GROOM
LAW GROUP

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James A. Klein
President
Association of Private Pension and Welfare Plans
1212 New York Avenue, NW
Suite 1250
Washington, D.C. 20005

Dear Mr. Klein:

You have asked that we analyze the liability provisions of draft legislation prepared by Representatives Norwood (R-GA) and Dingell (D-MI) (the "Bipartisan Consensus Managed Care Improvement Act of 2000," hereinafter "New Norwood-Dingell").

The New Norwood-Dingell bill has been characterized as a significant "compromise" on the issue of liability that is "consistent with the direction of the courts in interpreting ERISA." In fact, our analysis reveals that the bill is neither a compromise nor consistent with recent judicial developments. Indeed, the bill exposes employers, insurers and numerous other parties to virtually all the same suits authorized under the House-passed Norwood-Dingell bill (H.R. 2990), but with even fewer limits on liability.

- New Norwood-Dingell creates a far reaching set of federal and state personal injury suits that would cover virtually every aspect of health plan operations. The types of personal injury suits are nearly unlimited and cover any claim for benefits, including claims that do not involve medical judgments or claims reviewed on a retrospective basis after medical services are delivered. The bill does not stop with claims decisions, and further authorizes new federal suits relating to plan administration, including plan compliance with the bill's myriad of broad new patient protection provisions (*e.g.*, emergency room, specialty care). In addition, for the first time, the bill authorizes personal injury suits for errors in the administration of the COBRA continuation of coverage requirements, the

preexisting conditions limitations established in the Health Insurance Portability and Accountability Act ("HIPAA") and ERISA's benefit requirements relating to mothers and newborns, mental health coverage and reconstructive surgery for mastectomies.

- New Norwood-Dingell authorizes the award of unlimited compensatory damages (economic and noneconomic) and punitive damages under both federal and state law. The bill provides no effective mechanism or safe harbor that would limit exposure to uncapped damages. In this respect, New Norwood-Dingell creates more liability than H.R. 2990, which barred punitive damages where a group health plan complied with decisions made by an independent external reviewer.

- New Norwood-Dingell exposes employers to costly and frivolous health plan litigation.

- New Norwood-Dingell does not codify the Supreme Court's recent decision in *Pegram v. Herdrich* or other related cases. Rather, it undermines the Court's unanimous holding that HMO costs containment mechanisms do not violate ERISA and exposes health plans to state law suits well beyond traditional malpractice suits against treating physicians considered by the Court in *Pegram.*

- New Norwood-Dingell would generate a multiplicity of wasteful and duplicative lawsuits and invite conflicting federal and state legal interpretations of the bill's provisions.

Set forth below is our analysis of each of these issues in a question and answer format.

1. What new causes of action are health plans exposed to under New Norwood-Dingell?

The New Norwood-Dingell proposal adopts a "bifurcated" federal-state scheme of remedies broadly applicable to health plan administration. If enacted, new personal injury suits for unlimited damages would be authorized under both federal law – the Employee Retirement Income Security Act of 1974 ("ERISA") – and state law.

New ERISA Causes of Action

The New Norwood-Dingell bill amends ERISA to authorize two new federal personal injury and wrongful death claims against plan fiduciaries, health insurers, or agents of the plan, issuer, or plan sponsor. The first ERISA cause of action is for a failure to exercise ordinary care in connection with initial claims for benefits and internal appeals decisions that do not involve "medically reviewable" decisions. Claims decisions that are not eligible for external review are subject to this new cause of action (*i.e.*, claims that do not involve medical evaluations). New ERISA § 502(n)(1)(A)(i), (2). Notably, this provision is not limited to preauthorization claims decisions and, therefore, plaintiffs could assert that even a plan's retrospective review of a claim caused personal injury.

The second ERISA cause of action extends beyond claims for benefits, and covers a failure to exercise ordinary care in performing a duty under the "terms and conditions" of the plan. "Terms and conditions" is defined to include all of the bill's patient protection provisions (*e.g.*, disclosure, limits on provider incentive arrangements, internal and external appeals, gag rule, emergency care, specialty care), as well as the requirements of COBRA and HIPAA. New ERISA § 502(n)(1)(A)(ii), (3)(D).

These two causes of action are expansive. Under new section 502(n)(1), suits can be brought against fiduciaries, insurers, and agents of the plan, insurers, and plan sponsors. This is a significant expansion of settled ERISA principles, which generally imposes liability on those persons that

serve as plan fiduciaries. Under the New Norwood-Dingell framework, an *agent* of an employer or insurer may be sued even if they did not exercise discretionary authority with respect to the ERISA group health plan.[1]

Even more troubling is the second ERISA cause of action, which creates a broad new personal injury in the event of a failure to exercise ordinary care in performing a duty under the terms and conditions of the plan. Notably, this cause of action applies to circumstances that do not even involve a claim for benefits. Under this provision, a host of new personal injury suits could be brought challenging general plan administrative practices and operations, including suits challenging plan disclosures, provider compensation arrangements, or compliance with the obligation to provide timely access to specialists appropriate to the condition of the participant.[2] Suits could also be maintained to enforce the continuation of care provisions of COBRA, HIPAA's preexisting condition limitations, and ERISA's benefit requirements relating to mothers and newborns, mental health coverage and reconstructive surgery for mastectomies. *See* New ERISA § 502(n)(3)(D) (referring to Parts 6 and 7 of ERISA). Moreover, there will be a great deal of litigation over the precise scope of the definition of "terms and conditions" of the plan because the definition includes, but is not limited to, the bill's patient protections, COBRA and HIPAA. For example, this provision might be used

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[1] If the agent exercised discretionary authority over the plan, the agent would be a fiduciary under section 3(21)(A) of ERISA, and this provision would be unnecessary.

[2] Concerns about the litigation spawned by this provision are not remote given the fact that there is a great deal of preemption and fiduciary litigation already in this area without the creation of a new ERISA personal injury claim. *Compare with Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997) (original state law wrongful death suit challenging HMO's failure to disclose financial incentives was preempted, but administrator may have an ERISA duty to disclose financial arrangements).

to challenge decisions made by fiduciaries, insurers and various agents concerning the selection and retention of the plan's health care providers.

Before a new ERISA action can be filed, the bill appears to require that the plan's initial claims and internal appeals procedures be exhausted. New ERISA § 502(n)(5). However, several major exceptions are provided that make the provision meaningless. *First*, the bill provides an exception to exhaustion any time during the claims process that the participant alleges an injury has occurred. New ERISA § 502(n)(5)(C). This exception clearly swallows the bill's exhaustion rule. Such allegations could be made after an initial claims denial and before the internal plan appeal decision. Therefore, a participant could even allege an injury before an initial claims decision. Such suits are plausible because the bill establishes maximum time limits for initial claim decisions (*e.g.*, up to 28 days for routine prior authorization decisions), but claims must be handled more quickly if "the medical exigencies of the case" require. Bill § 102(b).[3] *Second*, the New Norwood-Dingell actually provides an exception to exhaustion in the event a participant does not even appeal an initial claim, provided that the injury first appears (or death occurs) after the time period lapses during which the participant could have filed an appeal. *See* New ERISA § 502(n)(5)(B) ("Late Manifestation of an Injury"). This provision is wholly without precedent and will actually discourage participants from filing timely appeals. Timely claims appeals are in the interest of everyone – participants, the ERISA plan and the external review entities and courts that will review such claims. *Third*, the exhaustion requirement does not apply to suits for a failure to perform a duty under the terms and conditions of the plan because those suits do not involve a claim for benefits. *Finally,* The exhaustion exceptions in New Norwood-Dingell are a dramatic departure from current law under ERISA where exceptions to exhaustion are only provided if completing the administrative process would be futile (no chance of a reversal of the initial claims decision) or would result

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[3] Importantly, while the bill does not "preclude" completion of administrative remedies if moved by any party, it does not require completion or provide that the previously brought lawsuit be dismissed in the meantime.

in irreparable harm. *E.g.*, *Diaz v. United Agric.*, 50 F.3d 1478, 1485 (9th Cir. 1995) (futility exception available only if plaintiffs can prove that it is *certain* that the claim will be denied); *Henderson v. Bodine Aluminum, Inc.* 70 F.3d 958, 962 (8th Cir. 1995) (participant in need of immediate medical treatment.).

New State Law Causes of Action

The New Norwood-Dingell bill amends ERISA's preemption provision (section 514) to allow personal injury and wrongful death suits under state law for "medically reviewable" claims decisions (*i.e.*, decisions eligible for external review). Claims eligible for external review are broadly defined to include claims involving medical necessity, experimental care, and determinations requiring an evaluation of medical facts. New ERISA § 514(d)(1)(A), (B); Bill § 104(d)(2). Notably, claims for benefits are not limited to preauthorization decisions, the only types of claims decisions where it might be asserted that a group health plan's claims denial may affect the treatment delivered. Moreover, plaintiffs could even challenge a plan's decision approving a claim, arguing that the claim was not approved in accordance with the "medical exigencies" of the case.

The specific causes of action available under state law will depend on the particular state law and the facts in question. However, states do not have to adopt the type of HMO liability law adopted by Texas, Georgia and other states in order for "any person" to face new liability immediately. Existing state tort, medical malpractice, contract, and insurance laws provide a panoply of existing causes of action that will be used by plaintiffs.

Because of the broad definition of "medically reviewable" claims decisions, significant plan interpretation issues will be committed to state courts and reviewed under a variety of state laws. The result will be inconsistent state regulation of ERISA plans, a result which the framers of ERISA intended to prevent. *See*, *e.g.*, 120 Cong. Reg. 29942 (1973) (remarks of Sen. Javits).

2. What new damages would group health plans face under New Norwood-Dingell?

New ERISA Liability

The New Norwood-Dingell bill authorizes *unlimited compensatory damages* under both new ERISA causes of action, including economic damages (*e.g.*, lost wages) and noneconomic damages (*e.g.*, mental anguish, pain and suffering). New ERISA § 502(n)(1). The bill further provides for *unlimited punitive damages* in the case of "willful or wanton disregard for the rights or safety of others." New ERISA § 502(n)(6).

Without doubt, establishing uncapped compensatory and punitive damages is an unprecedented expansion of ERISA liability and cannot fairly be characterized as a "compromise."[4] While it is true that certain suits that might have been brought in state court under H.R. 2990 would be moved to federal court under the New Norwood-Dingell bill, the New Norwood-Dingell bill's federal remedy affords the same unlimited liability that many state laws provide. Indeed, defendants may be exposed to greater liability under the New Norwood-Dingell ERISA liability provisions than H.R. 2990 because many states have adopted tort or medical malpractice reforms that could apply to the underlying state causes of action.

Perhaps the most surprising feature of the New Norwood-Dingell bill is the total absence of any limit on ERISA liability. This represents a departure from other federal laws designed with the similar remedial purpose of

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[4] The Supreme Court has conclusively held that ERISA's remedial scheme, which permits participant suits for benefits and to obtain equitable relief, does not permit participants to recover compensatory or punitive damages.[4] *Massachusetts Mut. Life Ins. Co. v Russell*, 473 U.S. 134 (1985) (participants may not recover damages on behalf of plan, but not personally); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993) (equitable relief does not include legal damages).

protecting the interests of employees. For example, with respect to acts of intentional discrimination ("disparate treatment"), Title VII of the federal civil rights laws and the Americans with Disabilities Act provide for the award of compensatory and punitive damages subject to a cap based on the size of the employer. For a large employer, the laws establish a combined limit on compensatory and punitive damages of $300,000 for each complainant and each claim. *See* 42 U.S.C. § 1981a.[5]

By providing for money damages, the New Norwood-Dingell bill would likely result in jury trials under ERISA for the first time. To date, each appeals court that has considered the issue has found that ERISA cases are tried before a judge. These courts have relied on the fact that ERISA is modeled on traditional trust law, and disputes about rights under a trust were almost always heard in equity courts. *E.g.*, *Wardle v. Central States, Southeast & Southwest Areas Pension Fund*, 627 F.2d 820 (7th Cir. 1980). Because money damages would be provided under the new section 502(n) of ERISA, the Seventh Amendment of the Constitution, which preserves the right to a jury trial "in suits at common law," would likely require jury trials. Under the Seventh Amendment, jury trials are available to cases that would have been heard in a court of law and are unavailable for cases that would have been heard in equity courts.[6]

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[5] Prior to 1991, neither compensatory nor punitive damages were recoverable under Title VII. Capped punitive and compensatory damages were added as part of the Civil Rights Act of 1991. *See* Pub. L. No. 106-166, § 102, 1991 U.S.C.C.A.N. (105 Stat.) 1071, 1072-1074. Even with these caps, Senator Kennedy (D-MA), the legislation's chief sponsor, called the bill "a significant step forward in the Nation's continued effort to provide every citizen . . .with equal job opportunity and equal justice under the law." *Cong. Rec.* S15233 (daily ed. Oct. 25, 1991).

[6] In *Chauffeurs, Teamsters and Helpers, Local No. 391 v. Terry*, 494 U.S. 558 (1990), the Supreme Court focused on the nature of the remedy in determining whether a jury trial is required. Generally, the Court found that

Finally, the proponents of the New Norwood-Dingell bill tout the proposal as limiting liability associated with class action litigation under ERISA. However, the bill only bars class action litigation to enforce the bill's new patient protection provisions and utilization review standards (like H.R. 2990). New ERISA § 502(o). This provision will not meaningfully limit liability associated with the new patient protection provisions because the second new ERISA cause of action allows individual participants to sue for unlimited damages under ERISA to enforce the very same rules. Thus, the class action limitation is a hollow limit on liability. Most importantly, the bill does nothing to address the real health plan class action problem: the currently pending, frivolous "Scruggs-type" class action suits challenging common managed care practices under ERISA, RICO and state law.

New State Law Liability

The bill provides that no punitive damages are available if the requirements relating to initial claims, internal appeals, and external appeals are met (*e.g.*, compliance with timeframes and the external review determination). However, a broad exception is provided if the plaintiff shows that the defendant acted with a "willful or wanton disregard for the rights or safety of others." New ERISA § 514(d)(1)(C). Again, the exception clearly swallows the rule.

In reality, the bill affirmatively permits the award of punitive damages under state law, subject to a federal "willful or wanton" standard. This federal standard would not meaningfully limit the award of punitive damages as compared to existing state laws because it is substantially similar to existing state law standards.[7] *This provision of the New Norwood-Dingell bill is*

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where money damages are sought, the relief is legal in nature (rather than equitable), and the claim is subject to a jury trial.

[7] *See, e.g.*, *Spinosa v. Weinstein*, 571 N.Y.S.2d 747 (N.Y. App. Div. 1991) (punitive damages under New York medical malpractice law for wanton or malicious conduct aimed at public generally); *Boyd v. Bulala*, 877 F.2d

significantly worse than H.R. 2990, which precludes punitive damages where the plan complies with an external review decision.

3. Are employers protected from health plan liability under the New Norwood-Dingell "direct participation" test?

Employers will be subject to both the new federal and state causes of action under the New Norwood-Dingell bill. With respect to ERISA causes of action, suits may be maintained if there is "direct participation" by the employer in making a claims decision that is not medically reviewable or performing a duty under the terms and conditions of the plan. Similarly, suits can be maintained under state law if there is direct participation by the employer in making a medically reviewable claims decision. New ERISA §§ 502(n)(4), 514(d)(3).

The New Norwood-Dingell bill defines "direct participation" as the "actual making of such decision or the actual exercise of control in making such decision . . . ." The bill further provides a complicated set of exceptions to the definition of direct participation, which include an employer's decisions with respect to selecting a plan or insurance coverage, and modifying or terminating the plan or benefit.

While these provisions in form appear designed to protect employers from liability and new litigation costs, they are illusory. Under the bill, determining whether an employer "directly participates" in a decision that is subject to new federal or state liability is a fact intensive inquiry. Even employers that have no involvement in the administration of their health plan will routinely be named as defendants in health plan litigation. Because of the fact intensive nature of the direct participation test, these employers will not

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1191 (4th Cir. 1989) (punitive damages under Virginia malpractice law for willful and wanton negligence); *Jackson v. Taylor*, 912 F. 2d 795 (5th Cir. 1990) (punitive damages under Texas malpractice law for conscious indifference to rights or welfare of persons affected).

be able to readily dismiss even frivolous suits on preliminary motions. Even more troubling, because jury trials will be held in suits for damages, a jury will be charged with making the factual determinations necessary to determine whether the employer directly participated in decision at issue.

Upon close examination, it is unclear whether the exceptions to direct participation are intended to provide any meaningful employer protection. For example, the bill provides that participation by the employer in creating, modifying or terminating the plan does not constitute direct participation, but only "*if such process was not substantially focused solely on the particular situation of a participant or beneficiary"* who may have a new cause of action under the bill. New ERISA §§ 502(n)(4)(C)(ii)(III), 514(d)(3)(C)(ii)(III) (emphasis added). This is a significant departure from current law and could discourage employers from taking the special needs or desires of an employee into account when making plan design decisions. Without doubt, this caveat will lead to a great deal of litigation as to the scope of the exception and will lead to plaintiffs challenging an employer's decision to amend or terminate a plan, even though such decisions are clearly nonfiduciary "settlor" decisions exempt from ERISA. *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432 (1999) (plan amendment is settlor decision and does not implicate ERISA fiduciary obligations); *Lockheed Corp. v. Spink*, 517 U.S. 882, 891 (1996) ("the act of amending a pension plan does not trigger ERISA's fiduciary provisions").

Finally, the direct participation test offers no liability protection whatsoever to those employers that both self-insure and self-administer their own group health plans or those employers that, in fact, "directly participate" in specific plan decisions, but the plan is administered by third party administrators or insurers. Similarly, because group health plans are separate legal entities, the plan itself may be a defendant in a state lawsuit. *See* New ERISA § 514(d)(1) (allowing suit against "any person"). Where the plan is self-insured, in the event of a judgment against the plan, the employer may have no practical choice but to satisfy that judgment, notwithstanding the bill's provisions limiting suits for indemnity and contribution against an employer.

4. Do the "bifurcated" federal-state liability provisions in New Norwood-Dingell simply codify the recent trend in judicial decisions, including the Supreme Court's recent decision in *Pegram v. Herdrich* and the Fifth Circuit's decision in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*?

Characterizing the New Norwood-Dingell bill as codifying the trend in judicial decisions is grossly misleading. (Of course, if that were the case, there would be no need for the legislation.) As noted above, the bill broadly authorizes federal personal injury suits under ERISA for unlimited damages. No court has authorized such suits. The bill further authorizes suits under state law challenging a plan's medical necessity determination. Such a sweeping rollback of ERISA's preemptive scope greatly exceeds the Supreme Court's holding in *Pegram* and effectively overturns the recent Fifth Circuit decision regarding the Texas HMO liability law in *Corporate Health Insurance, Inc.*

Proponents of the New Norwood-Dingell bill's federal-state remedial structure argue that the bill follows the Supreme Court's decision in *Pegram v. Herdrich*, 120 S.Ct. 2143 (U.S. 2000). In their view, *Pegram* should be read to allow state law challenges to an ERISA plan's medical necessity determination. In fact, the Court's holding in *Pegram* is quite narrow. Specifically, the Court considered an ERISA-based challenge to an HMO cost containment arrangement. The actual holding was that an HMO physician does not act as an ERISA fiduciary when making a medical treatment decision. 120 S.Ct. at 2158. And, since physicians do not act as ERISA fiduciaries in making medical decisions, the court found that HMO cost containment mechanisms that may affect a physician's treatment decisions may not be challenged under ERISA's fiduciary and prohibited transaction rules. The court concluded that to find otherwise would be to bar for-profit HMOs, and possibly nonprofit HMOs as well, which is clearly contrary to the intent of Congress, who itself promoted the formation of HMOs through the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e et seq. *Id.* at 2156-57.

Not surprisingly, in its *Pegram* decision, the Court indicated its straightforward understanding that physicians who make inappropriate treatment decisions in response to an HMO's cost containment mechanisms are subject to state malpractice suit. *Id.* at 2158. Indeed, that happened in *Pegram* and the treating HMO physician was found liable for a $35,000 malpractice judgment under Illinois law. *Id* .at 2148. The Court simply did not hold, as the proponents of New Norwood-Dingell assert, that ERISA plans may be sued under state law when they make "medical necessity" determinations.[8]

Proponents of the New Norwood-Dingell bill further claim that their bill is consistent with the Fifth Circuit's recent decision in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5th Cir. 2000). In reality, the New Norwood-Dingell bill effectively overturns the *Corporate Health Insurance, Inc.* decision by imposing liability on health plans decisions specifically not covered by the Texas law.

The *Corporate Health Insurance, Inc.* decision, handed down after *Pegram*, considered whether the Texas HMO liability law was preempted by ERISA. Although the Fifth Circuit concluded that the liability provisions in the Texas law were not preempted by ERISA, in doing so, the court narrowly construed the Texas statute. The court specifically found that the Texas law imposes liability for "a limited universe of events" and only permits suits where physicians are negligent in delivering care and imposes vicarious

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[8] We recognize that proponents of the New Norwood-Dingell proposal will point to the Court's characterization of the physician's decision as a "mixed eligibility decision" as supporting the bill's underlying framework. However, the crucial factual point is that the decision in question involved a physician making a *direct treatment decision* with respect to a patient. This is clearly the type of doctor-patient relationship subject to state medical malpractice laws and is not analogous to an ERISA administrator – who does not directly provide medical care – but may make medical necessity determinations.

liability on HMOs for such negligence. *Id.* at 534. The court specifically declined to extend the act to impose liability where an HMO denies coverage for a medical service recommended by the treating physician and concluded that the Texas law "simply codifies Texas's already-existing standards regarding medical care." *Id.* at 535.

Finally, proponents also point to a group of "quality of care" cases in justifying the framework of the New Norwood-Dingell bill. In our view, the "quality of care" cases do not represent a "trend" towards allowing state suits challenging ERISA plan medical necessity decisions. To date, the "quality of care" rationale has not been widely adopted, with the bulk of the decisions occurring in the Third Circuit. *E.g., In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir. 1999); *Dukes v. U.S. Healthcare, Inc.*, 57 F. 3d 350 (3d Cir. 1995). More importantly, these cases deal with federal court jurisdiction – *i.e.*, the defendant seeks to remove a claim from state court on the grounds that ERISA's civil remedy scheme (section 502 of ERISA) "completely preempts" state law. These decisions do not even reach the question as to whether ERISA's preemption provision (section 514 of ERISA) preempts state law and defendants are free to assert a preemption defense in subsequent state court litigation.[9]

5. How will the "bifurcated" federal-state liability provisions in New Norwood-Dingell increase the complexity and lack of uniformity in the law?

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[9] Indeed, earlier this summer the Supreme Court vacated and remanded a Pennsylvania State Supreme Court decision light of its *Pegram* decision. *See U.S. Healthcare Sys. of Pa., Inc. v. Pennsylvania Hosp. Ins. Co.*, 120 S. Ct. 2686 (2000), *vacating Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998). In *Pappas*, the Pennsylvania Supreme Court held that section 514 of ERISA did not preempt state tort suits against an insurer. The *Pappas* suit had earlier not been removed to federal court, consistent with the Third Circuit's *Dukes* decision.

The bifurcated approach of the New Norwood-Dingell bill invites a multiplicity of lawsuits and the likelihood that the state and federal courts will develop conflicting interpretations of the bill's provisions that will generate confusion, uncertainty, and the prospect of endless legal maneuvering. This benefits no one except the lawyers who will litigate disputes arising under this already complex bill.

As a starting point, the bill vests a "qualified external review entity" with the determination of whether a particular claim is a "medically reviewable decision." Bill § 104(d)(2). This initial decision by the external review entity may determine which court has jurisdiction over the claim, and whether federal or state causes of action apply. Thus, both participants and health plans will litigate whether an entity's decision is correct in many cases.

The bill does not make clear whether or how a court may review a determination by the external review entity that a claim is, or is not, "medically reviewable." However, it is certain that complicated federal-state jurisdictional issues will arise when personal injury suits are brought. For example, if a participant brings a lawsuit in state court following external review, the defendant may argue that state law is preempted, and the suit should be dismissed, because the underlying decision was not medically reviewable in the first instance. Defendants in this situation may also seek to remove the case to federal court asserting that the claim arises from a nonmedically reviewable decision, and the federal courts have exclusive jurisdiction because it falls within the scope of the enforcement scheme under section 502 of ERISA. *See Toumajian v. Frailey,* 135 F.3d 648, 654-56 (9th Cir. 1997). Similarly, plaintiffs may initiate a suit in state court, even where the external review entity determined the claim was not medically reviewable, asserting in that suit that the entity's decision was wrong.

This bifurcated jurisdictional structure would almost certainly give rise to conflicting federal and state judicial decisions interpreting the meaning of "medically reviewable decision," and generate protracted legal duels over what is a preliminary jurisdictional question having little to do with the merits

of the claim. Indeed, it seems possible that some state and federal courts could interpret the term in such a way that a particular type of decision was not "medically reviewable" under state law, and "medically reviewable" under federal law, leaving the claimant with no remedy in any court.

In addition to these jurisdictional questions, much complexity would arise in cases where the participant claimed injuries arising from separate decisions made during one course of treatment, one of which is "medically reviewable" and therefore actionable under state law and the other of which is not "medically reviewable" and therefore actionable under federal law. *See, e.g., Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461 (9th Cir. 1997) (vacating multiple claims arising from single course of treatment).[10] Lawsuits asserting both federal and state claims are particularly likely to arise because of the second ERISA cause of action, which establishes a federal personal injury suit for failures to follow the terms and conditions of the plan. Such situations would spawn either sequential lawsuits in state and federal courts over claims for injuries arising out of a single course of treatment, or suits brought originally in federal court, or removed to federal court from state court, that would require the federal court to apply both federal and state law in a single lawsuit.

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The New Norwood-Dingell bill has been characterized as a significant "compromise" that is structured in a manner consistent with recent court decisions. In fact, the bill is a radical departure from recent court decisions and would expose health plans to unlimited liability under a confusing

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[10] If a claim does not arise from a "medically reviewable decision," the federal courts have exclusive jurisdiction over the ERISA causes of action. If a claim arises from a "medically reviewable decision," state courts have jurisdiction over the claim, and apply state law to decide the case. Cases that involve both types of claims could be brought in federal court, but not in state court.

amalgam of federal and state law. Moreover, the bill exposes health plans to virtually all of the same types of suits authorized by H.R. 2990, but with even fewer limits on liability and increased complexity.

Sincerely,

Jon W. Breyfogle