CLIENT ALERT

Managed Care Lawsuit Watch - May 2008

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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 any member of the health law group.

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Love v. Blue Cross and Blue Shield Association
No. 03-cv-21296 Southern District of Florida settlement approved 4/21/08

On April 20, 2008, Judge Federico A. Moreno of the U.S. District Court for the Southern District of Florida approved the proposed settlement agreement as set forth on April 27, 2007 (the "Settlement Agreement") under which multiple Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association (together "BCBS") must pay over $130 million into a fund to settle a class action suit filed on behalf of approximately 900,000 physicians. Additionally, BCBS agrees to pay over $49 million in attorneys' fees and $7,500 to each representative plaintiff and the representative plaintiffs in other actions.

In addition, the Settlement Agreement requires BCBS to implement certain claims handling and business practice changes. These include, among other things, disclosing physicians applicable fee schedules, implementing reduced pre-certification requirements, implementing greater notice of policy and procedure changes, disclosing and make additional commitments concerning claims payment practices, establishing a physician advisory committee, implementing a new dispute resolution
process for physician billing disputes, and developing and implementing new processes for medical necessity and other coverage
determinations

The order releases and discharges BCBS and certain affiliates from "any and all causes of action, judgments, liens, indebtedness,
costs, damages, obligations and attorneys' fees, losses, claims, liabilities, and demands of whatever kind, source or character
whether arising under any federal or state law" arising on or before an effective date which are related to any of the conduct
related to the lawsuit.

The class action lawsuit, filed in 2003, involved allegations that the settling defendants and other Blue Cross Blue Shield plans
had violated the federal Racketeering Influenced and Corrupt Organizations statutes by, among other things, engaging in a
conspiracy to improperly deny, delay and/or reduce payments to physicians. The settlement involves only some of the
defendants.

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_Giesse v. Sec. of the Dept. of Health & Human Serv's_
6th Circuit No. 06-4497 Apr. 23, 2008

Raymond Giesse, an enrollee of an M+C plan, suffered a stroke in 2003, was treated at a hospital, was transferred to a skilled
nursing facility, and ultimately chose to move to an assisted living center. Giesse's plan terminated his SNF benefits and
terminated his request for redetermination, but submitted his case to an independent third party for external review.

The external reviewer also dismissed Giesse's claims, construing them as "grievances" under the terms of the plan rather than
"appeals for medical coverage." Giesse filed an appeal with an administrative law judge, who dismissed the claims for lack of
jurisdiction after finding that no reconsidered decision had been made. When the Medicare Appeals Council affirmed the
decision, Giesse filed a lawsuit in federal district court, alleging procedural and substantive due process violations, federal
constitutional tort, breach of contract, and fraud. Giesse sought nearly $5,000,000 in damages. The district court dismissed his
claims for lack of jurisdiction, and Giesse appealed.

The Sixth Circuit Court of Appeals agreed with the reasoning of the external reviewer, finding that Giesse's claims were not
reviewable because he had requested monetary damages while explicitly admitting that reinstatement of care would be an
inadequate remedy. In other words, because Giesse's plan could not have provided the relief he requested, it also could not
have made an "organizational determination" to deny it from him. As only organizational determinations are subject to judicial
review, the district court was correct to dismiss Giesse's claims for lack of jurisdiction.
**In re Evanston Northwestern Healthcare Corp.**
FTC No. 9315 April 28, 2008

The Federal Trade Commission recently issued a final Order detailing the terms that Evanston Northwestern Healthcare Corporation must follow in negotiating its managed care and certain government payor contracts following its merger with Highland Park Hospital. This final Order follows the FTC's August 6, 2007 ruling in which the FTC found that Evanston’s acquisition of Highland Park stifled competition in violation of federal antitrust law.

Instead of ordering divestiture, the FTC determined that the best remedy would be for Evanston to establish a separate contract negotiation team for Highland Park. Under the Order, separate negotiations are the default regime, though payors may opt to negotiate a joint contract to cover all facilities. Further, the Order requires Evanston to establish a firewall between the contract negotiation teams and prohibits either team from participating in joint contract negotiations.

Concerned about the effectiveness of the separate negotiations remedy alone, the FTC also established a dispute resolution process to resolve any contractual issues. Payors who dispute any of the prices or terms arising from the separate contract negotiations procedure may request that Evanston submit the disagreement to mediation. If the parties still are unable to resolve their issues, they must settle the dispute through binding arbitration. In conclusion, the FTC emphasized that no part of the dispute resolution process impacts its jurisdiction over possible violations of the Order itself.

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**In the Matter of: The Connecticut Chiropractic Association et al.**
FTC No. 071-0074 March 5, 2008 - Agreement Containing Consent Order to Cease and Desist

On March 5, 2008, the Connecticut Chiropractic Association (CCA), the Connecticut Chiropractic Council (CCC) and Robert L. Hirtle - legal counsel for CCA - entered into a proposed agreement with the FTC to settle charges alleging federal antitrust violations.

In its complaint, the FTC alleged that CCA, CCC and Hirtle violated Section 5 of the Federal Trade Commission Act when the parties conspired to boycott a health care benefits organization - American Specialty Health (ASH) - to preclude ASH from administering a cost-saving benefits administration program in Connecticut. Specifically, the FTC alleged that CCA and CCC unreasonably restrained competition when it conspired with its members and each other by collectively agreeing to boycott ASH. Furthermore, the FTC alleged that CCA’s attorney, Hirtle, unreasonably restrained competition when he encouraged and assisted chiropractors to boycott and terminate any existing relationships with ASH.

Under the proposed consent order, the parties are prohibited from entering into or facilitating any agreement among chiropractors 1) to negotiate with payors on any chiropractor’s behalf, 2) to deal, not to deal, or threaten not to deal with payors, or 3) to determine on what terms to deal with payors. The FTC noted that the proposed order was similar to other consent orders issued to settle charges of unlawful refusals to deal with health plans, but was unique in that it also settled charges that an attorney directly participated in the unlawful boycotts to deal with health plans.
Raudel Rodriguez v. Blue Cross of California, et al.
162 Cal. App. 4th 330

The plaintiff, Raudel Rodriguez, purchased health insurance from Blue Cross of California. He was subsequently hospitalized in September 2005. In December 2005, Blue Cross rescinded Mr. Rodriguez's coverage based on omission of material facts in the application. Mr. Rodriguez filed a class action lawsuit against Blue Cross for violation of the unfair competition law, declaratory relief, breach of contract, breach of the implied covenant of good faith and fair dealing and breach of the Consumers Legal Remedy Act. Blue Cross sought to compel arbitration based on the following provision in the enrollment application:

"[i]f you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice...'It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration...' Both parties also agree to give up any right to pursue on a class basis..."

In addition, the following statement was located immediately above the signature line:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL" [original bolded]

The trial court denied Blue Cross' petition to compel arbitration because the arbitration language failed to comply with California Health and Safety Code section 1363.1. The court concluded that the arbitration language "was not prominently displayed; the provision was limited to issues of medical malpractice; and the language above the signature line was limited to medical malpractice disputes. Because this case did not involve medical malpractice, the arbitration provision was unenforceable."

The California Court of Appeal, Second Appellate District, on de novo review, affirmed the trial court's decision. The court determined that the provision was unenforceable since the arbitration provision was inconsistent and ambiguous—some provisions addressed medical malpractice claims while others were more broadly drafted. The court explained, "[t]he confusion as to the extent of Rodriguez's waiver undermines the fundamental purpose of the statute—to ensure knowing waiver of the right to a jury trial."

The opinion provides an interesting roadmap of several decisions regarding the enforcement of arbitration provisions. The court reviewed several decisions, and similar to this one, "each [case] found the disclosures at issue deficient."
Medicare Part D enrollees can pay Prescription Drug Plans their monthly premiums by having the amount withheld from their Social Security benefits check. Plaintiffs claim their premiums were withheld even after they changed plans, joined subsidized premium programs or disenrolled from Social Security withholding.

Plaintiffs sued in federal court alleging that defendants, the U.S. Department of Health and Human Services and the Social Security Administration violated the Medicare Modernization Act of 2003 ("MMA") by witholding and retaining their Social Security benefits without authorization and the Fifth Amendment due process clause by "negligently" withholding incorrect premium amounts and unreasonably delaying their refunds. Plaintiffs seek an order requiring defendants to implement procedures guaranteeing that similar problems do not occur in the future or that such errors will be corrected more promptly.

The court dismissed most of the allegations because, "nothing in the MMA establishes any benchmarks for data accuracy or mandates any time tables by which CMS must provide eligibility data." (citing Long Term Care Pharm. Alliance v. Leavitt, 530 F. Supp. 2d 173, 184 (D.D.C. 2008)). In Long Term Care, the court denied plaintiff's request that the court order "CMS 'to be more timely or more accurate' in transmitting information," for provision of prescription drugs to persons in long term care facilities.

The District Court of Massachusetts also dismissed the counts alleging violations of 42 U.S.C. § 407(a), which prohibits the transfer or assignment of a person's right to Social Security benefits. The Court held that if Congress had meant for agencies to be liable for such errors under this statute, "it would have recognized this possibility explicitly."

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The District Court of Massachusetts did not dismiss plaintiffs' Constitutional claims. The Court held that "unconstitutional delays may be amenable to judicial remedies [including] the setting of deadlines for agency action." At this early stage, the Court could not say that plaintiffs had no legitimate due process claim. The Court found that the alleged five to thirteen month delays were "undisputably substantial." (citing Gray Panthers v. Schweiker, 652 F.2d 146, 156 (D.C. Cir. 1980).

Also relevant was that many of the plaintiffs had no other income outside of their Social Security checks. Although the Court noted that courts set a high standard for finding a governmental delay is unconstitutional, it ultimately held that the due process claim could not be decided solely based on the pleadings.

Stewart Scharfman, Zev and Linda Wachtel and Renee McCoy v. Health Net
Civ. Docket No. 2:05-cv-0301 - Brief - Order

The U.S. District Court, District of New Jersey has conditionally approved a settlement of a class action lawsuit that began in 2001. The representative plaintiffs in this class action are four Health Net members who allege that their health insurer implemented business practices and underpaid for out-of-network health care services and supplies in violation of federal ERISA and RICO laws. The class members include approximately two million former and current Health Net members.
The conditional settlement is between $249 and $265 million, and also include attorney's fees. Health Net has also agreed to make certain changes to its business practices, including the following:

- (i) for future UCR reimbursement based on Ingenix data, Health Net will pay an additionally 14.5% above the amount reported in the Ingenix database. This amount will be based on Ingenix's updated data and will not be subject to coinsurance;
- (ii) members may appeal the UCR calculation, which will represent the floor (rather than the ceiling) on out-of-network claims payments. The settlement provides specific processes and factors to be followed for the review;
- (iii) Health Net will modify subscriber contracts to replace UCR with another methodology; and
- (iv) Health Net will notify requesting members the UCR calculation for specific services and must make payments based on that amount.

Health Net estimates that the business practice changes will cost between $26 and $38 million.

**Ross v. Blue Care Network of Michigan**  
**No. 131711 (Mich. April 23, 2008)**

On April 23, 2008, the Michigan Supreme Court determined that under the Michigan Patient's Right to Independent Review Act ("PRIRA"), the OFIS is not bound by the recommendations of an independent review organization on issues of medical necessity and clinical review.

The Michigan Supreme Court reviewed the case after a series of administrative and legal appeals concerning Blue Care Network's denial of coverage for treatment of Ross - an enrollee - by University of Arkansas Medical Sciences ("UAMS"), an out-of-network facility. Blue Care had denied coverage for all of Ross' treatment because the treatment was not a medical emergency. Ross unsuccessfully appealed the denial through BCN's internal grievance review procedures, and then sought external review under PRIRA with the Commissioner of the OFIS. The Commissioner thereafter assigned the case to an independent review organization, which determined that the treatment was an emergency medical condition and recommended that Blue Care's denial of payment be reversed. The Commissioner, however, questioned the IRO's findings and instead found that the out-of-network treatment was not an emergency service and was not a covered benefit for BCN.

Ross appealed the Commissioner's order to the circuit court, which reversed the Commissioner's decision, finding that UAMS treated Ross on an emergency basis. The Michigan Court of Appeals affirmed the circuit's court decision, reasoning that the Commissioner exceeded her authority by discounting the IRO's recommendations and replacing them with her own.

On appeal, the Michigan Supreme Court reversed the Court of Appeals decision, noting the legislative intent of the PRIRA indicated that the IRO makes "recommendations" in reviewing claim denials and the Commissioner may disregard such recommendations with sufficient explanation. Accordingly, the supreme court reversed and remanded the decision to the trial court.
B & H Medical, L.L.C. v. ABP Admin., Inc.
Nos. 04-2438, 06-1338, 06-1339 (6th Cir. May. 7, 2008)

The United States Court of Appeals for the Sixth Circuit affirmed summary judgment for Wright & Filippis and its subsidiary ("W&F"), the defendants in an antitrust matter because B & H Medical ("B & H"), the plaintiff, did not adequately demonstrate it had antitrust standing. The court also sanctioned plaintiff and its attorney for filing a frivolous appeal.

W&F administered an exclusive network of preferred providers of durable medical equipment, prosthetics and orthotics to non-party Blue Cross Blue Shield of Michigan's members enrolled in certain health plans. B & H filed suit after it was denied membership in the network. Plaintiff alleged the network violated antitrust laws by preventing B & H from competing in the relevant market.

The District Court granted summary judgment for W & F because although B & H provided evidence of its loss of anticipated income, it did not prove "competition as a whole" suffered due to the exclusive agreement. B & H appealed the ruling on summary judgment and an order limiting its ability to secure broad discovery from BCBSM. B & H's attorney appealed a sanctions award levied against him for failing to dismiss the complaint after discovery revealed no antitrust violations.

The Sixth Circuit upheld summary judgment because B & H did not adequately address the lower court's assertion that B & H failed to allege an injury under antitrust law. B & H's Reply Brief included only three sentences regarding its antitrust standing. The Sixth Circuit cited Supreme Court precedent indicating that to prove an antitrust violation, "the competition foreclosed by the contract must be found to constitute a substantial share of the relevant market." W & F's exclusive dealing agreement with BCBSM did not meet this standard because it "foreclosed access to less than thirteen percent of the relevant market."

The Sixth Circuit also upheld the lower court's discovery order; B & H did not provide any "reasonable explanation" why the information it sought from BCBSM would enable B & H to define a relevant market."

The Sixth Circuit affirmed the District Court's order imposing sanctions against B & H's attorney, for "failing to dismiss this case." The Court also granted W & F's motion for appellate sanctions because "B & H's antitrust claims lack[ed] any conceivable merit, and this has been apparent for a long time." B & H's appellate briefs raised several new theories of antitrust liability but failed to address the District Court's reasons for granting summary judgment.

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