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CLIENT ALERT

Managed Care Lawsuit Watch - August 2016

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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 Care Group.

Cases in this issue:

- *Gobeille v. Liberty Mut. Ins. Co.*
- *Shane Group, Inc. v. Blue Cross Blue Shield of Michigan*
- *United States of America v. AseraCare, Inc.*
- *Gopal v. Kaiser Found. Health Plan, Inc.*
- *Kobold v. Aetna Life Ins. Co.*
- *Capital Health Sys., Inc. v. Horizon Healthcare Servs., Inc.*

Gobeille v. Liberty Mut. Ins. Co.
136 S. Ct. 936 (2016)

The U.S. Supreme Court affirmed the Second Circuit's ruling that Employee Retirement Income Security Act (ERISA) preempts a Vermont reporting statute that requires health plans to report detailed claims and member information as part of the state's efforts to track health care utilization, costs, and resources. Liberty Mutual Insurance Company (Liberty Mutual) maintains a health plan that provides benefits in all 50 states to over 80,000 individuals and is subject to ERISA. Liberty Mutual's plan was not required to report claim information under the Vermont statute because it covers fewer than the threshold number of Vermont residents. Liberty Mutual, however, uses Blue Cross Blue Shield of Massachusetts (Blue Cross) as a third-party administrator. Blue Cross serves several thousand Vermonters and thus must report the information it possesses about Liberty Mutual's Vermont members under the statute. Liberty Mutual, concerned in part that the disclosure of confidential information about its members may violate its fiduciary obligations under its plan, instructed Blue Cross not to comply with the Vermont statute.

Liberty Mutual sought a declaration in the U.S. District Court for the District of Vermont that ERISA preempts application of Vermont's mandatory reporting statute to Liberty Mutual's plan and sought an injunction precluding Vermont from acquiring data about Liberty Mutual members. The District Court granted summary judgment in favor of Vermont and the Second Circuit reversed.

In determining that ERISA preempts the Vermont statute, the majority explained that there are two categories of state laws that ERISA preempts. First, ERISA preempts state laws that reference ERISA plans and act exclusively upon them. Second, ERISA preempts state laws that govern a “central matter” of ERISA plan administration or interfere with ERISA's goal of nationally uniform plan administration. The Supreme Court recognized that the purpose of ERISA is to ensure the security of benefits promised by employers by mandating certain oversight systems and other standard procedures. These systems and procedures are intended to be uniform across the country.

Justice Kennedy, on behalf of the six justice majority, found that ERISA’s reporting and disclosure requirements for welfare benefit plans are central to, and an essential part of, the uniform system of plan administration contemplated by the federal statute. The panel concluded, therefore, that Vermont’s reporting regime both intrudes on a central matter of ERISA plan administration and interferes with ERISA’s goal of uniform plan administration. The panel also explained that differing, or even parallel, regulations from multiple states could create wasteful administrative costs and subject plans to wide-ranging liability. The majority further noted that preemption is necessary to prevent the states from imposing inconsistent and costly reporting requirements on benefit plans.

The majority rejected Vermont’s argument that Liberty Mutual failed to demonstrate the reporting statute in fact caused it to suffer economic costs, finding that a plan did not need to wait until it suffered the costs of inconsistent obligations in order to bring a preemption claim. Vermont also argued that ERISA does not preempt the state reporting scheme because it has different objectives than ERISA, namely, to manage health care costs of the state, as compared to ERISA’s goal of ensuring the security of employee benefits. The majority held that the perceived difference in the objectives of the Vermont statute and ERISA does not suffice to avoid preemption, because the Vermont statute still imposes a direct regulation on plans’ reporting and disclosure requirements, which is a key facet of ERISA plan administration. Finally, the majority rejected Vermont’s argument that the regulation of public health, as a traditional state police power, cannot be preempted. The majority explained that ERISA in fact contemplated the preemption of substantial areas of state regulation. It held that ERISA preempts a state law that regulates a central matter of plan administration even if the state law exercises a traditional state power.

Justices Thomas and Breyer wrote separate concurring opinions. Justice Thomas expressed concern that ERISA’s express preemption provision may be an improper exercise of Congressional power. On the other hand, Justice Breyer’s concurrence emphasized that the failure to find preemption would impose serious administrative problems by requiring plans to satisfy 50 or more reporting requirements imposed by various state statutes.

Justice Ginsberg filed a dissenting opinion, in which Justice Sotomayor joined. The dissent emphasized the need for state-based health care data-collection laws and concluded that the Vermont data-collection scheme does not infringe on the objectives of ERISA.

For more information, please contact: Lauren Riley and Harsh P. Parikh

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Shane Group, Inc. V. Blue Cross Blue Shield of Michigan
No. 15-1544, 2016 WL 3163073 (6th Cir. June 7, 2016)

According to the U.S. Department of Justice (DOJ), beginning no later than 2007, Blue Cross Blue Shield of Michigan (BCBS-MI) used its "extraordinary" market power to reach "most favored nation" agreements with Michigan hospitals. Under these agreements, BCBS-MI agreed to raise its own reimbursement rates for hospital services as long as the hospital agreed to charge other insurers rates at least as high as the hospital charged BCBS-MI. Several putative class actions were filed, adopting many of the government's allegations. Once consolidated, these cases sought more than $40 billion in damages, plus fees and expenses. In March 2013, Michigan banned the use of agreements like those BCBS-MI negotiated. With the relief it sought, the DOJ voluntarily dismissed its case. Plaintiffs' expert report estimated that the "most favored nation" agreements caused damages of $118 million. In June 2014, BCBS-MI agreed to settle the case for $30 million – leaving $14.6 million for class members after deducting attorney's fees and other expenses.

The U.S. Court of Appeals for the Sixth Circuit vacated the U.S. District Court for the Eastern District of Michigan's approval of the settlement primarily because of the extensive sealing of filings the appellate court said should have been available to the public. The sealed documents included class certification briefing and the expert report that purported to detail the scope of antitrust damage. In a strongly worded opinion, the appellate court pointed out that despite the "stark difference" between the standard for Federal Rule of Civil Procedure 26 protective orders applicable to documents exchanged during discovery and the standard for sealing documents filed with courts, parties routinely conflate the two. "One can only conclude that everyone in the district court was mistaken as to which standard to apply," the court said. "But one point is unmistakable: on the showings set forth in this record, every document that was sealed in the district court was sealed improperly." Unlike information exchanged during discovery, the "public has a strong interest in obtaining the information contained in the court record."

The appellate court went on to explain that in an antitrust case involving insurance rates Michigan residents paid, the public has an interest in understanding the conduct that gave rise to the case. Thus, documents should only be sealed if "a party can show a compelling reason" to do so, and the district court "set[s] forth specific findings and conclusions which justify nondisclosure to the public." The court explained that even if neither party objects, a court that seals something must explain precisely exactly why it did so.

The Sixth Circuit sent the case back to the district court ordering the district court to "begin the Rule 23(e) process anew."

For more information, please contact: Rochelle Leigh Rosenberg and Harsh P. Parikh

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United States of America v. AseraCare, Inc.
No. 2:12-CV-245-KOB, 2016 WL 1270521 (N.D. Ala. Mar. 31, 2016)

The U.S. District Court for the Northern District of Alabama awarded summary judgment to AseraCare in a False Claims Act (FCA) case stemming from whistleblower allegations that AseraCare knowingly certified clinically ineligible patients as eligible for Medicare hospice benefits. The court found that when hospice certifying physicians and medical experts look at the same medical records and disagree about whether the medical records support hospice eligibility, the opinion of one medical expert alone is not sufficient to prove falsity as a matter of law.

The government alleged that AseraCare submitted false claims to Medicare by certifying patients as eligible for hospice benefits who did not have a prognosis of "a life expectancy of 6 months or less if the terminal illness runs its normal course." Such certifications, known as Certificates of Terminal Illness, are based on the certifying physician's clinical judgment. To prove falsity, the government relied on the testimony of its medical expert, Dr. Solomon Liao, and the patients' medical records, which Dr. Liao contended did not support the patients' prognoses.

Although the court initially denied AseraCare's motion for summary judgment, the court *sua sponte* reconsidered the motion after vacating a jury verdict in favor of the government upon finding that the court's jury instructions were incorrect. Specifically, the district court determined that it should have instructed the jury that a mere difference of opinions among physicians, without more, is insufficient to show falsity under the FCA.

On reconsideration of AseraCare's motion for summary judgment, the court determined that the government failed to point to any admissible evidence to prove falsity other than Dr. Liao's opinion that the patients' medical records at issue did not support certification for hospice services. Importantly, AseraCare's medical experts opined that the information in the same patient medical records supported hospice eligibility. The court found that this difference in opinion among experts alone did not constitute falsity under the FCA. In support of its ruling, the court noted that CMS guidance emphasizes the importance of a physician's clinical judgment in the hospice certification process. Thus, the court reasoned that allowing a mere difference of opinion among physicians to prove falsity "would totally eradicate the clinical judgment required of the certifying physicians." The court further observed that the government had "backed itself into a corner regarding its proof of falsity" by representing to the court that the government did not intend to use the testimony of relators' or the treating clinicians' to prove falsity. Instead, the government relied solely on the testimony of an expert who simply offered expert opinion based on the expert's clinical judgment.

Because a difference of opinion between physicians and medical experts about which reasonable minds could differ was all the government presented to prove falsity of the claims for the patients at issue, the district court concluded that the falsity element could not be proven as a matter of law and, therefore, granted AseraCare's motion for summary judgment.

For more information, please contact: Brian Lewis and Harsh Parikh

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Gopal v. Kaiser Found. Health Plan, Inc.
B259808 (Cal. Ct. App. 2d Dist. May 26, 2016).

The California Court of Appeal affirmed summary judgment in favor of Kaiser Foundation Health Plan, Inc. (Kaiser Health Plan) and rejected plaintiffs' enterprise theory of liability in a wrongful death action based on the alleged failure of a Kaiser Health Plan-contracted hospital to treat a patient during an emergency.

The plaintiffs claimed that the failure of Kaiser Downey Hospital, which is exclusively contracted with Kaiser Health Plan, to appropriately care for plaintiff Gopal caused her death. The hospital initially determined that Gopal had a brain bleed—a neurosurgical emergency—but that the hospital did not have a neurosurgery department and therefore could not treat her. Gopal was not a Kaiser Health Plan member, so the hospital followed its procedures for members of non-contracted health plans by contacting Gopal's health plan, CareMore, and referring her for care pursuant to CareMore's instructions. Gopal received surgery after a lengthy wait, and died shortly thereafter.

At the trial court, the plaintiffs argued that the hospital's failure to provide timely treatment to Gopal resulted in her death and that Kaiser Health Plan should be liable for the omission because Kaiser Health Plan and the hospital "comprise one integrated, joint enterprise that is completely controlled by the entity with the money and power." The three-judge panel rejected plaintiffs' theory.

First, the court explained that Kaiser Health Plan is a health care service plan authorized under California's Knox-Keene Health Care Service Plan Act (Knox-Keene Act). Health care service plans are not health care providers. Rather, health care service plans contract with providers who deliver and furnish health care services. Kaiser Health Plan's exclusive contract with the hospital delegated duties onto the provider pursuant to the Knox-Keene Act and the Act "bars claims against a plan for vicarious liability."

The plaintiffs did not challenge the Knox-Keene Act's bar against vicarious liability, but instead claimed enterprise liability based on California common law. The court noted that enterprise liability is available to plaintiffs under limited circumstances. First, the separate entities must have interests that are so aligned that "the separate corporate personalities are merged," and one entity "is a mere adjunct of the other or the two companies form a single enterprise." Second, an inequitable result must follow if the acts or omissions at issue are treated as those of only one entity rather than the two as a combined entity.

The panel determined that neither condition was met. With respect to the first condition, the court did not find fault with the arrangement between Kaiser Health Plan and the hospital. The court stated that the contractual relationship between the two entities was not only appropriate, but it was necessary under the Knox-Keene Act to permit Kaiser Health Plan to meet its obligations. The court further determined that no inequitable result would follow by granting summary judgment as to Kaiser Health Plan because the appropriate defendants to the action, the hospital and the other providers that were involved with the patient's care, remained defendants. Therefore, the court upheld the trial court's grant of summary judgment to Kaiser Health Plan.

For more information, please contact: Joe Records and Harsh P. Parikh

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Kobold v. Aetna Life Ins. Co.
No. 1-CA-CV 12-0315 (Ct. App. Ariz. Mar. 31, 2016)

On March 31, 2016, the Arizona Court of Appeals, Division One issued its decision in *Kobold v. Aetna Life Ins. Co.*, 2016 Ariz. App. LEXIS 49 (Kobold II). In a concise decision on remand, the three judge panel unanimously held that the regulations regarding subrogation and reimbursement issued by the Office of Personnel Management (OPM) are entitled to deference under *Chevron* and the Court of Appeals was bound to interpret the Federal Employees Health Benefits Act (FEHBA) as preempting Arizona's anti-subrogation law.

The same court had previously ruled, in *Kobold v. Aetna Life Ins. Co.*, 233 Ariz. 100 (Ct. App. Ariz. Sept. 5, 2013) (Kobold I), that FEHBA did not preempt Arizona law prohibiting subrogation in personal injury cases. The court reasoned that the FEHBA preemption provision at 5 U.S.C. § 8902(m)(1) did not encompass subrogation and reimbursement because there is no direct and immediate relationship between subrogation and "coverage or benefits (or payments with respect to benefits)." Aetna appealed Kobold I to the Arizona Supreme Court, which declined to review the case. On June 9, 2014, Aetna filed a petition for writ of *certiorari* with the U.S. Supreme Court.

While the petition was pending before the Supreme Court, OPM promulgated new regulations construing the statute to include subrogation and reimbursement terms in FEHBA Program contracts (the "OPM regulations"). 5 C.F.R. § 890.106 (80 Fed. Reg. 29,203 (May 21, 2015)). The OPM regulations made clear the agency's view that subrogation and reimbursement "relate to" coverage and benefits (or payment with respect to benefits) as required to be encompassed under the FEHBA preemption provision. In light of the new OPM regulations, the Supreme Court vacated the Arizona Court of Appeals decision in Kobold I, and remanded the case for reconsideration of the preemptive effect of FEHBA. *Aetna Life Ins. Co. v. Kobold*, 135 S. Ct. 2886 (2015)

As an initial matter on remand, the court determined that the OPM regulations are procedurally eligible for *Chevron* deference. The administrative law principle of *Chevron* deference requires federal and state courts to defer to interpretations of federal statutes made by their enforcing federal agencies, unless such interpretations are unreasonable. OPM is specifically tasked with prescribing regulations necessary to carry out FEHBA and the OPM regulations are a product formal notice-and-comment rule-making process. 5 U.S.C. § 8913(a). Thus, the Arizona Court of Appeals found that the OPM regulations qualify procedurally for *Chevron* deference because Congress delegated authority to the agency to make rules carrying the force of law, and OPM's interpretation claiming deference was promulgated in the exercise of that authority. *See US v. Mead Corp.*, 533 U.S. 218, 226-27 (2001).

The Arizona Court of Appeals next determined that the OPM regulations qualify substantively for *Chevron* deference. The appellate court acknowledged that OPM's interpretation is reasonable in light of U.S. Supreme Court precedent holding that FEHBA's preemption provision was susceptible to multiple "plausible constructions" on the issue of whether subrogation and reimbursement are encompassed by 5 U.S.C. § 8902(m)(l), and therefore is entitled to *Chevron* deference. Under the *Chevron* doctrine, the court must defer to an agency's reasonable interpretation of a statute, even when the agency's interpretations is unwise or is not the most reasonable interpretation, so long as it is based on a "permissible construction of the statute." *Chevron*, 467 U.S. at 843; *US v. Mead Corp.*, 533 U.S. at 229. The Court of Appeals therefore observed that they were compelled to apply OPM's interpretation, although with the objections that the Kobold I interpretation of the FEHBA preemption provisions was more reasonable.

Accordingly, in view of 5 C.F.R. § 890.106, the Court of Appeals reversed the Arizona superior court's grant of summary judgment to Kobold and remanded for entry of judgment in Aetna's favor. The Court of Appeals also denied Kobold's request for attorneys' fees and costs.

For more information, please contact: Harsh P. Parikh

Capital Health Sys., Inc. v. Horizon Healthcare Servs., Inc.
No. A-2913-15T2, 2016 WL 3434140 (N.J. Super. Ct. App. Div. June 23, 2016)

St. Peter's Univ. Hospital v. Horizon Healthcare Servs., Inc.
No. A-2929-15T2, 2016 WL 3434140 (N.J. Super. Ct. App. Div. June 23, 2016)

Consolidating two related cases, the New Jersey Superior Court Appellate Division reversed a series of trial court discovery orders mandating that Horizon Healthcare Services, Inc. (Horizon) produce six categories of confidential and proprietary documents to seven of its in-network hospitals regarding Horizon's creation of its new OMNIA provider network.

Horizon established its two-tier OMNIA provider network in 2015, seeking approval of the network from the New Jersey Department of Banking and Insurance on June 25, 2015. Horizon publicly announced the launch of the network on September 10, 2015. The OMNIA network created two tiers of providers – Tier 1 and Tier 2 – and created incentives for members to select Tier 1 providers by offering lower premiums, deductibles, co-insurance, and co-payments. In consultation with McKinsey & Company, Horizon established the selection criteria for Tier 1 providers. After identifying seven hospitals that met those requirements, Horizon entered into agreements with those Tier 1 providers.

The plaintiffs – seven hospitals that Horizon designated as Tier 2 providers – subsequently filed suit, claiming that Horizon's creation of the OMNIA network, as well as their Tier 2 designations, violated the terms of the plaintiffs' network agreements with Horizon. The Tier 2 hospitals claimed, *inter alia*, that Horizon failed to provide 60 days' advance notice of the OMNIA network (as required by contract); failed to disclose the criteria used to select the Tier 1 hospitals; failed to select them as Tier 1 hospitals or provide an opportunity to demonstrate their eligibility for Tier 1 status; improperly established criteria that favored their competitors and larger hospital systems; and improperly marketed Tier 1 hospitals as better than Tier 2 hospitals.

In challenging their Tier 2 status, the plaintiff hospitals sought six categories of documents in expedited discovery: (1) a report prepared by McKinsey & Company regarding the Tier 1 selection criteria; (2) Horizon's agreements with the Tier 1 hospitals and a Letter of Intent with a specific Tier 1 hospital; (3) the template agreement that Horizon used for the Tier 1 hospitals; (4) information regarding the formulation of the Tier 1 selection criteria; (5) the "scores" of the Tier 1 hospitals under the criteria; and (6) communications between Horizon and the Tier 1 hospitals.

Horizon alleged that the documents the plaintiffs sought were irrelevant to the plaintiffs' claims, as well as confidential and proprietary under the terms of the various network contracts and protected under the trade secret privilege. Despite Horizon's arguments, the trial courts in both cases ordered that Horizon produce unredacted or minimally redacted versions of the documents, mandating the disclosure of business-sensitive rate information, financial projections, contract terms, and the proprietary Tier 1 ranking criteria for the OMNIA network.

The Appellate Division ruled that all of the documents the plaintiffs sought were marginally relevant to their claims – if at all – and that Horizon's production of unredacted or minimally redacted documents would give plaintiffs an unfair business advantage over Horizon and other provider competitors. Moreover, the court ruled that when balancing any alleged relevance against Horizon's interest in maintaining the confidential and proprietary nature of the documents, Horizon's interests undoubtedly prevailed. The court thus allowed Horizon to redact the confidential and proprietary business information contained in the requested documents.

For more information, please contact: Ashley Southerland and Harsh P. Parikh

MCLW editors: Arthur N. Lerner, William A. Helvestine, and Harsh P. Parikh

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For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Christopher Flynn
Partner – Washington, D.C.
Phone: +1 202.624.2864
Email: cflynn@crowell.com

Peter Roan
Partner – Los Angeles
Phone: +1 213.443.5571
Email: proan@crowell.com

Lauren R. Nunez
Counsel – Washington, D.C.
Phone: +1 202.624.2559
Email: lnunez@crowell.com

Rochelle-Leigh Rosenberg
Counsel – Washington, D.C.
Phone: +1 202.624.2683
Email: rrosenberg@crowell.com

Joe Records
Counsel – Washington, D.C.
Phone: +1 202.624.2709
Email: jrecords@crowell.com

Brian C. Lewis
Associate – Washington, D.C.
Phone: +1 202.624.2962
Email: blewis@crowell.com