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CLIENT ALERT

Managed Care Lawsuit Watch - December 2006

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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 Art Lerner or any member of the health law group.

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Cases in this issue:

Kansas City Urology Care, P.A., et al., v. Blue Cross and Blue Shield of Kansas City, Inc., et al.
Circuit Ct. of Jackson Cty., Missouri 0516-CV04219 Dec. 4, 2006

The Circuit Court of Jackson County, Missouri, refused to order arbitration of a group of doctors' class action claims that several health insurance companies conspired to, within the Kansas City area, fix the prices of physician services in violation of Missouri's antitrust statutes.

At issue were the arbitration clauses contained in the network participation agreements by and between the physicians and each of United Healthcare, Blue Cross and Blue Shield of Kansas City, and Humana. The court first determined that the arbitration provision in the agreement with Humana, which specifically touched upon the arbitration of antitrust claims and precluded the bringing of class action claims, would compel the arbitration of antitrust claims against Humana and further preclude any class action claim. However, the court refused to compel arbitration, determining that the provision was unenforceable and void as against public policy.

The court then determined that the arbitration clauses in the Blue Cross and Blue Shield of Kansas City and United agreements, which did not contain such specific language, would be construed not to compel arbitration of the physicians' claims, thereby avoiding the unconscionability issue.

Claiming that the physicians would be unable to try – let alone prove – their allegation that the insurers acted in concert without being able to join *all* parties in litigation, the court found "a factual perfect storm that makes these contracts unconscionable and against the public policy." For these reasons, the court voided the arbitration clauses at issue and denied all defendant insurers' motions to compel arbitration.

The court, anticipating an immediate appeal by the defendant insurers, stayed the entirety of the litigation and posed four questions that a Missouri State appellate court may wish to consider upon appeal.

Ciamaichelo v. Independence Blue Cross
Pennsylvania Supreme Court No. J-64-2004 Nov. 21, 2006

The Pennsylvania Supreme Court reinstated the state statutory and common law claims of an employee benefit plan sponsor and one of its insureds, who had alleged that Independence Blue Cross ("IBC"), instead of reducing health insurance premiums, had, as a non-profit, improperly retained an excessive amount of reserves in order to fund acquisitions of competitors, increase benefits to officers and directors, and invest in for-profit subsidiaries.

Rob Stevens Inc. and its president claimed, in a class action suit, that IBC's retention of $613 million in reserves in 2000 constituted a breach of contract, a breach of fiduciary duty and a violation of the Pennsylvania Non-Profit Law. IBC's reserves allegedly equaled 88% percents of what it paid in claims and expenses in 2000, and Blue Cross Blue Shield Association guidelines state that reserves of 25% of claims and operating expenses is appropriate surplus for unexpected circumstances and contingencies.

The trial court refused to dismiss the plaintiffs' claims, but a commonwealth court reversed, dismissed the claims for lack of subject matter jurisdiction and on the basis of the filed-rate doctrine, and further stated that the claims, which amounted to "nothing more than a request that the court of common pleas second-guess an approved rate," were within the province of the state insurance commissioner.

Nonetheless, the Pennsylvania Supreme Court allowed the claims to continue, finding that the courts have jurisdiction over statutory and common law claims, and further that at preliminary stages of litigation, such claims should only be dismissed if their lack of viability is "clear and free from any doubt."

The case was remanded to the commonwealth court in order for it to determine whether the plaintiffs had standing to bring a cause of action under the Non-Profit Law, an argument that IBC previously raised but the commonwealth court failed to address.

Vacca v. Trinitas Hospital
E.D. New York No. 05-cv-0368 (JFB) (AKT) Nov. 14, 2006

In 2001, Health Fund 917 (the "Fund") refused to precertify a fund participant for certain services but precertified the participant for $16,500, or 30 days, of inpatient psychiatric services. The participant stayed at Trinitas Hospital, an out-of-network hospital, for 30 days, but Trinitas Hospital billed the Fund for approximately $70,000. The Fund mistakenly paid the bill as if the hospital was an in-network hospital, resulting in an overpayment of approximately $39,000.

When the hospital refused to return the funds, the Fund filed suit under ERISA §502(a)(3) and, in addition, claimed unjust enrichment under federal common law and other state law claims. The court stated that claims under ERISA §502(a)(3) must seek "equitable relief," and while a claim for reimbursement may be deemed "equitable" if funds are traced with particularity, the Fund's identification of specific checks paid and bank accounts utilized was deemed insufficient tracing with particularity. The court stated that if it permitted such a method of identification to constitute sufficient tracing with particularity, nearly every payment between two parties could be the basis of an "equitable" claim under §502(a)(3).

The district court also found that the Fund had failed to distinguish its federal common law unjust enrichment claim from a typical collection action. For these reasons, summary judgment was granted in Trinitas Hospital's favor on the federal claims and the court refused to exercise supplemental jurisdiction over the state law claims.

Schoedinger v. United Healthcare of the Midwest Inc.
E.D. Missouri No. 4:04-CV-664-SNL Nov. 6, 2006

After George Schoedinger, a physician, terminated his network agreement with United Healthcare of the Midwest, Inc. ("United"), he brought an action alleging that United improperly processed ERISA and non-ERISA claims and sought to recover monies allegedly owed to him as a result. Schoedinger, along with Signature Health Services, brought the lawsuit under the Missouri Prompt Payment Act (MPPA) or, alternatively, under ERISA. United asserted that ERISA preempted the MPPA.

The court found that the point of ERISA's preemption clause is to create a nationally uniform administration of employee benefit plans and avoid a multiplicity of regulation. Because the court found that the MPPA allowed civil actions that have a substantial effect on ERISA plans, it held that ERISA preempts the MPPA.

The court awarded Schoedinger the amount of his ERISA claims, pre-judgment interest, reasonable costs and attorneys' fees. In doing so, the court was persuaded in part by the following: (1) United's improper processing of claims despite knowledge of its mistakes; (2) a desire to create incentive for insurance companies to more accurately administer claims; (3) United's ability to pay; and (4) the novel issue of law raised by the ERISA preemption question.

With respect to the non-ERISA claims, and despite the fact that United had paid the outstanding balance during the course of the litigation, the court applied the MPPA and held that United was liable for interest and attorneys' fees on those claims as well. However, the court denied Schoedinger's claims for injunctive relief and breach of contract.

Blue Cross & Blue Shield of Michigan v. Genord
U.S. Supreme Court No. 06-324 Nov. 13, 2006

On November 13th, the United States Supreme Court denied Blue Cross & Blue Shield of Michigan's ("BCBSMI's") petition for certiorari in a lawsuit brought by a group of gynecologists, alleging that the Blue plan violated the Racketeer Influenced and Corrupt Organizations Act. The Court's action leaves undisturbed a Sixth Circuit ruling that the McCarran-Ferguson Act does not preempt the RICO claims asserted by the physicians.

The physicians filed their lawsuit in 2003, alleging that a change in BCBSMI's billing codes for gynecological services resulted in systematic, improper payment denials. BCBSMI moved to dismiss the suit on the basis that the physicians' RICO claims were "reverse preempted" under the McCarran-Ferguson Act by the Michigan Nonprofit Health Care Corporation Reform Act (the "Michigan Act"), which regulates reimbursement agreements between insurers and physicians for the purpose of ensuring quality healthcare at a reasonable cost for Michigan policyholders.

The Sixth Circuit disagreed with BCBSMI, holding that the Michigan Act was not enacted to regulate the business of insurance, because it did not serve to transfer or spread policyholder risk, did not further policyholder interests, and was not integral to the policy relationship. Because the Michigan Act did not relate to the regulation of the business of insurance, the Sixth Circuit held it could not preempt the RICO claims asserted by the physicians. The Supreme Court's decision not to review BCBSMI's petition clears the way for the lawsuit to proceed.

Bauer et al. v. AdvancePCS, et al.
U.S. Supreme Court No. 06-410 Nov. 27, 2006

On November 27, 2006, the Supreme Court declined to review a decision by the Georgia Supreme Court that ERISA preempts participants' unjust enrichment claims against their plan's pharmacy benefit managers ("PBMs"), AdvancePCS and PCS Health Systems Inc.

The class action suit was filed in Georgia state court by plan participants who alleged that the PBMs unjustly enriched themselves by misclassifying the drug tamoxifen as a brand name drug (instead of a generic drug), thus enabling the PBMs to collect higher copays. The PBMs removed the case to federal court on the basis of ERISA preemption, but the federal court granted plaintiffs' motion for remand. On remand, the Georgia Court of Appeals held that the participants' claims did not relate to an ERISA plan because the allegations were not disguised claims for benefits, did not involve interpretation of plan terms, and were not filed against the plan, an employer, or plan fiduciary.

On appeal the Georgia Supreme Court reversed, holding that the participants' claims were entirely dependent upon whether the language of their plans entitled them to a generic copay for tamoxifen. The Georgia high court held that the lawsuit was

duplicative of an action for which ERISA provides an exclusive remedy, because the participants could have appealed the PBMs' classification of tamoxifen under Section 502(a) of ERISA.

By denying the participants' petition for certiorari, the U.S. Supreme Court extinguished the participants' hope that their claims would not be preempted by ERISA.

New England Carpenters Health Benefits Fund v. First Databank, Inc.
D. Massachusetts No. 05-11148-PBS Nov. 14, 2006

On November 14, 2006, in a preliminary ruling, a federal district court in Massachusetts held that a proposed settlement of a class action case is fair.

In 2005, the New England Carpenters Health Benefits Fund brought a class action alleging that First Databank and McKesson Corporation conspired to boost the markups between the amount pharmacies pay wholesalers for prescription drugs and the amount health plans and insurers reimburse pharmacies for those drugs.

After negotiation, the parties jointly requested the court to: (1) grant preliminary approval of a settlement between the plaintiffs and First DataBank; (2) certify a class of consumer purchasers and a class of third-party payors for the purposes of settlement under Fed. R. Civ. P. 23(a), (b)(2) and (b)(3); (3) direct issuance of a notice to the class; and (4) schedule a final fairness hearing on the settlement. McKesson opposed the motion.

The settlement provides that First DataBank will roll back the markup on 95% of branded drugs sold at retail in the United States. In exchange, First DataBank will be released from liability to the proposed class. No third-party payors or consumers would receive money damages under the settlement. Thus, the settlement seeks to extinguish the rights of past class members in exchange for providing benefits to future class members, particularly the third-party payors.

Although the court refused to certify the class under Rule 23(b)(3) because the proposed settlement offers no monetary damages, the court held that the proposed class met the requirements of Rule 23(a) and (b)(2) and, "on a preliminary basis," that the settlement is fair.

Wirth v. Aetna US Healthcare
3rd Circuit Court of Appeals No. 04-2198 Nov. 21, 2006

The Third Circuit Court of Appeals ruled that a plaintiff's claim that an HMO violated a Pennsylvania motor vehicle law that prohibits certain subrogation claims falls within the scope of ERISA. Additionally, the Court held that HMOs are exempt from Pennsylvania's Motor Vehicle Financial Responsibility Law ("MVFRL").

Wirth recovered a settlement from a third-party tortfeasor responsible for his injuries in a car accident. Aetna subsequently asserted a subrogation lien to recover money from the settlement for medical care it covered under an HMO healthcare agreement. Wirth paid over $2,000 to Aetna in order to release its lien, but then sued Aetna for unjust enrichment and violation of the MVFRL.

Wirth argued that his claim for a refund of the $2,000 was not a claim for "benefits due," but the court nonetheless held that ERISA preempted Wirth's claims against Aetna: "that the bills and coins used to extinguish Aetna's lien are not literally the same as those used to satisfy its obligation to cover Wirth's injuries is of no import – "the benefits are under something of a cloud."

Following Pennsylvania Supreme Court precedent and reasoning, the appellate court also held that the Aetna HMO was not subject to the MVFRL anti-subrogation provision: (1) the MVFRL's language was neither sufficiently specific nor exact to demonstrate an intent to bring HMOs within the ambit of the MVFRL; (2) the MVFRL fails to specifically mention HMOs, clearly indicating it does not apply to HMOs; (3) there was no conflict between the HMO Act and the MVFRL; and (4) there was no need to investigate the legislative intent because of the clear and unambiguous language of the HMO Act.

Florida Health Science Center Inc. v. Rock
M.D. Florida. No. 8:05-CV-1601-T-EAJ Nov. 3, 2006

Under the arbitrary and capricious standard of review, the District Court for the Middle District of Florida upheld a health plan's denial of a plan participant's medical expenses despite finding that the administrator's decision to deny benefits was "wrong."

Tanya Rock, a plan participant, acted as a surrogate mother for her brother and sister-in-law. When she began to experience complications related to her pregnancy, she submitted claims for benefits to her health plan. The health plan denied coverage under its "surrogate mother" exclusion. Rock argued that the exclusion was intended to deny coverage of expenses incurred by someone acting as a surrogate mother for a plan participant, but was not intended to deny coverage of expenses incurred by a plan participant acting as a surrogate mother herself (whether for another plan participant or not).

The court stated the surrogate mother exclusion was ambiguous and therefore had to be construed against the health plan. As a result, the Court ruled that the health plan's decision to deny benefits under the surrogate mother exception was "wrong." However, the court ultimately upheld the denial, ruling that the plan's "wrong" interpretation of the exclusion was reasonable and made in good faith.

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

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