid an ERISA preemption. This suggests that some courts are beginning to look more closely at the process of managed care decision-making, rather than simply following *Pilot Life*. Although state law tort claims do undergo an ERISA challenge, if well-plead, they can survive ERISA preemption. Specifically, this portion of the Article will look at more recent cases that have withstood ERISA preemption.

In *Smith v. HMO Great Lakes*, a beneficiary of an HMO's ERISA health plan and his wife brought an action against the HMO, hospital, and individual defendants, alleging negligence and professional malpractice.

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85. *Id.* at 43.
86. *Id.*
87. *Id.* at 45.
88. *Id.*
89. *Id.*
90. *Id.* at 47.
91. *Id.* at 51 (noting that "in expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy").
The Bipartisan Patient Protection Act claims.\textsuperscript{92} The District Court remanded the entire cause of action to the Circuit Court and held that ERISA did not preempt the medical malpractice claims against the HMO providing an ERISA plan, because the claims were based on the HMO’s contractual relationships with its participating doctors, which allegedly resulted in medically negligent treatment of the plan participant’s child during birth.\textsuperscript{93} Also, the court found that the connection between the claims against the HMO and the plan were too remote to warrant a finding that the state claims “related to” the plan.\textsuperscript{94} The holding by this court reflected the Supreme Court’s views in prior cases finding, “[s]ome state actions may effect an employee benefit plan in ‘too tenuous, remote, or peripheral’ a manner to warrant a finding that the state action ‘relates to’ the covered plan.”\textsuperscript{95}

Likewise, in \textit{Haas v. Group Health Plan, Inc.}, a patient brought a medical malpractice action against the physician and the HMO plan that employed the physician.\textsuperscript{96} The HMO moved for summary judgment alleging that the patient’s action was preempted under ERISA.\textsuperscript{97} The District Court found that a vicarious liability medical malpractice claim against a HMO plan is not preempted by ERISA where the HMO plan elects to directly provide medical services or leads participants to reasonably believe that it has, rather than simply arranging and paying for treatment.\textsuperscript{98}

The court reasoned that a vicarious liability medical malpractice action based solely on substandard treatment is not an alternative action to collect benefits, and does not interfere with calculation of benefits.\textsuperscript{99} “Similarly, a vicarious liability medical malpractice claim does not refer to and apply solely to an ERISA plan, but rather, state law on this subject is tort law of general application with an incidental effect on ERISA plans.”\textsuperscript{100}

\textsuperscript{92} Smith v. HMO Great Lakes, 852 F. Supp. 669, 670 (N.D. Ill. 1994).
\textsuperscript{93} Id. at 672.
\textsuperscript{94} Id.
\textsuperscript{95} Id. at 671 (citing Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983)).
\textsuperscript{97} Id.
\textsuperscript{98} Id. at 548.
\textsuperscript{99} Id.
The major dividing line, by now well known if not universally agreed upon, is the distinction between causes of action that challenge coverage decisions about the availability or quantity of insurance benefits and those that challenge the quality of medical care. This quantity/quality distinction was formulated by the Third Circuit Court of Appeals in *Dukes v. U.S. Healthcare, Inc.*\(^{101}\) In *Dukes*, plaintiffs filed suit in state court against HMOs organized by the defendant, U.S. Healthcare, Inc., claiming damages for injuries arising from the medical malpractice of HMO-affiliated hospitals and medical personnel.\(^{102}\) The defendants removed both cases to federal court, arguing (1) that the injured person in each case had obtained medical care as a benefit from a welfare-benefit plan governed by ERISA, (2) that removal was proper, and (3) that the plaintiffs’ claims were preempted.\(^{103}\)

The Third Circuit found that the claims brought by the representatives of ERISA plan beneficiaries attacked the quality of the benefits they received.\(^{104}\) The plaintiffs were not claiming that the plans erroneously withheld benefits due, nor were they implicating the courts to enforce their rights under the terms of their respective plans or to clarify their rights to future benefits.\(^{105}\) As a result, the plaintiffs’ claims fell outside of the scope of ERISA and were remanded to the state courts from which they were removed.\(^{106}\)

The Third Circuit has applied this reasoning in subsequent cases and other circuits have followed it.\(^{107}\) Hence, the quality/quantity distinction

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\(^{102}\) *Id.* at 351.

\(^{103}\) *Id.*

\(^{104}\) *Id.* at 357.

\(^{105}\) *Id.*

\(^{106}\) *Id.*

\(^{107}\) See *Ouellette v. Christ Hospital*, 942 F. Supp. 1160 (S.D. Ohio 1996) (finding that plaintiff’s claims based upon respondeat superior or implied agency liability theories do not rest upon the terms of the benefits plan, nor does resolution of her claims require the court to construe the terms of her benefits plan; plaintiff’s claim against health insurance provider focuses upon the relationship between the health insurance provider and the hospital, not between her and the health insurance provider; Plaintiff is not challenging the amount of benefits but the quality of the services she received); Plocica v. Nylcare of Texas, Inc., 43 F.
creates a tort/contract distinction. Cases about the quality of care provided can be brought as tort actions in state court, whereas cases about the quantity of benefits may or may not be brought under ERISA as contract claims for benefit denials.\textsuperscript{108} There is a more noticeable difference between delays in approving benefit coverage and delays in approving specific treatment procedures, providers, or facilities for medical conditions that are concededly covered.\textsuperscript{109} Approving benefit delays result from deciding whether or not a benefit is covered at all, and it could be argued that a covered benefit is being denied during the period of delay.\textsuperscript{110} The latter type of delay results from deciding how to provide benefits or what quality of care to provide, and should not be preempted by ERISA.\textsuperscript{111}

If the delay from deciding whether a benefit is covered at all is a benefit denial, then such a claim would be preempted because ERISA provides a specific remedy for benefit denials.\textsuperscript{112} However, if the benefits were eventually provided, the patient would have no claim for denied benefits

\textsuperscript{108} See Mariner, \textit{supra} note 81.
\textsuperscript{109} Mariner, \textit{supra} note 81, at 261.
\textsuperscript{110} \textit{Id}.
\textsuperscript{111} \textit{Id}.
\textsuperscript{112} \textit{Id}.

\textsuperscript{113} Mayer: The Bipartisan Patient Protection Act: Greater Liability on Manager Published by LAW eCommons, 2003
Practicing attorneys representing patients in ERISA plans typically attempt to frame complaints to state causes of action on the quality side of the line so that they are not preempted, while attorneys representing ERISA plans attempt to reframe the cause of action as one that is preempted.

Major battles for managed care liability are being fought in the courtroom and in lawyers' offices, where settlements are negotiated. However, in light of the few cases that go to trial, and the even smaller number that result in appellate decisions, judicial decisions are not the best means of influencing the content of laws affecting managed care. As several court decisions have noted, it is the responsibility of Congress and the courts to decide whether to fill the gap in remedies in ERISA, and it appears that some judges are inviting Congress to act. So far, federal bills have stalled, primarily due to competing views of whether and how to solve the liability issue and this may continue to occur. However, Congress cannot fend off legislation forever.

V. AMENDING ERISA

Congress attempted unsuccessfully in the last two terms to enact a law that would amend ERISA and give individuals more legal recourse against adverse health plan decision-making. In January 1998, in his State of the Union address, President Clinton spoke about a proposed Patients' Bill of Rights.
Rights that would cure some of the abuses associated with managed care. This proposal was a result of a commission appointed by President Clinton nearly ten months prior, which was formed to examine ways to protect people in the health care market. While the commission was unsure of what type of legislation, if any, was needed, the President and members of Congress were ready to generate legislative drafts. Interestingly, neither the Democrats nor the Republicans produced versions of the Patients' Bill of Rights that resembled the commission's proposals.

The Democratic version extended the commission's consumer protections, while the Republican version offered much narrower patient protection. During both the 105th and 106th Congress, Republican and Democratic versions were proposed but not accepted by majorities in both houses of Congress. In July 1999, the Senate passed, by a vote of fifty-three to forty-seven, a Republican version that regulated HMOs and insurance companies. In October of the same year, a broader Democratic bill passed in the House by a vote of two hundred seventy-five to one hundred fifty-one, with sixty-eight Republican votes.

Moreover, two Democrat senators, Edward Kennedy and Thomas Daschle, introduced their own versions of a Patients' Bill of Rights Act on September 15, 2000. This legislation would have amended ERISA and allowed state law claims for personal injury or wrongful death, which arise from health care plan decisions that are currently preempted by ERISA. The legislation further required that health care plans provide an independent appeal mechanism outside the industry for those individuals seeking to appeal a denial of benefits. On November 3, 2000, Republican Representative John Shadegg sponsored the Common Sense Patients' Bill of Rights. This legislation provided for an internal appeals mechanism, but did not specifically abrogate the ERISA provisions that preempt certain

122. Hyman, supra note 120, at 231.
123. Id. at 232.
124. Id. at 233.
125. Id.
126. See Theodos, supra note 121, at 89.
128. Id.
130. Id. § 302(a).
131. Id. §§ 102, 301.
state law claims resulting from the denial of benefits.\textsuperscript{133}

There are valid concerns on both sides of the debate regarding to what extent some version of the Patients' Bill of Rights should amend ERISA. Managed care entities argue that health care costs will increase with the corresponding increase in litigation that might arise when the ERISA shield goes down.\textsuperscript{134} Moreover, during the 106th Congress, Republicans talked about small businesses that would no longer be able to afford health insurance coverage, while Democrats presented daily stories that detailed the horrors of the managed care system.\textsuperscript{135}

VI. PATIENTS' BILL OF RIGHTS COMPARISON

A patients' bill of rights is a set of consumer-oriented managed care rules.\textsuperscript{136} According to the National Conference of State Legislature's Health Policy Tracking Service, more than forty states have adopted some version of a "patients' bill of rights."\textsuperscript{137} These new laws address the entire range of managed care issues, including, but not limited to: provider access, bans on gag clauses, consumer grievance procedures, direct access, disclosure, provider credentialing, medical records, insurer liability, solvency, drug formularies, certification, and in some cases, a point-of-service option.\textsuperscript{138}

The most contentious element in similar federal proposals is health plan liability—whether people can sue their health plans, especially self-insured plans.\textsuperscript{139} Currently, ERISA limits liability of employer plans to the value of services to be rendered.\textsuperscript{140} Thus, if a person is denied a diagnostic procedure and later suffers irreversible harm as a result of the denial, the ERISA liability is limited to the cost of the procedure.\textsuperscript{141} Supporters of creating greater liability say plans must be held to a standard of reasonable care, rendering them liable for decisions that affect treatment.\textsuperscript{142} Many states have considered such policies, and as of late 2000, seven states have enacted laws allowing residents to sue their health plans (three states used

\textsuperscript{133} Id. § 121.

\textsuperscript{134} Theodos, supra note 121, at 104-05. Despite this concern, only a few such malpractice suits have been filed in Texas since the law was enacted. See Johnson, supra note 76.

\textsuperscript{135} Hyman, supra note 120, at 237-38.

\textsuperscript{136} See National Conference of State Legislatures, supra note 9, at 8 (defining patients' bill of rights and listing factual information according to states' adoption of some form of a "patients' bill of rights").

\textsuperscript{137} Id.

\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} Id.

\textsuperscript{141} Id.

\textsuperscript{142} Id.
other approaches to hold plans liable). 143 Twenty-three states also banned "hold-harmless" clauses in contracts between plans and hospitals or physicians, leaving plans responsible for services, but not creating a new right to sue. 144

Opponents claim that the only group that will benefit from expanded liability is trial lawyers. 145 Thus, with the federal proposal, the pivotal issue of legal accountability needs to be resolved by the conference committee since there exists significant differences between the House and Senate versions of the bill. Both bills, however, address ERISA preemption of state tort claims against MCOs and would permit compensation for personal injuries resulting from negligent benefit denials. 146

The Senate and House bills create very different legal structures for ERISA plan liability, with different implications both for federalism and the applicability of ERISA. 147 Assuming ERISA continues to be applied to health plans, there are three basic options for allocating jurisdiction over liability, all of which require amending ERISA. 148 One option is to give state law exclusive jurisdiction over all patient disputes with health plans by ending ERISA preemption of state liability laws. 149 A second option is to divide jurisdiction between the federal and state governments according to the nature of the patient's claim, with claims based on medical judgments allocated to state law, and claims based on contract requirements allocated to federal law under ERISA. 150 The third option is to give federal law exclusive jurisdiction over all such disputes and expand the remedies beyond those currently available under ERISA to compensate patients for personal injury. 151 The Senate bill adopts the second option, while the House bill adopts the third. 152

A. The Senate Bill

The Senate bill, if enacted, amends ERISA by allowing a participant or

143. Id.
144. Id.
145. Id.
146. The bills also include a variety of consumer protection provisions, including standards for benefits offered by health insurance and managed care plans, disclosure of information to patients, and procedures for internal and independent external review of benefit decisions.
147. Mariner, supra note 81, at 268-69.
148. Id.
149. Id. at 269.
150. Id.
151. Id.
152. Id.
beneficiary (or the estate of such participant or beneficiary) to bring federal civil causes of action in cases not involving medically reviewable decisions, as well as ordinary state law claims for causes of action involving medically reviewable decisions. In order to assert a claim under the federal civil remedy section, the benefit denial must be based on administrative or contract requirements. The persons that are subject to suit under this section are a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer, or plan sponsor. The claim must be premised on contract principles. Additionally, in order for the plaintiff to be awarded the economic and non-economic damages (not exemplary or punitive damages) allowable, the persons subject to the suit must have failed to exercise ordinary care in making a decision and such failure must be a proximate cause of personal injury, or death of the participant or beneficiary.

The Senate bill provides an exclusion of liability provision for employers, other plan sponsors maintaining the plan, or employees of such

153. S. 1052, 107th Cong. § 402(a)(1) (2001) (adding new § 502(n)(2) to ERISA). Medically reviewable decisions are defined within the bill as benefit denials based on: (1) a determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms; (2) a determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms; or (3) a determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition. Id. § 104(d)(2).

154. Id. §§ 402(a)(1) (adding new § 502(n)(17) to ERISA), § 402(b)(2) (adding new subsection (d)(1)(A) to ERISA § 514).

155. Contract requirements involve those predicated on decisions (i) regarding whether an item or service is covered under the terms and conditions of the plan or coverage; (ii) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage), or (iii) as to the application of cost-sharing requirements or the application of specific exclusion or express limitation on the amount, duration, or scope of coverage of items and services under the terms and conditions of the plan or coverage. Id. § 402(a)(1) (adding new § 502(n)(1) to ERISA).

156. Id. (adding new § 502(n)(1) to ERISA).

157. Id. The decision-making process falls under § 102 of S. 1052 (relating to procedures for initial claims for benefits and prior authorization determinations) and § 103 of S. 1052 (relating to internal appeal of a denial of a claim for benefits). Id. Ordinary care means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved. Id. (adding new § 502(n)(3) to ERISA). Personal Injury means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease). Id.
employers or sponsors acting within the scope of employment.\textsuperscript{158} There is an exception to this exclusion of liability, however, and a cause of action may arise against the aforementioned groups if there was direct participation by the employer, other plan sponsor, or employee in the decision of the plan under section 102 or 103.\textsuperscript{159} Direct participation is defined in the bill and does not encompass any form of decision-making or other conduct that is merely collateral or precedent to the decision on a particular claim for benefits.\textsuperscript{160}

A group health plan that is self-insured and self-administered by an employer, including an employee of such an employer acting within the scope of employment, or a multi-employer plan, including an employee of a contributing employer of the plan, or a fiduciary of the plan, acting within the scope of employment or fiduciary responsibility, that is self-insured and self-administered are not liable for failing to perform any non-medically reviewable duty under the plan.\textsuperscript{161} Likewise, no hospitals, treating physicians or other treating health care professionals of the participant or beneficiary, and no person acting under the direction of such a physician or health care professional, can be found liable under the federal civil remedy section for performing or failing to perform any non-medically reviewable duty of the plan.\textsuperscript{162} Also, health insurance agents are not liable under the federal civil remedy section when their sole involvement with the group health plan is to provide advice or administrative services to employers or other plan sponsors relating to the selection of health insurance coverage.\textsuperscript{163}

\begin{itemize}
\item \textsuperscript{158} Id. (adding new § 502(n)(5)(A) to ERISA).
\item \textsuperscript{159} Id. (adding new § 502(n)(5)(B) to ERISA); Id. §§ 102-103 (relating to procedures for initial claims for benefits and prior authorization determinations) and (relating to internal appeal of a denial of a claim for benefits).
\item \textsuperscript{160} Id. (adding new § 502(n)(5)(C) to ERISA). Direct participation means in connection with a decision described in the federal civil remedy section, the actual making of such decision or the actual exercise of control in making such decision. Id. Also, in any case in which there is deemed to a designated decision-maker, all liability of such employer or plan sponsor (and any employee thereof acting within the scope of employment) shall be transferred to, and assumed by, the designated decision-maker and with respect to such liability, the designated decision-maker shall be substituted for the employer or plan sponsor (or employee) in the action and may not raise any defense that the employer or plan sponsor (or employee) could not raise if such a decision-maker were not so deemed. Id. § 402(a)(1) (adding new § 502(n)(18) to ERISA). A health insurance issuer shall be deemed to be a designated decision-maker for purposes of a denial of administrative or contract benefits, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation, unless the employer or plan sponsor affirmatively enter into a contract to prevent the service of the designated decision-maker. Id.
\item \textsuperscript{161} Id. § 402(a)(1) (adding new § 502(n)(5)(D) to ERISA).
\item \textsuperscript{162} Id. (adding new § 502(n)(6) and (7) to ERISA).
\item \textsuperscript{163} Id. (adding new § 502(n)(16) to ERISA).
\end{itemize}
This is a general application, however, and liability (whether direct or vicarious) of the plan, the plan sponsor, or any health insurance issuer offering coverage in connection with the plan is not limited. 164

The Senate bill contains an exhaustion of administrative processes provision maintaining that a cause of action may not be brought under the federal civil remedy section until all administrative processes under sections 102 and 103 have been exhausted. 165 This requirement may be excepted, and a participant or beneficiary may seek relief exclusively in federal court prior to the exhaustion of administrative remedies if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. 166 Also, any determination made by a reviewer in an administrative proceeding under section 103 is admissible in any federal court proceeding and shall be presented to the trier of fact. 167

The Senate bill also states that a cause of action does not arise under the federal civil remedy section where the denial involved relates to an item or service already fully provided to the participant or beneficiary under the plan or coverage, and the claim relates solely to the subsequent denial of payment for the provision of such item or service. 168 This language is not construed to prohibit a cause of action under the federal civil remedy section where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to under the administrative or contract requirements, or that are part of a continuing treatment or series of procedures. 169 Also, this language does not prohibit or limit a cause of action under the federal civil remedy section relating to quality of care or liability that would otherwise arise from the provision of the item or services or the performance of a medical procedure. 170

One of the major disparities between the Senate bill and the House bill is that the Senate bill permits an assessment of civil penalties. 171 Under the Senate bill, not only are participants and beneficiaries (or the estate of such participants or beneficiaries) entitled to the remedies provided under the federal civil remedy section (relating to the failure to provide contract benefits in accordance with the plan), but they also are allowed to recover a

164. Id. (adding new § 502(n)(8) to ERISA).
165. Id. (adding new § 502(n)(9)(A) to ERISA).
166. Id. (adding new § 502(n)(9)(B) to ERISA).
167. Id. (adding new § 502(n)(9)(D) to ERISA).
168. Id. (adding new § 502(n)(19)(A) to ERISA).
169. Id. (adding new § 502(n)(19)(B) to ERISA).
170. Id.
171. Id. (adding new § 502(n)(10)(B) to ERISA).
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civil assessment, in an amount not to exceed five million dollars. The claimant, in order to receive this assessment, however, must establish by clear and convincing evidence that the alleged conduct carried out by the defendant demonstrated bad faith and flagrant disregard for the rights of the participant or beneficiary under the plan. In addition, the claimant must establish that the defendant’s conduct was a proximate cause of the personal injury or death that is the subject of the claim. Accordingly, a statute of limitation for claimants bringing actions under the federal civil remedy section exists.

Just as the Senate bill authorizes a federal civil remedy cause of action for cases not involving medically reviewable decisions, it also authorizes an ordinary state law cause of action for some cases involving medically reviewable decisions. Hence, a claimant can receive damages for personal injury or wrongful death if the cause of action arises under a medically reviewable decision. However, a limitation on punitive damages with respect to a cause of action involving a medically reviewable decision is found in this bill.

This general limitation is not warranted with respect to an action for wrongful death if the applicable state law provides for damages in such an action that are only punitive or exemplary in nature. Also, state law is not superseded with respect to any cause of action for personal injury or wrongful death if, in such action, the plaintiff establishes by clear and

172. id.
173. id.
174. id. (adding new § 502(n)(12) to ERISA). The federal civil remedy section shall not apply in connection with any action commenced after three years after the later of: (a) the date on which the plaintiff first knew, or reasonably should have known, of the personal injury or death resulting from the failure described in the administrative and contract benefits denial provisions, or (b) the date as of which the requirements for exhausting administrative processes are first met. Id. The statute of limitations for any cause of action arising under state law relating to a denial of a claim for benefits that is the subject of an action brought in federal court shall be tolled under certain conditions. Id. (adding new § 502(n)(13) to ERISA).
175. S. 1052, § 402(b)(2) (2001) (adding new subsection (d)(1)(A) to ERISA § 514). This particular subsection is not construed to supersede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medically reviewable decision. Id.
176. Id.
177. Id. (adding new subsection (d)(1)(C)(i) to ERISA § 514). Senate bill provides State law is superseded insofar as it provides any punitive, exemplary, or similar damages if, as of the time of the personal injury or death, all the requirements of sections 102, 103, and 104 were satisfied. Id. § 104 (relating to independent external appeals procedures).
178. id. (adding new subsection (d)(1)(C)(ii) to ERISA § 514).
convincing evidence that conduct carried out by the defendant with willful or wanton disregard for the rights or safety of others was a proximate cause of the personal injury or wrongful death that is the subject of the action.\textsuperscript{179}

Just as the federal civil remedy section excludes liability from attaching to employers and plan sponsors, likewise, the ordinary state law cause of action section states that non-preemption does not apply to any cause of action against an employer, or other plan sponsor maintaining the plan, or against an employee of such an employer or sponsor acting within the scope of employment. In addition, non-preemption does not apply to a right of recovery, indemnity, or contribution by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person.\textsuperscript{180}

Additionally, the state law cause of action section is analogous to the federal civil remedy cause of action section.\textsuperscript{181} A cause of action brought under the state law cause of action section is governed by the law (including choice of law rules) of the state in which the plaintiff resides.\textsuperscript{182}

\textbf{B. The House Bill}

There are some vast distinctions between the House bill and the Senate bill. The differences in language as well as the resounding effects of the remedies provided to participants and beneficiaries are noticeable.

If the House bill is enacted, it will amend ERISA by allowing for causes of action relating to health benefits.\textsuperscript{183} A participant or beneficiary (or the

\textsuperscript{179} Id. (adding new subsection (d)(1)(C)(iii) to ERISA § 514). Personal injury, defined in Id. § 402(a)(1) (2001) (adding new subsection (n)(4)(B) to ERISA § 502).

\textsuperscript{180} S. 1052, § 402(b)(2) (2001) (adding new subsection (d)(3)(A) to ERISA § 514). However, non-preemption does apply to any cause of action that is brought by a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any employer, or other plan sponsor maintaining the plan, or against an employee of such an employer or sponsor acting within the scope of employment, if such cause of action arises by reason of a medically reviewable decision.

\textsuperscript{181} Id. (adding new subsection (d)(1)(A) to ERISA § 514). There is a provision holding employers or plan sponsors not liable for direct participation if their decision making or other conduct is merely collateral or precedent to a decision regarding medically reviewable decisions. (Adding new subsection (d)(3)(C)(i) to ERISA § 514). Any determination made by a reviewer in an administrative proceeding under section 104 shall be admissible in any federal or state court proceeding and shall be presented to the trier of fact. (Adding new subsection (d)(4)(F) to ERISA § 514). There is the tolling provision stating that the statute of limitations for any cause of action arising under § 502(n) relating to a denial of a claim for benefits that is the subject of an action brought in state court shall be tolled. (Adding new subsection (d)(5) to ERISA § 514).

\textsuperscript{182} Id. (adding new subsection (d)(12) to ERISA § 514).

\textsuperscript{183} H.R. 2563, 107\textsuperscript{th} Cong. § 402(a) (2001) (adding new § 502 (n)(1)(A) to ERISA).
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The estate of the participant or beneficiary may commence these causes of action. The person that is subject to suit is the designated decision-maker. The plan sponsor or named fiduciary of a group health plan is given the authority to appoint a person as a designated decision-maker. There are two exceptions to this vested authority.

In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a health insurance issuer, such issuer is the only entity that may be qualified to serve as a designated decision-maker, and it shall serve as such unless the employer or other plan sponsor acts affirmatively to prevent such service. This issuer must also assume, unconditionally, the exclusive authority under the group health plan to make determinations on claims for benefits (irrespective of whether they constitute medically reviewable determinations).

The House bill provides that a claim under a group health plan may be alleged only if a designated decision-maker failed to exercise ordinary care in making a determination denying a claim for benefits under section 503A, in making a determination denying a claim for benefits under section 503B, or in failing to authorize coverage in compliance with the written determination of an independent medical reviewer that reverses a determination denying the claim for benefits. The delay in receiving, or failure to receive, benefits attributable to the failure must be the proximate cause of personal injury to, or death of, the participant or beneficiary. Such a designated decision-maker shall be liable to the participant or

184. Id.
185. Id. (adding new § 502 (n)(2) to ERISA).
186. Id. (adding new § 502(n)(2)(A)(i) to ERISA).
187. Id.
188. Id. (adding new § 502(n)(2)(C)(ii) to ERISA).
189. Id. (adding new § 502(n)(2)(B)(ii)(III) to ERISA).
190. Id. (adding new § 502(n)(1)(A)(i) to ERISA). Ordinary care means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved. Id. (adding new § 502(n)(16) to ERISA).
192. Id. (adding new § 502(n)(1)(A)(i)(II) to ERISA). Internal appeals of claims denials.
193. Id. (adding new § 502(n)(1)(A)(i)(III) to ERISA).
194. Id. (adding new § 502(n)(1)(A)(ii) to ERISA). Personal Injury means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease. Id. (adding new § 502(n)(16)(f) to ERISA).
195. Id. (adding new § 502 (n)(1)(A)(ii) to ERISA). The House bill changes one word in the causation language; thus, the Bush-Norwood amendment eliminates virtually all patients’ claims. Id. Designated decision-makers’ refusal of benefits have to be “the,” rather than (as in the original legislation) “a,” proximate cause of the injury or death. Id.
beneficiary (or the estate) for economic and non-economic damages in connection with such failure and such injury, or death (subject to some limitations on recovery of damages). 196

If a cause of action is brought under a determination denying a claim for benefits under section 503A, or under a determination denying a claim for benefits under section 503B, this bill states, if an independent medical reviewer under section 503C 197 upholds the determination denying the claim for benefits involved, there shall be a presumption (rebuttable by clear and convincing evidence) that the designated decision-maker exercised ordinary care in making such determination. 198

Similar to the Senate bill, the House bill contains an exhaustion of remedies provision.

Similar to the Senate bill, the House bill contains an exhaustion of remedies provision. Also, under this bill, a participant or beneficiary may seek injunctive relief prior to the exhaustion of administrative remedies under section 503B or 503C if it is demonstrated that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. 199

The limitations on the amount of recovery damages provision, in the House bill, proclaims that the aggregate amount of liability for non-economic loss under a claim for health benefit denials may not exceed one and a half million dollars. 200 Furthermore, with a claim for health benefit denials, the court may not award any punitive, exemplary, or similar damages against a defendant, except that the court may award punitive, exemplary, or similar damages (in addition to the non-economic loss damages), in an aggregate amount not to exceed one and a half million dollars. 201 There is a caveat attached to the punitive damage language that states that this aggregate amount can only be awarded if the denial of a claim for benefits was reversed pursuant to a written determination by an independent medical reviewer and there has been a failure to authorize coverage in compliance with such written determination. 202

The House bill allows a State to limit damages for non-economic loss or

196. Id.
197. Id. (adding new § 502(n)(1)(B) to ERISA).
198. Id. Note that this rebuttable presumption language is not expressed in the Senate bill.
199. Id. (adding new § 502 (n)(3)(B) to ERISA). A preponderance of the evidence standard is not found in the Senate bill.
201. Id. (adding new § 502 (n)(4)(B) to ERISA).
202. Id.
similar damages to amounts less than the amounts permitted by their bill.\textsuperscript{203} The statute of limitations provided by the bill states that a claim for health benefit denials is inapplicable in connection with any action that is commenced more than five years after the date on which the failure occurred or, if earlier, not later than two years after the first date the participant or beneficiary became aware of the personal injury or death.\textsuperscript{204} This bill provides that a claim or cause of action may not be maintained as a class action, as a derivative action, or as an action on behalf of any group of two or more claimants.\textsuperscript{205} Furthermore, a civil action brought in any State court against any party (other than the employer, plan, plan sponsor, or other entity) arising from a medically reviewable determination may not be removed to any district court of the United States.\textsuperscript{206}

VII. CONCLUSION

Analysis of the two bills indicates that the Senate bill places greater liability on managed care plans. The Senate bill accomplishes this by allowing a claimant to bring an action against a plan in federal court, if the underlying cause of action involves a non-medically reviewable (contract or administrative) decision.\textsuperscript{207} Conversely, it permits suits to be brought in State court if the underlying cause of action engages a medically reviewable decision.\textsuperscript{208} The Senate bill, therefore, grants plaintiffs greater access to sue managed care plans. Furthermore, the Senate bill allows for punitive damages in cases involving medically reviewable claims, and provides a "civil penalty assessment" of up to five million in federal cases.\textsuperscript{209}

On the other hand, under the House bill, plaintiffs cannot hold managed care plans accountable under state law.\textsuperscript{210} Actions are still only available in federal court and would be subject to numerous statutory restrictions, including a one and a half million-dollar cap on non-economic damages. Punitive damages are also capped at one and a half million-dollars, and States with even more restrictive terms may apply them.

\textsuperscript{203} \textit{Id.} (adding new § 502 (n)(4)(C) to ERISA).
\textsuperscript{204} \textit{Id.} (adding new § 502 (n)(7) to ERISA).
\textsuperscript{205} \textit{Id.} (adding new § 502 (n)(12) to ERISA).
\textsuperscript{206} \textit{Id.} § 402(b)(2) (adding new § 502 (e)(1) to ERISA). Note that the Senate bill allows suits in State courts for medically reviewable decisions even if it involves an employer, plan sponsor, etc., as long as there was direct participation.
\textsuperscript{207} \textit{See supra} notes 153-155 and accompanying text (discussing provisions of the Senate bill).
\textsuperscript{208} \textit{See supra} notes 153-155 and accompanying text.
\textsuperscript{209} \textit{See supra} note 171.
\textsuperscript{210} H.R. 2563, § 402(b)(2) (2001) (adding new § 502 (e)(1) to ERISA).