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CLIENT ALERT

Managed Care Lawsuit Watch - February 2014

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Sebelius v. Hobby Lobby Stores, Inc.
No. 13-354 (10th Cir. Nov. 26, 2013)

The United States Court of Appeals for the Tenth Circuit, sitting *en banc*, held that two for-profit family businesses—a craft store chain (Hobby Lobby) and a Christian bookstore (Mardel), both operating according to a set of Christian principles—were "persons" entitled to standing under the Religious Freedom Restoration Act (RFRA). The court also held that the plaintiffs had established a likelihood of success under RFRA and established irreparable harm for purposes of obtaining a preliminary injunction.

The plaintiffs claimed that the Department of Health and Human Services (HHS) regulations implementing the Patient Protection and Affordable Care Act (ACA), which required the provision of certain contraceptive services as part of the plaintiffs' employer-

sponsored health care plan, infringed upon their sincerely held religious beliefs and thus violated the RFRA and the Free Exercise Clause.

Applying the four-prong test for a preliminary injunction, the district court determined that plaintiffs were unlikely to succeed on the merits of their claims that the ACA imposed a substantial burden on their exercise of religion as prescribed under the RFRA. The district court therefore denied plaintiffs' request for injunctive relief. The Court of Appeals, however, found that the ACA's contraceptive-coverage requirement substantially burdened the rights of the plaintiff companies under RFRA.

On this point, the appellate court concluded that for-profit corporations like the plaintiffs counted as "persons" exercising religion for the purposes of the statute, and therefore were not excluded from the RFRA's protections. It also concluded that the plaintiffs had made a threshold showing that the contraceptive-coverage requirement placed substantial pressure on them to engage in conduct contrary to their sincerely-held religious beliefs by forcing them either to compromise those beliefs or pay substantial monetary penalties. If Hobby Lobby and Mardel chose to provide a health plan but not meet the contraceptive-coverage requirement, it would be fined $100 per employee per day. With over 13,000 employees, the fine would amount to more than $1.3 million per day, or close to $475 million per year. Hobby Lobby and Mardel could also eliminate health insurance benefits for all 13,000 employees and pay a fine of $2000 per employee per year, or $26 million annually. Hobby Lobby and Mardel thus have three options: (1) compromise their religious beliefs; (2) pay close to $475 million more in taxes per year by offering health insurance benefits but not contraceptive coverage; or (3) cancel health insurance benefits and pay about $26 million more annually in taxes.

The court found that the government failed to show a narrowly tailored compelling interest to justify the burdensome options placed on Hobby Lobby and Mardel. The court rejected the government's claims of public health and gender equality as compelling interests, and found that the government failed to explain how those interests would be undermined by granting the plaintiffs' their requested exemption.

Despite the district court not having reached the issues, the Court of Appeals went on to find—in light of the impending deadline for the imposition of tax penalties for the plaintiffs' noncompliance with the contraceptive-coverage requirement—that the preliminary injunction factor of irreparable harm also weighed in the plaintiffs' favor. The court, therefore, reversed the denial of plaintiffs' motion for preliminary injunction and remanded to the district court with instructions to address the two remaining elements—balance of equities and the public interest—to establish grounds for issuance of a preliminary injunction and to assess whether to grant or deny the plaintiffs' motion.

The Supreme Court of the United States has granted certiorari to resolve the conflict between the Tenth Circuit's decision and the Third Circuit's ruling in *Conestoga Wood Specialties v. Sebelius* below.

Conestoga Wood Specialties v. Sebelius
No. 13-356 (3rd Cir. Nov. 26, 2013)

The United States Court of Appeals for the Third Circuit affirmed the denial of plaintiffs' motion for a preliminary injunction, holding that for-profit, secular corporations are unable to engage in religious exercise under the Free Exercise Clause and are not "persons" with standing under the Religious Freedom Restoration Act (RFRA).

The plaintiffs, the Hahns, are practicing Mennonites and owners of 100 percent of the voting shares in Conestoga, a for-profit wood cabinet manufacturing corporation. They claimed that the regulations promulgated by the Department of Health and Human Services (HHS) pursuant to the 2010 Patient Protection and Affordable Care Act (ACA), requiring that group health plans and health insurance insurers provide coverage for contraceptives, violated RFRA and the Free Exercise Clause. Specifically, the plaintiffs objected to two "emergency contraception" drugs that must be provided under the contraceptive-coverage mandate.

As to their Free Exercise claim, the plaintiffs contended that the United States Supreme Court's recent decision in *Citizens United v. Federal Election Commission*, 558 U.S. 310, 130 S. Ct. 876 (2010) recognized the general application of the First Amendment to for-profit corporations, without any distinction between the Free Exercise and Free Speech Clauses. The plaintiffs also advanced the application of the "pass through" theory, developed in the Ninth Circuit, which recognized that for-profit corporations could assert free exercise claims that "passed through" from their owners.

Rejecting the plaintiffs' Free Exercise Clause contentions, the Court of Appeals found that no cases preceding the contraceptive-coverage mandate had ever extended Free Exercise protections to for-profit corporations, and that no cases had ever found that for-profit corporations (versus non-profit corporations or churches) can "exercise religion." The court also rejected the plaintiffs' "pass through" argument, finding paramount the obligation to respect the corporate form and the fact that the contraceptive-coverage requirements of the ACA applied to the corporation *itself*, not to the Hahns. As to their RFRA claim, the court rejected the plaintiffs' contention that the for-profit corporation was a "person" under the RFRA statute.

The Supreme Court of the United States has granted certiorari to resolve the conflict between the Third Circuit's decision and the Tenth Circuit's ruling in *Sebelius v. Hobby Lobby Stores, Inc.* above.

Curry et al., v. AvMed, Inc.
No. 10-cv-24513-JLK (S.D. Fla. Oct. 21, 2013)

On October 21, 2013, Florida-based health insurer AvMed, Inc. (AvMed) formally settled a data breach class action lawsuit for $3 million, even though not all plaintiffs could prove that they had suffered identity theft or any other similar harm as a result of the 2009 privacy breach. Specifically, the settlement agreement requires AvMed to return $10 to customers for every year that they purchased insurance from the company, up to a $30 cap. In addition to the financial award, the settlement requires that AvMed institute a compliance plan for data protection, which includes: (1) mandatory security awareness and training programs for all company employees; (2) mandatory training on appropriate laptop use and security for employees who access company laptops; (3) additional security mechanisms on all laptops; (4) new password protocols and encryption technology on all

company desktops and laptops; (5) physical security upgrades at company facilities and offices; and (6) the review and revision of written policies and procedures to enhance information security.

The settlement agreement marks a departure from most data security class actions, which are usually dismissed due to a lack of standing or the plaintiffs' inability to prove that the breach resulted in any cognizable harm. In fact, the district court had dismissed the claims against AvMed in 2011 after finding that the plaintiffs failed to prove any injury resulting from the theft of the unencrypted laptops. The Eleventh Circuit reversed this decision in 2012, holding that the lawsuit should proceed because the plaintiffs had demonstrated a clear connection between the stolen data and the subsequent opening of false bank accounts. The appellate panel also upheld the plaintiffs' unjust enrichment count, under which the plaintiffs had argued that they should be able to recoup a portion of their payments to the company because this money was intended to help the company implement safeguards to protect private information. By relying on the unjust enrichment prong, the plaintiffs were able to overcome the challenge of demonstrating that a specific incident of fraud or identity theft was the result of a data breach.

St. Alphonsus Medical Center-Nampa et al. v. St. Luke's Health System Ltd.
No. 1:12-cv-00560 (D. Idaho Jan. 24, 2014)

The United States District Court for the District of Idaho permanently enjoined St. Luke's Health System (St. Luke's) from acquiring Saltzer Medical Group (Saltzer) and ordered the divestiture of the affiliation between St. Luke's and Saltzer. The district court based its decision on Section 7 of the Clayton Act and an analogous provision of Idaho state law.

In a transaction that closed on December 31, 2012, St. Luke's acquired all of Saltzer's tangible and intangible assets, and Saltzer entered into an agreement to provide professional services exclusively on behalf of St. Luke's for a term of five years. St. Luke's operates eight hospitals in Idaho and employs several hundred physicians, including 450 in the geographic market at issue. At the time of the acquisition, Saltzer employed 44 physicians. The combined entity included 80 percent of the primary care physicians in the market. According to the district court, the entity's size and the "sterling reputations" of St. Luke's and Saltzer made it the "dominant" provider in the market for primary care.

Two groups of plaintiffs sued, claiming the combination violated the antitrust laws, namely Section 7 of the Clayton Act and the analogous Idaho state law. First, the Federal Trade Commission and the State of Idaho (hereafter, the "Government Plaintiffs") alleged that the transaction will result in undue concentration in the market for adult primary care physician services. This market power will allegedly allow St. Luke's to extract higher reimbursements from health plans, who will pass those price increases to consumers and employers. As a result, the Government Plaintiffs argued that healthcare costs will rise for Idaho consumers.

Second, two of St. Luke's competitors—St. Alphonsus Health System and Treasure Valley Hospital Limited Partnership (hereafter, the "Private Plaintiffs")—alleged that the transaction will harm competition by effectively cutting off access to Saltzer physicians for competitors. Without access to the major physician group in the area, the Private Plaintiffs contend that they can no longer compete with St. Luke's. As a result, they allege, the transaction violates Section 7 of the Clayton Act and Section 1 of the Sherman Act, as well as the analogous provisions of Idaho state law. St. Alphonsus previously lost a bid to enjoin the transaction

before its closing date, arguing that the deal would raise prices on medical imaging procedures and block referrals to St. Alphonsus.

St. Luke's defended the acquisition on numerous grounds, focusing on the value of integrated delivery systems and the resulting efficiencies that could benefit the consumer. St. Luke's argued that the Affordable Care Act (ACA) promoted integrated care, encouraging providers to offer patients managed care as qualifying Accounting Care Organizations. St. Luke's pointed to studies demonstrating that integrated delivery systems could better align incentives between providers and patients and enhance information sharing across providers, thereby improving patient care.

The district court agreed with St. Luke's that patient care might be enhanced and applauded the medical center's efforts to improve healthcare delivery, but the court ultimately decided that the transaction violated the antitrust laws. The court held that St. Luke's dominant market position would likely lead to anticompetitive effects. Specifically, St. Luke's would be able to negotiate higher reimbursement rates from health insurance plans and raise rates for ancillary services, like x-rays. These higher rates would likely be passed to the consumer, who thus faces higher healthcare rates in the geographic market post-transaction.

The district court then found that St. Luke's proffered efficiencies defense could not overcome the presumption of illegality created by its dominant market share. The district court noted that efficiencies achieved by a transaction must be "merger-specific" so that the transaction is the *only* way the efficiencies can be gained. In this case, the district court found that St. Luke's could achieve the same efficiencies without buying up a competitor in the market. The district court thus ordered St. Luke's to divest itself fully of the Saltzer assets and permanently enjoined the acquisition.

CarePlus Health Plans, Inc. v. Interamerican Medical Center Group, LLC
No. 3D13-1459 (Fla. Dist. Ct. App. Oct. 23, 2013)

The Florida Third District Court of Appeal upheld the lower court's ruling denying a motion to compel arbitration filed by CarePlus. In 2004, CarePlus entered into a risk capitation agreement with Interamerican Medical Center Group, LLC (Interamerican) under a Medicare Advantage plan. The risk capitation contract had no arbitration clause. Further, it contained a provision stating that it "may not be amended, supplemented, waived or changed … but only by a written and signed document … and which shall make specific reference to this Agreement."

In 2010, Interamerican entered into an independent practice association participation agreement (the "IPA Agreement") with Humana. CarePlus was not a signatory to the IPA Agreement, but maintained that it was covered under the contract as an "affiliate" of Humana. The IPA Agreement required arbitration of all disputes "arising out of [the] business relationship" between the parties. Additionally, per the IPA Agreement, all disputes concerning the scope or applicability of the arbitration clause were to be determined *at arbitration* as well.

In 2011, CarePlus terminated the risk capitation contract and later provided final reconciliation, but Interamerican filed suit to dispute the reconciliation. CarePlus responded by filing a motion to compel arbitration based on the IPA Agreement. Citing the broad language of the IPA Agreement's arbitration clause, CarePlus argued that matters relating to the 2004 risk capitation

contract "arise out of the business relationship" between CarePlus and Interamerican. CarePlus further cited Florida precedent upholding a contractual restriction that the scope of the arbitration clause be resolved by arbitration, in a similar manner to the clause in the IPA Agreement.

The appellate court rejected CarePlus's argument for two main reasons. First, the court found that the parties did not intend to arbitrate disputes arising from the risk capitation contract because it contained no arbitration clause and further required any amendment to "make specific reference to" the risk capitation agreement. Second, the court cited Florida precedent that in order for an arbitration clause to require the arbitration of a legal claim, the claim must have a "significant relationship" or "nexus" to the contract containing the clause. The court found that Interamerican's legal claims had no such relationship with the IPA Agreement. Thus, despite the language of the IPA Agreement, the dispute was not arbitrable in this case.

Royal Mile Co., Inc., et al. v. UPMC et al.
No. 10-1609 (W.D. Pa. Sept. 27, 2013)

In early 2009, groups of WellPoint subscribers, physicians who treated WellPoint subscribers, and various associations filed an action in California federal district court alleging that WellPoint had conspired with UHG and Ingenix, a company that maintained a data services platform, to systematically reimburse subscribers and providers for out-of-network care at artificially low rates. According to the plaintiffs, Ingenix, which was wholly-owned and operated by UnitedHealth Group, Inc., maintained a claims database that it used to create "usual, customary, and reasonable" (or "UCR") pricing schedules. Plaintiffs claim that Ingenix conspired with WellPoint and UHG to manipulate the claims data in order to establish UCR pricing schedules with artificially low usual and customary rates. According to the plaintiffs, WellPoint then contracted with Ingenix to use these UCR pricing schedules to calculate reimbursement amounts for out-of-network services, thus resulting in under-reimbursement for these services.

On July 19, 2013, the court ruled on the defendants' motions to dismiss the Corrected Fourth Consolidated Multi-District Litigation Complaint (CFAC), which added new allegations and legal theories to previous versions of the complaint. The CFAC asserts a series of different causes of action, including violation of the federal antitrust laws, violations of California unfair competition and antitrust laws, ERISA claims, RICO violations, breach of contract, and breach of the covenant of good faith and fair dealing.

In its decision, the court first dismissed the associations' ERISA claims and the subscribers' antitrust-related claims on standing grounds—in the latter case, finding that the plaintiffs had failed to plead injury of the type proscribed by the antitrust laws, or that the plaintiffs were participants in the data market. It then dismissed the RICO claims against WellPoint and UHG and dismissed the ERISA claims (which only related to WellPoint). As to the ERISA claims, the defendants successfully argued that (1) the plaintiffs had not sufficiently exhausted administrative remedies and (2) ERISA does not impose on insurers the obligation to disclose how reimbursement rates were calculated. The court's ruling essentially confirms one of its earlier rulings that there is "no ERISA provision or implementing regulation requiring an insurer to provide every bit of data underlying a claim decision and details about the way in which that data was used." The court then partially dismissed the breach of contract, good faith and fair dealing, and California statutory claims. Remaining in the case are Ingenix ERISA benefit reduction claims by the subscribers and

providers, as well as certain individual plaintiffs' claims for breach of contract, implied covenant of good faith and fair dealing, and unfair competition.

Commonwealth of Pennsylvania v. Geisinger Health System Foundation, Lewistown Health Care Foundation
No. 13-cv-02647-YK (M.D. Pa. Oct. 25, 2013) | Final Order - Complaint

On October 25, 2013, the Pennsylvania Attorney General (AG) brought an action under federal and state antitrust laws to enjoin Geisinger Health System Foundation ("GHSF" or "Geisinger") from acquiring Lewistown Health Care Foundation ("LHCF" or "Lewistown") and its affiliates: Lewiston Hospital; Family Health Associates of Lewistown Hospital, a related physicians group; Health Enterprises, Inc.; and Lewistown Ambulatory Care Corporation. The AG alleged that the proposed combination is likely to substantially lessen or eliminate competition in the provision of primary care physician services and primary and secondary inpatient acute care hospital services in Mifflin and Juniata Counties.

The AG alleged in the complaint that post-acquisition Geisinger—the parent corporation of Geisinger Medical Center, Geisinger Clinic, and Geisinger Health Plan—would control nearly seventy percent of all primary care physicians and seventy-four percent of hospital discharges in the two counties. Without competition between GHSF and LHCF, the AG alleged, GHSF will have the ability to demand higher reimbursement rates from health plans. This increased bargaining power could increase the overall cost of health care, thereby harming consumers and employers. Furthermore, new entry in the market is unlikely to occur in a timely or sufficient manner to deter or counteract the likely anticompetitive effects of the acquisition. The AG also noted that consumer loyalty to primary care physicians makes it unlikely that a new entrant would succeed.

Following settlement discussions, the AG entered into a settlement agreement with GHSF entered by the United States District Court for the Middle District of Pennsylvania on October 25, 2013, which imposes various restrictions on GHSF designed to maintain "quality, affordable health care services" in the affected counties.

First, GHSF must maintain Lewistown Hospital for at least eight years as an acute care hospital offering substantially the same scope and level of services and programs as provided by the hospital pre-acquisition. Second, GHSF must honor all health plan contracts for Lewistown Hospital and its physician group for the remainder of their terms. GHSF must negotiate future health plan contracts in good-faith, and the health plan may enter into a third-party review process if the parties reach an impasse after sixty days of good-faith negotiations. Third, GHSF agreed to stipulations that sought to preserve competition in the physician-services market and that disallowed most-favored-nation clauses in future contracts.

Pennsylvania Chiropractic Assoc. v. Blue Cross Blue Shield Assoc.
1:09-cv-05619, 2013 WL 59517665, 2013 WL 5951510, 2013 WL 5951505 (N.D. Ill. Nov. 7, 2013) (unpublished) | [PDF 1] [PDF 2] [PDF 3]

In three separate opinions the United States District Court for the Northern District of Illinois granted summary judgment or partial summary judgment to chiropractors who alleged that various health plans violated ERISA by offsetting prior overpayments in subsequent payments to the chiropractors, and then failing to provide those chiropractors with notice and appeal rights.

The plaintiff chiropractors alleged that following a retrospective review of previously paid claims, the defendant health plans sought reimbursement of what they contended were overpayments and eventually offset those overpayments in subsequent payments to the chiropractors. Plaintiffs alleged that this constituted an "adverse benefit determination" under ERISA, thus triggering the requirement that the health plans give the chiropractors notice and appeal rights—something the plans did not do.

The court first held that because one of the chiropractors, Andrew Reno, obtained a valid assignment of benefits from the ERISA beneficiaries, he had standing to assert an ERISA claim. It next held that the health plans' recoupment efforts constituted "adverse benefit determinations" under ERISA because the health plan informed Reno, as holder of his patients' assignments, that the services were not medically necessary and thus not covered under its insurance plans. As a result, Reno was entitled to notice and appeal rights, which the health plans did not provide. Moreover, Defendants failed to address Reno's argument that its denials of certain claims based on a blanket determination that the services were never medically necessary were arbitrary and capricious. As a result, it granted Reno summary judgment on this issue.

The court also granted summary judgment in part for Plaintiffs Mark Barnard and Barry Wahner, chiropractors who contracted with the defendant health plans, as to liability on the claim that a health plan's recoupments from them were arbitrary and capricious. The plaintiffs contended that the health plan reviewed their claims *en masse*, rather than through an individualized look at each claim, to decide that it would recoup payments for certain categories of services. The health plan did not provide a direct response to these allegations, so the court granted summary judgment as to liability. But the court denied the plaintiff's request for summary judgment on the question of standing and whether the health plan afforded them the appropriate notice and appeal rights.

In a separate opinion, the court held that the plaintiff chiropractic organizations had standing to sue on behalf of their members because they sought prospective declaratory and injunctive relief, and thus the participation of the individual organization members was unnecessary.

In another opinion, the court held that the claims of two chiropractors, Jay Koren and Ian Barlow, were prohibited by the rule against claim-splitting. According to the court, the same set of facts giving rise to Koren and Barlow's current claims was litigated in a prior suit, barring the assertion of claims in this action.

Connecticut General Life Insurance Company v. Roseland Ambulatory Center LLC
No. B232338 (Cal. Ct. App. Sept. 10, 2013)

The United States District Court for the District of New Jersey denied a motion to dismiss claims under the Employee Retirement Income Security Act of 1974 (ERISA) that the defendant health care provider's billing practices were contrary to the terms of Connecticut General Life Insurance Company's (CIGNA) plan, as well as claims that funds paid by CIGNA were induced by deceptive and fraudulent billing practices.

Roseland Ambulatory Center, the defendant, engaged in a billing practice known as "cost-share waiver," in which it allegedly accepted amounts paid to it by CIGNA and waived, declined, or failed to collect in whole or in part the cost-sharing amounts (deductibles, copayments or coinsurance) that participants in the relevant CIGNA plan were obligated to pay. CIGNA asserts that its representatives advised the defendant that the participants were subject to a deductible or coinsurance obligation, and that the defendant failed to disclose its practice of waiving these fees on individual claim forms that it submitted to CIGNA.

CIGNA asserted a claim for equitable relief under ERISA section 502(a)(3) seeking repayment of the overpaid amounts. The plaintiff also asserted claims to recover the amounts based on a theory of fraud and unjust enrichment.

The defendant brought a motion to dismiss the plaintiff's ERISA claims based on three arguments. First, the defendant relied on the Supreme Court's holding in *CIGNA v. Amara* to argue that the terms of plaintiff's plan, which were laid out in the summary plan documents (SPDs) submitted by plaintiff, were insufficient to allow the plaintiff to bring the action. But the district court disagreed, holding that *CIGNA v. Amara* did not preclude reliance on an SPD where the terms of the SPD do not conflict with governing plan documents. The court denied the motion to dismiss due to *Amara* because the plaintiff was not relying on its SPDs to establish inconsistent terms from the plan.

Second, the defendant argued that the plaintiff's action to recover amounts overpaid to the defendant was not a category typically available in equity and, therefore, was improper under ERISA section 502(a)(3). The court disagreed, stating that (1) CIGNA had identified a provision in its plan that entitles it to recoup the overpaid funds, and (2) CIGNA claimed that the defendant is in possession of such funds, making the claim equitable in nature. Consequently, the Court denied the motion to dismiss based on this argument.

Third, the defendant argued that an overpayment demand is an adverse benefit determination, which triggers certain ERISA notification requirements. The defendant argued that CIGNA did not meet the ERISA notification requirements relevant to an adverse benefit determination, and the action thus violates ERISA. Relying on both Eighth Circuit case law that an adverse benefit determination only includes an insurer's initial denial of a benefit and another holding in the District of New Jersey stating that facts are necessary to determining whether an overpayment demand is an adverse benefit determination, the court denied the motion to dismiss CIGNA's ERISA claim.

CIGNA also brought a claim under the "New Jersey Health Claims Authorization, Processing, and Payment Act," which imposes an eighteen-month statute of limitations to bring a claim unless the plaintiff establishes clear evidence of fraud. The defendant argued that the claim in this case was brought after the eighteen-month limit and should be dismissed. The court denied the motion to dismiss for failure to abide by the eighteen-month limit, stating that CIGNA's action clearly was premised on the idea that the defendant engaged in a pattern of inappropriate billing and fraud.

Finally, CIGNA brought a fraud claim and an unjust enrichment claim. The defendant argued that these state law claims must be dismissed because state law claims are preempted by ERISA. The court denied the motion to dismiss on these grounds, because the plaintiff brought the state law claims in the alternative to its ERISA claim. The defendant also alleged that CIGNA failed to plead its fraud claim with particularity, that it failed to sufficiently identify the plans, and that it did not set forth sufficient facts to state a claim for unjust enrichment. The court rejected all of these arguments.

Killian v. Concert Health Plan
No. B232338 (Cal. Ct. App. Sept. 10, 2013)

The United States Court of Appeals for the Seventh Circuit, sitting *en banc*, affirmed summary judgment denying death benefits, affirmed a remand to the district court for recalculation of statutory penalties against an employer, and reversed and remanded a district court's grant of summary judgment that had been in favor of defendant Concert Health Plan (Concert) on a breach of fiduciary duty claim.

The plaintiff is the husband and estate administrator for the deceased Mrs. Killian. Mrs. Killian was an employee of Defendant Royal Management, and she participated in her employer's health plan administered by Concert. After being diagnosed with lung cancer in 2006, Mrs. Killian sought a second opinion at the Rush University Medical Center (Rush), where she underwent emergency brain surgery. The plaintiff called the number provided by Concert to determine whether the Rush doctors were in plaintiff's network on two separate occasions. Concert representatives did not inform the plaintiff on either phone call whether the Rush doctors were in Mrs. Killian's network.

The emergency brain surgery was successful, but Mrs. Killian passed away from the lung cancer within several months. Concert denied payment for Mrs. Killian's treatment at Rush. Plaintiff sued for payment of death benefits, statutory penalties, and breach of fiduciary duty. The district court granted summary judgment in favor of defendants on the denial of death benefits and breach of fiduciary duty claims, and the district court awarded statutory penalties against employer Royal Management.

The Court of Appeals panel affirmed the district court's decisions regarding the denial of death benefits and breach of fiduciary duty claims, but remanded for recalculation of statutory penalties. Sitting *en banc*, the Court of Appeals affirmed the panel's reasoning regarding the death benefits and statutory penalties claims, but reversed and remanded to the district court the appellate panel's ruling regarding the breach of fiduciary duty. Plaintiff alleged that defendants failed to provide an adequate summary plan description and failed to notify the plaintiff that the Rush doctors were outside the plan's network.

If the plan documents are clear and the fiduciary exercises appropriate oversight over what its agents advise participants and beneficiaries, then the fiduciary will not be held liable. Here, the plan documents were not clear as to who was in plaintiff's network. The plaintiff never received a summary plan description, and the master group policy did not identify which providers were in the network. Instead, users were instructed to call a number to determine whether a provider is in-network.

Although the court determined that the plan documents were deficient, Concert could have cured that deficiency during either of the two phone calls it had with the plaintiff. It did not. Concert's representative did not clearly say whether the Rush doctors were in the network, and during the second call Concert had an affirmative duty to inform the plaintiff whether the Rush

treatment was in Concert's network. The Court explained that an insurance company cannot defeat a breach of fiduciary duty claim by asserting it was unaware that an insured sought information when the insured called the phone numbers provided by the insurance company on two separate occasions. The Court thus held that the plaintiff provided sufficient evidence to overcome a summary judgment ruling, and the court remanded the case to the district court.

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

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