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CLIENT ALERT

Managed Care Lawsuit Watch - April 2014

April 25, 2014

This summary of key lawsuits affecting managed care is provided by the Health Care Group of Crowell & Moring. 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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Maimonides Med. Ctr. v. First United Am. Life Ins. Co.
981 N.Y.S.2d 739 (App. Div. 2014)

The New York Appellate Division determined that claimants can bring a private suit against insurers that fail to comply with the Prompt Pay Law to recover the full amount of the claim plus 12 percent interest.

New York's Prompt Pay Law, Insurance Law § 3224, requires an insurer to pay undisputed claims within 30 days after receipt of submission (45 days if the submission is not electronic). If the claim is disputed, the Prompt Pay Law requires that the insurer notify the claimant of the reason of the denial or request additional information necessary to determine the insurer's liability for payment of the claim within 30 days of receiving the claim. An insurer that does not comply with the Prompt Pay Law must pay the health care provider or the claimant the full amount of the claim plus 12 percent interest per annum.

Maimonides Medical Center provided services to six patients who had insurance coverage policies with First United American Life Insurance Company. After the patients assigned their benefits under the First United policy to Maimonides, the health care provider sued First United.

Maimonides alleged, *inter alia*, that First United violated the Prompt Pay Law for failing to pay the balance owed to the beneficiaries or to provide written notice of denial or a request for more information despite repeated demands for payment.

First United moved to dismiss Maimonides' complaint, arguing that the Prompt Pay Law can be enforced only by the New York State Superintendent of Insurance and cannot be enforced through a private right of action. The Supreme Court disagreed, reasoning that since subsection (c) of the Prompt Pay Law provides that insurers "shall be obliged" to pay health care providers or patients in full for any violations, the Prompt Pay Law is properly interpreted to expressly provide a private right of action.

On appeal, the New York Appellate Division affirmed the trial court's decision to deny First United's motion to dismiss but held that the Prompt Pay Law provides an *implied* right of action (not *express*). The panel determined that subsection (c) does not expressly provide for a private right of action, but does impose specific duties on insurers and creates rights in patients and health care providers. Relying on *Henry v. Issac*, 214 A.D.2d 188, which held that an implied private right of action existed to enforce rights provided by the New York Social Services Law, the court concluded that the creation of an implied right to enforce the Prompt Pay Law would be fully consistent with the legislative scheme of the New York Insurance Law. Moreover, because of the straight-forward nature of the law, the court noted that private enforcement would not put the court in position of settling disputes that require agency expertise.

As a result, health care providers may assert a private cause of action for alleged violations of the Prompt Pay Law if an insurer fails to pay a claim in full or dispute it within the specified time.

PAMC v. Sebelius
No. 12-56652 (9th Cir. April 8, 2014)

Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 establishes a financial incentive for certain hospitals to report on the quality of the inpatient care they provide. This section authorizes CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates.

Pacific Alliance Medical Center (PAMC), a certified provider of inpatient Medicare services, participated in the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program established under Section 501(b). Because of an error by its third-party vendor, PAMC missed the deadline to submit certain data pursuant to RHQDAPU program by about 12.5 hours – submitting data at 12:27 pm on November 21, 2007, instead of by 11:59 pm on November 20, 2007. As a result, CMS notified PAMC that it would reduce PAMC's market basket update by two percent (the measure of inflation in costs of goods and services used by hospitals in treating Medicare patients).

PAMC requested that CMS reconsider its decision, arguing that it had been diligent in submitting the data and that the delay resulting from an error by PAMC's third-party agent should be excused. CMS and the Provider Reimbursement Review Board (Board) denied PAMC's appeal. PAMC then sought review of the denial by the district court, under the Administrative Procedures Act (APA). The District Court held that the decision did not violate the APA because CMS and the Board did not have authority to award equitable relief when the provider had missed the statutory deadline through its own fault, and that the doctrine of substantial compliance did not apply in the Medicare context.

The United States Court of Appeals for the Ninth Circuit affirmed. The court agreed that the Board did not have authority to grant equitable relief to PAMC for its failure to comply with the statutory deadline. The court noted that while CMS may have discretion to waive the penalty if the error was its own, this discretion does not expand to the Board for curing errors resulting from the provider or the provider's agent. Therefore, the Ninth Circuit concluded that the Board did not act arbitrarily or capriciously when it denied equitable relief.

The court also rejected PAMC's argument that the contractual doctrine of substantial performance should apply. In relying on CMS's long-standing strict policy in the area of timely submissions of data report, the court held that the Board's adherence to this strict compliance policy was not arbitrary and capricious. The Ninth Circuit, however, was careful to limit its holding to the facts of the case and made clear that its holding should not be read as a blanket ban on the application of the substantial compliance doctrine in the Medicare arena.

Connecticut General Life Insurance Company v. Grand Avenue Surgical Center, Ltd.
No. 1:13-cv-04331 (N.D.Ill. Jan. 14, 2014)

The United States District Court for the Northern District of Illinois denied a motion to dismiss the defendant health care provider's counterclaim that it was entitled to payment for services based on state law theories of negligent misrepresentation and promissory estoppel, disagreeing with the plaintiff's argument that the counterclaim was preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

Grand Avenue Surgical Center, Ltd. (GASC), the defendant, engaged in a billing practice known as "fee forgiveness," in which it allegedly accepted amounts paid to it by CT General as full payment for its services, and waived or failed to collect charges billed to patients such as coinsurance rates, copayments, and amounts necessary to meet plan deductibles. CT General maintains that the defendant's fee forgiveness practice triggers two plan provisions under which coverage is excluded for: (1) charges which the plan members are not obligated to pay, for which they are not billed, or for which they would not have been billed except that they were covered under the plan; and (2) charges which would not have been made if the plan member had no insurance.

Based on these plan provisions, CT General claimed that GASC is not entitled to reimbursement on disputed or denied reimbursement claims. In its counterclaim for payment for services, GASC alleged that CT General confirmed eligibility, coverage and benefits before each plan member's scheduled procedure and failed to disclose any limitations or restrictions on coverage, and that it is entitled to payment based on state law theories of negligent misrepresentation and promissory estoppel.

CT General brought a motion to dismiss the defendant's counterclaim based on three arguments. First, CT General argued that the defendant's counterclaim was preempted by ERISA section 502(a). The court applied a two-part test established by the Supreme Court (the *Davila* test) to determine whether a state law claim falls within the scope of ERISA section 502(a). The court stated that the counterclaim was not preempted because under the first prong of the test, GASC's promissory estoppel counterclaim could not have been brought under ERISA section 502(a) as it did not arise from the terms of the plan but rather from alleged oral representations. It also failed the second prong of the test because the counterclaim implicated legal duties independent of ERISA. As neither prong of the test supports the preemption argument, the Court denied the motion to dismiss due to preemption under ERISA section 502(a).

Second, CT General argued that the defendant's counterclaim was preempted by ERISA section 514(a), which (subject to the savings clause that is not relevant here) preempts any and all state laws that relate to ERISA plans. The court disagreed, stating that ERISA section 514(a) does not preempt a state law claim that makes no reference to or functions irrespective of the existence of the ERISA plan, and that, here, the defendant's counterclaim was not premised on the existence of an ERISA plan. The Court denied the motion to dismiss due to preemption under ERISA section 514(a) because the counterclaim did not "relate" to an ERISA plan.

Third, CT General sought to dismiss the defendant's counterclaim for failure to state a claim upon which relief may be granted. The court held that because the preemption arguments did not apply here, whether GASC stated a plausible claim must be evaluated under Illinois law. Finding that a plausible claim existed under Illinois law, the court denied the motion to dismiss.

GASC's cross motion for partial summary judgment on the ERISA preemption defense was also denied as moot for the reasons above.

In Re Humana Insurance Company (Regulatory Settlement Agreement)
NAIC # 73288 (December 4, 2013)

On December 4, 2013, Humana Insurance Company (Humana) entered into a Regulatory Settlement Agreement with the Missouri Department of Insurance, Financial Institutions and Professional Registration, the Wisconsin Office of the Commissioner of Insurance and the Mississippi Insurance Department (the "Lead States") and other insurance regulators.

The Lead States had alleged that Humana required employers who purchased small group medical insurance to also have purchased a group life insurance product. Humana and the Lead States agreed to a corrective plan that contains several notice and payment requirements. First, Humana will enhance compliance procedures and resources, particularly in regards to additional staffing and training, to improve its regulatory compliance. Second, Humana will communicate the fact that small group medical insurance sales may not be contingent upon a sale of life insurance products. Humana is to give notice to agents (within 60 days of the settlement agreement) and employers who have both the relevant medical and insurance coverage. Finally, Humana will establish an employer reimbursement program (containing a pool of $2.7 million) to provide a monetary settlement to employers who were sold medical insurance contingent upon purchase of life insurance. The Lead States will monitor compliance with the agreement.

Melamed v. Blue Cross of California
No. 12-55284, 2014 WL 543409, (9th Cir. Feb. 12, 2014)

The United States Court of Appeals for the Ninth Circuit affirmed the removal and dismissal of an underpayment action brought by Dr. Hooman Melamed on behalf of himself and his medical practice, Hooman Melamed MD., Inc. (collectively "Melamed"), against Blue Cross of California and Anthem Blue Cross Life and Health Insurance Company (collectively the "WellPoint

defendants"). The Ninth Circuit held that Melamed's breach of implied contract claims were completely preempted by the Employee Retirement Income Security Act of 1974 (ERISA) and were barred under Federal Rule of Civil Procedure 41(a)(1)(B)'s "two dismissal" rule.

Prior to bringing the instant action, Melamed filed and voluntarily dismissed two prior suits against the WellPoint defendants, both of which alleged that the defendants had failed to pay him the usual, customary, and reasonable rate for the care he provided as an out-of-network provider.

After his first two voluntary dismissals, Melamed subsequently filed the third action against the WellPoint defendants in the Los Angeles County Superior Court, again claiming that the defendants systematically underpaid him. Specifically, Melamed alleged that as a direct and proximate result of the WellPoint defendants' breach of their obligations under written contracts between themselves and their members—to which Melamed was a third-party beneficiary—Melamed had suffered damages in the form of underpayments.

The WellPoint defendants removed the case to the United States District Court for the Central District of California on the ground that at least one of Melamed's claims was completely preempted by ERISA. The District Court held that removal was proper and that Melamed's breach of implied contract claim was completely preempted "because through that claim, Melamed s[ought] reimbursement for benefits that exist[ed] 'only because of [the defendant's] administration of ERISA-regulated benefit plans.'"

The court then dismissed Melamed's complaint with prejudice pursuant to the "two dismissal" rule of Rule 41(a)(1)(B), which provides that if a plaintiff "previously dismissed any federal- or state-court action based on or including the same claim, a notice of dismissal operates as an adjudication on the merits." The court found that Melamed's claims "arose out of 'the same transactional nucleus of facts,' involve[d] infringements of the same rights, and would involve the same evidence" as the first two voluntarily dismissed lawsuits. The court also staunchly rejected Melamed's argument that because the present action contained claims based on patient treatment that post-dated the dismissal of his first voluntarily-dismissed complaint the current action did not fall under the "two dismissal" rule.

United States ex rel. Estey v. Tennessee Orthopaedic Clinics PC et al.
No. 3:12-cv-00085 (E.D. Tenn. Jan. 24, 2014)

Two orthopedic clinics in Tennessee entered into settlements with federal and state enforcement authorities, totaling approximately $2 million, relating to the purchase of drugs from international sources. The settlements allege that Appalachian Orthopaedic Associates, P.C. (AOA) and Tennessee Orthopaedic Clinics, P.C. (TOC) purchased the viscosupplement medications Syncvisc and/or Orthovisc from abroad and billed federal health care programs for the drugs. These viscosupplement drugs, which are used to treat knee pain, are reimbursed by Medicare, Medicaid, and other federal health care programs based on their average sales price in the United States. The international market price for the drugs is lower. The enforcement authorities contend that by purchasing and reimporting the unregulated drugs at lower prices on international markets, and then submitting claims to the federal health care programs for the drugs based on the higher U.S. average sales price, the clinics were submitting false claims and garnering an unlawful profit. On a general level, enforcement authorities expressed concerned that

when the drugs are purchased internationally, there are no assurances about how the drugs have been stored and if they have been tampered with—risks that are potentially shifted onto the patient for whom the medications are prescribed.

The investigation and settlements emerged from a *qui tam* suit filed by a physician representative for a pharmaceutical manufacturer of one of the viscosupplements. TOC will pay over $1.3 million to settle the matter; AOA will pay approximately $600,000 in connection with its settlement. Reports have indicated that the relator will receive approximately $325,000 for his participation in the matter. Each of the two settlements was entered into between federal and state authorities and the relevant clinic, and covered the False Claims Act, the Civil Monetary Penalties Law, the Program Fraud and Civil Remedies Act, and certain common law claims, among other types of liability. TOC's settlement covers the period of time between January 2008 and August 2012; AOA's settlement covers April 2007 to April 2012.

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