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CLIENT ALERT

Managed Care Lawsuit Watch - February 2017

Feb.02.2017

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.

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Deborah Heart & Lung Center v. Virtua Health, Inc.
833 F.3d 399 (3d Cir. 2016)

The U.S. Court of Appeals for the Third Circuit affirmed dismissal of a Sherman Act Section 1 antitrust claim brought by New Jersey Hospital Deborah Heart and Lung Center ("Deborah Heart") against competitor health system Virtua Health, Inc. ("Virtua") and The Cardiology Group P.A. (CGPA). The court held that Deborah Heart failed to introduce sufficient evidence of harm to competition in the designated relevant market as a whole.

Deborah Heart alleged that CPGA and Virtua engaged in an illegal exclusive dealing arrangement with Penn Presbyterian Hospital of Philadelphia that harmed competition by forcing some consumers to obtain certain cardiology procedures at Penn Presbyterian when, in a competitive market, they would have chosen Deborah Heart. In order to proceed to trial Deborah Heart was required to provide sufficient evidence of anticompetitive effects in the "relevant market." The court further explained that, for Section 1 claims, anticompetitive effects could be demonstrated either by showing "actual anticompetitive effects" or by showing the defendant has "[m]arket power—the ability to raise prices above those that would prevail in a competitive market."

Deborah Heart defined the product markets at issue in the dispute as emergency and non-emergency advanced cardiac interventional (ACI) procedures. The parties agreed that the relevant geographic market for emergency ACI procedures consisted of a three-county area in New Jersey, and that the relevant geographic market for non-emergency ACI procedures consisted of a five-county area in New Jersey plus portions of Philadelphia. Because CGPA and Virtua did not have sufficient

market power (*e.g.*, CGPA's physicians represented less than eight percent of the cardiologists practicing in the relevant market for emergency ACI procedures), Deborah Heart attempted to show actual anticompetitive effects.

Despite using relevant market definitions that included multiple hospitals and hundreds of cardiologists, Deborah Heart's arguments to show actual anticompetitive effects pertained only to CGPA and Virtua patients. After pointing out this inconsistency, the court went on to explain that such a narrow definition would be improper even if it matched with Deborah Heart's expert's relevant market definition, noting that . . . courts have routinely concluded that "absent an allegation that the hospital is the only one serving a particular area or offers a unique set of services . . . the relevant geographic market" may not be limited "to a single hospital." No evidence was introduced indicating that CGPA or Virtua were sufficiently unique to call for reducing the size of the geographic market only to those entities. Thus, the court concluded that even if Deborah Heart had been able to provide sufficient evidence that CGPA's and Virtua's agreement caused some anti-competitive effects to the patients of those entities, such a showing would be insufficient to demonstrate the type of anticompetitive effects on the overall market necessary to prove a Section 1 claim.

The court concluded that a plaintiff who asserts actual anticompetitive effects to prove a Section 1 violation must, absent evidence of market power possessed by the defendants, show anticompetitive effects on the market as a whole. Where, as here, a plaintiff shows effects only on a small subset of that market while making no attempt to show broader effects, the plaintiff cannot meet the requirements of the antitrust inquiry. The court noted that resolution of this appeal was relatively simple but that it wrote to clarify the burden on an antitrust plaintiff alleging a Section 1 claim in which the plaintiff does not assert that the defendants possessed market power.

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Taylor v. Extendicare Health Facilities, Inc.
No. 19 WAP 2015, 2016 WL 5630669 (Pa. Sept. 28, 2016)

Shortly after her admission to an Extendicare skilled nursing facility, Anna Marie Taylor died. When Ms. Taylor was admitted, her family had signed an arbitration agreement. Ms. Taylor's beneficiaries brought a wrongful death and survival action against Extendicare (and others) in state court. The trial court denied Extendicare's motion to sever the claims and compel arbitration of the survival claim. After losing this same argument at the intermediate appellate court, Extendicare prevailed at the Pennsylvania Supreme Court.

Under Rule 231(e) of the Pennsylvania Rules of Civil Procedures, wrongful death and survival actions "may be enforced in one action, but if independent actions are commenced they shall be consolidated for trial." But, under the Federal Arbitration Act (FAA), 9 U.S.C. § 2, arbitration agreements "shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." Relying on *AT & T Mobility LLC v. Concepcion*, 563 U.S. 333 (2011), the Pennsylvania Supreme Court held that the FAA preempted Rule 231(e).

The Supreme Court's decision in *Concepcion* grappled with the FAA's two primary purposes: (1) enforcement of Alternative Dispute Resolution agreements and (2) efficiency. When there is a conflict between the FAA's two purposes, enforcement wins

out over efficiency. Additionally, according to *Concepcion*, the FAA's savings clause, which preserves generally applicable contract defenses, does not apply to state-law rules impede the FAA's objectives.

The Pennsylvania Supreme Court held that the FAA's savings clause did not apply to Rule 213(e). But even if it did, in light of *Concepcion*, the Rule would be preempted by the FAA because application of Rule 213(e) would prohibit arbitration of the survival claim. The court said that where a survival claim is subject to an arbitration agreement it must be bifurcated from a wrongful death claim that could be brought in court. Here, the court remanded the case to the trial court to determine whether the arbitration agreement was valid and enforceable. The court also noted that its opinion was consistent with recent federal court precedent on the same topic.

It is worth noting that after the opinion was issued, the U.S. Department of Health and Human Resources, Center for Medicare and Medicaid issued a final rule that bars federally funded long-term care facilities (like Extendicare) from imposing mandatory pre-dispute resolution agreements (*i.e.* arbitration clauses).

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Morris B. Silver M.D., Inc. v. Int'l Longshore & Warehouse Union—Pac. Maritime Assoc. Welfare Plan
No. B267941, 2016 WL 4434735 (Cal. Ct. App. Aug. 22, 2016)

The California Court of Appeal, Second Appellate District, reversed the trial court's order dismissing all of Silver's state law causes of action as preempted by ERISA. The California Court of Appeal first explained that the purpose of preemption is to prevent ERISA plans and plan sponsors from being subject to a myriad of diverse and potentially conflicting, substantive standards promulgated by the state courts. Congress' goal in providing for preemption was to minimize the administrative and financial burden of compliance for ERISA plan and plan sponsors by preserving a uniform body of federal ERISA law to which they are subject.

The Supreme Court has made clear, however, that run-of-the-mill lawsuits against ERISA plans that do not substantively affect the benefits under ERISA plans are not preempted. In analyzing whether a particular claim is preempted, the Fifth Circuit has articulated a two-part test. Under the test, state law claims are generally preempted by ERISA if: (1) the claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries.

The California Court of Appeal applied the Fifth Circuit's two-part test in determining that Silver's contract and quasi-contract claims were not preempted. It explained that the gravamen of Silver's causes of action for breach of contract, *quantum meruit*, and promissory estoppel is that the Plan orally agreed to pay Silver for health care services, authorized the provision of those services, and then failed to pay as agreed. Silver is not seeking compensation for the Plan's decisions to deny coverage under the terms of the plan. Rather, Silver's claims are predicated on a garden-variety failure to make payment as promised for services rendered.

The court explained the public policy reason behind carving out commonplace claims against ERISA plans from the reach of preemption. If providers have no recourse in situations such as the one at bar, providers will understandably be reluctant to accept the risk of non-payment and may require payment up front by beneficiaries—or impose other inconveniences—before treatment is provided. This aim does not conflict with ERISA's goal of uniformity. If a patient is not covered under an insurance policy, despite the insurance company's assurances to the contrary, a provider's subsequent recovery against the insurer in no way expands the right of the patient to receive benefits under the terms of the plan. In fact, a provider's state law action under these circumstances does not arise due to the patient's coverage under an ERISA plan, but precisely *because* there is no ERISA plan coverage.

On the other hand, the California Court of Appeal concluded that Silver's claim for interference with contractual relations was preempted by ERISA. This claim is predicated on the Plan's sending its policyholders explanation-of-benefits forms (EOBs) indicating that the billed procedures were not covered, and that neither the plan nor the patient had any obligation to pay Silver. Silver alleged that the Plan knew Silver had separate agreements with the policyholders to pay whatever portion of the charges the Plan did not cover, and in sending the EOBs, the plan interfered with such agreements.

Under ERISA, Plans are required to notify participants of an adverse determination, which the Plan here did vis-à-vis the EOBs. The court explained that whether the use of the EOBs rose to the level of interference with contractual relations—a question with wide-ranging implications for any plan using a similar form—is precisely the kind of question that preemption is intended to eliminate: one that could result in inconsistent directives among the states and increased administrative and financial burdens for plans and plan sponsors in complying with ERISA. Under the two-part test, the interference with contractual relations claim was not preempted because it: (1) addresses an area of exclusive federal concern (the manner in which adverse determinations are communicated to plan participants) and (2) directly affects the relationship between the plan and the participants.

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Vishva Dev, M.D., Inc., v. Blue Shield of California Life & Health Ins. Co.
207 Cal. Rptr. 3d 185 (Cal. Ct. App. 2016)

The California Court of Appeal affirmed the lower courts grant of summary judgment for two insurers on the ground that a physician's lawsuit was untimely under the two-year statute of limitations for quantum meruit. In affirming the lower court's decision, the Court held that the statute of limitations on a physician's quantum meruit claim for payment against two health insurers began to run upon the receipt of the Explanation of Benefits (EOB), which the panel determined to be the date of the first unequivocal written denial, despite the physician's engagement in the insurers' internal appeals process.

The plaintiff, Vishva Dev, M.D., Inc. ("Dev"), provided medical services between 2011 and 2012 to two patients that had health care coverage through Blue Shield of California Life Insurance Company ("Blue Shield Life") and one patient that had health care coverage through California Physician Services, also known as Blue Shield of California ("Blue Shield of California"). Dev submitted claims for all three patients, requesting payment from their respective health insurer. Dev did not have a contract with either Blue Shield Life or Blue Shield of California. Dev received EOBs on March 8, 2011 and June 22, 2012 for the two patients insured by Blue Shield Life, and an EOB on August 15, 2012 for the patient insured by Blue Shield of California. Under all

three responses, the insurers denied payment of the additional amount billed. Dev then voluntary engaged in both insurers internal appeals process. The appeals process for the two patients covered by Blue Shield Life was exhausted on March 26, 2013 and August 20, 2013, and for the patient covered by Blue Shield of California was exhausted on December 6, 2012.

Once the appeals processes were exhausted, Dev filed an action against Blue Shield Life and Blue Shield of California for payment of the claims on October 7, 2014. The insurers filed a joint motion for summary judgment, alleging that Dev's claims for *quantum meruit* were barred by the two-year statute of limitations. Dev alleged that its claims were not time-barred, as the cause of action for a quantum meruit claim did not accrue until the conclusion of the parties' communications, as continued through the insurers' internal appeals process. Dev further alleged that the correspondence between the parties created an "expectation of compensation" that undercut the notice of the written denials.

The trial court granted summary judgment to the insurers on the ground that Dev's *quantum meruit* claim was untimely. The California Court of Appeals affirmed the lower court's ruling.

The panel noted that the statute of limitations for *quantum meruit* claims is two years in California, and it commences when a party knows or should have known the facts essential to the claim. The Court, relying on cases involving homeowner's insurance, determined that the statute of limitations for a *quantum meruit* claim begins to run once the insurer has issued an unequivocal denial of payment in writing, giving the insured knowledge of the facts essential to the insured's claim. Thus, the sole issue in this case was when Dev knew or should have known the facts essential to its *quantum meruit* claim that Blue Shield Life and Blue Shield of California denied payment in full or in part for its rendered services.

The Court of Appeal held that the date Dev first received the EOB, he had or should have had knowledge of the facts essential to the *quantum meruit* claim. Since Dev filed suit on October 7, 2014, more than two years after the EOB denied its claim for payment (March 8, 2011, June 22, 2012, and August 15, 2012), the Court held the *quantum meruit* claim against Blue Shield Life and Blue Shield of California was time-barred under the state of limitations.

The Court further determined that engaging in an insurer's internal appeals process does not toll the statute of limitations. The court reasoned that a review of the denial does not make the previous denial unequivocal. Additionally, as a matter of policy, the statute of limitations would be a nullity if any party could arbitrarily extend the period by engaging in an optional appeals process.

The lesson for health care providers and plans in California is clear: in the absence of an explicit contract provision to the contrary, the issuance of an EOB that denies all or a part of a claim may start the statute of limitations. Additionally, engagement with the insurer's voluntary, internal appeals process will not toll the statute of limitations.

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In re WellPoint, Inc. Out-of-Network "UCR" Rates Litigation
No. 2:09-ml-02074 (C.D. Cal. July 19, 2016)

The U.S. District Court for the Central District of California dismissed claims in a multidistrict litigation (MDL) accusing insurers of knowingly creating and using flawed data as a basis to set "usual, customary and reasonable" (UCR) reimbursement rates.

The primary question in the action was whether Anthem, which changed its corporate name from WellPoint, Inc. to Anthem in December 2014, paid the UCR rate when reimbursing out-of-network services (ONS). The case was initially brought by insurance subscribers, health care providers, and medical associations who claimed that they were allegedly promised a UCR reimbursement, but were underpaid due to flawed UCR data provided by an ONS reimbursement database called Ingenix and by the insurer's use of non-Ingenix ONS reimbursement methodologies. At bottom, the subscribers and health care providers argued that the reduced reimbursement rates resulted in higher out-of-pocket expenses for subscribers and asserted claims under the Racketeer Influenced and Corrupt Organizations Act (RICO), the Sherman Antitrust Act, the Employee Retirement Income Security Act of 1974 (ERISA), federal regulations, and state law.

In July 2013, the Court issued an order granting in part and denying in part Anthem's motion to dismiss most, but not all claims. The Court held that the state and federal anti-trust claims, as well as the RICO claims, should be dismissed in their entirety with prejudice. It also found that the ERISA claims, to the extent that they involved non-Ingenix methodologies, along with those that involved alleged non-disclosures should be dismissed with prejudice. The Court also dismissed most of the plaintiffs' state law claims with prejudice.

Ultimately, after 2013, only some claims by certain subscribers remained including an ERISA benefits claim and certain state law claims. For example, insurance subscribers, Darryl and Valerie Samsell asserted a claim for breach of the implied covenant of good faith and fair dealing under Virginia law. Specifically, they alleged that Anthem failed to properly reimburse ONS for oral surgery their daughter received in July 2004 and May 2005 under their Anthem Virginia health care policy. On July 19, 2016, the Court dismissed these claims because the Samsells failed to file their case within the three-year limitations period established in their insurance contract.

Another subscriber, Mary Cooper, asserted an ERISA claim for unpaid benefits arguing that the insurer improperly reduced her ONS benefits via two mechanisms: "(1) undisclosed exceptions which had the effect of reducing Mrs. Cooper's ONS payments at the claim level, and (2) employment of low [ONS] rates based upon Ingenix data." In particular, Cooper claimed that Anthem did not pay its full 70% reimbursement share under a New Jersey policy when her late husband received ONS for cancer between 2006 and 2007. Cooper argued that, as a result of Anthem's failure to properly reimburse, health care providers billed her higher balances than she would otherwise have been billed. Anthem argued that Cooper lacked standing because she did not produce evidence that she was billed for the balance the insurer did not cover. The Court agreed.

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