CLIENT ALERT

Managed Care Lawsuit Watch - September 2003

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Aetna and American Dental Association Settlement
(8/19/03)

Aetna and the American Dental Association announced that they had settled a class action lawsuit brought by 147,000 dentists against Aetna in 2001 for alleged underpayment of patients’ out-of-network dental services. The lawsuit, originally filed in Illinois, was transferred to Judge Moreno in the Southern District of Florida and consolidated with the Multi-District Litigation (MDL) case known as In re Managed Care Litigation.

Under the terms of the settlement, Aetna will take actions that will result in increased predictability and speed of claims payment for dentists and reduce the administrative requirements it places on dentists to be paid for their services. Aetna agrees to establish a $4 million settlement fund for dentists, and also to contribute $1 million to the ADA Foundation. The settlement agreement must be approved by Judge Moreno before it can take effect.
Blue Cross and Blue Shield of Kansas v. Praeger  
Kansas Supreme Court No. 89,075 (8/6/03)

The Kansas Supreme Court upheld the Kansas Insurance Commissioner’s decision to block the merger of Blue Cross and Blue Shield of Kansas with Indianapolis-based Anthem, Inc. Announced in May 2001, the prospective acquisition of the Kansas Blue plan would have been a sponsored demutualization, with Blue Cross converting from a mutual-insurance company to a stock insurance company. Anthem would have bought all the resulting shares of Blue Cross stock for around $190 million. Blue Cross policyholders would have received $131 million in special cash distributions, as well as the value of the stock minus expenses.

After appointing a special counsel to review the proposed acquisition, then-Insurance Commissioner (and current KS governor) Kathleen Sebelius issued an order rejecting the merger on the basis that it would not benefit policyholders or the public. Sebelius argued the acquisition would lead to larger premium increases than would have otherwise occurred, while at the same time result in a 50% decrease in the insurer’s operating surplus.

A Kansas district court judge had overturned the Commissioner’s ruling on the grounds that she had denied the merger in order to require that the insurer continue to use large group insureds to subsidize individual and small group insureds, which he ruled was against the law. Further, the judge ruled that the Commissioner did not have the power to reject the acquisition on the grounds that the surplus would be reduced because the projected surplus would still exceed the state’s required minimum. The Kansas Supreme Court reversed the district court and upheld the Commissioner’s original ruling. The Supreme Court wrote that the Commissioner has broad discretion under the Kansas Insurance Holding Companies Act to reject a proposed acquisition she determines is not beneficial to policyholders and/or harms the public. The Commissioner’s decision, the Court found, was not arbitrary, and therefore must be upheld.

Lefler v. United Healthcare of Utah, Inc.  
10th Cir. Court of Appeals No. 01-4428 (8/14/03 unpublished)

The 10th Circuit Court of Appeals upheld a district court’s ruling in favor of United HealthCare of Utah in a class action lawsuit brought by some of its insureds. The lawsuit alleged that United HealthCare had violated ERISA through its practice of charging its policyholders a co-payment based on the full billed charges of providers, rather than on the reduced rates that United HealthCare had negotiated with providers. United HealthCare responded that it had routinely made its co-payment policy known to its policyholders, and that its policy comported with the requirements of ERISA. The district court found that both the plaintiffs’ and United’s interpretation of its plan’s language to be reasonable. Because United enjoyed the prerogative to construe its own policy terms and conditions, the district court granted summary judgment for United. The 10th Circuit affirmed the District Court.
**U.S. v. Baldwin, et al**
D. C. No. 02-0323 (PLF) (8/14/03)

The U.S. District Court for the District of Columbia denied a motion to dismiss a health care fraud claim, declining to agree with defendants' argument that 18 U.S.C. § 1347 did not apply to fraud against a nonprofit HMO. Defendants were charged with defrauding Kaiser Foundation Health Plan, Inc. They argued that the alleged fraud does not fall within the purview of the statute because although the fraud was against a health care benefit program, the statute was not applicable to this specific fraud. The Court, agreeing with the Government, found that there was no limiting language in the statute precluding indictment of the defendants, and that the facts of the case support the charges. The Court found it "indisputable" that the fraud alleged was "directed at Kaiser in its role as a health care benefit program, and was a scheme to obtain monies by false representation."

N.D. Ill., Eastern Div. No. 01 C 6064 (7/23/01)

The District Court for the Northern District of Illinois denied defendant-Aetna's motion for summary judgment, finding the company's decision to deny benefits for physical, occupational, speech, and other therapies arbitrary and capricious. Plaintiff filed suit on behalf of his minor son, who suffered from autism, alleging that Aetna violated ERISA by wrongfully denying coverage for medical treatments. Aetna claimed that its denial of benefits was reasonable based on the medical records and the plan's language.

Aetna denied speech therapy on the grounds that it would only be covered for non-chronic conditions, for acute illness and injuries impairing speech or for speech-language disorders. The Court found that Aetna never explained why the Wheeler child did not qualify for coverage of speech therapy when there was support in the medical records to show that the speech loss was likely due to the autism. Further, the Court found that Aetna's interpretation that it would not cover certain therapies that had "unproven effectiveness" was arbitrary and capricious since there was no such exclusion in the plan language. The court also found that Aetna's denial letters failed to consider the plan language and did not "connect" its denials to specific diagnoses or the evidence in the medical records.

In reaching its decision, the Court noted that based on the record, it appeared that it would be appropriate to grant summary judgment for the plaintiff if the plaintiff had filed a motion for summary judgment. The Court granted leave for defendants to file a memorandum showing cause why the Court should not enter summary judgment for the plaintiffs *sua sponte*. 

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