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CLIENT ALERT

Managed Care Lawsuit Watch - July 2003

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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 those listed below or any member of the health law group.

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Cases in this issue:

- *Care Choices HMO v. Engstrom*
- *Horvath v. Keystone Health Plan East, Inc.*
- *International Healthcare Management v. Hawaii Coalition for Health*
- *Nordella v. Blue Cross of California*
- *United States ex rel. Willard v. Humana Health Plan of Texas, Inc.*

Care Choices HMO v. Engstrom
6th Cir. No. 01-2682/2717 (05/30/2003)

The Sixth Circuit Court of Appeals ruled that there is no federal cause of action for Medicare HMOs seeking reimbursement for benefits paid to an insured who also receives benefits from another source of insurance. The case began in 1998 when the defendant slipped and fell in a supermarket, sustaining serious injuries. Care Choices HMO, the defendant's Medicare HMO, paid over $56,000 in medical expenses to cover her injuries. The defendant filed a personal injury lawsuit against the supermarket, ultimately settling the suit for over $100,000. The settlement amount was paid by the supermarket's third party liability insurer.

Care Choices then filed suit in federal court to recoup the $56,000 the HMO had paid to cover the defendant's medical expenses. The district court dismissed the lawsuit for lack of subject matter jurisdiction, finding that the statutory provision permitting Medicare HMOs to seek reimbursement of benefits paid to an enrollee who also receives benefits from another insurer did not provide an avenue for the HMO to bring its suit in federal court. The Sixth Circuit agreed, finding that the provision neither contained an express right of action nor gave rise to an implied cause of action. Rather, the court found that while the statute allows an HMO to include a provision in its insurance contract making the HMO a secondary payer, such a provision must be enforced through a standard insurance contract claim. Care Choices, which had pursued and lost its contract claims in Michigan state court, was therefore not permitted to pursue reimbursement in federal court.

Horvath v. Keystone Health Plan East, Inc.
3rd Cir. No: 02-1731 (6/23/2003)

The Third Circuit upheld a district court's decision that Keystone Health Plan East, Inc., a Pennsylvania HMO, had no fiduciary obligation under ERISA to disclose its physician compensation scheme to a subscriber. The employee benefits administrator for a law firm, herself an enrollee in the health plan offered by her employer, filed a class action lawsuit against Keystone in January 2000 alleging that Keystone had violated its fiduciary duties under ERISA by failing to disclose information on physician compensation incentives. The plaintiff argued that these incentives impact the medical treatment decisions made by physicians in the Keystone plan. In upholding the district court's dismissal of the case, the Third Circuit found that the plaintiff had not alleged that she personally was harmed by not having such information, nor had she made Keystone aware that she needed such information to prevent her from making a harmful decision with respect to her coverage. The Third Circuit did, however, leave open the possibility for an HMO plan member to bring a suit on the basis that HMO financial incentives caused inadequate medical care to be provided.

International Healthcare Management v. Hawaii Coalition for Health
9th Cir. No. 01-17451 (6/6/2003)

The Ninth Circuit upheld a district court decision that activity by physician and consumer advocacy groups to influence the terms of an HMO's participating provider agreement ("PPA") did not violate federal antitrust laws. The HMOs had brought the suit in the federal court for the District of Hawaii after several physician groups had worked together to successfully pressure a competing HMO to change its PPA. When International Healthcare Management ("IHM") sent a mass mailing to 1000 physicians in Hawaii seeking to start a new HMO, the heads of several physician groups demanded that IHM make changes to its PPA, and also made their members aware of what the physician groups perceived to be deficiencies in the IHM plan. The physician groups' complaints related to IHM's credentialing procedures, hospital privilege requirements, indemnification provision, and other non-monetary terms. The physician groups did not seek to fix prices or boycott the plan's provider network. Absent a finding of such conduct, the Ninth Circuit ruled that the physician and consumer groups had not engaged in anticompetitive activity in violation of the Sherman Act.

Nordella v. Blue Cross of California
Cal. Super. Ct. BC297291 (6/11/2003)

Plaintiff Nordella, a California physician, filed a suit against Blue Cross of California, alleging that Blue Cross terminated him as a participating provider in retaliation for his refusal to accept the company's medical coverage policies. After losing a lawsuit to

Nordella over nonpayment of patient claims, Blue Cross put Nordella on "claims audit" status, citing his higher-than-average utilization of lab services. Blue Cross's medical director also informed Nordella that he was overusing lab tests and that he was billing a higher office visit code while his records indicated a less extensive examination. Nordella did not change his billing practices or lab usage, and was ultimately terminated by Blue Cross for billing Blue Cross for services that Blue Cross determined were not medically necessary. Nordella then filed the subject lawsuit, alleging that Blue Cross downcoded or denied hundreds of claims submitted by Nordella during the audit, and seeking damages for wrongful termination in violation of public policy, breach of contract, defamation, breach of implied covenant of good faith, and violation of due process, among other things.

United States ex rel. Willard v. Humana Health Plan of Texas, Inc.
5th Cir. No. 02-40285 (6/26/2003)

The Fifth Circuit upheld a district court's dismissal of a *qui tam* action against Humana Health Plan of Texas. The action had alleged that Humana had violated the federal False Claims Act by discouraging less healthy patients from joining Humana's Medicare+Choice plan. In a lawsuit brought in 1999, fired Humana sales representative turned whistleblower Irvin Willard filed a lawsuit alleging that Humana was systematically "cherry-picking" healthy Medicare beneficiaries to enroll and trying to prevent less healthy beneficiaries from learning about Humana's services. Humana had received a Medicare contract for the five counties in the Houston area. Willard alleged that Humana only sought to enroll beneficiaries in metropolitan Harris County, while discouraging enrollment in the four more rural counties. The United States declined to intervene in Willard's suit, and the district court in Texas dismissed Willard's suit for failure to state a claim.

Before the Fifth Circuit, Humana argued that any alleged discrimination must occur within the population for which uniform rates have been set, and that because CMS sets rates on a county-by-county basis, Willard would have to show that Humana discriminated within each county, not that Humana discriminated between counties. The court agreed, finding that Willard had not alleged that Humana had actually discriminated against the rural counties, only that Humana had not aggressively advertised in the rural counties. In the court's view, this did not amount to discrimination.