CLIENT ALERT

Managed Care Lawsuit Watch - October 2004

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This summary of key lawsuits affecting managed care is provided by the Health Care Law 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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Cases in this issue:

- Cicio v. Does
- Connecticut v. Health Net, Inc. (In re Managed Care Litigation)
- Land v. CIGNA Healthcare of Florida
- Smith v. United Health Care Services, Inc.

Cicio v. Does
2nd Cir., No. 01-9248 (9/23/04)

Reviewing its February 2003 Cicio v. Vytra decision in light of the U.S. Supreme Court’s recent decision in Aetna Health Inc. v. Davila, the Second Circuit Court of Appeals vacated its earlier decision and affirmed the district court’s dismissal of a state law medical malpractice claim as preempted by ERISA.

The plaintiff in Cicio had brought a malpractice claim under New York law based on a medical decision made by an HMO’s medical director in the course of utilization review. The district court had dismissed the claim as ERISA preempted, but the Second Circuit reversed. The defendants appealed to the Supreme Court, who remanded the case back to the Second Circuit to be reviewed in light of Davila. In Davila, the Supreme Court declared that any state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy is preempted.

Following Davila, the Second Circuit held that the Cicio plaintiff’s state law malpractice claim was preempted because if the claim were successful, it would supplement the remedial scheme established in ERISA § 502(a)(1)(B) by providing compensation that went beyond the value of the services due under the terms of the plan. Further, the Second Circuit held that the state malpractice claim was subject to complete ERISA preemption, as the Cicio defendants did not actually provide medical care to the plaintiff’s decedent.
Connecticut v. Health Net, Inc. (In re Managed Care Litigation)
11th Cir., No. 03-16287 (9/10/04)

In what the Eleventh Circuit described as an issue of first impression, it held that Connecticut had no standing to pursue the ERISA claims of its citizens in its capacity as assignee, because Connecticut failed to show that it had or would suffer actual or imminent harm to a legally protected interest. The court also concluded that Connecticut lacked standing to assert the claims of its citizens in parens patriae.

The case arose when Connecticut sued eight managed care companies in the District Court of Connecticut on behalf of its citizens, alleging that the companies had violated ERISA. Connecticut alleged that the companies were using improper, arbitrary guidelines to deny coverage to enrollees and failing to disclose important information relied on by enrollees. Connecticut brought suit in its capacity as an assignee of some of its citizens and in its capacity as parens patriae.

The case was subsequently transferred to the Southern District of Florida for consolidation as part of In re Managed Care Litigation. The District Court for the Southern District of Florida rejected Connecticut’s claims, agreeing with the reasoning of a recent Second Circuit decision, Conn. v. Physicians Health Services of Conn., Inc., which held that Connecticut lacked standing to pursue similar claims in another lawsuit against a managed health care company. Connecticut appealed the district court’s ruling to the Eleventh Circuit.

In determining that Connecticut lacked standing to sue as an assignee, the Eleventh Circuit remarked that the citizens’ assignment of their claims to the State of Connecticut lacked consideration. The court also noted that Article III standing requires that the plaintiff sustain an actual, not hypothetical, injury. The court observed that there was no evidence that Connecticut had or would suffer injury based on the alleged ERISA violations. Instead, the court found that Connecticut was merely seeking redress for alleged injuries to its citizens and that the right to seek money damages remained with its citizens.

The court also found that Connecticut lacked statutory standing to sue in parens patriae capacity. The court observed that nothing in the plain language of ERISA suggests that Congress intended that the states be permitted to bring suit in parens patriae.

Land v. CIGNA Healthcare of Florida
11th Cir., No. 02-15549 (8/27/04)

The Eleventh Circuit reviewed its July 2003 Land v. CignaHealthcare of Florida decision, which the U.S. Supreme Court had vacated and remanded for consideration in light of Aetna Health Inc. v. Davila, and determined that the Land plaintiff’s state law malpractice claims were preempted by ERISA.

The Land plaintiff had brought a state law malpractice claim against his HMO based on the decision by the HMO’s approval nurse to treat his infection with outpatient rather than inpatient care. The district court ruled that the claim was preempted by
ERISA. The Eleventh Circuit initially reversed, concluding that the approval nurse’s decision to authorize outpatient rather than inpatient treatment was a “mixed” eligibility and treatment decision under Pegram and not preempted by ERISA.

The 11th Circuit also initially held that the plaintiffs’ claims did not fall under ERISA as they were tort claims and not claims to recover contract benefits. The defendants appealed, and the Supreme Court vacated and remanded the decision for review in light of Davila. The Eleventh Circuit subsequently affirmed, noting that Davila held that state law duties regarding coverage decisions do not arise independently of the terms of ERISA plans and thus fall within the scope of ERISA’s remedy provision. The 11th Circuit also noted that Davila found that Pegram “mixed” decision analysis only applies in circumstances in which the providers are either the injured party’s treating physicians or those physicians’ employers, which was not the case in Land.

Smith v. United Health Care Services, Inc.
D. Minn., No. 00-1163 settlement entered 9/10/04

A federal judge accepted a settlement between UnitedHealth Group and two named plaintiffs in a class action that alleged the company over-billed beneficiaries for their prescription drugs. The complaint, filed in Minnesota in 2001, alleged that the company required subscribers to pay higher copayments than their plan stipulated between October 1, 1997 and September 30, 1999. The copayment was supposed to be the lesser of the fixed dollar copayment or the actual prescription cost, but the lawsuit contended that UnitedHealth was billing for the copayment amount even when the cost of the prescription was lower than the copayment.

The settlement requires UnitedHealth Group to pay $9.95 million plus the costs of settlement administration, but does not require the Group to admit liability. The class is capped at the 250,000 members who over-paid the most, according to attorneys for the plaintiffs. A fairness hearing is scheduled for November 4, 2004 in St. Paul.