LITIGATION TRENDS IN MANAGED CARE

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I. BALANCE BILLING AND "U&C" PRICING

Generally, hospitals, physicians and other healthcare providers enter into a written reimbursement contract with a health plan that establishes a fixed rate of reimbursement the health plan pays to the provider (i.e., participating provider) for various services rendered. But it is not uncommon for providers (often in the emergency room setting) to lack payor reimbursement contracts for certain patients (i.e., non-participating providers). In these circumstances, the patient's plan often pays only the reasonable and customary value for services rendered (the "U&C" rate). The health plan's calculated U&C rate is typically less than the amount the provider bills for the services.

While managed care litigation involving balanced billing is an established and familiar topic to health lawyers, today's struggling economy (causing providers to more aggressively pursue their billed charges) has driven the issue back into the forefront of health law litigation trends. Non-participating providers are suing health plans with greater frequency, or alternatively, are suing the plan members to recover the balance of the outstanding bill (i.e., "balance billing"). Generally, most states allow participating providers to obtain only copays and deductibles from plan members. Some states extend this limitation to non-participating providers, thus precluding a non-participating provider from collecting the remainder of a bill's balance from a plan member. But, regardless of such restrictions, non-participating providers continue to file suit asserting that health plans fail to fully compensate for services rendered to plan members.

The direct receipt of a provider's bill can be confusing to those numerous patients who are not familiar with the complexities of our healthcare payment system. This can lead to patient inquiries, patient complaints, or even complaints by patients to state regulatory officials. Thus, compliance officers need to be informed about these issues given the likelihood of patient/provider, patient/plan and provider/plan controversies that may arise from balance billing issues.

A. Recent Case Law Regarding Balance Billing.

1. California Department of Managed Health Care v. Prime Healthcare Services, Inc., No. 30-2008-00108627-CU-MC-CJC (June 27, 2008). In June 2008, the California Department of Managed Health Care ("DMHC") filed suit in the Orange County Superior Court

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against Prime Healthcare Services, a hospital organization, to bar Prime from balance billing insured patients for services received at its hospitals. The lawsuit seeks penalties of \$2,500 for each violation. DMHC became aware of Prime's balance billing practices in April 2008 upon receiving information that Prime had sent collection notices to a large number of Kaiser members who were treated at emergency rooms at one of its nine hospitals in Southern California.

In May 2008, Kaiser obtained a temporary restraining order against Prime prohibiting it from balance billing 6,000 of the plan's members. The TRO remains in place pending the outcome of the litigation brought by the California DMHC.

- 2. California Medical Association v. Deptartment of Managed Health, No. 34-2008-80000059-CU-WM-GDS (2008). In December 2008, the Sacramento Superior Court in a tentative ruling upheld the California DMHC's regulation that seeks to protect consumers from balance billing for emergency services. The regulation, 28 C.C.R. § 1300.71.39, bars hospitals and their physicians from billing patients for emergency services that are the responsibility of insurers by defining the practice as an "unfair billing pattern." The six provider groups seeking to block the regulation include the California Medical Association ("CMA"), the California Hospital Association, the California Chapter of the American College of Emergency Physicians, the California Orthopedic Association, the California Radiological Society, and the California Society of Anesthesiologists.
- In Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, No. S142209, 2009 WL 36855 (Cal. Jan. 8, 2006), the Supreme Court overturned a lower-court ruling and held that billing disputes over emergency medical care must be resolved solely between providers and health plans without the involvement of patients. The Plaintiffs filed suit to prevent non-participating emergency physicians from collecting the balance of a hospital bill from plan members. Plaintiffs asserted that an implied contractual relationship existed between the out-of-network physicians and the plan, which limited non-participating physicians to the same reimbursement as participating physicians and thus prohibited balance billing. The intermediate California appellate court held in favor of the physician group, finding that no implied contract existed and that the group was entitled to bill plan members for the outstanding amount due after receipt of payment by the plan. However, in an unanimous ruling, the California Supreme Court overturned the lower appellate court decision. The Court gave no deference to the California regulation adopted by the Department of Managed Health Care that defines balance billing as an unfair billing pattern. Rather, the Court based its holding on its interpretation of the California law regulating HMOs (the Knox-Keene Act), concluding that "HMO members are *not* liable to pay for emergency care." *Id.* at *8.

B. Recent Legal Challenges to U&C Pricing.

1. In *Michael Davekos, P.C. v. Liberty Mutual Insurance Co.*, No. 10002, 2008 WL 241613 (Mass. Dist. Ct. 2008), a Massachusetts state appellate court vacated and remanded the lower court's judgment against the plaintiff non-participating chiropractor who challenged a health plan payments as not usual, customary, fair, or reasonable. The health plan reimbursed the plaintiff for treatment provided to a plan member using pricing data provided by Ingenix, a

supplier of usual and customary (U&C) reimbursement rates. The appellate court held that the Ingenix "reasonable value" pricing data should not have been admissible evidence because the health plan failed to prove that the underlying U&C data was reliable or that it contained representative charges for the chiropractic services rendered within the specific geographic area.

2. In February 2008, New York Attorney General Andrew Cuomo announced a large-scale investigation into healthcare billing information provided by the UnitedHealth Group subsidiary Ingenix. The New York Attorney General contends that health plans and/or Ingenix may have kept out-of-network payments unreasonably low by relying on faulty methods for determining the U&C rate and thereby defrauded healthcare consumers. Attorney General Cuomo contends that by distorting the U&C rate the health plans are able to keep their reimbursements artificially low and force patients to absorb a higher share of the costs. Attorney General Cuomo also asserts that "United's ownership of Ingenix, coupled with the inherent problems with the data it is using, clearly demonstrates a broken reimbursement system designed to rip off patients and steer them towards in-network-doctors that cost the insurer less money." See BNA Health Care Daily Report, Health Insurers Rig Provider Payments Using Faulty Data, New York AG Charges (Feb. 2, 2008).

Attorney General Cuomo issued subpoenas to 16 large health insurance companies seeking information on how U&C rates are calculated, copies of member complaints and appeals, and communications with members and between Ingenix and United on the issue. Health plans and Ingenix maintain that the reimbursement rates applied are those customarily applied in various locales.

While Attorney General Cuomo has not filed any lawsuit targeting the UnitedHealth Group subsidiary, a class action lawsuit was filed in May 2008 against Ingenix regarding its billing practices. *See Weintraub v. Ingenix*, Case No. 3:08-cv-00654, U.S. District Court, District Court of Connecticut; *see also McCoy v. Health Net Inc.*, D.N.J., No. 03-cv-1801, *settlement* July 24, 2007; *Wachtel v. Health Net Inc.*, D.N.J. No. 01-cv-4183, *settlement* July 24, 2007; *Scharfman v. Health Net Inc.*, D.N.J., No. 05-cv-301, *settlement* July 24, 2007 (Health Net, Inc. paid \$215 million to settle three consolidated class actions alleging that Health Net, Inc. used a flawed database produced by Ingenix to determine U&C rates for medical services provided by out-of-network providers. Forty million dollars of the settlement funds will be disbursed to some two million people who were billed by their out-of-network providers for the balance outstanding after Health Net paid their insurance claims); *Cooper v. Aetna Health, Inc.*, D.N.J., No. 07-3541 (filed July 30, 2007); *Malchow v. Oxford Health Plans, et al.*, D.N.J. No. 08-935-FSH-PS (Filed February 19, 2008).

II. PROVIDER LITIGATION AGAINST PAYORS

Provider litigation against payors accounts for much of the managed care litigation that has taken place in recent months. Most of these cases involve claims by providers concerning the timeliness or amount of reimbursement for medical services rendered.

- In response to the Prime Healthcare Services balance billing case discussed above, Prime has filed five lawsuits in various California courts alleging that an HMO improperly failed to pay claims for plan members who received out-of-network treatment in the hospital's emergency rooms. Prime also alleges that the HMO established an Emergency Provider Response Program ("EPRP") to manage transfers of the HMO members to the HMO's affiliated facilities for financial purposes and that the EPRP often causes patients to be transferred before their medical condition has been appropriately stabilized. In the case of stable patients, Prime alleges that the EPRP program delays transfer and then declines payment on the grounds that the EPRP did not authorize services rendered by the hospital or retroactively determines that the patient did not have an emergency medical condition. The complaint also alleges delay tactics by the HMO that resulted in the denial of claims payment. Sherman Oaks Hospital v. Kaiser Foundation Health Plan, Cal. Super. Ct., No. LC080295, filed Jan. 1, 2008; Desert Valley Hospital v. Kaiser Foundation Health Plan, Cal. Super. Ct., No. 800317, filed Jan. 23, 2008; Chino Valley Medical Center v. Kaiser Foundation Health Plan, Cal. Super. Ct., No. 800590, filed Jan. 23, 2008; La Palma Intercommunity Hospital v. Kaiser Foundation Health Plan, Cal. Super. Ct., No. 00101717, filed Jan. 28, 2008; Paradise Valley Hospital v. Kaiser Foundation Health Plan, Cal. Super. Ct., No. 800590, filed Jan. 23, 2008.
- B. In *Midwest Emergency Associates-Elgin Ltd. v. Harmony Health Plan of Illinois, Inc.*, 888 N.E.2d 694 (Ill. App. Ct. 2008), an Illinois appellate court affirmed a trial court's dismissal of a suit by emergency health care providers against a state Medicaid managed care organization ("MCO") for unjust enrichment. The court held that a MCO Medicaid plan is entitled to pay an emergency health care provider who is furnishing services to plan enrollees at Medicaid fee-for-service program rates rather than the provider's billed charges -- even if the provider is not enrolled in the MCO's network.

Here, two MCOs paid Midwest Emergency Associates-Elgin Ltd., a non-contracted provider, at the rates set by the Illinois Department of Healthcare and Family Services ("HFS") for the Medicaid fee-for-service program. Midwest, in turn, sued the defendants, "seeking to recover the difference between its billed charges and the reimbursement amounts actually paid by the [MCO] over the five-year period preceding the lawsuit." *Id.* at 974. Midwest claimed that it was entitled to relief because the MCOs unilaterally set its payment rates. However, the Court rejected Midwest's claim and relied in part on the MCOs' contract with HFS, which required the MCOs to "pay for all appropriate Emergency Services rendered by a non-affiliated provider at the same rate [HFS] would pay for such services, unless a different rate was agreed upon." *Id.* at 978. The Court held that this language authorized the MCOs to reimburse Midwest at the HFS fee-for-service rate. The Court also stated that Midwest's complaint was inconsistent with the purpose of the Medicaid program to provide health care to the indigent; "if Midwest prevailed, providers would have little to no incentive to privately negotiate reimbursement rates with such managed care organizations." *Id.* at 982-983.

C. In *Boca Raton Community Hospital Inc. v. Great-West Healthcare of Florida*, No. 06-80750-CIV, 2008 WL 728538 (S.D. Fla. March 17, 2008), a Florida federal district court denied the defendant's summary judgment motion and held that an acute care hospital may continue to pursue its claim to collect over \$2 million in alleged underpayments from a health insurer. The insurer restructured its arrangements with a preferred provider network which led to

the hospital being terminated from the preferred provider network arrangement without notice. The insurer nevertheless continued to pay the hospital at the network's discounted rates. The court found that once terminated, neither the insurer, nor any of its affiliates, had a contractual right to participate in or claim rate discounts. Additionally, the court held that the hospital did not ratify the act of continuing payment at discounted rates when the hospital accepted the insurer's reduced payments and the continued benefit of the insurer's patient referrals. However, the Court concluded that a trial was necessary to determine when the hospital acquired knowledge of the withdrawal and whether this knowledge may have ratified the continued payment of discounted rates to the hospital.

- D. In *Health Options, Inc. v. Palmetto Pathology Services P.A.*, 983 So. 2d 608 (Fla. Dist. Ct. App. 2008), a Florida appellate court affirmed the lower court's holding that pathology providers were entitled to \$1.5 million in payments withheld by an HMO. Palmetto Pathology Services, P.A. ("PPS") sued a Florida HMO after the HMO refused to pay for the professional component of clinical pathology services provided to the HMO's members at two Florida Hospitals. The HMO alleged that the services rendered by PPS did not constitute "approved physician care" covered under the members' contracts. The court rejected this argument, finding that (i) the services fell within the definition of "physician care" which includes care "supervised by physicians" and (ii) that "PPS's medically necessary clinical pathology services 'rendered to' (not 'rendered directly to') a member are compensable whether or not a pathologist and patient meet directly." *Id.* at 614-615. The court held that PPS was an intended third-party beneficiary of the contracts between the HMO and its members and thus was entitled to prevail. *Id.* at 615. The court also affirmed the lower court's holding that PPS's claims were not preempted by ERISA. *Id.* at 615.
- E. In *Merkle v. Health Options, Inc.* 940 So. 2d 1190 (Fla. Dist. Ct. App. 2006), a Florida appellate court considered allegations by a named plaintiff in one of four class actions against several HMOs, alleging that the HMOs underpaid non-participating providers by paying class members 120% of Medicare reimbursement rates, rather than the usual and customary provider charges. The HMOs moved to dismiss, arguing that the statute did not authorize a private cause of action. On appeal, the Florida appellate court held that the applicable statute imposed a duty on HMOs to reimburse non-participating providers according to the statute's dictates, not based on Medicare reimbursement rates. The question, according to the court, was not whether the HMOs are liable under the statute, but what is the appropriate method for determining the extent of their liability. The court also rejected the HMOs argument that there was no private right of action under the statute. Accordingly, the court remanded the case for further proceedings.
- F. In *Trustees of the University of Pennsylvania v. AmeriChoice of Pennsylvania, Inc.*, No. 4392 (Phila. Ct. Com. Pl. Jan. 23, 2007), out-of-network emergency care providers sued a health plan, alleging unjust enrichment and violation of a Pennsylvania statute based on the plan's failure to reimburse full published rates for emergency medical services provided to the plan's Medicaid participants. The applicable statute required health plans to pay out-of-network providers for all "reasonable and necessary costs" for emergency care provided to plan members and also required a managed care plan to "consider both the presenting symptoms and the services provided" when determining "reasonably necessary costs". The court found that

"reasonable and necessary costs" presented factual issues to be determined at trial based upon what the evidence showed regarding presenting symptoms and services rendered. Accordingly, the court held that the case should proceed to trial and held that the providers had the burden of showing that their actual costs were in excess of the amount the plan had previously paid on the claims.²

G. In *Allstate Insurance Co. v. Thorpe*, 170 P.3d 989 (Nev. 2007), the Nevada Supreme Court held that healthcare providers cannot sue insurance companies in state court to enforce timely payment of claims under the state's prompt pay law. Section 690B.012 of the Nevada Revised Statutes requires insurers to "approve and pay, or deny, casualty claims, including claims for medical payment benefits" within a limited time frame. The Court explained that the Nevada Department of Insurance ("NDOI") has exclusive original jurisdiction to resolve such claims. Thus, providers must exhaust their administrative remedies and then may seek judicial review of those decisions in state court. In addition, the Court held that the providers have standing to proceed before the NDOI, regardless of whether they hold a valid patient assignment of benefits. Because providers are persons with a "direct and immediate pecuniary interest in prompt payments ... [t]his right is independent of the rights of the patient and, thus, no formal assignment of rights is required." *Id.* at 996.

III. PHYSICIAN TIERING PROGRAMS

Physician tiering is a process whereby health plans rank physicians based on certain performance standards. Generally, health plans that utilize tiering will group physicians into tiers according to a calculated score and then either create an elite plan that includes only the plan's highest ranked providers, or provide for lower cost-sharing for the top-tiered physicians. Critics of the practice argue that there must be assurance that: (1) tiering is based on quality rather than cost; (2) the tiering process is open to review; (3) the methodology used is appropriate; and (4) there will be adequate disclosure to consumers regarding the basis for tiering or network participation decisions. Tiering may expose health plans to litigation risks for failure to tier physicians appropriately, which could give rise to defamation and breach of contract claims. Also, failure to adequately disclose tiering practices could lead to claims under state unfair trade practices and consumer protection laws. Litigation in Washington and Massachusetts, as well as a wide-scale investigation by the New York Office of Attorney General, provide recent examples.

A. Litigation.

1. In Washington State Medical Associates v. Regence Blue Shield, No. 06-230665-1SEA (Wash. Super. Ct. filed Sept. 21, 2006), the Washington State Medical Association

Effective January 1, 2007, the United States Congress passed legislation requiring that any out-of-network provider of emergency services that renders services to a member of a Medicaid managed care plan must accept, as payment in full, no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary were a Medicaid beneficiary not enrolled with a Medicaid managed care plan.

("WSMA") and representatives of the Society of Professional Engineering Employees in Aerospace sued insurer Regence Blue Shield ("Regence") alleging unfair and deceptive business practices, defamation, libel, intentional interference with commerce, and breach of contract. The dispute arose following Regence's decision to exclude approximately 500 physicians from its "Select Network Program," allegedly based on flawed methodology. The Plaintiffs sought an injunction to prevent Regence from implementing the Program, and, additionally, sought monetary damages for alleged inaccurate statements to patients regarding certain physicians' failure to meet the Program's quality and efficiency standards.

In November 2006, the American Medical Association Litigation Center (a coalition of the American Medical Association and state medical associations) joined the lawsuit as coplaintiff. In December 2006, Regence announced it would delay implementation of the Select Network, and in August 2007, the parties settled the lawsuit.

Under the settlement, Regence agreed to disclose to WSMA any new rating system or performance program and its methodology prior to implementation, and agreed to allow WSMA meaningful opportunity to provide input regarding the performance measurement program. Additionally, Regence agreed to: (1) provide WSMA ten days prior notice before releasing physician performance scores; (2) make reasonable efforts to advise physicians that their scores were going to be released; and (3) post scores on its provider website along with an explanation or the methodology for determining the scores, data relied on in score calculation, and a means to identify patients included in the data. The settlement also provides that physicians will be allowed to appeal their scores before they are released to the public.

For further discussion, see Mark Joffe & Kelli Back, Physician Tiering Programs: Holding Health Plans Responsible for Tiering Methodology and Disclosure to Their Insured, American Health Lawyers Association, HMOs & Health Plans, Feb. 2008; Carol M. Ostrom, Regence Doctor-Ratings Lawsuit Settled, The Seattle Times, Aug. 9, 2007.

2. Massachusetts Medical Society, et al. v. Group Insurance Commission, et al., No. 08-2124 (Suffolk Super. Ct. filed May 21, 2008). In May of 2008, the Massachusetts Medical Society (the "MMA") filed suit against the Group Insurance Commission (the "GIC"), Tufts Health Plan ("Tufts"), and Unicare for defamation and fraud. The allegations stem from the GIC's implementation of its Clinical Performance Improvement Initiative (the "CPI Initiative"), and the utilization of the CPI Initiative by Tufts and Unicare to group its physicians into tiers. Under the CPI Initiative, health plans that contract with the GIC must offer their members variable co-pays based on physician or hospital tier designation.

In its complaint, the MMA claims that the ranking system is arbitrary, and uses inaccurate and unreliable data. For instance, the complaint states that the CPI Initiative is arbitrary because the GIC requires that a pre-determined percentage of physicians be placed in each tier. The complaint also states that the purported quality measures are flawed because they allegedly: (1) do not take differences in individual patients into account, and (2) attribute costs for all services related to an episode of patient care to one physician, despite how many different providers actually treated the patient. The MMA alleges that, as a result, lower ranked doctors are defamed because they are portrayed as providing inferior quality of care and failing to

provide cost effective treatment, and patients who have been forced to pay higher copays as a result of choosing to see the lower ranked doctors are defrauded. Additionally, the MMA alleges that Tufts and Unicare do not provide physicians with a fair or meaningful method by which any physician can appeal his or her tier designation.

The MMA's complaint asserts a number of examples of allegedly flawed rankings attributed to the system. For instance, the MMA alleges that one cardiologist discovered that his "cost efficiency rating" calculated by a health plan had been largely based (68%) on his treatment rendered to a population of patients with which he had no direct physician-patient contact; rather, he had only interpreted an echocardiogram or an exercise tolerance test, and, thus had no opportunity to influence the cost of care. Another physician was placed into a lower tier based on her failure to respond to a survey regarding her practice measures. The MMA alleges that even though the physician utilized measures that would entitle her to a Tier 1 score, the survey itself comprised 50% of her quality score, and, thus, her failure to respond resulted in a Tier 2 placement. As of the time of this writing, the case is still pending in Suffolk Superior Court.

B. New York Office of Attorney General Investigation.

In 2007, New York Attorney General Andrew Cuomo announced an investigation of the physician ranking programs of United Healthcare, Aetna, Empire Blue Cross Blue Shield, HIP Health Plans of New York/GHI, and CIGNA. United was the first company contacted by Attorney General Cuomo's office. In its July 2007 letter to United, the Office of Attorney General ("OAG") requested that United refrain from implementing its "Premium Designation" program (the "Program"), stating that the Program had a strong likelihood of creating consumer confusion, if not deception. Specifically, the OAG's letter outlined three primary concerns regarding the Program: (1) consumers may be steered towards doctors based on faulty data and criteria; (2) the doctor-patient relationship could be undermined because consumers may be steered towards physicians based on lower cost rather than quality of care provided; and (3) United's profit motive could affect the accuracy of its quality rankings because high quality physicians may cost United more money. Letter from Linda A. Lacewell, Counsel for Economic and Social Justice, State of New York Office of the Attorney General, to Thomas J. McGuire, Esq., Regional Deputy General Counsel, United Healthcare (July 13, 2007), available at http://www.oag.state.ny.us/media_center/2007/jul/United%20letter.pdf.

By November 2007, the OAG reached settlements with all of the above named managed care organizations ("MCOs").³ Under the settlement agreements,⁴ the MCOs agreed to implement a set of model standards developed by the OAG in conjunction with the American Medical Association, the Medical Society of the State of New York, and other consumer advocacy groups. The model standards focus on accuracy of data, transparency of process and oversight.

³ See Press Release, Office of the Attorney General of the State of New York, Attorney General Cuomo Announces Doctor Ranking Agreement with United Healthcare (Nov. 20, 2007), available at http://www.oag.state.ny.us/media center/2007/nov/nov20b 07.html.

⁴ The settlement agreements are substantially similar, but not identical. For information on specific settlement agreements, see the New York Office of Attorney General's website, at http://www.oag.state.ny.us/.

Under the settlement agreements, MCOs may use both cost efficiency and quality measures; however, such performance measures must be calculated and disclosed separately for public reporting purposes and consumer information. If quality and cost scores are combined for a total score, the individual component scores and their proportion of the total combined score must be disclosed.⁵

Additionally, the settlement agreements require the MCOs to appoint an oversight monitor – the "Ratings Examiner" – to ensure compliance with the agreement and to facilitate collection and presentation of information about the MCO's processes and methodologies for ranking. The Ratings Examiner must be a nationally-recognized standard-setting organization paid for by the MCO and approved by the OAG. In July 2008, the National Committee for Quality Assurance– designated Ratings Examiner for Aetna, CIGNA, and United – launched an internet site to provide details on physician ranking programs. *See* http://nyrxreport.ncqa.org/Overview.aspx.

IV. EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

ERISA Overview. The Employment Retirement Income Security Act of 1974 ("ERISA") is a comprehensive federal statute regulating employee benefit plans including employer-sponsored health insurance. The statute provides (i) requirements relating to participation, funding and vesting of benefits in benefit plans and (ii) uniform standards for reporting, disclosure and fiduciary duties. An ERISA plan is defined to mean a plan, fund or program maintained or established by an employer "for the purpose of providing for its participants or their beneficiaries through the purchase of insurance or otherwise," certain fringe benefits, including "medical, surgical or hospital care or benefits." 29 U.S.C. § 1002. Common ERISA plans include employee pension benefit plans and employee welfare benefit plans (e.g., employer-sponsored health insurance plans, employer-sponsored life and disability insurance plans, and employer-sponsored unemployment or vacation benefits).

<u>ERISA Preemption</u>. ERISA preemption in the context of provider/payor litigation often arises when a payor removes a case filed against it to federal court on the basis of ERSA preemption. ERISA can come into play to the extent the claims at issue involve healthcare services provided to enrollees of ERISA-qualified plans.

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until the appeal is completed.

⁵ In the settlement agreement, the MCOs agreed to (i) increase accuracy by comparing physicians within the same specialty and within the same geographic market and use appropriate risk adjustment to account for characteristics of the physician's patient population (e.g., severity of condition); (ii) increase transparency to consumers by disclosing to consumers where they can find physician performance ratings and explain how physician performance is measured; and (iii) increase transparency to physicians by, no less than forty-five days prior to publishing new or revised evaluations, providing physicians with: (1) the methodology and measures used to assess performance; (2) access to the data utilized in determining their score; and (3) an explanation of the physicians' right to make corrections and appeal. If a physician appeals, the MCO cannot publish the information

A. <u>Complete Preemption</u>.

The basis for removal to federal court under ERISA is referred to by the courts as "complete preemption," (or sometimes as "super preemption") and applies when the plaintiff is seeking relief that is available under 29 U.S.C. § 1132(a). See, e.g., Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1212 (11th Cir. 1999). The party seeking removal must demonstrate three elements: (i) there must be a relevant ERISA plan; (ii) plaintiff must have standing to sue under the plan (e.g. a participant); and (iii) the complaint must seek relief akin to that available under ERISA (see 29 U.S.C. § 1132(a)). Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).

In most cases, a plan or insurer will prefer to have the claims considered as ERISA claims in federal court. For example, as a general rule, plan benefit determinations are reviewed under ERISA pursuant to an "arbitrary and capricious" standard, with a less deferential standard often used where there is a conflict of interest involved (e.g., an administrator with a financial interest in the plan). See McGraw v. Prudential Ins. Co. of Am., 137 F. 3d 1253, 1258 (10th Cir. 1998). See, however, Metropolitan Life Ins. Co. v. Glenn, 128 S. Ct. 2343 (2008), discussed below. There is no right to a jury trial in ERISA cases. See, e.g., Broaddus v. Fla. Power Corp., 145 F.3d 1283, 1287 (11th Cir. 1998).

B. <u>Conflict Preemption</u>.

A second type of preemption exists under ERISA referred to as conflict preemption, also sometimes referred to as "defensive" or "express" preemption. The party seeking removal must demonstrate two elements: (i) there must be a relevant ERISA plan; and (ii) the complaint must raise claims that "relate to" the ERISA plan (see 29 U.S.C. § 1144(a)). In a 2007 conflict preemption case, the Fourth Circuit found that Maryland's Fair Share Health Care Fund Act "relates to" ERISA plans and is, therefore, defensively preempted because it affects how the employers covered by the act structure their ERISA plans. The act required employers with 10,000 or more employees that spend less than 8% of total wages on health insurance to pay the difference to the State of Maryland. See Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007).

Courts have found that independent state law claims of providers brought against third-party payors are not preempted by ERISA. See, e.g., In Home Health, Inc. v. Prudential Ins. Co. of Am., 101 F.3d 600, 606 (8th Cir. 1996); Lordmann Enters., Inc. v. Equicor, Inc., 32 F.3d 1529 (11th Cir. 1994). Preemption, however, may be available where the provider sues as an assignee of the plan beneficiary. See, e.g., Misic v. Bldg. Serv. Employees Health & Welfare Trust, 789 F.2d 1374, 1378 (9th Cir. 1986). The district court for the Southern District of Florida, in In re Managed Care Litigation, 135 F. Supp. 2d 1253 (S.D. Fla. 2001), summarized the rationale of those courts which have declined to extend the preemptive reach of ERISA to independent claims of providers:

⁶ Maryland announced on April 16, 2007 that it would not appeal the Fourth Circuit's ruling. *See* Erin Marie Daly, *Maryland Backs Down In "Wal-Mart Law" Fight*, HEALTH LAW 360, April 18, 2007.

In Lordmann Enterprises, Inc. v. Equicor, Inc., 32 F.3d 1529 (11th Cir. 1994), the Eleventh Circuit agreed with the position of Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990), that 'state law claims brought by health care providers against plan insurers too tenuously affect ERISA plans to be preempted by the act.' Lordmann Enterprises, 32 F. 3d at 1533. In this case, the Provider Plaintiffs assert that they seek to enforce the terms and conditions of their own contracts with the Defendants, rather than assignments from ERISA beneficiaries. Amended Complaint, ¶ 297. See also, Variety Children's Hospital, Inc. v. Blue Cross/Blue Shield, 942 F. Supp. 562, 568 (S.D. Fla. 1996) (claim not preempted where provider plaintiff brought suit in its independent status as a third-party rather than as an assignee of benefits). The Plaintiffs allege that the Defendants engaged in bundling and downcoding, actions which might sustain a breach of contract claim without a need for reference to the interpretation of ERISA plans. The Plaintiffs' state law contract claims therefore do not 'relate to' the ERISA plans, and are not preempted by the Act.

The policy arguments set forth in *Memorial Hospital* and adopted by the Court in *Lordmann Enterprises* elucidate the wisdom of this result. First, preemption of provider contract claims would 'defeat rather than promote' ERISA's goal to 'protect the interests of employees and beneficiaries covered by benefit plans.' *Lordmann Enterprises*, 32 F.3d at 1533. The Court theorized that as a result of preemption, health care providers could no longer rely as freely on the representations of insurers and would therefore act to protect themselves by denying care or raising fees. *Id.* Second, health care providers are not within the scope of ERISA. *Id.* Although employer and employees traded their right to bring a state cause of action in exchange for the benefits of ERISA, the statute does not provide a cause of action for health care providers who treat ERISA participants. In short, preemption of state law claims would leave health care providers with no viable civil remedy. *Id.* at 1533-34.

Id. at 1268.⁷

C. ERISA's Savings Clause.

Some provider/payor disputes may involve provisions or issues that relate to the "regulation of insurance" and thereby fall into the ERISA "savings clause." ERISA's savings clause applies to state laws which "regulate insurance" and are thus saved from ERISA preemption. See 29 U.S.C. § 1144(b)(2)(A). The Supreme Court unanimously affirmed the Sixth Circuit's opinion that ERISA's savings clause saved from preemption Kentucky's "any willing provider" laws relating to the rights of providers to participate on HMO provider panels. Ky Ass'n. of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003).

⁷ Although beyond the scope of this paper, for a recent and more detailed discussion of ERISA preemption with respect to state legislation addressing Medicaid shortfalls and the uninsured, see the March 2007 Member Briefing for the HMO's and Health Plan's Practice Group of the American Health Lawyers Association, entitled State Legislative Approaches to Medicaid Shortfalls and the Growing Number of Uninsured and Underinsured: The Preemption of Maryland's "Fair Share" Legislation Under ERISA, by K. Polvino, J. Burnett, and N. Antia.

D. Recent Cases Finding No ERISA Preemption.

- 1. In Omega Hospital L.L.C. v. Healthnow New York, Inc., No Civ. A. 08-1373, 2008 WL 2038933 (E.D. La. May 19, 2008), the U.S. District Court for the Eastern District of Louisiana held that ERISA does not preempt a hospital's state law claims that it detrimentally relied on a health plan administrator's misrepresentation of the level of coverage for the hospital's treatment of two plan participants. The court remanded the case to state court for further proceedings. Omega Hospital rendered medical treatment to two patients who were covered under HealthNow New York plans. Omega alleged that the health plan paid the hospital's claim for treatment at a lower rate than the plan originally orally quoted. Because the hospital was suing as a third-party healthcare provider, and not as an assignee of the participants, the hospital's detrimental reliance and breach of oral contract claims did not depend on or derive from the participant's rights to recover benefits and thus ERISA preemption was not proper. See also Catholic Healthcare West-Bay Area v. Seafarers Health & Benefits Plan, No. 07-15281, 2008 WL 4951648 (9th Cir. Nov. 18, 2008) (court remanded to state court hospital's claims that the health plan misrepresented the amount of coverage plan participant held under an employersponsor plan and then refused to pay amount as orally agreed for services rendered); Mem'l Hermann Hosp. Sys. v. Coventry Health and Life Ins. Co., No. Civ. H-07-3816, 2008 WL 2714120 (2008) (same); Doctors Med. Ctr of Modesto Inc. v. Principal Mut. Life Ins. Co., E.D. Cal., No. 08-1496 WBS EFB, filed 09/02/08 (same).
- 2. In a similar case before the U.S. District Court for the Eastern District of Louisiana, Omega Hospital L.L.C. v. Aetna Life Insurance Co., No. Civ. A. 08-3712, 2008 WL 2787466 (E.D. La. July 16, 2008), the court held that ERISA did not apply to the hospital's claims that it detrimentally relied on a health plan administrator's oral assurances that it would pay for the hospital's treatment of a plan participant. The court remanded the case to state court for further proceedings. While the health plan argued that the claim was preempted because it could have been brought under Section 502(a) of the Act as an assignee of the plan beneficiary's rights under the plan, the hospital countered that it was suing to enforce its own rights and not those of the beneficiary. The court found immaterial the fact of whether the patient's insurance coverage was pursuant to an ERISA plan and whether the procedures were actually covered under the plan. "When Aetna subsequently denied the claim for the medical care provided, Omega incurred a financial loss which it would not have incurred had it not relied on the oral information/assurances given by Aetna or its agents." Id. at *3. The court also held that the hospital's claim was not preempted under ERISA's conflict preemption provision. See also Omega Hosp., LLC v. Aetna Life Ins. Co., No. Civ.A. 08-3715, 2008 WL 4747864 (E.D. La. Oct. 24, 2008) (remanding to state court the hospital's detrimental reliance claim that health plan would pay for plan patient's services rendered as orally promised); Omega Hosp., LLC v. Aetna Life Ins. Co., Civ. A. No. 08-3717, 2008 WL 4724294 (E.D. La. Oct. 22, 2008) (same); Omega v. Aetna, No. Civ. A. 08-3710, 2008 WL 4747837 (E.D. La. Oct. 22, 2008) (same); Omega Hosp., LLC v. Aetna Life Ins. Co., No. Civ. A. 08-3714, 2008 WL 4091078 (E.D. La. Aug. 27, 2008) (same); Omega Hosp., LLC v. Aetna Life Ins. Co., No. Civ. A. 08-3713, 2008 WL 4059854 (E.D. La. Aug. 25, 2008) (same); Omega Hosp., LLC v. Aetna Life Ins. Co., No. Civ. A. 08-3719, 2008 WL 2945914 (E.D. La. July 28, 2008) (same); St. John's Mercy Health System v. Healthlink, Inc., No. 4:08CV999 RWS, 2008 WL 4204721 (E.D. Mo. Sept. 9, 2008) (hospital

alleged health plan misrepresented that patient was covered under plan and subsequently refused to pay for treatment based on fact patient's COBRA coverage had been terminated).

E. <u>Recent Cases Finding ERISA Preemption</u>.

- 1. In Quality Infusion Care Inc. v. Humana Health Plan of Texas Inc., Nos. 07-20703, 07-20887, 2008 WL 3471861 (5th Cir. 2008), the U.S. Court of Appeals for the Fifth Circuit dismissed a home pharmacy provider's state claims that two ERISA health plans violated the Texas "any willing provider" ("AWP") law by refusing to pay for out-of-network services provided to two plan participants. The Fifth Circuit relied on the complete preemption analysis established by the U.S. Supreme Court in Aetna Health Inc. V. Davila, 542 U.S. 200 (2004), concluding that the pharmacy's claims under the AWP law could have been brought as a claim for benefits under ERISA Section 502(a) and thus were completely preempted by ERISA. Because the claims "not only involve participants and assignments, [but] [] also rely on Plan 'terms and requirements," the court concluded that the pharmacy was making a claim for benefits under the ERISA plans and thus the claims were subject to ERISA preemption. Id. at *9. The Fifth Circuit acknowledged that its decision appeared to be in conflict with the earlier Supreme Court decision in Kentucky Association of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003) (holding that the Kentucky's AWP law, similar to the Texas AWP law, was a law that regulated insurance and thus was saved from preemption under ERISA Section 514). However, the court explained that while the Kentucky Health Plan case focused only on conflict preemption under Section 514, the pharmacy could have brought a claim for benefits under ERISA Section 502(a)(1)(B) as the participants' assignee and thus the complete preemption analysis used by the Court in Davila applied.
- In Alabama Dental Association v. Blue Cross & Blue Shield of Alabama, Inc., No. 205-CV-1230-MEF, 2007 WL 25488 (M.D. Ala. Jan. 3, 2007), the district court found that ERISA preempted out-of-network dentists' state law claims that Blue Cross of Alabama allegedly engaged in improper billing procedures that violated contractual agreements that Blue Cross had made with either the dentists or their individual patients. The Alabama Dental Association along with two individual dentists, one "in-network" and one "out-of-network," filed suit in an Alabama state court alleging that Blue Cross engaged in "down coding," and "bundling" of submitted claims. The Alabama Blue Cross plan removed the case to federal court on the basis that the interpretation of the contracts at issue would implicate matters completely preempted by ERISA; the plaintiffs then filed a motion to remand the case to state court. The district court denied the plaintiffs' motion to remand, finding that Alabama Blue Cross had provided undisputed evidence that most of the dentists' Blue Cross patients received their dental benefits under ERISA plans. The court found that any analysis of Alabama's Blue Cross' actions concerning the dental services provided by the out-of-network dentists would necessarily involve these ERISA-covered plans. Moreover, the court found that ERISA preempted the outof-network dentists' claims because they sought relief similar to that available under ERISA. Although the court concluded that the claims of the in-network dentists were based on their own independent contracts with Alabama Blue Cross and, therefore, not preempted, the court elected to retain jurisdiction over their claims pursuant to the court's supplemental jurisdiction since the claims of both sets of dentists involved the same "facts, occurrences, witnesses and evidence." The court also dismissed the Alabama Dental Association as a plaintiff, finding that the

organization lacked standing as a plaintiff, and also granted Alabama Blue Cross' motion to transfer the case to the Northern District of Alabama where its offices are located.

3. Advance PCS v. Bauer, 632 S.E.2d 95 (Ga. 2006), provides an example of a court finding both complete and conflict preemption. In this case, employee benefit plan participants filed a state law class action against prescription drug providers and pharmacy benefit management companies. The employees alleged they had to pay higher copayments because the defendants misclassified a generic drug as a brand name drug. The court held that the action was: (1) preempted under ERISA § 514(a), ERISA's conflict preemption provision, because the resolution of the plaintiffs' claims "[were] entirely dependent on the language and terms of the plaintiffs' ERISA plans;" and (2) completely preempted because the plaintiffs could have brought an ERISA benefits action under ERISA § 502(a)(1)(B) seeking the difference between the generic co-payment and the brand name drug co-payment. The court further held that the plaintiffs could not avoid this result by suing the plan's pharmacy benefits manager rather than the plan or the plan's fiduciaries.

F. ERISA Conflict of Interest.

In 2008 the Supreme Court issued an important decision addressing the standard of review to be applied when an employee benefit plan administrator operates under a conflict of interest. In *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343 (2008), the Supreme court held that insurers that both fund and administer employee benefit plans operate under a conflict of interest that reviewing courts must consider in determining whether a plan administrator abused its discretion in denying a benefit claim. Because the Court provided only a loose framework for evaluating an ERISA plan administrator's conflict of interest, it is unclear how the *Metropolitan Life* decision will affect the standard of review in future ERISA denial of benefits cases. However, the Court's decision indicates that employers and insurers should proactively reduce plan administrators' conflicts of interest and establish internal firewalls and internal controls to promote claims-processing accuracy.

The *Metropolitan Life* decision involved an insurance company's denial of disability benefits for a Sears employee with a heart condition. The insurance company served as an administrator and the insurer of Sears' long-term disability plan. The insurance company initially approved short-term disability benefits for the employee based on opinions from several doctors that the employee was incapable of performing any kind of work. The employee also applied for and was approved to receive Social Security disability insurance, with the Administration finding her totally unable to work. At the end of the employee's short-term disability coverage period, Metropolitan re-examined her eligibility status to receive long-term disability payments. Despite the prior physicians' opinions and the Social Security Administration decision, Metropolitan concluded that the employee was able to physically perform sedentary work and thus rejected the employee's claim for long-term disability. The employee then filed suit against both Sears and Metropolitan under §1132(a)(1)(B) of ERISA, seeking judicial review.

The District Court upheld the claims denial. The court relied on the Supreme Court's decision in *Firestone Tire & Rubber Co. & Bruch*, 489 U.S. 101 (1989), that courts must defer to

claims decisions by fiduciaries possessing interpretive discretion over plan terms unless such decisions are found to be arbitrary and capricious. On appeal, the Sixth Circuit reversed, also relying in part on the *Firestone* decision, stating that the presence of a conflict of interest is one factor a court can consider in determining whether to defer to fiduciary's claims decision. The Supreme Court affirmed the decision of the Sixth Circuit finding that (i) the conflict of interest was properly weighed as one factor, among many, in determining whether there was an abuse of discretion and (ii) that the deferential standard of review was appropriate. However, the Court held that the presence of an administrator's conflict of interest does not automatically convert the standard of review from one of deference to that of increased scrutiny (i.e., de novo review).

The Court defined when a conflict arises (i.e., when the claims decision maker has an interest at odds with the interest of plan beneficiaries). The Court indicated that there may be circumstances that diminish the significance or severity of the conflict of interest in certain cases. For example, the significance of the conflict would be diminished if the insurance company has screened claims administrators from those involved in the company finances or imposed management checks that punish inaccurate decision making. However, if the facts show an insurer's history of biased claims administration or other circumstances that indicate that the conflict of interest affected the benefits decision, then the existence of a conflict of interest should be more heavily weighed.

V. ARBITRATION

Arbitration, along with other forms of alternative dispute resolution ("ADR"), plays a prominent role in managed care litigation. Payor contracts typically include arbitration clauses, and litigation often arises regarding the enforceability of such clauses. Summarized below are notable arbitration decisions from 2008, including a United States Supreme Court opinion regarding the ability of parties to supplement standards set forth in the Federal Arbitration Act, as well as several California decisions discussing compliance with arbitration disclosure language requirements.

A. Supreme Court Case.

1. In *Hall Street Associates, L.L.C. v. Mattel, Inc.*, 128 S. Ct. 1396 (2008), the Supreme Court considered whether parties seeking review of arbitration awards under the Federal Arbitration Act ("FAA") could modify the standard of judicial review. The FAA provides for expedited review to confirm, modify, or vacate arbitration awards and sets forth specific standards for doing so. Under § 9 of the FAA, a court must confirm an arbitration award unless it is vacated pursuant to grounds specified in § 10, or modified pursuant to grounds specified in § 11. The parties in *Mattel* attempted to supplement those enumerated grounds by contract, and the Supreme Court found it was improper to do so, holding that the statutory grounds enumerated in the FAA provide the exclusive grounds for modification or vacation of arbitration awards under the FAA. Accordingly, parties cannot supplement the FAA's modification and vacation grounds by mutual agreement.

B. <u>California Cases</u>.

Recent litigation in California highlights the importance of compliance with arbitration clause statutory requirements. California Health and Safety Code § 1363.1 provides that a health care service plan requiring its members to agree to settle disputes via binding arbitration must comply with specific disclosure requirements. Under the Code, the arbitration disclosure must: (1) clearly state that the plan uses binding arbitration for dispute settlement and specify whether binding arbitration applies to medical malpractice claims; (2) appear in a separate article of the application and be prominently displayed on the enrollment form; (3) clearly state whether the enrollee is waiving his or her right to a jury trial; and (4) be displayed immediately before the signature line. Cal. Health & Safety § 1363.1 (West 2008). The California Court of Appeals has held that failure to comply with § 1363.1 renders an arbitration clause unenforceable. *See Malek v. Blue Cross of Cal.*, 16 Cal. Rptr. 3d 687, 692 (Cal. Ca. App. 2004) ("A violation of section 1363.1 renders a contractually binding arbitration provision in a health service plan enrollment form unenforceable.").

1. In *Burks v. Kaiser Foundation Health Plan, Inc.*, 73 Cal. Rptr. 3d 257 (Cal. Ct. App. 2008), the California Court of Appeals held a plan's binding arbitration clause unenforceable for failure to comply with § 1363.1, and, thus, refused to force an enrollee to arbitrate his medical malpractice claim against the plan. According to the Court, the plan's arbitration disclosure failed to meet § 1363.1's prominence requirements because its disclosure language: (1) was printed in the same or smaller typeface as the remainder of the enrollment form; (2) was not bolded, italicized, or highlighted; and (3) was not placed under a separate heading.

Although the Court acknowledged that § 1363.1 does not dictate any particular means for complying with the prominence requirement, it dismissed the plan's argument that placement above the signature line satisfies the prominence requirement. Instead, the Court explained that placement and prominence are two separate requirements, and a health plan "must be able to point to something other than the placement of the disclosure above the signature line that makes it stand out from its surroundings, such that it could reasonably be expected to command the attention of the person filling out the form." *Id.* at 262. The Court also rejected the plan's substantial compliance argument, explaining that "a health plan's failure to prominently display the arbitration disclosure on its enrollment form can never be deemed a mere technical imperfection...[t]he essential purpose of section 1363.1 is to ensure the knowing waiver of the jury trial right by the health plan enrollee." *Id.*

2. In *Rodriguez v. Blue Cross of California*, 75 Cal. Rptr. 3d 754 (Cal. Ct. App. 2008), the California Court of Appeals upheld the trial court's denial of Blue Cross of California's petition to compel arbitration and allowed a class action lawsuit against Blue Cross of California ("Blue Cross") to proceed. Plaintiff Rodriguez and his wife, both Spanish speakers, applied for Blue Cross coverage in response to an advertisement on Spanish language television. After calling the phone number and speaking with a representative in Spanish, Mr. and Mrs. Rodriguez received completed Blue Cross applications, written in English, which they signed and returned to Blue Cross. Subsequently, Mr. Rodriguez was hospitalized, resulting in over \$100,000 of medical bills. Blue Cross rescinded Rodriguez's coverage claiming that he omitted material facts from his application.

As a result, Rodriguez filed a class action suit against Blue Cross on behalf of himself and others similarly situated alleging, *inter alia*, violation of the unfair competition law and breach of contract. Blue Cross petitioned to compel arbitration based on the arbitration clause in its contract with Rodriguez, and Rodriguez countered that the arbitration clause was unenforceable for failure to comply with § 1363.1. The trial court found in favor of Rodriguez and stated that the Blue Cross arbitration language was not prominently displayed and found that the clause limited its language to medical malpractice issues – an issue not raised by Rodriguez.

The Court of Appeals recognized that parts of Blue Cross's arbitration language had prominence features, noting that the language was set off in a separate paragraph and that much of the text was bolded and in uppercase. The Court, however, found Blue Cross's language problematic. The bolded portion of the statement was limited to "any dispute as to medical malpractice" as was the statement immediately above the signature line. Only the first sentence of the arbitration disclosure, in normal sentence case and plain text, contained broad enough language to encompass the Rodriguez suit: "Please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice." *Id.* at 761. Considering that sentence in isolation, the Court found that it did not satisfy the § 1363.1 requirements and therefore could not be enforced.

Additionally, the disclosure did not clearly state whether Rodriguez was waiving his right to a jury trial for medical malpractice claims, all claims, or both against Blue Cross. The "confusion as to the extent of Rodriguez's waiver undermines the fundamental purpose of the statute – to ensure a knowing waiver of the right to a jury trial." *Id.* at 762. Accordingly, the Court of Appeals held Blue Cross's arbitration clause unenforceable for failure to comply with § 1363.1.

3. In Moreno v. Kaiser Foundation Health Plan, Inc., No. B196789, 2008 WL 2222947 (Cal. Ct. App. May 30, 2008) (unpublished/noncitable) (Cal. Rules of Court, Rules 8.1105 and 8.1110, 8.1115), the California Court of Appeals upheld an arbitration award in favor of a health plan in a wrongful life action brought against it. The plan's contract included a binding arbitration clause, and, as such, the parties submitted their dispute to binding arbitration. The arbitrator issued an award in favor of the plan on the wrongful life claim and Plaintiffs petitioned the trial court to vacate the arbitration award. In their oral argument to vacate, Plaintiffs, for the first time, contested the validity of the arbitration clause for failure to comply with § 1363.1.

The trial court denied Plaintiffs' petition and the Court of Appeals affirmed. Unlike the courts in *Burks* and *Rodriguez*, the *Moreno* court did not analyze whether the plan failed to comply with § 1363.1; rather, it declined to consider § 1363.1 compliance because Plaintiffs failed to timely raise the issue. The Court acknowledged precedent cases holding arbitration clauses unenforceable for failure to comply with § 1363.1; however, the Court noted that the plaintiffs in those cases raised the validity issue before the arbitrator. Accordingly, the Court held that the Plaintiffs' failure to raise their validity claim before the arbitrator constituted a waiver of that claim.

VI. POST-CLAIMS UNDERWRITING -- RESCISSION OF HEALTH INSURANCE CONTRACTS

"Post-claims underwriting" generally refers to the practice whereby an insurer reexamines policy coverage after a claim has been filed by an insured and either dramatically changes or revokes the insured's policy. Post-claims underwriting has received much attention in California, as it has been the subject of recent litigation, settlements, and legislation.

A. Recent Litigation.

In California, the post-claims underwriting discussion has centered on what is required during the pre-contract medical underwriting process. Generally, the medical underwriting process involves an applicant's disclosure of health history on an application form. Insurers use the disclosed information to assess risk and determine coverage. If an insurer issues coverage and later learns that an enrollee misrepresented information on his application, the general rule is that the insurer may retroactively rescind the contract. If, however, the information obtained in the underwriting process provided reason to suspect the accuracy of the information, then the insurer may not rely on the information and must independently investigate the issues.

This second part to the general rule -- that insurers need not independently investigate applicant information unless the accuracy of the information provided is suspect -- has recently been called into question. California Health & Safety Code § 1389.3 prohibits an insurer from engaging in post-claims underwriting, which is defined as "the rescinding, canceling, or limiting of a plan contract due to the plan's failure *to complete medical underwriting* and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract." Cal. Health & Safety § 1389.3 (West 2008) (emphasis added). Recent case law has changed the understanding of what health care service plans must do "to complete medical underwriting," and, thus, not engage in prohibited post-claims underwriting by subsequently rescinding coverage.

1. In *Hailey v. California Physicians' Service*, 69 Cal. Rptr. 3d 789 (Cal. Ct. App. 2007), plaintiffs Steve and Cindy Hailey sued California Physicians' Service d/b/a Blue Shield of California, alleging that Blue Shield engaged in post-claims underwriting, a practice prohibited by § 1389.3. Blue Shield cancelled the Haileys' coverage after an underwriting investigation revealed that Steve Hailey's medical history had not been disclosed on the enrollment application. Ms. Hailey completed the application for herself, her husband and their son, and neglected to include any information regarding her husband's medical history because she believed that the application questions only applied to her. Subsequently, Mr. Hailey was hospitalized for a stomach condition which prompted Blue Shield to initiate an investigation, and, subsequently rescind the Haileys' coverage for failure to disclose Mr. Hailey's history of health issues.

Blue Shield moved for summary judgment, arguing that it legally rescinded the Haileys' contract based on the Haileys' misrepresentations and omissions. The trial court granted Blue Shield's summary judgment motion, finding that Blue Shield was justified in rescinding the contract. The Court of Appeals reversed, holding that under § 1389.3, to lawfully rescind a contract, a California health care service plan must show a willful misrepresentation or omission,

or that it made reasonable efforts to ensure the accuracy of a subscriber's enrollment application as part of the medical underwriting process prior to issuing coverage. According to the court, triable issues of fact existed on both points, and, thus, summary judgment was improper.

Perhaps most significant to health care plans is the *Hailey* Court's interpretation of the phrase "to complete medical underwriting." (*see* Cal. Health & Safety § 1389.3 defining post claims underwriting). Blue Shield argued that the phrase "to complete medical underwriting" requires resolution of any questions that arise from the answers given by the applicant. The Court concluded that in order to complete medical writing within the meaning of § 1389.3, a plan has a duty to take steps to ensure accuracy and completeness of information even when there is no indication that the information submitted is problematic. If such steps are not taken, then a plan will not have completed medical underwriting, and, consequently, will not be able later to rescind coverage.

Unfortunately, the *Hailey* court provided little guidance as to what would be considered "reasonable steps" to ensure accuracy and completeness, stating that "[b]ecause the circumstances of each case vary, we do not precisely spell out what steps constitute a reasonable investigation. This will usually present a question of fact." *Id.* at 802. Thus, the *Hailey* decision has generated uncertainty about the level of investigation required in California during medical underwriting to preserve a plan's right to rescind upon later discovery of alleged misrepresentations. At a minimum, however, the *Hailey* decision increases the burden on California plans to investigate during the enrollment process in order to preserve the ability to rescind a member's coverage.

For further discussion, see Gregory N. Pimstone, *The Rescission of Health Insurance Contracts: A Case Study*, American Health Lawyers Association, HMOs & Health Plans, June 2008.

2. Callil v. California Physicians' Serv., No. B203085, 2008 WL 5050431 (Cal. Ct. App. Nov. 18, 2008) (unpublished/noncitable (Cal. Rules of Court, Rules 8.1105 and 8.1110, 8.1115). In November, the California Court of Appeals applied Hailey's medical underwriting standard to the case of Callil v. California Physicians' Service and reversed a trial court's grant of summary judgment to Blue Shield. In Callil, Blue Shield rescinded coverage of Plaintiff Callil after it discovered she had an undisclosed history of uterine fibroids, among other issues. According to Blue Shield's underwriting guidelines, it would not have issued the policy had Callil disclosed her medical history. After Blue Shield's Appeals and Grievance Department denied Callil's appeal of its rescission decision, Callil filed suit alleging Blue Shield engaged in post-claims underwriting prohibited by § 1389.3. Blue Shield moved for summary judgment, arguing that § 1389.3 did not apply because Callil's application information did not raise any reasonable questions warranting investigation. The trial court agreed, and granted Blue Shield's motion for summary judgment.

After Callil filed her notice of appeal, the California Court of Appeals decided *Hailey*. Accordingly, on appeal, Callil argued that Blue Shield's argument failed to support a grant of summary judgment because *Hailey* requires a plan to make reasonable efforts to investigate an applicant's information regardless of whether it raises questions. The Court of Appeals agreed and reversed summary judgment.

B. Settlements.

In April 2008, the California Department of Managed Health Care (the "DMHC"), the state agency responsible for enforcing the laws that govern health care service plans in California, announced its plan to review all health care insurance rescissions that had taken place since 2004. As a result of its review, DMHC reached settlements with the five largest health plans offering individual coverage to Californians to resolve allegations of improper rescission or cancellation of health care contracts.

- 1. Kaiser Foundation Health Plan, Inc. In May 2008, DMHC and a health plan entered into a Settlement Agreement (the "Agreement") to resolve the plan's alleged violations of § 1389.3. According to the DMHC, the plan improperly rescinded the membership agreements of 1,092 enrollees between January 2004 and December 2006. Under the Agreement, the plan agreed to pay a \$300,000 fine and an additional fine of up to \$3 million if it fails to develop and implement a corrective action plan within an eighteen month timeframe. Additionally, the plan voluntarily agreed to: (1) not rescind any membership agreements entered on or before May 15, 2008; (2) offer enrollees whose membership agreements were rescinded between January 1, 2004 and May 15, 2008, the option to purchase coverage without the need for medical underwriting; (3) forgive or refund medical charges incurred during the time of coverage; and (4) allow former plan members to pursue any available legal actions or remedies. For a copy of the Agreement, see http://www.hmohelp.ca.gov/aboutthedmhc/gen/ann/genannlandmark.aspx.
- 2. HealthNet of California, Inc. ("HealthNet") entered into a similar Settlement Agreement (the "HealthNet Agreement") to resolve HealthNet's alleged violations of § 1389.3. Under the HealthNet Agreement, HealthNet agreed to offer healthcare coverage to eighty-five former enrollees whose coverage was rescinded between January 2004 and November 2007, and pay a \$300,000 fine. HealthNet could also be fined up to \$3 million if it fails to develop and implement a corrective action plan. For a copy of the HealthNet Agreement, see http://www.hmohelp.ca.gov/aboutthedmhc/gen/ann/gen_ann_landmark.aspx.
- 3. PacifiCare of California. In June 2008, PacifiCare of California ("PacifiCare") became the third major health plan to enter into a Settlement Agreement (the "PacifiCare Agreement") with the DMHC. The PacifiCare Agreement is similar to the prior agreements discussed above: PacifiCare must restore or offer to restore coverage to approximately sixty-four individuals whose policies it cancelled in the past several years, and it must reimburse past medical claims. The PacifiCare Agreement is different, however, in that PacifiCare's fines are significantly less than the others: \$50,000 up front and up to \$500,000 if PacifiCare fails to complete and implement its corrective action plan. The reason for the lower fine may be explained by the fact that the DMHC recognized that, unlike the other plans, PacifiCare cancelled contracts on a prospective basis when it suspected fraud rather than choosing to rescind

⁸ Announcement, California Department of Managed Health Care, *DMHC Reinstates Coverage for Consumers Wrongfully Rescinded by Health Plans* (April 17, 2008), *available at* http://www.hmohelp.ca.gov/library/reports/news/prrescissionreinstatement.pdf.

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the contracts. For a copy of the PacifiCare Agreement, see http://www.dmhc.ca.gov/library/enforcements/noteworthy/28147.pdf.

4. Blue Shield of California and Anthem Blue Cross. The DMHC entered into its fourth and fifth settlements with Blue Shield of California ("Blue Shield") (07/18/2008) and Anthem Blue Cross (07/22/2008). Blue Shield allegedly improperly rescinded coverage of 450 enrollees while Anthem Blue Cross rescinded coverage of 1,770 enrollees. Each of the two settlements is similar to the previous settlements discussed above. The fines, however, are much more severe. Blue Shield agreed to pay an immediate \$3 million fine and potentially an additional \$2 million if it failed to complete and implement its corrective action plan. Anthem Blue Cross's fine was even greater: an immediate \$10 million fine and an additional fine "proportional to the identified deficiencies" if Anthem Blue Cross fails to complete and implement a corrective action plan.

In a released statement, DMHC Director Cindy Ehnes explained that the magnitude of Blue Shield's fine was necessary because by not settling with the DMHC two months earlier it caused unnecessary delay in restoring coverage to members, leaving them in limbo. With respect to the Anthem Blue Cross fine, Director Ehnes stated that the "fine is a record amount and sends the message that if you come into California to sell health insurance, you must play by the rules." Announcement, California Department of Managed Health Care, DMHC Director Ehnes Issues Statement Regarding Settlement With Anthem Blue Cross to Offer Coverage to 1770 Rescinded Members *Formerly* (July 17, 2008), available http://dmhc.ca.gov/library/reports/news/bcstatment.pdf.

C. <u>Legislation</u>.

On December 1, 2008, California Assembly member Hector De La Torre introduced legislation that would outline specific requirements for medical underwriting. Among other things, Assembly Bill 2 ("A.B. 2") would require plans and insurers to: (1) complete medical underwriting prior to issuing coverage; (2) develop and implement written underwriting policies and file those policies with state regulators; (3) submit any planned rescission actions to the appropriate agency for approval before they could rescind coverage; and (4) notify consumers about an initiated investigation that could result in rescinded coverage. A.B. 2 comes approximately two months after Governor Arnold Schwarzenegger vetoed A.B. 1945, a similar bill designed to limit rescissions. At the time of this writing, the action history for A.B. 2 states that it may be heard in committee on January 1, 2009. For the text of A.B. 2, see http://info.sen.ca.gov/pub/09-10/bill/asm/ab_0001-0050/ab_2_bill_20081201_introduced.pdf.

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⁹ For a copy of the Blue Shield Agreement, *see* http://www.hmohelp.ca.gov/library/enforcements/noteworthy/28760.pdf. For a copy of the Anthem Blue Cross Agreement, *see* http://www.hmohelp.ca.gov/library/enforcements/noteworthy/28787.pdf.

VII. PHARMACY BENEFIT MANAGERS

A. <u>Breach of Fiduciary Duty.</u>

Several cases have been brought against pharmacy benefit managers ("PBMs") alleging that the PBMs are fiduciaries under ERISA and have breached their fiduciary duties. The allegations in most cases are that the PBMs are receiving discounts and rebates from drug manufacturers without disclosing or passing along those amounts. Results have generally been in favor of the PBMs.

In Chicago District Council of Carpenters Welfare Fund v. Caremark, Inc., 474 F.3d 463 (7th Cir. 2007), a multi-employer health fund alleged that the PBM breached fiduciary duties by charging the fund higher drug prices than the PBM itself paid and by failing to pass on to the fund the full amount of rebates and discounts. The Seventh Circuit, however, found that the PBM was not an ERISA fiduciary and the multi-employer health fund's claims were unsuccessful.

In *Mulder v. PCS Health Systems, Inc.*, 432 F. Supp. 2d 450 (D.N.J. 2006), the court held that the PBM was not an ERISA fiduciary and thus did not breach its fiduciary duties under ERISA. The plaintiff, an individual who participated in an employer-sponsored plan administered by an HMO that contracted with the PBM, alleged that the PBM breached fiduciary duties by not passing on rebates and discounts to the plan participants that the PBM had negotiated with drug manufacturers. The court found that the PBM's actions did not constitute fiduciary functions.

In Glanton ex rel. ALCOA Prescription Drug Plan v. AdvancePCS, Inc., 465 F.3d 1123 (9th Cir. 2006), cert. denied, 128 S. Ct. 126 (2007), two participants in employer-sponsored prescription drug plans sued the PBM for breaching its alleged ERISA fiduciary duties by retaining the difference between what the PBM was charging health plans and what it was paying suppliers. Although the Ninth Circuit found that the PBM did qualify as an ERISA fiduciary, the plaintiffs were nonetheless unsuccessful. The court held that the plaintiffs lacked standing to bring a lawsuit as representatives of their plans and that the plaintiffs failed to prove that a favorable outcome in the litigation would likely redress their alleged injuries of higher copayments and contributions.

Individual plan beneficiaries and trustees brought class actions against PBM Merck-Medco Managed Care, L.L.C., Merck & Co., Inc. and Medco Health Solutions ("Medco") for alleged breach of fiduciary duties to employee plans under ERISA, resulting in a \$42.5 million settlement. The Southern District of New York approved the settlement. The Second Circuit in Central States Southeast & Southwest Areas Health & Welfare Fund v. Merck-Medco Managed Care, L.L.C., 433 F.3d 181 (2nd Cir. 2005), however, vacated the settlement approval, questioning whether the plaintiffs had suffered any injury sufficient for Constitutional standing and remanding the case to the district court for consideration of the plaintiffs' standing.

In re Express Scripts, Inc. Pharmacy Benefits Management Litigation, MDL No. 1672, 2006 WL 2632328 (E.D. Mo. Sept. 13, 2006) involved a fund trustee filing a lawsuit against a

PBM and its parent company alleging they secretly entered into deals with drug manufacturers to increase their profits and then failed to disclose that compensation. The court found that the parent entity could not be held liable for any allegedly fraudulent behavior of the PBM before it purchased the PBM; however, after its acquisition, the parent could be held liable under agency law for the actions of its subsidiary PBM.

In a subsequent *In re Express Scripts* member case, the court found that a labor union could proceed with a breach of fiduciary duty claim against the PBM. *In re Express Scripts, Inc. PBM Litig.*, 522 F. Supp. 2d 1132 (E.D. Mo. 2007). In that case, a municipal employee labor union brought a class action suit against the PBM for allegedly inflating prescription drug prices and failing to disclose receipt of drug rebates. The court found that the labor union successfully pleaded the existence of a fiduciary relationship because it alleged that the parties had unequal bargaining positions in negotiating their agreement and that the PBM had access to information regarding drug prices, rebates, and discounts that it refused to disclose to the labor union. Moreover, the court found that the parties' relationship exceeded the scope of their contract because although the contract specified the covered drugs and cost-determination methods, the amounts paid by the PBM and received from providers depended on the ability, success, and full disclosure of the PBM's negotiations to the labor union. *See also In re Express Scripts, Inc. PBM Litig.*, No. 4:05-MD-01672, 2008 WL 2952787, at *13 (E.D. Mo. July 30, 2008) (finding PBM a fiduciary because it exercised discretion in classifying and distributing "savings" from its generic preference program that it owed to the plan).

In *Bickley v. Caremark RX, Inc.*, 461 F.3d 1325 (11th Cir. 2006), a participant of an ERISA employee benefits plan filed a class action lawsuit against the plan's PBM alleging breach of fiduciary duties. The plaintiff alleged that the PBM was a fiduciary of the plan because it managed the prescription drug benefits, and allegedly breached fiduciary duties by not disclosing additional rebates or other discounts that it was receiving from drug manufacturers. The Eleventh Circuit affirmed the dismissal of the lawsuit on the ground that the plaintiff had not exhausted its administrative remedies.

In *Moeckel v. Caremark, Inc.*, No. 3:04-0633, 2007 WL 3377831 (M.D. Tenn. Nov. 13, 2007), a participant of an employee benefits plan brought suit against the plan's PBM alleging, *inter alia*, that the PBM breached its fiduciary duties by failing to disclose to the plans the discounted price it paid for drugs purchased by plan participants and beneficiaries at retail pharmacies. As a result, the participant alleged that the PBM concealed from the plans the fact that it exercised discretion to create a "spread" between the discounted price the PBM paid retail pharmacies and the plan contract's reimbursement price, which it retained. Further, the participant alleged that the PBM contracted with drug manufacturers in ways that enriched the PBM and engaged in self-dealing by characterizing compensation in ways that would maximize its own profit to the plan's detriment. The court dismissed the plaintiff's claims alleging breach of fiduciary duty because it found that the alleged improper activities related to the basic administration of the PBM's own business, which is non-fiduciary in nature, and, thus, outside the scope of ERISA.

B. Class Action.

In June 2008 a federal district court in Alabama certified a class of drug stores suing an insurer and PBM for alleged underpayments. *Eufala Drugs, Inc. v. TDI Managed Care Servs.*, 250 F.R.D. 670 (M.D. Ala. 2008). The Named Plaintiffs are two pharmacies that allege breach of contract claims against Defendants TDI Managed Care Services Inc. (TDI) and Eckerd Health Services (EHS) (a PBM) for failure to properly reimburse pharmacies for dispensed drugs. More specifically, the Named Plaintiffs claim that the contract language "current average wholesale price" requires Defendants to use daily, rather than weekly, updates to the average wholesale price ("AWP") which was part of the contract's reimbursement formula. As a result of using weekly AWP updates, approximately 10,000 network pharmacies allegedly lost \$16.1 million in reimbursements.

The Court certified the class under FRCP 23(b)(3). With respect to the typicality requirement, the Court noted that although the Named Plaintiffs did not contract directly with Defendants, the Named Plaintiffs shared the same "essential characteristics" with independent retail pharmacies who did directly contract with Defendants, because the Named Plaintiffs were reimbursed "according to the same basic formula, pursuant to contracts containing the same definition of AWP." Id. at 676. With respect to the adequacy requirement, the Court dismissed several arguments by Defendants, including an argument that Named Plaintiffs' lower potential damage award compared to that of larger retail pharmacy class members gave them less incentive to represent the class, and, thus, made them inadequate representatives. In rejecting that argument, the Court noted that "the fact that named representatives have a small stake in the litigation does not make them inadequate" and that "[i]f the existence of a few putative class members with relatively large damages was a justification for denying certification of a class, then there would be no mechanism for the individuals with relatively small damages to vindicate their rights." *Id.* at 678. Lastly, the Court rejected Defendants' argument that the class members would have to individually prove the issue of breach or waiver of breach, noting that if the Court accepted that argument then "there would be virtually no circumstance in which a breach of contract dispute would be susceptible to a class action." *Id.* at 680.

C. Drug-Switching Settlements.

In 2008, two PBMs entered into settlement agreements to resolve allegations that the PBMs engaged in "drug switching" -- a process whereby a PBM contacts a patient's physician without the patient's knowledge and replaces the prescribed drug with a different brand medication. Washington v. Caremark Rx LLC, No. 08-2-06098-5 (Wash. Sup. Ct. Feb. 14, 2008); Washington v. Express Scripts, Inc., No. 08-2-01255-4 (Wash. Sup. Ct. May 28, 2008); New York v. Express Scripts Inc., No. 4669-04 (N.Y. Sup. Ct. July 29, 2008). Both PBMs entered into settlements with 28 states 10 and the District of Columbia for allegedly encouraging physicians to switch patients to different brand name drugs so that the PBMs could collect manufacturers' rebates.

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¹⁰ The states are: Arizona, Arkansas, California, Connecticut, Delaware, DC, Florida, Illinois, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia and Washington.

In addition to settlement payments totaling in excess of \$75 million, under the settlement agreements, the PBMs agreed to implement certain measures that will allegedly increase consumer protection and transparency. To increase consumer protection, the PBMs must provide notice to consumers of any PBM-initiated drug switches and must provide consumers with notice of their right to choose to refuse a drug switch and continue taking their regularly prescribed medication. Further, the settlements prohibit the PBMs from switching a prescription if: (1) the cost of the new drug is higher than the current drug's cost, (2) the current drug's patent will expire within six months; (3) a generic equivalent is available for the current drug but not for the new drug; or (4) if the prescription already has been switched in the past two years. To increase transparency, the PBMs agreed to disclose: (1) pricing methods, (2) the amount of payment received from drug manufacturers, and (3) the percentage of manufacturer payments retained.

VIII. COVERAGE ISSUES

A. Eating Disorders.

Both Aetna and Horizon Blue Cross Blue Shield of New Jersey ("Horizon") settled class action lawsuits challenging the insurers' denial of claims for reimbursement of medical expenses associated with treatment of eating disorders. DeVito v. Aetna, Inc., 536 F. Supp. 2d 523 (D.N.J. 2008); Drazin v. Horizon Blue Cross Blue Shield of New Jersey, No. 06-cv-6219 (D.N.J. Nov. 24, 2008) (proposed settlement); Beye v. Horizon Blue Cross Blue Shield of New Jersey, No. 06-cv-5337 (D.N.J. Nov. 24, 2008) (proposed settlement). Plaintiffs filed the suits over alleged improper denials of coverage for lack of medical necessity or alleged improper coverage restrictions. Both insurers categorized eating disorders as "non-biologically based" mental illnesses, and, thus, imposed stricter benefit limits than if the insurers classified the disorders as biologically-based. Without admitting any liability or wrongdoing, Aetna agreed to pay approximately \$250,000 to an estimated 100 New Jersey plan members while Horizon agreed to pay approximately \$1.18 million to cover claims by approximately 500 members. Both insurers also agreed to pay attorneys' fees - Aetna will pay up to \$350,000 to plaintiffs' counsel plus an additional \$10,000 to each lead plaintiff, while Horizon will pay up to \$2.45 million to plaintiffs' counsel and an additional \$20,000 to each lead plaintiff.

Under the settlements, both insurers will treat claims related to the diagnosis and treatment of eating disorders the same as those of biologically based illnesses. The parity treatment will apply on a prospective basis for fully-insured plan members. Both insurers will also provide an eating disorder specialist to review denial of coverage decisions rather than sending such decisions to an independent utilization review board for review.

The Aetna settlement, however, is more limited in coverage. First, the settlement includes in the definition of the class only those members who actually submitted claims for treatment prior to August 31, 2008, and who were denied coverage or received limited benefits because of Aetna's restrictions for non-biologically based illnesses. This limitation of the class to members who actually filed claims excludes those members who incurred expenses but did not file claims because they believed such claims to be futile. Second, the settlement limits

future parity coverage to current Aetna policyholders. Thus, future policyholders would face the same coverage limitations that instigated the suit. The Horizon settlement, on the other hand, includes both members who submitted claims and members who did not submit claims. Horizon will determine for each class member the amount of claims it denied or limited due to coverage restrictions. Additionally, Horizon will pay class members for verifiable expenses not submitted as claims.

B. Obesity.

1. Arbitrary and Capricious Standard of Review.

Several recent cases in Ohio involve judicial review of denial of benefits under an arbitrary and capricious standard. This standard of review requires a court to uphold a benefit determination if it is rational in light of the plan's provisions, even if the plan's participants offer an alternative equally rational interpretation. *See Gismondi v. United Techs. Corp.*, 408 F.3d 295, 298 (6th Cir. 2005); *Sowers v. Sun Healthcare Group, Inc.*, No. 2:06-CV-230, 2008 WL 3285752 (S.D. Ohio Aug. 8, 2008).

In Smith v. Medical Mutual of Ohio, Inc., No. 2:06-CV-941, 2008 WL 780613 (S.D. Ohio Mar. 24, 2008), the district court found that Defendant did not arbitrarily deny Plaintiff's precertification request for an abdominoplasty (a procedure to remove excess skin as a result of significant weight loss following gastric bypass). Plaintiff's plan covered medically necessary surgery but specifically excluded "Surgery following weight loss...except as specified." Id. at *6. Defendant's Corporate Medical Policy ("CMP") specified that three specific criteria must be met in order for an abdominoplasty to be deemed medically necessary: (1) photographs must demonstrate that skin extends to specific areas; (2) the medical record documents chronic skin inflammation or ulcer that consistently recurs over a six month period; and (3) the excess skin must interfere with the activities of daily living. Defendant's reviewing physician determined that Plaintiff failed to meet all three of the CMP criterion, and, thus, denied her request for precertification. Consequently, Plaintiff filed suit alleging that Defendant's denial was arbitrary and capricious. Defendant argued that its reliance on its CMP was a rational basis for denial, and the Court agreed. The Court noted that it was not its job to determine "what the appropriate criteria may be so long as the decision made is rational in light of the plan provisions." Id. at *8.

In Sowers v. Sun Healthcare Group, Inc., No. 2:06-CV-230, 2008 WL 3285752 (S.D. Ohio Aug. 8, 2008), the U.S. District Court for the Southern District of Ohio found that Defendant's denial of Plaintiff's appeal was arbitrary and capricious. Plaintiff sought preapproval through her general practitioner for coverage of gastric bypass surgery to treat her morbid obesity. CIGNA, the claims administrator for Defendant Sun Healthcare, denied Plaintiff's request for lack of medical necessity. CIGNA's denial letter explained that, to be medically necessary, Plaintiff must: (1) have a Body Mass Index (BMI): (a) greater than forty for at least one year or (b) between 35-40 if certain clinical documentation is included; (2) provide medical record documentation of participation in two professionally supervised weight loss programs for a minimum of six months each; and (3) undergo psychiatric evaluation to be

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¹¹ Note that although CIGNA was the Plan's claims administrator, Sun Healthcare was responsible for benefit decisions.

cleared for surgery. In response, Plaintiff's physician provided CIGNA with the information required to prove medical necessity; however, CIGNA again denied Plaintiff's claim.

Subsequently, Plaintiff sued Sun Healthcare, alleging arbitrary and capricious denial of her request for pre-approval. The Court found that by denying Plaintiff's appeal, Defendant acted in an arbitrary and capricious manner, inconsistent with the express terms of the Plan and without rational explanation. Although Plaintiff did provide evidence of her BMI, participation in supervised weight loss programs, and psychiatric evaluation, Defendant denied Plaintiff's appeal for failure to provide such information. The Court stated that such "ignorance or disregard" of Plaintiff's supplied information was "inexcusable and unreasonable in light of the Plan's provisions." *Id.* at *5.

The Court also rejected Defendant's argument that Plaintiff could not cure her failure to prove medical necessity. Defendant argued that because Plaintiff could not prove medical necessity on the date she requested coverage, she could not subsequently cure that defect by providing additional information. The Court rejected Defendant's position, noting that it contradicted the Plan language and the purpose of an administrative review process. Furthermore, the Court rejected Defendant's argument that Plaintiff failed to exhaust her administrative remedies, finding that any appeals beyond the first appeal were voluntary and that, even if required, any additional appeal would have been futile. Because no factual determinations needed to be made, the Court granted retroactive benefits to Plaintiff

2. Estoppel and Breach of Fiduciary Duty Claims.

In *Kenseth v. Dean Health Plan, Inc.*, 568 F. Supp. 2d 1013 (W.D. Wis. 2008), the U.S. District Court for the Western District of Wisconsin found that Defendant was not estopped from denying payment for a preapproved surgical procedure. Prior to surgery, Plaintiff called Defendant's customer service representative and asked whether her plan covered a surgical procedure to treat acid reflux. After conferring with colleague, the representative told Plaintiff that her plan covered the procedure subject to a \$300 copay. Plaintiff, however, neglected to tell the representative that her acid reflux condition was caused by complications from a prior gastric bypass surgery. Plaintiff's plan specifically excluded surgical or hospital treatment for morbid obesity as well as services related to such excluded services. Several days after Plaintiff underwent the surgery, Defendant refused to pay for the surgery and informed Plaintiff it was not covered under her plan.

Plaintiff filed suit, alleging that defendant: (1) breached its fiduciary duty, (2) was estopped from denying payment because Plaintiff relied on Defendant representative's incorrect information; and (3) violated state law limiting exclusions for preexisting conditions. The Court granted summary judgment in favor of Defendant on all counts. In rejecting Plaintiff's fiduciary duty argument, the Court found that Defendant did not have a fiduciary duty to provide a procedure for participants to confirm particular treatment coverage; rather, Defendant had a duty to explain the plan adequately. Looking at the language of the plan exclusions, the Court concluded that "[h]ad plaintiff read the plan documents, she could have determined that the surgery would not be covered." *Id.* at 1017. Turning to Plaintiff's estoppel argument, the Court first noted that Plaintiff failed to provide Defendant's representative with all the relevant information. Next, the Court explained that oral misrepresentations by an insurer's employee

may bind the insurer and modify terms of a written agreement only when that written agreement is ambiguous. Because the agreement was clear, the customer service representative's misstatement could not bind Defendant to pay for the excluded procedure.

Lastly, the Court considered Plaintiff's state law claim that Defendant's refusal to pay for her procedure violated a state law prohibiting insurers from having a preexisting condition exclusion for longer than one year. In dismissing this argument, the Court noted that Plaintiff was not challenging a preexisting condition exclusion: "[u]nder defendant's plan, it is irrelevant when plaintiff had the gastric bands inserted; why she did so is the only thing that matters." Id. at 1019.

C. Investigational/Experimental

In Simmons v. Blue Cross Blue Shield of Tennessee, 258 Fed. Appx. 878 (6th Cir. 2008), a beneficiary sued Blue Cross Blue Shield of Tennessee (the "plan") for its alleged improper refusal to cover the beneficiary's knee surgery. The plan denied coverage of the procedure - an Autologous Chondrocyte Implantation ("ACI") - because it determined that the procedure was investigational and therefore excluded from coverage. In making its determination, the plan relied on the health plan's definition of investigational service and exercised its discretion reserved under the plan to determine which procedures fall under that definition. Further, the plan relied on its "Medical Policy Manual," which specifically stated that the ACI procedure was investigational. During a hearing in front of the plan's Level II Grievance Committee, the plan agreed to have its Medical Policy Review Committee review the status of the ACI procedure. Upon review, however, the Committee determined that the procedure would remain investigational, and, thus, excluded from coverage. Accordingly, the beneficiary sued the plan and alleged that the plan used an arbitrary and capricious method to determine that the procedure was investigational.

The district court found in favor of the plan and the Court of Appeals for the Sixth Circuit affirmed. The district court considered whether the plan's denial was arbitrary and capricious in light of the plan provisions and evidence presented during administrative review. Under that standard, the district court concluded that substantial evidence in the administrative record supported the plan's decision. The district court also dismissed the beneficiary's argument that the plan's responsibility to determine both eligibility and payment created a conflict of interest because it found that the Beneficiary did not establish that any conflict of interest "actually influenced" the plan's decision to deny benefits. *Id.* at 881. The court also denied the beneficiary's motion to amend the judgment under FRCP 59(e) because she did not timely raise her arguments that the district court applied failed to determine whether the plan violated ERISA's Full and Fair Review Regulations and failed to review the plan's actions *de novo*.

In Summers v. Touchpoint Health Plan, Inc., 749 N.W.2d 182 (Wis. 2008), the Wisconsin Supreme Court held that Touchpoint Health Plan Inc. (the "HMO") acted arbitrarily and capriciously when it terminated health insurance benefits of a minor child with a rare form of childhood cancer and ordered that the benefits be reinstated. The HMO paid for the child's surgery to remove his tumor and approved follow-up care; however, because the child's pediatric oncologist recommended ongoing cancer treatment that the HMO considered experimental, it

terminated coverage. The minor child's parents (the "Plaintiffs") requested that the HMO submit its determination to an independent review organization. Although the review organization agreed that the treatment was experimental under the plan's criteria and upheld the HMO's decision to terminate benefits, it recommended approving the therapy since " 'it would be one of the standard approaches for three-year-old children with this disorder." *Id.* at 187. Further, the review organization stated that the treatment was "medically necessary" because there was "no alternative [treatment] with superior or proven results." *Id.* Despite this recommendation, the HMO terminated coverage and issued a letter to Plaintiffs notifying them of its decision.

Regardless of the termination, the child's oncologist administered treatment and the Plaintiffs sued the HMO to gain coverage, alleging that the HMO's denial was arbitrary and capricious under ERISA. The lower court granted summary judgment for the HMO but the Wisconsin Court of Appeals reversed and remanded to the trial court with instructions to reinstate benefits retroactively. The HMO appealed to the Wisconsin Supreme Court, and it affirmed the decision of the Court of Appeals. According to the Wisconsin Supreme Court, the HMO's termination decision was arbitrary and capricious because its termination decision was made despite the findings by the review organization that the treatment met the criteria for medical necessity and met the standard of care. Further, the Court held that the HMO's termination letter to Plaintiffs -- which merely stated that treatment was excluded and referred Plaintiffs to the Certificate of Coverage -- was arbitrary and capricious because it did not provide adequate explanation for the HMO's decision to terminate benefits, and, thus, did not provide Plaintiffs the opportunity for full and fair review as required under ERISA. The appropriate remedy, according to the Court, was retroactive reinstatement of benefits because the child had already undergone some cancer treatment which, along with the subsequent treatments, were part of an ongoing treatment protocol that the Plaintiffs could reasonably expect to be covered.

IX. False Claims Act ("FCA")

Numerous False Claims Act ("FCA") cases involving health insurance plans were filed in 2008. Summarized below are the more notable cases, including the Supreme Court decision *Allison Engine*, which has potential significant ramifications for health insurance plans involving Medicare and Medicaid.

A. *Allison Engine*.

In Allison Engine Co. v. United States ex rel. Sanders, 128 S. Ct. 2123 (2008), the U.S. Supreme Court held that a claim brought under 31 U.S.C. § 3729(a)(2) requires proof that the defendant intended that the false record or statement be material to the government's decision to pay or approve the false claim. Because health care claims are typically paid by intermediaries who are not U.S. officers or employees, the Allison Engine decision has possible significant implications for health care plans that involve Medicare or Medicaid coverage.

The Allison Engine decision involved a Navy defense contract. The Navy awarded contracts to prime contractors to build guided missile destroyers, and the prime contractors

subsequently awarded subcontracts to three subcontractors, including Allison Engine Co., to provide generators for the destroyers. Allison Engine contracted with company GTC to assemble the generator sets. Two former GTC employees (the relators) filed a FCA qui tam action alleging Allison delivered generators that did not comply with contract specifications and Navy regulations. However, at trial, according to the District Court, the relators did not present invoices submitted by the shipyards to the Navy and thus the District Court held that "absent proof that false claims were presented to the Government, respondents' evidence was legally insufficient under the FCA." The Sixth Circuit reversed holding that "such claims do not require proof of an intent to cause a false claim to be paid by the Government."

The Court reversed the Sixth Circuit decision, finding that if a subcontractor makes a false statement to a private entity and does not intend the government to rely on that false statement as a condition of payment, the statement is not made with the purpose of inducing payment of a false claim by the government. The Court also explained that its holding "does not mean ... that §3729(a)(2) requires proof that a defendant's false record or statement was submitted to the Government." *Id.* at 2125. However, under § 3729(a)(2), a defendant must intend that the government itself pay the claim. In contract, however, as the Court noted, a claim under § 3729 (a)(1) does require proof that the defendant presented a false or fraudulent claim to the government.

B. <u>FCA Allegations Against PBMs</u>.

In *United States, ex rel. Ramadoss v. Caremark Inc.*, No. SA-99-00914-WRF, 2008 WL 3978101 (W.D. Tex. Aug. 27, 2008), the U.S. District Court for the Western District of Texas granted in part and denied in part a pharmacy benefit manager's ("PBM") motion for partial summary judgment, holding that the PBM had not presented reverse false claims to the government. A reverse false claim exists when a person "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(7).

The qui tam lawsuit alleged that the PBM knowingly avoided or reduced its obligation to reimburse Medicaid and other federal health care programs in situations where patients were covered by government and private plans. The parties disputed whether certain "benefit plan limitations" (e.g., restrictions on the timing of claim's submission) could be applied to state Medicaid requests for reimbursement after the state had paid claims it said were the responsibility of the PBM. The court concluded that the PBM's informing Medicaid of the restrictions did not constitute false claims. Specifically, the Court determined that "the application of a restriction [to a request for reimbursement by Medicaid] contained in the corresponding plan was not a lie that triggered FCA liability." Therefore, the Court granted partial summary judgment in favor of PBM, holding it had not submitted reverse false claims to the government.

C. Dismissed FCA Qui Tam Lawsuit.

In *United States ex. rel. Sterling v. Health Insurance Plan of Greater New York, Inc.*, No. 06 Civ. 1141(PAC), 2008 WL 4449448 (S.D.N.Y. Sept. 30, 2008) the U.S. District Court for the

Southern District of New York dismissed a qui tam lawsuit brought by a relator, claiming that a health plan made alleged false statements to secure accreditation from the National Committee for Quality Assurance ("NCQA"). The relator alleged that the false statements were actionable as FCA claims because but for the false statements, the health plan would have lost its ability to obtain payment for health services furnished to state and federal health care program beneficiaries. However, the relator failed to show that the allegedly false statements were made with the intent of securing a government payment. The district court explained that presentment of falsified information to the NCQA is not equivalent or analogous to presentment to the government.

D. Insurer's Duty to Defend FCA Claims.

In Zurich American Insurance Co. v. O'Hara Regional Center for Rehabilitation, 529 F.3d 916 (10th Cir. 2008), the U.S. Court of Appeals for the Tenth Circuit affirmed a district court's decision, holding that the insurers did not have a duty to defend or indemnify a nursing facility against false billing claims alleged by the United States and Colorado. The appeals court concluded that because the alleged failure to furnish adequate nursing services was not an activity covered by the insurance policies nor "directly related" or "inextricably linked" to the injury claimed by the government (as required by the insurance policies), the facility failed to demonstrate that the insurers had a duty to defend the nursing facility. The Tenth Circuit remanded the case to the lower court for further proceedings consistent with its opinion.

Specifically, in an FCA complaint filed in 2004, the United States and Colorado sought to recover damages alleging that the nursing home facility submitted false claims to the Medicare and Medicaid programs for services it failed to provide because it was understaffed. The nursing home facility was covered under three general liability insurance policies: one policy covered any injury caused by a medical incident, including providing or failing to provide professional services or treatment conducive to health while the other two policies covered allegations of billing irregularities caused by errors and omissions in furnishing or failing to furnish professional services.

Here, the Tenth Circuit held that processing Medicare and Medicaid claims was not a professional service under the policies. The appeals court rejected the facility's argument that the government's alleged injury was caused by the facility's failure to provide adequate professional services and that such activity was covered under the insurance policies. The court explained that the government's injury actually resulted from the facility's submission of false and fraudulent claims for reimbursement as a result of inadequate staffing levels and that the false billing activity was not a covered activity under the policies. Furthermore, the Tenth Circuit found that the alleged failure to furnish adequate nursing services was not in necessary relation (as required by the policies) to the government's alleged injury and thus the facility failed to demonstrate the insurers' duty to defend the facility.

X. PUNITIVE DAMAGES

A. <u>Public Disclosure of Insurer's Internal Procedures for Policy Cancellations.</u>

Activities within health insurance company's cancellation departments have been a recent focus of intense scrutiny by lawmakers, state regulators and consumer advocates. Most major insurers have cancellation departments or individuals assigned to review coverage enrollment applications. The company employees typically pull a policyholder's records after major medical claims are made to ensure that the client qualified for coverage at the outset. Insurers maintain that cancellations are necessary to eliminate fraud and maintain affordable premiums. Individual coverage is issued to certain applicants who must disclose preexisting conditions. While companies' internal procedures for reviewing and cancelling coverage are generally not a matter of public record, the 2008 arbitration case, described below, provides a relatively detailed review of a company's internal operations. The publicly released decision provides information on the potential correlation between or among coverage cancellations, employee performance goals and the company's financial position.

In *Patsy Bates v. Health Net Inc.*, Case No. BC321432 (Feb. 21, 2008), an arbitration judge ordered a California health insurance group to pay an approximate \$1 million in special damages and \$8.4 million in punitive damages for its bad faith cancellation of a beneficiary's policy. In January 2004, the beneficiary Patsy Bates had been undergoing chemotherapy for breast cancer and had accrued medical expenses in excess of \$129,000 when the insurance group cancelled her coverage. The insurance group claimed that the policy had been cancelled because the beneficiary failed to provide her correct weight or reveal a pre-existing heart condition on the insurance application. However, the beneficiary presented evidence that the application had been completed by an aggressive broker for the insurance group who made no effort to explain the significance of the application to Bates and had changed the reported weight on the application without the beneficiary's written consent as required under the California Insurance Code. Bates also presented internal company documents that showed a quota-based program that rewarded employees with bonuses for meeting a quota of cancellations measured by the amount of money the cancellations save the company. State law forbade insurance companies from tying compensation for claims reviewers to their claims decisions.

The arbitration judge concluded that the health insurance group acted in bad faith and violated several state laws. The company's failure to investigate the accuracy of the information provided on the application prior to issuing the policy was "particularly troubling since ... the applicant ... already had a policy with significant coverage, which [the health insurance group] knew was going to be cancelled if the application was approved." *Id.* at 17. The judge awarded Bates an approximate \$129,000 in medical costs plus interest, \$750,000 in emotional distress damages and \$8.4 million in punitive damages.

B. Fraud or Misrepresentation by Insurers.

Many states' insurance laws provide for punitive damages when the insurer's agent makes misrepresentations to the insured regarding the scope of coverage under the policy, so long as the agent was acting within the scope of employment when making the misrepresentations.

In Cook v. Medical Savings Insurance Co., 287 Fed. Appx. 657 (10th Cir. 2008), the Tenth Circuit upheld a trial court jury award of \$550,000 in compensatory and \$550,000 in

punitive damages, holding that an insurance company committed fraud when it sold to the plaintiff an insurance policy that misrepresented the insurer's actual reimbursement rate.

In 2003, the insurance company sold to the plaintiff an insurance policy representing that the insurer would pay 100% of all reasonable and customary medical expenses greater than the \$5,000 deductible, up to \$1 million. The policy defined "reasonable and customary charge" to mean the most common charge for particular services or supplies and included seven factors the insurer could consider when determining the reasonableness of the charge. However, the policy failed to disclose that the insurer limited Medicare reimbursement for hospital bills greater than \$3,000 to the Medicare rate plus 26% of billed charges.

In 2004, the plaintiff submitted a hospital bill for his surgery costing approximately \$19,500. The insurer reimbursed the plaintiff the Medicare rate plus 26% (approximately \$7,000). The plaintiff subsequently filed suit against the insurer, alleging fraud and breach of good faith and fair dealing.

At trial, the jury found in favor of the plaintiff on the fraud claim and awarded him \$1.1 million -- \$550,000 in compensatory and \$550,00 in punitive damages. On appeal, the Tenth Circuit upheld the verdict holding that (i) the evidence presented was sufficient to support the jury's verdict and (ii) the agent's misrepresentations permitted the punitive damages award against insurer, and (iii) the jury's award was not excessive or so extreme as to "shock the conscience."

XI. MISCELLANEOUS

A. <u>Plan Regulation</u>.

On November 30, 2008, the New York State Insurance Department requested that United Healthcare delay an anticipated change in its hospital payment policy. The United policy would require hospitals to contact the health plan within 24 hours of plan patients' admission or face a reduction of up to 50 percent payment from United if the hospital failed to provide notice. The Department is investigating the potential financial impact of the policy on hospital reimbursement. Department representatives are also looking into whether the notice requirement may be in violation of state laws protecting consumer access to emergency services. Additionally, in response to hospital complaints that health plans act unilaterally by changing policy manuals, rather than negotiating amendments to their provider contracts, the Department plans to investigate the manner in which United was planning to implement the policy.

B. Medicare Part C Preemption.

In *Medical Card System v. Equipo Pro Convalecencia*, No. Civ. 08-2007, 2008 WL 4966550 (D.P.R. Nov. 24, 2008), the U.S. District Court for the District of Puerto Rico held that Medicare Part C does not preempt contractual claims between Medicare Advantage ("MA") organizations and a medical equipment supplier or other providers. The court dismissed the lawsuit filed by the MA organizations for lack of jurisdiction.

Here, the MA organization plaintiffs had entered into contracts with DME suppliers, which required that upon termination by either party the DME supplier agreed to provide continued benefits to plan beneficiaries until the MA organizations could make alternative arrangements with a different supplier. The agreements also required the DME suppliers to cooperate in transferring beneficiaries to other suppliers following termination. The agreement provisions were aligned with 42 C.F.R. § 422.504, which requires MA organizations to provide continued benefits to plan beneficiaries.

In June 2008, the MA organizations gave notice of their intent to terminate the contract. In response, the DME suppliers indicated their intent to discontinue supplying services and refused to cooperate with transferring the Medicare beneficiaries to other suppliers. The MA organizations then filed suit in federal court asserting that the DME suppliers' actions violated both the supplier agreements and Medicare regulations. However, the court determined that section 42 C.F.R. § 422.504(g) was intended to regulate the behavior of MA organizations and not the behavior of health care providers under contract with MA organizations. Therefore, the court dismissed the lawsuit, holding that Medicare Part C did not preempt contractual claims between MA organizations and the health care providers.

C. Class Action Settlement.

In Love v. Blue Cross and Blue Shield Association, S.D. Fla., No. 03-cv-21296 (settlement approved April, 21, 2008), a federal district court judge in Miami approved a settlement between Blue Cross Blue Shield Association and a nationwide class of approximately 90,000 physicians. In the class action, the physicians alleged that BCBS plans improperly delayed or denied their reimbursement and improperly rejected claims for medically necessary services. As part of the settlement, BCBS must pay over \$130 million to a fund established to pay the physicians' claims and pay nearly \$50 million in attorneys' fees. Additionally, BCBS and approximately twenty-three affiliates agreed to implement certain key business practice initiatives and restructure their methods of plan administration and payment. Key initiatives include: (1) greater availability of fee schedules and scheduled payment dates to physicians; (2) reduced precertification requirements; (3) greater notice to participating physicians/organizations of policy and procedure changes; (4) increased transparency concerning claims payment practices; (5) establishment of a physician advisory committee to discuss issues arising from or related to the relationships and interactions between and among physicians, patients, and the Blue Plan; and (6) adoption of new processes for resolving billing disputes and making coverage more information on the settlement, see http://www.ama-For assn.org/ama/pub/category/18037.html; and see Court Gives Final Approval to Settlement; AMA to Facilitate Blues Plan Compliance, Health Care Daily Report (BNA) (April 24, 2008).

D. RICO Claim

In *Allstate Insurance Co. v. Weir*, No. 5:07-CV-498-D, 2008 WL 4877047 (E.D.N.C. Nov. 10, 2008), three insurance companies filed RICO claims against defendant medical service providers alleging that the defendants had made fraudulent insurance claims for car accidents. Granting in part the motion to dismiss, the United States District Court for the Eastern District of North Carolina held that the insurers failed to show that the defendants, by submitting false

insurance claims, had "participated in the conduct of the operation or management of the insurer." *Id.* at *4-6. The court held that the insurers' RICO claim under 18 U.S.C. §1962(c) failed to show that the defendants conducted or participated in the conduct of the enterprise's affairs. The court determined that the defendants did not make or carry out any decisions on the behalf of the enterprise. Moreover, the court distinguished the case from the First Circuit precedent on which the insurance companies relied, explaining that there was no allegation that the insurer's own employees played a knowing role in defrauding the insurance company.