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Legal Sidebar

COVID-19 and Liability Limitations for the Health Care Sector

July 1, 2020

The ongoing Coronavirus Disease 2019 (COVID-19) pandemic has required health care professionals and facilities to care for a surge of patients with COVID-19 symptoms. This is occurring in a health care environment where the treatment guidelines specific to COVID-19 are still evolving and where some health care facilities are experiencing various resource shortages related to their pandemic response, including shortages in staffing as well as certain protective and treatment equipment. For some health care facilities, these shortages have also caused the delay or cancelation of non-COVID-19 treatments or procedures. Various commentators and policymakers have recognized that these conditions may generate certain liability risks for the health care sector, including risks resulting from unsuccessful COVID-19 treatments, potential COVID-19 transmission, and canceled or delayed non-COVID-19 treatments. These risks have prompted a debate over whether the government should grant certain liability limitations to the health care sector, and if so, what the appropriate scope of those limitations should be. Since the onset of the pandemic, several states have already provided varying degrees of liability protection to their health care sector. While some stakeholders believe that robust federal liability protections may be necessary to encourage the provision of health care services and ensure the economic viability of health care facilities, others believe that such protections would reduce accountability and harm the individuals receiving care. To facilitate Congress's review of this issue, this Sidebar provides an overview of the existing federal and state limitations on liability for the health care sector that are relevant to the current pandemic before identifying several legal considerations for Congress.

Background

In general, individuals can file a state-law tort suit against their treating health care professionals and facilities if the professionals' or facilities' negligent or wrongful conduct results in injury. In the context of COVID-19, several early lawsuits have asserted, for instance, medical malpractice claims against individual care providers for allegedly failing to diagnose and treat the condition timely and properly. As to health care facilities, plaintiffs have asserted, for instance, corporate negligence and wrongful death claims based on the facilities' alleged failure to implement procedures properly to prevent plaintiffs' exposure to COVID-19, to provide staff with adequate protective equipment, or to provide proper treatment. Several federal and state laws may limit the scope of this liability in the context of the pandemic, which the federal government and all fifty states have declared an emergency.

Congressional Research Service
https://crsreports.congress.gov
LSB10508

Existing Liability Limitations Under Federal Law

Federal law currently limits *individual* health care professionals' tort liability in three circumstances.

First, the Secretary of Health and Human Services' (HHSs') declaration of a public health emergency triggers immunity limitations under the Public Readiness and Emergency Preparedness Act (PREP Act). With exceptions discussed below, the PREP Act immunizes, among others, health care professionals from liability (under state and federal law) relating to the administration or use of any medical product that constitutes a "covered countermeasure" under that law. In the case of COVID-19, the Secretary declared a public health emergency on January 31, 2020. Relevant "covered countermeasures" for the current pandemic that may receive PREP Act immunity include, for instance, a drug or device developed to diagnose or treat COVID-19. (For more detailed analysis of the PREP Act, see this CRS product.)

Second, with exceptions discussed below, Section 3215 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) immunizes *volunteer* health care professionals from liability (under state and federal law) for their acts or omissions when performing health care services during the period of the declared COVID-19 emergency, if the professionals perform those services (1) within the scope of their state license and (2) under the good faith belief that the treated individual needs health care services.

Third, the federal Volunteer Protection Act of 1997 (VPA) immunizes *volunteers*—including volunteer health care professionals—of a nonprofit or governmental entity from liability for certain acts or omission on behalf of the entity. Unlike the PREP Act and Section 3215 of the CARES Act, the VPA's liability limitations do not depend on an emergency declaration. Instead, this subset of volunteer health care professionals are immune from liability for acts or omissions on behalf of their entity as long as they were acting within the scope of their responsibilities at the entity; were properly licensed to engage in the conduct at issue (if a license is required); and their operation of a vehicle, vessel, or aircraft did not cause the harm. This group of volunteer health care professionals may thus be additionally immune from tort claims related to non-health care services they provide, if such services are within the scope of their responsibilities with their nonprofit or governmental entity.

Each of these liability limitations has, at minimum, a "willful misconduct" exception that generally excludes from immunity conduct performed in knowing disregard of the safety of others. In the case of the PREP Act, the exception applies only if the willful misconduct causes death or serious physical injury. In contrast, both the CARES Act and VPA more broadly exclude from immunity any injury caused by "willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed." Because the VPA applies to a broader range of volunteer activities, the law further excludes from immunity any misconduct that constitutes crimes of violence, acts of international terrorism, hate crimes, sexual offenses, or violations of federal or state civil rights law. In addition to these exceptions, VPA's liability limitations for volunteers is subject to another caveat: the immunity does not apply to the volunteers' nonprofit or governmental entities, which may be sued and held vicariously liable for the negligent conduct of their volunteers. The VPA expressly reserves the entities' right to then bring a civil action against the volunteer. The VPA limits, in any action against a volunteer, the volunteer's potential liability for noneconomic damages (i.e., damages related to nonpecuniary losses, such as pain and suffering) and punitive damages (i.e., damages beyond the amount needed to compensate the plaintiff and intended to punish the defendant).

Existing Liability Limitations Under State Law

Beyond federal liability limitations, state law may further limit their health care sector's liability exposure during an emergency. Even before the onset of the COVID-19 pandemic, the laws of some states—including Indiana, Louisiana, Maryland, and Virginia—automatically conferred certain immunity to their health care professionals and/or facilities upon a gubernatorial emergency declaration. Other states—over twenty according to one analysis—have granted immunity in specific response to COVID-19.

In general, these liability protections, at minimum, insulate individual health care professionals—including non-volunteers—from liability related to COVID-19 care provided during the emergency period, including care that may not constitute a "covered countermeasure" under the PREP Act. Like the federal immunity provisions under the CARES Act and VPA, states generally do not extend tort immunity to acts of willful or criminal misconduct, gross negligence, and reckless misconduct. Beyond this baseline, state laws vary in scope:

- **Potential immunity holders.** Several states appear to limit immunity protections only to individual health care professionals. On the other hand, other states have also extended liability protections to health care facilities and entities, such as hospitals (and other facilities that provide acute care) and long-term care facilities, including nursing homes and assisted living facilities.
- **Conduct subject to immunity.** The immunity protections several states have granted appear to extend only to acts or omissions related specifically to COVID-19 care. Other states also immunize from liability activities related to non-COVID-19 care if that care was affected by the potential immunity holder's pandemic response.
- **Standard governing the application of immunity.** To receive immunity protection, many but not all states require those who may be entitled to immunity to have acted in "good faith" in providing care. Most states that have imposed this "good faith" standard do not define it. One court that has considered the standard in the health care decisionmaking context held that good faith entails a defendant's "honest belief in the suitability of the actions taken" and the performance of those actions "honestly, with proper motive, even if negligently." At least one state with a "good faith" standard also imposed different evidentiary standards depending on who may be entitled to immunity: individual health care professionals—but not health care facilities—are *presumed* to have acted in good faith. Such a presumption makes it easier for a defendant to assert immunity by placing the burden on a plaintiff to disprove the existence of good faith. Without that presumption, a defendant invoking the immunity provision would typically bear the burden of proving good faith.
- **Exceptions to immunity.** In addition to the exceptions noted above for willful or criminal misconduct, gross negligence, and reckless misconduct, some states exclude certain additional conduct or circumstances from liability protection. Massachusetts, for instance, also excludes from liability protection conduct with an intent "to discriminate based on race, ethnicity, national origin, religion, disability, sexual orientation or gender identity." Moreover, Massachusetts excludes the immunity protection from applying in consumer protection actions brought by the state attorney general and in false claims actions brought by or on behalf of the commonwealth.

Considerations for Congress

As the above discussion illustrates, states that have chosen to expand liability limitations for their health care sector during the COVID-19 pandemic have taken different approaches to calibrating the scope of immunity. These approaches reflect an effort to balance several interests and concerns. A grant of immunity to particular persons or entities can incentivize certain socially desirable (and often high-risk) activities by reducing exposure to potential lawsuits related to those activities. In the context of the COVID-19 pandemic, the granted immunity is generally intended to encourage provision of health care services during a health emergency characterized by many uncertainties, including evolving treatment protocols, potential transmission risks, and resource shortages. At the same time, however, these liability protections can be viewed as harming accountability by removing a key legal deterrent—suits by injured parties—to careless or wrongful conduct. To balance these competing concerns—which can entail a different set of calculations for different groups—states have generally imposed various conditions and exceptions to the liability limitations provided to their health care sector.

Expansion of existing federal liability limitations related to COVID-19 for the health care sector may raise several legal considerations. First, one threshold issue is how to define the immunity's scope. Congress may, for instance, consider whether or how much to expand the class of immunity holders (which, under federal law, currently consists primarily of volunteer health care professionals), whether to extend liability protection only to claims related to COVID-19 care, and what standards and exceptions should apply to the grant of immunity (and whether those standards and exceptions should differ for various groups of immunity holders). Congress may also consider whether and to what extent to extend liability protections beyond state-law claims. While state-tort law comprises a primary source of liability for the health care sector in this context, some potential immunity holders may also be exposed to claims related to COVID-19 care under certain federal laws, such as the Americans with Disabilities Act.

Second, as an alternative or in addition to expressly immunizing certain conduct from civil liability, Congress may also contemplate other ways of mitigating such liability. To the extent Congress permits any civil suit against particular persons or entities, Congress could—similar to the approach taken under the VPA—limit the types and/or amounts of damages that plaintiffs can recover. Congress could also streamline the procedures governing how the lawsuit would be conducted, including imposing certain limits on the scope and timing of discovery, shortening the applicable statute of limitations, creating a fee-shifting provision, or requiring an alternative dispute resolution process. To the extent any existing state law governs these procedures or requirements, those state tort rules could be displaced in accordance with preemption principles discussed below if they conflict with a federal requirement.

Finally, Congress may consider how any federal liability limitations would interact with existing state immunity protections. Whenever Congress legislates in an area in which it shares regulatory responsibilities with the states, the doctrine of preemption is implicated. Under the doctrine, which is grounded in the Supremacy Clause of the Constitution, "any state law . . . however clearly within a State's acknowledged power, which interferes with or is contrary to federal law, must yield." Federal law can preempt state law either *expressly* (i.e., through a statutory clause that explicitly specifies the categories of state law that are displaced) or *impliedly* (i.e., when Congress's command is implicitly contained in the relevant federal law's text, structure, and purpose). The scope of preemption may implicate different values and policy preferences (e.g., the benefits of uniform national regulation versus policy experimentation at the state level). To the extent Congress decides to provide certain liability limitations for the health care sector in the COVID-19 context—an action many states have taken through different approaches—Congress may consider whether to include an express preemption clause that clarifies the intended scope of preemption. The VPA, for instances, specifies that it preempts any inconsistent state law but preempts no state law that provides additional liability protections to volunteers of a nonprofit or governmental entity. The VPA, however, also allows states to opt out of the law by following certain

specified procedures. For states that do not opt out, the VPA further saves from preemption several state requirements or conditions that are not "inconsistent" with the VPA.

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