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Ahmad v. Aetna U.S. Healthcare
E.D. Pa. No. 02-08673-RB (9/14/05)

The United States District Court for the Eastern District of Pennsylvania remanded a lawsuit by a physician against Aetna U.S. Healthcare to state court because it found no basis for federal jurisdiction. The district court found that the physician's claims were not preempted by Section 502(a) of ERISA or the Medicare Act.

The physician's complaint was filed in Pennsylvania state court alleging defamation and tortious interference with present and prospective contractual relationships. Aetna sought to remove the action to federal court, asserting that the physician's claims were preempted by Section 502(a) of ERISA and by the Medicare Act. The district court determined that the action was improperly removed to federal court. The court observed that the physician could not have brought his claims under ERISA because he was not a participant or a beneficiary, and therefore, ERISA did not provide a basis for federal jurisdiction. The court
also determined that state law, not the Medicare Act, provided the basis for the physician's defamation and tortious interference claims. Therefore, the Medicare Act did not provide a basis for federal jurisdiction.

**Collins v. Anthem Health Plans, Inc.**  
**Conn. Supreme Court No. SC 17233 (9/6/05)**

The Connecticut Supreme Court determined that a state trial court erred in granting class certification in a complaint by physicians and physician groups against Anthem Health Plans, Inc. ("Anthem").

The lawsuit was brought by orthopedic surgeons alleging that Anthem breached its contract by, among other things, failing to make timely payments. The physicians and group practices sued Anthem alleging breach of contract, tortious interference with business expectancies, and breach of an implied covenant of good faith and fair dealing. The trial court granted class certification, but the appellate court remanded the case with instructions to determine whether the predominance requirement for class certification was satisfied. The trial court determined that four subparagraphs in the complaint presented claims that were suitable for class resolution.

On appeal, the Connecticut Supreme Court remanded the case to the trial court with instructions to deny class certification on the four subparagraphs at issue. The appellate court found that (1) the trial court did not apply the proper legal standards in determining whether the predominance requirement had been met; and (2) the trial court failed to properly consider the management problems that would occur if the case were tried as a class action, in that proof of injury and causation would have to be made separately for each of the potential class members.

**Harris Methodist Fort Worth v. Sales Support Services Inc. Employee Health Care Plan**  
**5th Circuit No. 04-10761 (9/20/05)**

The Fifth Circuit reversed a grant of summary judgment in favor of a self-insured employee welfare benefit plan by the District Court for the Northern District of Texas, finding that an expectant mother had sufficiently assigned her benefits claim on behalf of her twins to the admitting hospital.

Harris Methodist Fort Worth ("Harris") brought an ERISA claim against a patient's employer and its employee welfare benefit plan ("the Plan") (collectively, "Defendants"), after the Plan refused to reimburse Harris for expenses incurred in providing care to the patient's prematurely born twins. The district court granted summary judgment in favor of Defendants on the grounds that (1) Harris lacked standing to sue under ERISA because the assignment of benefits executed by the patient did not extend to her twins' claims; and (2) the Plan's contractual statute of limitations provision barred Harris's claims.

The Fifth Circuit, in holding that plaintiff Harris was entitled to reimbursement for the care it provided to the twins, addressed both findings by the district court on appeal. The court found that the assignment of benefits form signed by the patient
indicated that the patient intended to assign both her benefits claim and the twins' benefits claims to Harris. The court also observed that the Summary Plan Description included language imposing an obligation on the Plan to pay providers directly, regardless of whether there was an assignment of benefits.

The court also found that the Plan's requirement that any action to recover benefits be commenced within "three (3) years from the time written proof of loss is required to be given" was reasonable. The court acknowledged that Plan documents did not define the term "loss," but rejected Defendants' assertion that "loss" meant the dates of each of Harris's interim bills. The court concluded that in cases where "loss" is ambiguous, a practical approach should be taken based on the circumstances of the medical care rendered. Thus, the court determined that hospitalization constituted one event of "loss" for the purposes of applying the Plan's three-year deadline for filing suit. Thus, the Fifth Circuit found that plaintiff Harris' claims were not time barred.

*In re Managed Care Litigation*
S.D. Fla. MDL No. 1334 Settlements approved (9/26/05)

The proposed Health Net settlement can be viewed at: [http://www.crowell.com/pdf/ManagedCare/HealthNet_Settlement.pdf](http://www.crowell.com/pdf/ManagedCare/HealthNet_Settlement.pdf)

The proposed Prudential settlement can be viewed at: [http://www.crowell.com/pdf/ManagedCare/Prudential_Settlement.pdf](http://www.crowell.com/pdf/ManagedCare/Prudential_Settlement.pdf)

On September 26, Judge Moreno of the U.S. District Court for the Southern District of Florida gave final approval to proposed settlements involving Health Net Inc. and Prudential Financial Inc. that would resolve the claims against those companies in the national class actions filed by over 700,000 physicians against the nation's major managed care companies.

The physician plaintiffs in the long-running case alleged that the managed care companies violated numerous federal and state laws, including the Racketeer Influenced and Corrupt Organizations ("RICO") Act and state prompt-pay laws, in their effort to hold down physician payments. Various lawsuits were consolidated before the District Court for the Southern District of Florida in 2000, and class certification was granted for the federal RICO claim. Judge Moreno's final approval of these settlements brings to four the number of managed care companies who have completely resolved the claims filed against them in this litigation.

Pursuant to its settlement agreement, Health Net agreed to make business practice changes including adopting a new definition of medical necessity, providing physicians with external review boards for medical necessity determinations and billing disputes, ceasing the automatic downcoding of claims, eliminating "all product" and "gag" clauses in provider contracts, and giving providers 90-days notice before instituting policy or billing changes. The Health Net settlement also included a payment of $39 million to a settlement fund for payments to physicians. Prudential, which sold its healthcare business in 1999, agreed in its final settlement to pay $22.2 million to a fund which will be used to monitor abuses in managed care.
**McDonald v. Household International Inc.**  
7th Cir., No. 04-3259, (9/29/05)  
The Seventh Circuit reversed a district court's dismissal of a complaint based on state law claims, holding that although the claims were preempted by ERISA, the facts alleged were sufficient to permit the case to go forward in a claim under ERISA.

McDonald, an employee of Household International Inc., sued his employer and United Healthcare Group ("United") for breach of contract and negligence. McDonald suffered a catastrophic stroke following Defendants' alleged failure to properly activate his employer-sponsored health insurance and to cover the cost of his prescription blood pressure control medication, which he could not afford to purchase on his own. The district court dismissed McDonald's claims as preempted by ERISA.

On appeal, the Seventh Circuit agreed with the district court's preemption determination, but emphasized that "[p]arties do not need to plead legal theories in their complaints in federal court" and "specifying an incorrect theory is not fatal." Rather, the Seventh Circuit found that relief was possible under ERISA § 502(a) through a claim for reimbursement of medical expenses, noting that Plaintiff's pleadings "entitle him to explore these possibilities further." The case was remanded for further proceedings consistent with the Seventh Circuit's opinion.

**Medical Staff of Doctors Medical Center in Modesto v. Kamil**  
California Court of Appeals, No. B179237 (9/8/05)  
A California court held that an arbitration clause in a contract between a health insurer and a hospital employing a group of physicians did not compel the physicians to arbitrate defamation claims against the health insurer.

The medical staff of Doctors Medical Center brought an action alleging defamation against Blue Cross of California ("Blue Cross"), its parent corporation WellPoint Health Networks, and Health Benchmarks after Blue Cross made statements about plaintiffs' practice of medicine in various California newspapers that, according to the court, Blue Cross later admitted were false.

Blue Cross argued that plaintiffs' claims fell within the scope of the hospital agreement's arbitration clause, because plaintiffs' claims had their "roots" in the contractual relationship. The trial court rejected defendants' argument, finding that the arbitration clause was not broad enough to cover plaintiffs' claims.

The trial court's decision was affirmed. The appellate court held that the defamation claims did not concern the terms of the agreement and thus were outside the bounds of the arbitration clause. The court observed that even if plaintiffs' claims did come within the scope of the general arbitration clause, the claims related to utilization review, and an exception to the arbitration clause provided that disputes concerning utilization review were only governed by the arbitration clause to the extent they involved claims payment disputes. The court also noted that the medical staff was a separate legal entity that was not bound by the agreement between Blue Cross and the hospital.
Minnesota v. Medica Health Plans
Minn. Dist. Ct., 4th Dist. No. MC 01-004100 (8/17/05)

The Minnesota District Court for Hennepin County dismissed a suit brought by the Minnesota Attorney General that alleged wrongdoing by the Board of Medica Health Plans ("Medica"), finding that there was no evidence that Board members acted improperly in carrying out their court-ordered responsibilities.

In late 2001, following an investigation by the Minnesota Attorney General of alleged corruption and fraud, Medica was reorganized and a new court-approved Board was appointed. The Minnesota Attorney General subsequently brought suit against the new Board, claiming that Board members engaged in self-dealing by running for election at the end of their terms. In addition, the State alleged that three Board members improperly received free health care policies.

The court found that the State failed to prove that the Board engaged in self-dealing, noting that "[d]irectors of nonprofits are entitled to exercise sound 'business judgment' and are not subject to second-guessing by courts or regulatory agencies when they do." The court stated that there was no evidence that the Board members, hand-picked by the Minnesota Attorney General, failed to act in good faith.

Nechis v. Oxford Health Plans, Inc.
2d Cir. No. 04-5100-cv (8/24/05)

The United States Court of Appeals for the Second Circuit affirmed the dismissal of two health benefit plan participants' claims that Oxford Health Plans ("Oxford") engaged in deceptive practices in violation of ERISA.

Oxford hired Triad Healthcare ("Triad") to review its chiropractic claims. Plaintiffs had previously received chiropractic care without incident, but after Triad was hired, plaintiffs' claims were allegedly denied. Plaintiffs filed suit for breach of ERISA disclosure obligations, failure to provide benefits under an ERISA plan, and breach of fiduciary duties. Plaintiffs claimed Oxford engaged in deceptive practices by failing to disclose its cost-based criteria for claims review and that Triad received financial incentives to deny claims or limit coverage.

The appeals court affirmed the district court's ruling that plaintiff Mady lacked standing, holding that because Mady's coverage with Oxford terminated before the suit was filed, she was no longer a "participant" eligible to seek injunctive relief under ERISA.

The court also held that plaintiff Nechis' claims failed on their merits. Nechis did not satisfy the criteria under § 502(a)(3) for obtaining equitable relief because her claims of "restitution" and "unjust enrichment" sounded more properly in contract. Moreover, the court held that §§ 104 and 1002 of ERISA require plan administrators to notify subscribers of material reductions in benefits or services. Since Oxford did not fall within the definition of "plan administrator," Nechis' breach of disclosure claim also failed.
Finally, the court denied plaintiffs' request for leave to amend, finding that the deficiencies in their pleadings could not be remedied.

**Tow Distributing Inc. v. Blue Cross and Blue Shield of Minnesota**

Minn. Dist. Ct. No. C4-02-9317 (9/7/05)

A Minnesota court approved settlement of a class-action lawsuit brought by employer groups challenging the plans of Blue Cross and Blue Shield of Minnesota ("BCBSMN") to distribute the proceeds of its tobacco suit.

In 1994, BCBSMN joined Minnesota in a lawsuit against the tobacco industry. The suit was settled in 1998, with BCBSMN receiving $469 million.

As a not-for-profit health plan, the company developed a plan for disbursing the settlement proceeds. The plan itself became the subject of a lawsuit in 2002, when employer groups argued they should be reimbursed for increased insurance premiums they paid because of smoking-related illnesses.

Under the terms of the settlement, BCBSMN will pay $41 million dollars, less attorneys fees and costs, to the settlement class. The class includes all fully insured groups, service cooperatives, pools and associations who had a contract with the company prior to June 15, 2001.

The agreement provides guidelines for determining eligibility, calculation of group size and years of coverage, claim filing and distribution, and dispute resolution. It also allows BCBSMN to withdraw in the event that an exclusion threshold is met. Groups have 60-days from the date of settlement to appeal the decision. After that, BCBSMN may begin releasing funds to eligible employer groups.

The remaining money will be distributed as follows: $30 million will be invested in community clinics; $70 million will go to reducing the deficit carried by the Minnesota Comprehensive Health Association; $30 million will be distributed directly to fully insured individuals who had BCBSMN coverage; and the remaining $241 million will be spent on preventive health programs for all Minnesotans.

**U.S. v. AdvancePCS**

E.D. Pa. Civil Action No. 02-CV-9236 Civil Action No. 03-CV-5425 (9/8/05)

Settlement Agreement

Consent Order

On September 7, pharmacy benefit manager AdvancePCS reached agreement with the federal government to settle False Claims Act and Public Contract Anti-Kickback Act claims that had been brought against it on the basis of its financial relationships with
pharmaceutical manufacturers and customers. AdvancePCS, currently a subsidiary of Caremark Rx Inc., agreed to pay $137.5 million and to change its business practices as part of the settlement.

The U.S. Attorney’s Office for the Eastern District of Pennsylvania, with assistance from the Office of Personnel Management and the HHS OIG, had investigated AdvancePCS and brought claims alleging, *inter alia*, that AdvancePCS solicited and received payments from pharmaceutical manufacturers for providing pharmacy and medical data to the manufacturers. The government also alleged that AdvancePCS solicited and received lump sum and rebate contracts with manufacturers in return for AdvancePCS treating the manufacturers favorably in its contracts to provide services under FEHB and Medicare + Choice, and also that AdvancePCS improperly offered payments to its client plans for favorable treatment in those clients’ contracts with FEHB and Medicare + Choice.

AdvancePCS agreed to pay $137.5 million to settle the claims. In addition, AdvancePCS entered into a consent order whereby it agreed to change its business practices, including disclosure to its client plans the payments it receives from manufacturers, no longer paying implementation or development fees to a client plan unless such fees are fair and transparent, and not initiating drug interchanges that require the client plan to pay more than they would for the drug initially prescribed. AdvancePCS will also be subject to a corporate integrity agreement with the HHS OIG.