Crowell

Client Alert

Managed Care Lawsuit Watch - December 2005

December 7, 2005

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

Please click to view the full Crowell & Moring Managed Care Lawsuit Watch archive.

Cases in this issue:

In re Arbitration between United Healthcare of Illinois Inc. and Advocate Health Care Network
No. 51 195 Y 01990 03, (11/18/05) - Click to view Panel's Order

A panel of arbitrators dismissed United Healthcare of Illinois' ("United") price fixing and group boycott antitrust claims against Advocate Health Care, a Chicago health system that owns eight hospitals and either employs or is affiliated with over 2,500 physicians. United had sought over $250,000,000 in treble damages, imposition of a five-year hospital and physician services agreement, and third-party monitoring of Advocate's contracting activities.

United challenged not only Advocate's fee-for-service physician services agreements throughout 1999-2002, but also Advocate's attempt to negotiate a "clinically integrated" agreement in 2003. The panel found that United's price-fixing claims relating to the 1999-2002 agreements were barred by the "equal responsibility doctrine," since United was not coerced into its joint contract with Advocate for the services of its 2,500 employed and affiliated physicians.

The panel found that United (and other payors) benefited from the "substantial administrative efficiencies" of jointly contracting with Advocate, i.e., the ability to quickly establish and stabilize a network of providers that made United attractive to its customers. Moreover, the panel found that United did not establish that Advocate had the necessary "market power" to violate Section 1 under a Rule of Reason analysis.

With respect to Advocate's conduct in 2003, the panel determined that since no agreement was ultimately executed, Advocate had failed to fix prices.

United claimed that Advocate's 2003 decision to terminate its hospital agreement with United constituted an illegal group boycott. However, the Panel determined that Advocate terminated that agreement unilaterally, and that a group boycott claim was unproven in the absence of evidence that its network of physicians were concertedly refusing to contract individually with United. Because the action was unilateral, the requisite "agreement" in restraint of trade was not present, the panel ruled.

Kentucky Office of Insurance fines Anthem Health Plans of Kentucky, Inc.
Fine announced 11/22/05 - Click for The Office of Insurance announcement

The Kentucky Office of Insurance ("KOI") ordered Anthem Health Plans of Kentucky, Inc. ("Anthem") to refund approximately $23.7 million to more than 81,000 individuals enrolled in Anthem's Medicare supplement plans. The refunds were ordered because Anthem's Medicare supplement premiums for 2005 were allegedly "unreasonable in relation to the benefits provided." KOI also fined Anthem $2 million for overstating medical cost projections, which is reportedly the largest insurer fine ever issued by the agency.

KOI alleges that in 2004 Anthem realized that it had overpaid providers for medical claims and began recouping extra payments. According to KOI, Anthem did not notify the agency when it learned of these errors; rather, KOI claims that Anthem requested a 17 percent increase in premiums for Medicare supplement plans, partially based on higher payments to providers made in 2004. Anthem has noted that KOI approved its 2005 rate increase, and has stated its intention to appeal.

Life Care Centers of America v. CalOptima
Cal. Ct. App. No. G034479 (10/31/05)

The California Court of Appeals, Fourth District, ruled that a county health system providing services to Medi-Cal beneficiaries through contracts with providers did not violate state law by requiring long-term care providers to submit treatment authorization requests within 21 days of a patient's admission.

The case arose when Life Care Centers of America, a long-term care provider, submitted several treatment authorization requests to county health system CalOptima after CalOptima's 21-day deadline. Pursuant to its policy CalOptima refused to pay the full amount requested, and Life Care filed a petition in court for full payment. The trial court found for Life Care, stating that CalOptima did not provide evidence to support a statutory mandate that it should deny reimbursement if certain forms were not returned in 21 days.

The Court of Appeal reversed, concluding that Life Care failed to prove that CalOptima's enforcement of its 21 day policy was arbitrary, capricious, unsupported by substantial evidence, or illegal. The court stated that the legislature had granted county health systems broad flexibility in their manner of providing services to Medi-Cal beneficiaries.

These county health systems operated under a contract negotiated with the state, and the court ruled that since CalOptima's contract with the state did not prohibit claim submission deadlines, CalOptima was free to adopt and apply a 21-day submission policy as part of its utilization controls. The court also found that county health systems were given broad statutory authority in the manner in which they could choose to reimburse providers, so long as the amount payable did not exceed the estimate of the Medi-Cal fee-for-service program.

Merkle v. Aetna Health, Inc. / Vista Healthplan Inc. / Health Options Inc. / Neighborhood Health Partnership Inc.
Fla. Cir. Ct. (No. 502005CA004454; No. 502005CA004511; No. 502005CA004514; No. 502005CA004516) 11/7/05 - Click for lead case opinion

A Florida Circuit Court held that there is no private right of action under a provision of the Florida Health Maintenance Organization ("HMO") statute that governs reimbursement in cases where a provider does not have a contract with a HMO.

A physician providing emergency hospital services brought actions against four managed care companies ("Defendants"), alleging violations of Florida Stat. § 641.513, which governs reimbursement where a provider does not have a contract with a HMO. Plaintiff alleged that Defendants violated the statute by artificially reducing the usual and customary provider charges. Plaintiff also claimed unjust enrichment and account stated.

In four similar opinions, the Florida Circuit Court dismissed the claims against Defendants alleging violations of Florida Stat. § 641.513. The court determined that because the statute provided administrative remedies but did not expressly authorize a private right of action, it is implied that the Florida legislature intended administrative remedies to be the exclusive remedies under the statute.

In dismissing the unjust enrichment claims, the court determined that Plaintiff failed to prove that the provision of services to Defendants' enrollees had conferred a benefit on Defendants. The court also observed that allowing Plaintiff to pursue an unjust enrichment claim would render the administrative remedies provided by the statute meaningless.

Finally, the court dismissed Plaintiff's claims for account stated, noting that because the central dispute between Plaintiff and Defendants was the amount Defendants owed Plaintiff, there was no agreed-upon amount on which a claim for account stated could be based.

Neighborhood Health Partnership, Inc. v. Fischer
Fla. Dist. Ct. No. 3D05-175 (10/19/05)

The District Court of Appeals for Florida's Third Circuit reversed the trial court's grant of class certification in a suit brought by a local doctor against a South Florida HMO alleging that the HMO regularly engaged in downcoding.

Dr. Kenneth Fischer brought suit against Neighborhood Health Partnership ("NHP") for breach of contract, alleging the HMO (1) automatically downcoded certain high intensity procedures without conducting a medical review; or (2) would automatically pend claims, then deny them without conducting a medical review. Fischer sought to represent a class of all physicians who contracted with NHP, provided services to NHP members between January 2000 and December 2004, and submitted a clean claim to NHP that was automatically downcoded or pended without a clinical medical review.

When NHP deposed Fischer, he estimated his damages to be $10,000 to $15,000. NHP subsequently performed an audit on the high-intensity claims Fischer submitted during the time period at issue. The auditor found that Fischer regularly filed high-intensity claims that were not supported by medical records, and there was no instance of Fischer being underpaid. Based on this information, NHP appealed the grant of class certification. NHP argued that Fischer lacked standing to sue because he could not show he was damaged by NHP's payment practices.

Noting that Fischer probably owed a refund to NHP, the court agreed that Fischer lacked standing to serve as class representative. The court opined that standing is a threshold inquiry that must be addressed at the outset of a class certification determination. Where a potential class representative, such as Fischer, has no current damages and no additional claims for damages, that person cannot serve as class representative.

New York Insurance Department fines 22 health insurers
Fines announced 11/28/05 - Click for The New York State Insurance Department press release

The New York State Insurance Department levied fines against 22 health insurers and HMOs for alleged violations of New York's prompt pay law. The alleged violations were associated with complaints closed between October 1, 2004 and March 31, 2005. The 22 companies were fined a total of $178,600, with individual fines

ranging from $1,000 to $26,100. The Department's press release announced that since the enactment of New York's prompt pay law in 1998, health insurers and HMOs have been fined approximately $6.2 million.

In the Matter of North Texas Specialty Physicians
Federal Trade Commission Docket No. 9312 (11/29/05)

The Federal Trade Commission ("FTC") unanimously affirmed a ruling by an Administrative Law Judge ("ALJ") that North Texas Specialty Physicians ("NTSP") illegally fixed prices in contracting with health insurers.

NTSP is an association of independent physicians that operates in the Fort Worth, Texas, area and has approximately 500 members. NTSP negotiates and reviews payor contract proposals for its members. The challenged conduct in the case involved NTSP's negotiation of non-risk contracts.

The complaint alleged that NTSP's physician participation agreement gave NTSP a right of first refusal for the negotiation of all payor contract offers. Member physicians agreed not to individually pursue payor offers until NTSP notified them that it permanently discontinued negotiations with the payor. NTSP also gathered powers of attorney from physicians for use in contract negotiations. Finally, NTSP conducted annual polls of its members to determine the minimum reimbursement rates it would use for negotiating payor contracts.

The ALJ found NTSP had taken collective action to extract fee concessions from payors and that such conduct constituted horizontal price-fixing. NTSP appealed the ALJ's ruling on six grounds, including lack of jurisdiction, lack of concerted action, and the ALJ's failure to find sufficient pro-competitive justifications for NTSP's activities.

The FTC agreed that NTSP had engaged in unlawful horizontal price fixing, and concluded that it was "not really a close case." While it could have applied a per se analysis, the Commission chose to analyze the case under the more flexible analysis outlined in *Polygram Holding, Inc. v. FTC,* because of its recognition that "innovative approaches to health care should be encouraged."

The Commission then addressed each of NTSP's claims. It found the FTC had jurisdiction over the matter because NTSP is a corporation organized to carry on "business for its own profit and that of its members," and its actions could be expected to affect the flow of payments from out-of-state payors to NTSP physicians. The FTC found that NTSP was the agent of its member physicians, not a "sole actor," when it engaged in contract negotiations on behalf of its members. Thus, member physicians conspired to fix prices even though none of the physicians communicated directly with one another. The FTC rejected all of NTSP's arguments that its activities were justified by pro-competitive effects, finding they were unsupported by the evidence.

The FTC's final order prevents NTSP from engaging in the anticompetitive conduct alleged in the complaint, from attempting to engage in such activities, or from encouraging others to engage in such activities. NTSP is not barred from participating in any permissible messenger or agency arrangement, but for the next three years it

must notify the FTC at least sixty days before entering into such an arrangement. The order also imposes various notification and reporting requirements on NTSP.