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CLIENT ALERT

Managed Care Lawsuit Watch - July 2004

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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 Chris Flynn, Peter Roan, or any member of the health law group.

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Aetna Health Inc. v. Davila and Cigna Healthcare of Texas, Inc. v. Calad
U.S. Supreme Court No. 02-1845 and No. 03-83. (6/21/04)

The United States Supreme Court unanimously ruled in two consolidated cases that ERISA preempted claims brought by individuals against their HMOs under a Texas law that allows patients to sue HMOs for refusing to cover services recommended by their treating physicians. The Supreme Court's decision confirms the reach of ERISA preemption where state law claims challenge the coverage decisions of employee benefit plans.

The two respondents were enrolled in ERISA-regulated employee benefit plans, and had suffered injuries that they alleged were caused from their HMOs' decisions not to provide coverage for treatments recommended by their treating physicians. Pursuant to the Texas Health Care Liability Act (THCLA), the respondents sued their HMOs in state court, alleging that the HMOs' refusal to cover the recommended services violated the HMOs' duty set forth in the THCLA to exercise ordinary care when making

health care treatment decisions. The HMOs argued that the respondents' causes of action fit within the scope of ERISA § 502(a)(1)(B), and were thus preempted and removable from state court to federal court. Their claims were dismissed at the trial court level on ERISA preemption grounds, but reinstated by the Fifth Circuit Court of Appeals.

The Supreme Court held that that the respondents' THCLA causes of action sought only to redress denials of coverage promised to the respondents' under the terms of their ERISA-regulated benefit plans. The Court rejected the respondents' argument that THCLA claims actually alleged the violation of a legal duty independent of ERISA- namely, that the HMOs made decisions that violated the duty of ordinary care set forth in the THCLA. The Court reasoned that if an ERISA plan did not cover a particular treatment, then an HMO could not be held liable under the THCLA for denying coverage for that treatment; accordingly, the Court determined that THCLA liability derived entirely from the particular rights and obligations established by the plans. Because the respondents' THCLA claims were thus deemed to be not entirely independent of their ERISA plans, the Court held that the respondents' state law claims fell within the scope of the ERISA remedial scheme and were preempted.

The Court rejected several arguments presented in support of the respondents' position. Most notably, the Court rejected the argument that the respondents' claims did not "relate to [an] employee benefit plan" because the HMOs' actions were mixed eligibility and treatment decisions under the Supreme Court's decision in *Pegram v. Herdrich*. The Court interpreted *Pegram* to mean that only when eligibility decisions and treatment decisions are made by the same party (or by parties in an employment relationship) are they "truly 'mixed eligibility and treatment decisions.'" In contrast, the Court reasoned that when administrators like the petitioner HMOs only make benefits determinations - even when those determinations are based largely on medical judgments - the administrators are acting as plan fiduciaries and the language from *Pegram* is not implicated.

Ayotte v. Matthew Thornton Health Plan, Inc.
D.N.H. No. 03-227-JD (6/28/2004)

A lawsuit by a beneficiary to recover benefits and for breach of fiduciary duty was dismissed for being time barred by a 1-year limitation in the insurance policy, the U.S. District Court for the District of New Hampshire ruled.

Bertin Ayotte, a beneficiary with health insurance through his employment, was insured by Matthew Thornton Health Plan (MTHP). In 2000 Ayotte was diagnosed with prostate cancer. After considering treatment options recommended by his urologist, Ayotte learned of an alternative treatment at a university in California. He requested authorization from MTHP for this treatment, but his request was denied as being experimental, and Ayotte's plan did not cover experimental treatments. Ayotte paid for the treatment himself, and then went through the appeals process provided by MTHP to request reimbursement for the treatment. Ayotte's appeals were denied three times, the second two by independent reviewers.

In 2002, MTHP was replaced by Matthew Thornton Blue. In 2003, Ayotte filed suit in state court claiming MTHP wrongfully refused to provide coverage for his prostate cancer treatment, which was removed to federal court under ERISA preemption. The Court dismissed Ayotte's claims because they were subject to a 1-year limitation provision in the MTHP Certificate. In the absence of statutory time limits under 29 U.S.C. § 1132(a)(1)(B), courts look to the law of the forum state. But, as here, contractual time limits provided as part of a plan are enforceable, so long as they are reasonable.

CIGNA HealthCare of Florida v. Land
U.S. Supreme Court No. 03-649, judgment vacated (6/28/04)
11th Cir. Decision: 339 F.3d 1286 (11th Cir. 2003)

The U.S. Supreme Court vacated this decision by the 11th Circuit Court of Appeals, which held that ERISA did not preempt a medical malpractice claim asserted by a patient against an HMO. The 11th Circuit's decision was vacated in light of the Supreme Court's ruling in *Aetna Health Inc. v. Davila*, 542 U.S. ___ (June 21, 2004), in which the Court unanimously held that ERISA preempted two patients' claims that their HMO violated Texas law by refusing to cover medical services ordered by their treating physicians. In *Land v. Cigna Health Care of Florida*, Land's doctor had prescribed an aggressive inpatient treatment, but Land's HMO approval nurse determined that he should only receive outpatient care. Land subsequently worsened, and he sued his HMO for malpractice under state law. The 11th Circuit, citing the "compelling persuasive force" of the Supreme Court's holding in *Pegram v. Herdich* that mixed eligibility and treatment decisions fell outside of ERISA, decided that ERISA did not preempt Land's claim as it involved a similar mixed decision. The *Land* case will now be remanded back to the 11th Circuit to be reheard in light of *Davila*.

Healthplan Services Inc. v. Gunnells
U.S. No. 03-1282, cert. denied 6/14/04
4th Cir No. 01-2419 (10/30/03)

The United States Supreme Court denied *certiorari*, leaving in place the Fourth Circuit Court of Appeals' October 20, 2003 ruling that a U.S. District Court did not abuse its discretion by certifying a class action in a suit brought by employers and employees against a health plan's third party administrator (TPA) for allegedly negligently administering the plan.

Plaintiffs were purchasers and beneficiaries of a multi-employer health plan, and the plan's TPA had created a massive backlog of unprocessed claims that the plaintiffs alleged caused the plan's collapse. The plaintiffs filed suit in District Court, which granted class certification as to the plaintiffs' mismanagement claim against the TPA. The Fourth Circuit ruled that the District Court did not abuse its discretion, noting that the plaintiffs advanced a single theory of liability against the TPA that did not require individualized determinations. The Fourth Circuit rejected the TPA's contention that the class, which included both employers and employees, had members with impermissible conflicts of interest; the court noted that the TPA presented no evidence of such conflicts. The Fourth Circuit also held that the lower court had abused its discretion by certifying 23 subclass actions against 23 individual insurance agents who sold the plan; the Fourth Circuit determined that individualized inquiry would be necessary to determine whether each plaintiff had relied on misrepresentations made by the agents.

Klassy v. Physicians Plus Insurance Co.
7th Cir., No. 03-2841 (6/15/04)

The U.S. Court of Appeals for the Seventh Circuit upheld a district court's ruling that a medical director's denial of payment for a procedure performed by an out-of-network physician was a pure eligibility decision subject to the exclusive remedies under the Employee Retirement Income Security Act ("ERISA").

Klassy, a Jehovah's Witness, requested authorization from Physicians Plus Insurance Company for payment to an out-of-network surgeon capable of performing bloodless hip surgery in accordance with Klassy's religious beliefs. Plan documents required payment to out-of-network providers only if plan physicians could not provide "medically indicated" treatments. Dr. Johnson, the plan medical director, authorized payment for the surgery by a plan physician, but no plan physician was willing to perform a bloodless surgery. Dr. Johnson refused to authorize payment to an out-of-network physician willing to perform the bloodless surgery, and Klassy paid for the bloodless procedure herself.

The district court dismissed Klassy's medical malpractice claim on the grounds that the claim was preempted by ERISA. The appellate court affirmed, emphasizing that the "sole question facing Dr. Johnson was one of eligibility and whether a bloodless surgery performed by an out-of network physician was covered by the Plan." The appellate court also noted that Mrs. Klassy had the opportunity to amend her complaint to allege an ERISA denial of benefits claim, but instead she chose to appeal.

M-Plan Inc. v. Indiana Comprehensive Health Insurance Assoc.
Ind. No. 49S02-0312-CV-605 (6/8/04)

The Indiana Supreme Court ruled that HMOs must exhaust administrative remedies before filing a lawsuit against the administrator of the state's high-risk insurance pool.

All Indiana health insurers, including the plaintiff HMOs, were required to be members of the Indiana Comprehensive Health Insurance Association (ICHIA), which insured high-risk individuals at capped rates. ICHIA annually lost money, and was statutorily required to assess its losses to its members on an equitable basis. ICHIA was also authorized by statute to create a Plan of Operation, which once approved by the Insurance Commissioner, allowed ICHIA to carry out its statutory requirements. ICHIA's Plan included a procedure by which members aggrieved by ICHIA actions had to appeal to the ICHIA Board and the Insurance Commissioner before pursuing litigation.

Plaintiff HMOs filed suit in Superior Court, alleging that ICHIA caused them to bear a disproportionate share of ICHIA's losses. The superior court dismissed the complaint, holding that the HMOs failed to exhaust the required administrative remedies before suing. The Court of Appeals reversed, holding that the HMOs were not required to first exhaust administrative remedies because ICHIA was not a state agency. The Supreme Court determined that the issue of whether ICHIA qualified as a state agency was not determinative, and held that ICHIA's members were required to exhaust ICHIA's internal remedies regardless of whether ICHIA was viewed as a private association or a state agency.

The Supreme Court noted that courts allow private associations, even involuntary ones, to require their members to be bound by validly adopted internal dispute provisions. The court also decided that ICHIA's Plan had essentially the same status as an administrative regulation, because the ICHIA statute authorized the Plan's creation and required the Insurance Commissioner to approve the Plan after notice and a hearing for it to take effect.

Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.
11th Cir. No. 03-14202 (6/3/2004)

The Eleventh Circuit Court of Appeals reversed a District Court summary judgment ruling and damages award, and held that an anti-assignment clause in an ERISA plan benefits contract barred the beneficiary's assignee from suing the Plan under ERISA.

A plan beneficiary developed a severe infection and received treatment from plaintiff Physicians Multispecialty Group (PMG). When she died, her estate signed an agreement assigning all of her rights to health benefits to PMG. When the plan refused to pay benefits on the grounds that the beneficiary was not an eligible dependent of her father, PMG sued in District Court on the basis that the Plan had violated ERIS by refusing to pay. PMG won a summary judgment motion, and was awarded nearly $70,000 in benefits.

On appeal, the Eleventh Circuit reversed on the grounds that PMG lacked derivative standing under ERISA to sue the Plan because the assignment was forbidden by the Plan's terms. While the Court noted that ERISA is silent on assignment of plan benefits, such plans are ruled by contract law. As such, parties are free to bargain for certain provisions, such as the anti-assignment clause here.

Spry v. Thompson
D. Ore., No, 03-121-KI (5/20/04)

The United States District Court for the District of Oregon ruled that Oregon could not charge co-payments to expansion populations covered by a revised version of the Oregon Health Plan (OHP). Plaintiffs were participants in a plan under the OHP that extended care to low-income expansion populations who would not have been eligible for regular Medicaid coverage without a 42 U.S.C. § 1315 waiver. The plan, called OHP Standard, charged monthly premiums and co-payments regardless of an individual's ability to pay. Individuals who did not pay the OHP Standard's premiums for any reason were disqualified from the plan for six months. The District Court had previously ruled that the OHP Standard plan violated 42 U.S.C. § 1396o(f) by imposing co-payments pursuant to a § 1315 waiver without the Secretary first finding, after notice and comment, that the five criteria in § 1396o(f)(1)-(5) had been met. The court had also earlier ruled that OHP Standard violated § 1396o(e) by permitting providers to deny care to an individual who could not meet the scheduled co-payment. In this disposition, the court held that while the state could legally charge nominal co-payments under § 1396o(b)(1) and (3), those provisions did not apply to expansion populations;

thus the court ordered the state to cease imposing co-payments on the plaintiffs. The court's opinion also denied the plaintiffs' motion for class certification.

UnitedHealthcare of North Carolina, Inc. and United HealthCare Insurance Co.
North Carolina Dept. of Insurance (11/04/2004)

The North Carolina Insurance Commissioner announced a voluntary settlement agreement between the North Carolina Department of Insurance and UnitedHealthcare of North Carolina, Inc. and United Healthcare Insurance Co. The Department had alleged that the companies violated state laws by failing to make prompt and effective corrections to the problems with their claims systems when they became aware of them. The Department also alleged that the companies failed to promptly investigate and resolve complaints about claims errors.

Each company will pay $1.1 million in civil penalties. Neither company admitted any wrongdoing. Both companies have already conducted an in-depth study of their operations and have prepared to address the concerns at the heart of the Department's allegations.

The Stop & Shop Supermarket Co. and Walgreen Eastern Co. v. Blue Cross & Blue Shield of Rhode Island et al.
1st Cir., No. 03-2061 (6/24/04)

The U.S. Court of Appeals for the First Circuit upheld a district court's ruling that no *per se* violation of the antitrust laws was shown in an antitrust suit against a health plan and its pharmacy benefit manager for the establishment of a closed network of pharmacies. A three-judge panel determined that the defendants had not offered enough evidence to overturn a ruling made on summary judgment motion by the district court. The plaintiffs argued that Blue Cross & Blue Shield's creation of a closed network of pharmacies by contracting with PharmaCare, a subsidiary of CVS, to manage the insurer's pharmacy benefits program was a *per se* violation of the antitrust laws. The district court determined that the closed network is an exclusive dealing arrangement and therefore is not a *per se* violation, although it might still be considered unlawful using the rule of reason. Plaintiffs' also contended that an agreement between Blue Cross Blue Shield and United Healthcare of New England to admit their respective network pharmacies into each other's closed networks, which excluded Stop & Shop and Walgreens, was exclusionary. The district court characterized the horizontal agreements as not facially exclusionary or anti-competitive, and the appellate court agreed, stating that "*per se* condemnation is not appropriate."