CLIENT ALERT

Managed Care Lawsuit Watch - August 2010

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**Borrero v. United Healthcare of New York, Inc.**

**No. 02-20080 (11th Cir. July 6, 2010)**

The Eleventh Circuit Court of Appeals upheld a lower court ruling that ERISA completely preempted provider claims against an insurer arising from alleged underpayments for services rendered to ERISA beneficiaries. The court did, however, reverse the lower court's order dismissing claims subject to claim preclusion.

Plaintiffs – three physicians and four representative organizations – sued a health insurer in state court, alleging underpayments made to participating providers for services rendered to insured members. Defendant United Healthcare of New York, Inc. removed the action to federal court on the basis of complete preemption under ERISA. The federal court found the claims were completely preempted by ERISA and then dismissed the claims, reasoning those claims were precluded by a judgment dismissing a class action based on the Racketeer Influenced and Corrupt Organizations Act ("RICO"), which was also brought against the insurer by physicians for alleged underpayments.
The Eleventh Circuit first concluded that plaintiffs' state law claims were completely preempted by ERISA, finding the providers had derivative standing to assert the rights of their patients as beneficiaries of an ERISA plan based on assignment of benefits from their patients.

The Court of Appeals, however, reinstated the providers' claims, finding claim preclusion did not apply where the disparity in evidence needed to prove the claims in the RICO class action were not the same as what was needed to prove the contract-based ERISA claims.

**Louisiana Appeals Court Approves $262 Million Class Action Settlement Between A Subsidiary of Coventry Health Care Inc. and Several Health Providers**

A Louisiana Appeals Court approved a lower court's ruling against First Health Group Corp. Inc., a wholly owned subsidiary of Coventry Health Care Inc., in a case brought by several health providers, including Southwest Louisiana Hospital Association, against First Health. The judgment amount was $262 million. The providers brought a class action lawsuit alleging that First Health violated the notice provisions of Louisiana's Any Willing Providers Act in their treatment of patients with worker's compensation claims, because First Health allegedly provided reimbursement at the lower preferred provider organization contracted rates, instead of the higher mandated workers' compensation rates without informing the patients. Coventry intends to appeal the decision.

**Palmyra Park Hospital, Inc. v. Phoebe Putney Memorial Hospital**  
*No. 09-11818 (11th Cir. Apr. 29, 2010)*

The plaintiff, Palmyra Park Hospital, and defendant, Phoebe Putney Memorial Hospital, are competing hospitals in a Georgia metropolitan region. Phoebe is the only hospital in the area with a certificate of need (CON) in three specialized services ("CON services"), which is required for a hospital to offer services in those areas -- acute-care obstetrics, neonatology, and cardiac catheterization. Thus, any insurance company wishing to offer a full range of services to its members would need to include Phoebe in its network as a practical matter. Aside from the three specialty areas, both hospitals offer largely the same services. Palmyra alleged that Phoebe threatened to impose significant rate hikes for the CON services unless insurance companies agreed to exclude Palmyra from their networks for the other services that both hospitals provided.

The district court held that Palmyra lacked standing to pursue its claim. The court acknowledged Palmyra had suffered an injury of the type that the antitrust laws are designed to protect. Nevertheless, the court determined that Palmyra would not be an "efficient enforcer of the antitrust laws" because the harm to Palmyra was indirect at best, damages were highly speculative, and the true harm would be felt by patients and insurers forced to pay higher reimbursement rates rather than Palmyra. Thus, because Palmyra could not establish an element of antitrust standing -- that it would be an efficient enforcer -- the court dismissed the complaint.

The Eleventh Circuit reversed the district court, noting that Palmyra was likely the best suited to enforce the law. The court acknowledged that several steps would occur before Palmyra was harmed -- insurers would have to agree with Phoebe, deny Palmyra in-network status, and then direct their members away from Palmyra -- but explained that the harm alleged was not
too remote. More importantly, consumers and insurers were both unlikely to pursue the suit: insurers could simply pass on increased costs to their members and each individual member would experience such a minute increase in premiums that they would be unlikely to expend resources litigating a claim with little potential recovery. Thus, the court held Palmyra had standing to pursue its tying claim and reinstated the complaint.

Saltzman v. Independence Blue Cross
No. 09-2965 (3d Cir. June 10, 2010)

The plaintiffs subscribed to an ERISA medical insurance plan sold by the defendant, which contained an "open formulary" as part of the plan's prescription drug coverage. This plan design placed medications into one of three "tiers," each of which required a different copayment. Brand-name drugs not otherwise covered by the plan were placed into the tier with the highest copayment amount.

For several years prior to the suit, the plaintiffs used a prescription drug classified as a second-tier drug. When a generic equivalent was released, the defendants reclassified the brand name medication into the more expensive drug tier even though a different court subsequently enjoined production of the generic based on unrelated patent infringement claims. In response to the category change, the plaintiffs filed a class action suit alleging that the reclassification amounted to a denial of benefits due under the terms of their plans pursuant to ERISA § 502(a)(1)(B).

The U.S. District Court for the Eastern District of Pennsylvania granted the defendants' motion to dismiss, concluding the plan documents granted the defendants discretion to determine what copayment would apply to which drugs and that the defendants' decision to reclassify the drug at issue was not an abuse of discretion.

Affirming the district court, the Third Circuit acknowledged that the general terms of the plan granted plaintiffs the right to "comprehensive" prescription drug coverage. Nevertheless, the plan documents did not provide plaintiffs with a "vested right" regarding the copayment amount and classification of any given drug. To the contrary, more specific provisions in the plan documents unambiguously granted the plan administrator discretion to select the terms of the plan, including the placement of drugs in the formulary. The court concluded that the decision to reclassify the drug at issue as a "non-formulary" drug (and therefore subject to the highest copayment amount) "was an exercise of discretion" and did not "conflict with the unambiguous terms of the plan." Consequently, the court affirmed dismissal of the ERISA claims.

City of New York v. Group Health Inc., et al.
06-cv-13122 (S.D.N.Y. May 11, 2010)

The City brought this antitrust action, seeking to unwind the merger of Defendants. This action was brought in November 2006, after the Defendants reached a deal to affiliate under a common holding company. The Defendants, along with several other health plans, offer health benefits to current and former employees of the City. The City brought antitrust claims under the Clayton Act, the Sherman Act, and New York's Donnelly Act. In early 2010, the Defendants brought a motion for summary judgment, and the City brought a cross-motion to amend the complaint.
The court found that to state a claim under any of the statutes in the complaint, the City must identify the product market in which competition would be impaired. The relevant market is defined as all products "reasonably interchangeable by consumers for the same purposes," because the ability of consumers to switch to a substitute restrains a firm’s ability to raise prices above the competitive level. The City's complaint, however, defined the relevant product market as the "the low-cost municipal health benefits market." While other companies offer health insurance, the City's complaint alleged that their prices are sufficiently higher so they are not in the same market as Defendants.

The court held that the market definition contained in the complaint was deficient as a matter of law, as it was improperly limited to a single purchaser. Purchasing constraints on a single consumer, such as a required competitive bidding procedure, do not create a market of which only that consumer is a member. Also, the City’s market definition was not supported by its own expert.

Finally, the court denied the plaintiff's motion to amend the complaint that would add an "upwards pricing pressure" test as an avenue of proof. The court stated that not a single federal court has adopted this test, outlined in recent merger guidelines by the Department of Justice and the Federal Trade Commission, and the law required that a plaintiff allege a particular product market in which competition would be impaired.

**Ingenix v. Ham**  
*No. 2D09-2211 (Fla. Dist. Ct. App. May 5, 2010)*

UnitedHealthcare paid nearly all of insured Gerald Ham's medical bills ($154,075.46) for his laparoscopic gastric bypass procedure. The procedure and its complications ultimately led to his death. Subsequently the insured's estate brought a medical malpractice action against the medical providers who had performed the procedure. From this lawsuit, the insured's estate recovered $1,150,000 in settlement proceeds. The insured's estate then filed a motion for equitable distribution to determine that the insured's estate only owed UnitedHealthcare $86,282.25 out of the total amount that UnitedHealthcare had paid for the insured's medical procedure.

Even though UnitedHealthcare's insurance policy contained a provision stating that it was entitled to reimbursement in full from any settlement recovery, the Court found that Section 768.76(4) of the Florida Statutes limits the insurer's ability to recover in full. Namely, the statute reduces the insurer's right to reimbursement by the insurer's "pro rata share of costs and attorney's fees incurred by the claimant in recovering such collateral sources from the tortfeasor." The Court therefore held that because the insured's estate spent the equivalent of 44% of the total settlement recovery on attorney's fees and costs, UnitedHealthcare's right to reimbursement is limited to 56% of the amount it paid for the insured's medical procedure.

**Woodley v. Aetna Health Inc.**  
*No. C08-1612 (W.D. Wash. Apr. 9, 2010)*

Aetna had denied a member's claim for benefits on the basis of the procedure falling within an excluded "experimental procedure" provision. The member then brought a suit against Aetna in the Federal District Court of the Western District of Washington. When ruling to deny Aetna's motion for summary judgment because genuine issues of material fact remained, the
Court explained that the agreement Aetna alleged controls was insufficient to change the Court's standard of review of Aetna's coverage denial to abuse of discretion from the default *de novo* standard as provided under ERISA.

The relevant language in the Agreement provides: "[The Contractholder] delegate[s] to Aetna authority to make determinations on behalf of the Contractholder with respect to benefit payments under the Plan and to pay such benefits." Because the Court concluded that this language does not unambiguously confer discretion to Aetna, the Court commented that ERISA's default *de novo* standard of review would still apply.

*Peterson v. First Health Life & Health Ins. Co.*  
*No. 2:09-cv-00029 (D.S.C. July 9, 2010)*

A federal district court finds an insurer's rescission of health care coverage unreasonable and subject to state law limitations under ERISA's savings clause.

Plaintiff sued his health insurer under ERISA for denial of benefits, alleging that the insurer unreasonably rescinded his coverage in violation of South Carolina state law. The insurer had rescinded plaintiff's health care coverage based on incorrect answers on the plaintiff's insurance application.

The parties filed cross-motions for summary judgment. The insurer asserted its right to rescind ERISA coverage obtained by misrepresentation. Plaintiff claimed that the right of rescission is subject to South Carolina state law, which limits rescission to cases where the insured made material misrepresentations with the intent to deceive the insurer.

The federal court found that under ERISA's saving clause, South Carolina state law – limiting rescission to material misrepresentations with the intent to deceive the insurer – governed the right of an insurer to rescind ERISA coverage. The court then found no evidence showing that the plaintiff intended to deceive the insurer and ruled that the insurer's decision to rescind coverage was unreasonable.