CLIENT ALERT

Managed Care Lawsuit Watch - November 2004

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**California Pacific Medical Center v. Concentra Preferred Systems Inc.**

* N.D. Cal., No. C 04-3083 SBA (10/15/04)

A federal district court granted defendants Redwood Empire Electrical Workers Health and Welfare Trust Fund and Zenith Administrators, Inc.‘s motion to dismiss because the Employee Retirement Income Security Act (“ERISA”) preempted state claims.

In 1997, California Pacific agreed with Interplan Corp. and Redwood Empire to furnish medical services to beneficiaries under Redwood Empire’s health care benefit plan. In 2001, California Pacific provided services to a beneficiary for the delivery of a child which should have given the hospital $828,99.54, according to the agreed to rates of reimbursement, it alleged. Contending that it had been underpaid by $485,000, California Pacific sued in state court for breach of contract, unfair business practices, services rendered, unjust enrichment, and declaratory relief. The case was removed to federal court on ERISA grounds.

The court determined that the harm that California Pacific suffered was “inextricably intertwined with the plan’s decision not to pay” and that a dispute over the amount of reimbursement “goes to the fundamental purpose of the Plan,” thereby coming within ERISA’s preemption provisions.
Cuccia v. Roberson Advertising Services, Inc.
E.D. La., No. 04-1293 Section “T”(5) (9/27/04)

The U.S. District Court for the Eastern District of Louisiana held that where an employee sues for medical benefits under ERISA, a health care plan is the only proper defendant. In granting the defendant health care providers’ motion to dismiss, the district court noted that although the Fifth Circuit has not yet addressed the issue, other district courts in the circuit have decided that a health care plan is the only proper defendant where the claim is to recover benefits under ERISA. In addition, the court declared that it would not consider the lack of an ERISA remedy when determining whether a plaintiff’s state law claims were preempted by ERISA.

The case involved an employee covered by a “qualified plan” under ERISA that was issued by Aetna. Plaintiff received medical treatment for morbid obesity from various providers, including Tenet Healthcare (the “Tenet defendants”). Plaintiff sought gastric bypass surgery and submitted information to Tenet indicating that she satisfied Aetna’s requirements for the surgery. After submitting the information to Aetna, Aetna informed Tenet that it needed additional information from Plaintiff’s primary care physician. Plaintiff claimed that Tenet treated the request for additional information as a denial and that Tenet did not provide the additional information to Aetna in a timely manner.

Plaintiff brought an action against Plaintiff’s employer, Aetna, and the Tenet defendants alleging wrongful denial of access to her health care benefits under ERISA, as well as various state law claims including breach of contract, negligence, fraud, detrimental reliance and deceptive trade practices.

The U.S. District Court for the Eastern District of Louisiana granted the Tenet defendants’ motion to dismiss, holding that Plaintiff had no claims against Tenet under ERISA because the only proper defendant in a suit to recover benefits is the health care plan.

The court next turned to Plaintiff’s state law claims to determine if they were preempted by ERISA. The district court noted that any state law claim that “duplicates, supplements, or supplants” ERISA remedies is preempted, because Congress intended that ERISA remedies be exclusive. The district court found that all of Plaintiff’s state law claims were preempted by ERISA because the claims derived from and related to her health care plan. It rejected Plaintiff’s fairness argument that preemption of her state law claims would leave her without any cause of action against Tenet. The district court explained that it would not consider the lack of an ERISA remedy when determining whether ERISA preempted a state law claim.

Manny v. Central States, Southeast and Southwest Areas Pension and Health and Welfare Funds
7th Cir., No. 04-1797 (10/26/04)

The U.S. Court of Appeals for the Seventh Circuit affirmed a ruling by the U.S. District Court for the Northern District of Illinois, holding that trustees of a health fund did not act unreasonably in refusing coverage for gastric bypass surgery. The appeals court
determined that the only question before the court was whether the trustees’ interpretation of plan language was “completely unreasonable.”

Manny, a participant in the health fund for the Teamsters union, sought coverage for gastric bypass surgery, which he believed was needed for medical reasons. The trustees did not comment on the medical necessity of the procedure, instead interpreting plan language to exclude coverage for all gastric bypass surgeries, without regard to whether the purpose is cosmetic or medical.

The Seventh Circuit acknowledged Manny’s arguments regarding medical need, noting that the fund participant was overweight and suffered from numerous obesity-related health conditions. However, the court remarked that its “hands are tied” because the trustees’ interpretation of the plan as excluding coverage for all obesity-related surgeries was not unreasonable.

**McCoy v. Unicare Life and Health Insurance Co.**

*N.D. Ill., No. 04 C 1126 (10/14/04)*

The District Court for the Northern District of Illinois held that where a medical malpractice claim concerns benefit eligibility, rather than a provider’s treatment decisions, such a claim is preempted by the Federal Employee Health Benefits Act (“FEHBA”).

The case arose when Plaintiff, who was covered by a FEHBA HMO plan provided by Unicare, brought suit alleging malpractice against Unicare and health care providers Oak West and Westlake Community Hospital.

Plaintiff was treated for burns at Loyola University Medical Center and received a skin graft. His treating physician recommended occupational therapy for the skin graft. Plaintiff was allegedly informed that he could only receive occupational therapy from Westlake Community Hospital. Plaintiff claimed that Westlake was not competent to perform occupational therapy on a skin graft patient, and brought a malpractice action alleging personal and pecuniary injury.

The district court first found that Plaintiff’s claim did not involve a “mixed plan eligibility and treatment” issue because the doctor making treatment decisions was not simultaneously the administrator of Plaintiff’s plan or owner or operator of the plan. The district court then addressed the question of whether Plaintiff’s claim was preempted by FEHBA. The district court noted that the broad language in FEHBA supported a finding of preemption.

The court also stated that the legislative history suggested Congress wished to expand the preemption of state and local law in the FEHBA context. In determining that FEHBA preempted Plaintiff’s claim, the district court explained that although Plaintiff phrased his claim as a malpractice action, the allegations really concerned a challenge to benefit eligibility, and thus it fell within the remedy provisions of FEHBA.
McKenzie-Willamette Hospital v. PeaceHealth
D. Or. Civil No. 02-6032-HA (10/13/2004)

The United States District Court for the District of Oregon denied motions by PeaceHealth for a new trial and for judgment as a matter of law, upholding a jury’s decision that PeaceHealth engaged in anti-competitive behavior that harmed the McKenzie-Willamette Hospital (“McKenzie”).

In 2002, McKenzie, a community hospital in Springfield, Oregon, sued PeaceHealth, which owned the largest hospital in the region, claiming that PeaceHealth violated federal and state antitrust and tort laws. McKenzie alleged that PeaceHealth, in its nonexclusive insurance arrangements, priced services in which it competed with McKenzie below cost while linking these prices to its pricing services for which PeaceHealth had no effective competition substantially in excess of cost. McKenzie claimed that this pricing scheme enabled PeaceHealth to depress the price of services in which it competed with McKenzie while recouping revenues through supracompetitive prices for services in which it had no competition.

McKenzie also alleged that PeaceHealth formed a preferred-provider agreement with health insurer Regence Blue Cross Blue Shield of Oregon under which Regence agreed to exclude McKenzie from preferred-provider status in exchange for PeaceHealth providing Regence with large discounts. McKenzie was thus left off of Regence’s preferred-provider panel, which required Regence’s insureds to pay substantial additional costs to use McKenzie’s services. McKenzie claimed that its patient visits significantly declined as a result.

In October 2003, a jury found for McKenzie on three of its claims, concluding that PeaceHealth attempted to monopolize the provision of health care in the relevant market, unlawfully discriminated in price of services, and unlawfully interfered with McKenzie’s prospective relations with others. The jury awarded McKenzie $5.4 million in damages for each of the three claims, plus $9.2 million in punitive damages. PeaceHealth moved for a new trial on the grounds that McKenzie had been allowed to amend its claims without sufficient notice, that evidence was improperly admitted or excluded, that erroneous jury instructions were issued, and that the jury’s damage awards were unsupported. The court denied PeaceHealth’s motion, concluding that none of PeaceHealth’s grounds amounted to a miscarriage of justice that would require a new trial.

In a companion opinion issued the same day, the court denied PeaceHealth’s motion for judgment as a matter of law on McKenzie’s claims. The court ruled that McKenzie presented sufficient evidence to support the jury’s conclusions against PeaceHealth for attempted monopolization and price discrimination. The court also denied PeaceHealth’s challenge to the jury’s award of punitive damages, noting that the challenge was moot because McKenzie elected to recover its antitrust remedies rather than the compensatory and punitive damages provided for under state law.
Medical Savings Ins. Co. v. HCA, Inc., et al.
U.S. Dist. Court for the Middle Dist. of Florida 04-cv-156-FtM-29DNF (10/25/04)

A federal judge granted defendants’ motion to dismiss antitrust and state Deceptive and Unfair Trade Practices claims filed by a health insurer against several hospitals in Florida. The court found that the insurer lacked standing to bring its claims, and that one of the defendant hospitals, as a state-owned facility, was immune from two of the three counts of alleged antitrust violations under the Eleventh Amendment to the US Constitution.

Medical Savings Ins. Co (“MSIC”), is hospitalization insurance provider operating in, among other places, Florida. It features high deductible “health savings account” products. An allegedly distinguishing feature of MSIC’s policies is its payment of “reasonable and customary” charges, as opposed to the standard “usual and customary” charges. This provision has led to MSIC refusing to pay for some charges which it deems “unnecessary,” despite the industry-standard practice of paying them. MSIC has approximately 15,000 insureds in FL, which represents a small market share, and alleges that anticompetitive behavior by the defendants has caused its sales growth to decline.

MSIC alleged that the hospitals engaged in three types of anticompetitive behavior: (1) a group boycott and/or a concerted refusal to deal through refusal to accept 75% of the checks written by MSIC for its insureds and more than 25 lawsuits filed by defendants against MSIC and its insureds; (2) price-fixing through sharing of chargemasters; and (3) monopolization.

Regarding defendant Lee Memorial Health System, the court found that because it was state-owned, it was immune from MSIC’s group boycott and monopolization claims because its alleged behavior was contemplated by the state legislature in the statutory provisions relied on by Lee Memorial. The court found no state immunity for the price-fixing claim, finding that the state legislature did not contemplate that a state-owned facility would engage in price-fixing.

Ultimately, however, the court granted defendants’ motions to dismiss all claims brought by MSIC because MSIC did not meet the two-pronged test to establish antitrust standing. That is, MSIC did not assert that it had suffered any of the harm resulting from the alleged wrongdoing. Rather, all of the alleged wrongdoing affected MSIC’s insureds, not MSIC. MSIC had made it clear that it did not pass on allegedly exorbitant hospital pricing to its insureds, but rather refuses to pay for such pricing. The court found that MSIC had not alleged any direct harm to itself because of the alleged wrongdoing.