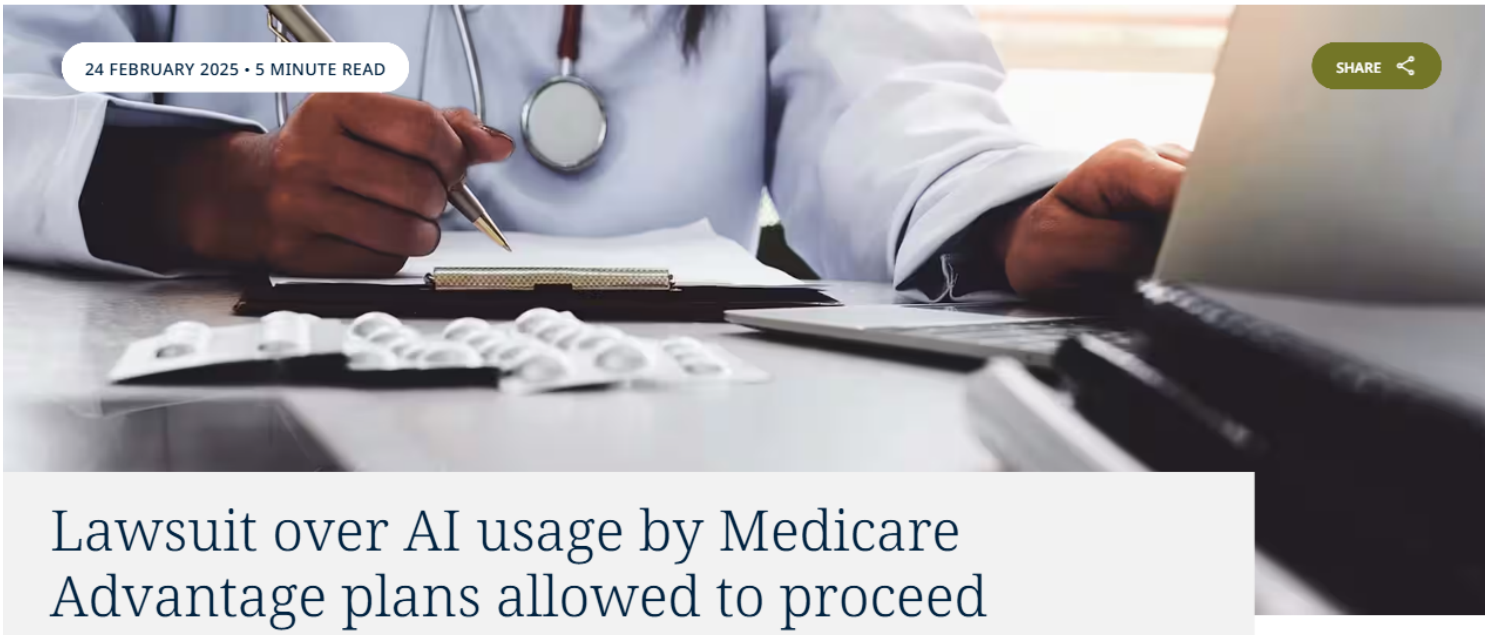

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Lawsuit over AI usage by Medicare Advantage plans allowed to proceed

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The US District Court for the District of Minnesota has ruled that plaintiffs may proceed in a putative class action lawsuit brought against a Medicare Advantage organization (MAO) to challenge its alleged use of an artificial intelligence (AI) algorithm to make coverage determinations. While the February 13, 2025 order dismissed most of the plaintiffs' state common law and statutory claims as preempted by the Medicare Act, the order (1) found that the Medicare Act did not preempt the breach of contract and breach of implied covenant of good faith and fair dealing claims involving the alleged use of AI, and (2) waived the Medicare Act's requirement for exhaustion of administrative remedies based on the facts at issue.

The order is part of a growing trend of courts closely examining the limits of federal preemption under the Medicare Act. However, here, the court avoids Medicare Act preemption by decoupling the ultimate denial of benefits from the plaintiffs' allegation that the MAO is using AI inconsistently with its contractual representations. In so finding, the court has opened the door to other lawsuits and claims by private plaintiffs and government litigants who seek to circumvent Medicare Act preemption, provided they only challenge whether the use of AI is consistent with the MAO's contractual terms.

Case summary

In *Estate of Gene B. Lokken et al. v. UnitedHealth Group, Inc. et. al.*, a class action lawsuit was brought against United Health Group, Inc., UnitedHealthcare, Inc., and naviHealth, Inc. (collectively, UHC) by UHC Medicare Advantage members. They alleged that UHC used an AI program, nH Predict, to improperly deny their post-acute care claims. The plaintiffs' complaint alleges that UHC used nH Predict in lieu of physicians to make coverage determinations based on comparing a specific patient with similar patients to estimate the amount of post-acute care needed, regardless of the recommendation given by their treating physician.

These plaintiffs brought seven causes of action under state law theories, including breach of contract, breach of the implied covenant of good faith and fair dealing, unjust enrichment, insurance bad faith, negligence per se, unfair and deceptive insurance practices, and unfair competition. UHC filed a motion to dismiss the plaintiffs' claims for (1) a lack of jurisdiction due to the plaintiffs' failure to exhaust administrative remedies, and (2) a failure to state a claim upon which relief can be granted based on a theory of preemption.

The court first assessed whether the plaintiffs failed to exhaust the administrative appeal process under the Medicare Act. Given that the plaintiffs' claims arose from a denial of benefits, the court found that the claims were subject to – but failed to meet – the exhaustion requirement. However, based on the plaintiffs' allegations about UHC's denial system and practices in the appeals process, the court concluded it was appropriate to waive exhaustion due to the class plaintiffs' allegations of irreparable injury and the futility of exhaustion.

The court next assessed whether the Medicare Act preempted the plaintiffs' state law claims. The Medicare Act's preemption clause states that it supersedes any state law or regulation with respect to Medicare Advantage plans offered by MAOs under the Medicare Advantage program. In the view of the court, the Medicare Act only preempts state law or regulation if it regulates the same subject matter as the Medicare Act, or otherwise frustrates the purpose of the Medicare Act's standards. Applying that interpretation, the court allowed the common law claims of breach of contract and breach of the implied covenant of good faith and fair dealing claims to proceed since these claims

only require the court to review UHC's insurance documents to determine whether UHC complied with its written agreements.

More specifically, the court quoted language from UHC's evidence of coverage documents that described claim decisions as being made by "clinical services staff," and "physicians," with no mention of AI. The court believed it could assess the aforementioned common law claims by only investigating whether UHC "complied with its own written documents" under basic contract principles.

The court dismissed the remaining common law claims because they would require the court to analyze issues covered by the subject matter of the Medicare Act (*eg*, assessing covered benefits and confirming the reasonableness of coverage decisions). Likewise, the court dismissed all statutory claims since the court held that the claims did not merely supplement federal standards under the Medicare Act.

Key takeaways

While still in its early stages, this case demonstrates the complicated legal framework governing the integration of AI into insurance operations and decision-making. In some cases, that legal framework predates the uses of AI and was, thus, not specifically designed with AI in mind. Increasingly, however, federal and state legislatures and agencies are promulgating laws, regulations, and advisory guidance targeting AI in insurance. As this legal framework and, therefore, liability risks continue to evolve at the federal and state levels, insurance-regulated entities and vendors are encouraged to continue to adapt their usage of AI, compliance policies and procedures, contractual obligations, and representations in their insurance policy documents to anticipate and mitigate that risk.

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