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CLIENT ALERT

Managed Care Lawsuit Watch - May 2010

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This summary of key lawsuits affecting managed care is provided by the Health Care Group of Crowell & Moring LLP. If you have questions or need assistance on managed care law matters, please contact Chris Flynn, Peter Roan, or any member of the health law group.

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Cases in this issue:

United States v. McMillan
No. 08-31148 (5th Cir. Mar. 11, 2010)

The Court of Appeals for the Fifth Circuit held that Barry Scheur, owner, president and CEO of the HMO The Oath, and Robert McMillan, the Vice President, COO, and CFO of The Oath, had fraudulently represented the HMO's financial condition to ensure the plan's continued operation despite having a capital surplus of less than the $3 million dollar Louisiana statutory minimum. The Oath's parent companies were two other companies that were controlled by Scheur. The Government accused the defendants of creating a scheme to defraud and obtain money or property by filing false financial reports with the Louisiana Department of Insurance in order to perpetuate The Oath's continued operation including the collection of premiums and management fees.

According to the court, the Defendants performed, for example, the following actions in order to falsify their financial reports: (1) recording speculative or nonexistent receivables as assets that did not meet state accounting guidelines and (2) obtaining a personal loan for $1.2 million, transferring this money to HMO's parent company in Massachusetts, then transferring it to the HMO's account and reporting the transaction in the HMO's 2000 annual financial report to the state insurance department as a capital infusion from the parent in order to raise the HMO's net worth above the $3 million statutory capital surplus threshold.

The Court of Appeals affirmed the District Court's sentence of 20 months and 13 months in prison, respectively, which was a downward departure from the sentencing guidelines. The Court found that for sentencing purposes, the proper way to measure the Defendants' gain in this case was through their salaries, about $200,000 and $130,000, rather than from the $6.1 million in management fees that were collected through the HMO and instead of from the $40.1 million by which the HMO's liabilities exceeded its assets at the time it was finally placed into receivership by the Louisiana Department of Insurance. With respect to the management fees, the Court found that the company was a legitimate business that provided healthcare coverage to its insureds. With respect to The Oath's losses, the Court found that The Oath had been in monetary trouble when the Defendants initially acquired it and that the Court could not accurately determine which losses had resulted from the Defendants' actions versus those that would have occurred anyway.

Sacred Heart Health Systems v. Humana Military Healthcare
No. 08-16430 (11th Cir Mar. 30, 2010)

The Eleventh Circuit Court of Appeals reversed a District Court's class certification order, finding no predominant commonality over the class of 260 hospitals seeking to sue a TRICARE plan for underpayments and remanding the case to determine whether any subset of claims could be certified.

Provider hospitals filed a class action complaint against Humana, alleging breach of the provider contracts for alleged underpayment for medical services rendered to TRICARE beneficiaries.

The Court of Appeals found no commonality among the provider class where the hospitals each had different provider agreements with Humana that included substantially different terms. The Court of Appeals also found that the affirmative defenses with respect to the hospitals greatly varied as regards their individual responses to defendant's change in payment policy.

The Court of Appeals remanded the case to determine whether any subset of claims could be certified.

Midwest Special Surgery v. Anthem Insurance Cos.
No. 4:09cv646 (E.D. Mo. Feb. 23, 2010)

A federal district court granted, in part, Anthem's motion to dismiss plaintiffs' first amended complaint.

The plaintiffs, non-participating providers with Anthem, alleged that Anthem paid an "Artificially Reduced Payment Amount" instead of the "Usual and Customary Rate." Plaintiffs sought reimbursement for the difference between these amounts.

The district court, citing the Supreme Court's *Twombly* decision, dismissed plaintiffs' ERISA claims because plaintiffs failed to identify a coverage plan or its specific provisions or otherwise support the allegations with facts. Furthermore, the plaintiffs were precluded from stating an alternative basis for relief under § 1132(a)(3) because the relief plaintiffs sought was available under § 1332(a)(1)(B). The court also dismissed the plaintiffs' claims under the RICO Act and the Missouri Prompt Pay Act, as well as those for declaratory judgment, breach of contract, and refusal to pay.

The court, however, denied Anthem's motion to dismiss plaintiffs' causes of action under quantum meruit and unjust enrichment. Plaintiffs submitted claim forms and alleged that Anthem did not pay the usual and customary rates for such medically necessary services. These allegations were sufficient to withstand the motion to dismiss.

Baker County Medical Services Inc. v. Aetna Health Management
No. 1D08-0067 (Fla. Dist. Ct. App. Feb. 24, 2010)

Baker County Medical Services, Inc. ("BCMS") operates a rural not-for-profit hospital that is mandated to provide emergency medical services to every person in need of such care. Aetna and Humana, HMOs that do not have a contract with BCMS so that the hospital is out-of-network, have subscribers who seek emergency medical services at BCMS. For payment of its services, BCMS billed Aetna and Humana at the rates listed in BCMS's chargemaster, and in turn, Aetna and Humana would remit checks marked as "payment in full" even though the checks were for a lesser amount than what was billed.

The amount a hospital may be reimbursed for treatment of a patient who subscribes to an HMO that does not have a contract with the hospital is determined according to Florida Statutes § 641.513(5). On appeal, the Court interpreted the following sentence from the law: "Reimbursement for services… shall be the lesser of:…(b) The usual and customary provider charges for similar services in the community where the services were provided…"

The Court found that the term "provider" is unambiguously defined in the statute to include all providers of similar services and is not limited to just hospitals. Additionally, the Court interpreted the phrase "usual and customary provider charges" to equate to the fair market value of the services which is the "price that a willing buyer [would] pay and a willing seller [would] accept in an arm's-length transaction."

Therefore, the Court found that consideration of the amounts billed by providers of similar services, as well as the amounts accepted by providers as payment is appropriate in determining the "usual and customary" rate, but it would not be appropriate to consider Medicare and Medicaid reimbursement rates as they are set by the government and the provider must provide emergency medical services to Medicare and Medicaid beneficiaries.

Spring E.R., LLC v. Aetna Life Insurance Company
No. 4:09-cv-02001 (S.D. Tex. Feb. 17, 2010)

The plaintiff, Spring E.R., is an emergency care facility that provided services to individuals insured under various ERISA plans administered by Aetna. After treating the patients, Spring sent bills to Aetna, which refused to pay. Consequently, Spring sued Aetna in state court, alleging claims for relief under theories of implied contract, quantum meruit and the Texas Prompt Pay Act. Aetna removed the case to the U.S. District Court for the Southern District of Texas, arguing that ERISA completely preempted the claims, and Spring moved to remand.

The dispute centered on whether Spring had received assignments of benefits for the claims at issue. If Spring received such assignments, it would have standing under ERISA because it would "stand in the shoes" of the beneficiaries who had assigned

their benefits to Spring. Absent some independent legal duty that would not require reference to the terms of the ERISA plan, Spring's state law claims would then be completely preempted and remand would be improper.

Spring offered deposition testimony of its administrator that it did not have patients execute an assignment of benefits form. Aetna countered by introducing insurance forms Spring had submitted that indicated that it had received assignments of benefits. Although Spring argued the forms were ambiguous, the court concluded that it was unlikely that an experienced administrator such as the plaintiff would have submitted insurance claims without understanding the meaning of the forms. Further, Spring did not explain why it would send claims to and then sue Aetna directly, rather than the patient, unless Spring was simply filing claims on behalf of patients from whom it had received assignments of benefits. Because Spring therefore had at least a "colorable claim" for benefits, it had standing to sue under ERISA.

Finally, the court concluded that at least one of Spring's claims – breach of implied contract – necessarily implicated the terms of the ERISA plan, and thus ERISA completely preempted the claim. Spring argued that the membership identification cards that patients presented created an implied contract for payment. The court agreed with Aetna, however, that the explicit reference to the terms of the ERISA plan on the card would require analyzing the plan terms to determine if Aetna had breached an implied contract by denying benefits. Thus, this claim implicated no duty independent of ERISA and was completely preempted, making remand improper.

Monteleone v. United Concordia Companies
No. 09-1114 (W.D. Pa. Feb. 19, 2010)

A district court dismissed a dentist's claim that United Concordia Companies, a health plan, violated his Fourteenth Amendment rights under when it refused to reinstate him as a participating dentist after restrictions on his license were lifted. The plaintiff, Monteleone, had previously entered into an agreement with United Concordia to provide dental services to individuals eligible for Medicare. United Concordia terminated this arrangement when the Pennsylvania Board of Dentistry placed restrictions on his license. Although the Pennsylvania Board subsequently reinstated the plaintiff's license, United Concordia refused to renew the previous provider agreement.

Monteleone sued United Concordia under 42 U.S.C. § 1983, which prohibits individuals from violating federal constitutional or statutory rights under color of state law. United Concordia moved to dismiss, arguing that it is neither a state actor, as required to state a claim under § 1983, nor did it deprive Monteleone of any interest protected by the Fourteenth Amendment. In opposition to the motion to dismiss, the plaintiff argued that the Commonwealth of Pennsylvania authorized United Concordia to enter into contracts with dentists to provide services to Medicare and Medicaid participants, and that by exercising this delegated authority, United Concordia acted under color of state law. The plaintiff also argued that applying for and receiving a professional license to practice dentistry created a property and liberty interest in pursing this vocation.

The court rejected both of the plaintiff's arguments. First, the plaintiff failed to show sufficient facts to demonstrate there was a "close nexus" or a "symbiotic relationship" between the Commonwealth and United Concordia. The plaintiff did not allege that the Commonwealth "coerced or encouraged" United Concordia to engage in the allegedly improper act -- refusing to renew the provider participation agreement. Further, the court explained that the Commonwealth's extensive regulation of United Concordia did not render it a state actor. Second, Monteleone did not have a vested interest in providing dental services to

enrollees in *the defendant's* health plan and he remained free to practice his profession with other health care providers. Thus, the court held that United Concordia was not a state actor for purposes of the § 1983 claim and further that the plaintiff failed to allege a deprivation of a protected liberty or property right.

Cotton v. Starcare Medical Group
No. G040920, G041809 (Cal. Ct. App. Mar. 30, 2010)

The children of a deceased Medicare beneficiary and enrollee in the health plan SecureHorizons operated by PacifiCare brought several common law claims against PacifiCare, such as wrongful death, negligence-willful misconduct, constructive fraud, breach of fiduciary duty, and bad faith. Plaintiffs also brought suit against StarCare, a company that contracted with SecureHorizons for the provision of physician services to enrollees and for utilization review (the process of reviewing requests for authorization of medical services for medical appropriateness), alleging that StarCare breached its duty to conduct a utilization review without regard to the cost of the medical services requested.

The deceased had underwent surgery to repair a broken leg and then was placed in St. Edna's nursing facility where Plaintiffs allege the deceased failed to receive adequate care resulting in "starvation, dehydration, infection, and emotional distress" ultimately causing his death. Following the deceased's treatment at St. Edna's, he was placed in a hospital in need of urgent care and Plaintiffs allege that the deceased was not provided with the necessary care because of a dispute between PacifiCare and its network providers, such as StarCare, with regard to financial responsibility for the deceased's treatment.

Both StarCare and PacifiCare argued that the claims brought against them were preempted by 42 U.S.C. § 1395w-26(b)(3), preemption provisions of the Medicare Act. In response, the Court held that the Medicare Advantage law's preemption provision only expressly preempts state "laws and administrative regulations, but not the common law."

With regard to implied preemption, the Court found that only the constructive fraud claim as to the physician incentive agreement between PacifiCare and its providers was impliedly preempted because of the existence of a federal regulation governing such agreements. Otherwise, the remaining claims either could not have been remedied by CMS's administrative review process, could have been proven without consideration of coverage determinations under CMS's standards, or were not specifically targeted by Medicare regulations.

This ruling – that the common law is not within the class of "law" encompassed by Medicare Advantage's express preemption clause -- is potentially far-reaching.