Managed Care Litigation Developments: Legal and Practical Considerations for Health Plans and Providers

Tuesday, July 24, 2007
1:00 pm-2:30 pm Eastern / 10:00 am-11:30 pm Pacific

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I. Class Action Suits

A. Latest Developments

1. In re Managed Care Litigation (D.C. S.D. Fla., MDL No. 1334, 2006 U.S. Dist. LEXIS 6669 (S.D. Fla. 2006))

- On June 19, 2006, the district court dismissed all claims brought by 700,000 physicians in the *Shane* class action suit against the two remaining defendants, UnitedHealth Group Inc. and Coventry Health Care, Inc., in which the plaintiffs alleged that the insurers violated federal racketeering laws by failing to properly reimburse physicians. Previously, in February 2006, the court granted summary judgment to PacifiCare Health Systems, Inc. on similar grounds.

- In granting summary judgment to United and Coventry, the court stated that the physicians, despite "multiple opportunities to demonstrate triable issues of fact," had simply not presented evidence that would allow a jury to reasonably find that the insurers had engaged in a conspiracy to underpay physicians.

- The other seven defendants (Humana, Inc., Health Net Inc., Prudential Financial Inc., WellPoint Health Networks, Inc., Anthem, Inc., Aetna Inc. and CIGNA HealthCare Plan) had previously entered into settlement agreements with the physicians.

- On June 13, 2007, in a per curiam decision, the Eleventh Circuit affirmed the grant of summary judgment to United and Coventry, finding that the district court's judgment was "due to be affirmed under the facts and circumstances of [the] case."

- On April 27, 2007, a settlement was announced in the *Love v. Blue Cross and Blue Shield Association* case, a nationwide physician class action modeled on the *Shane* case.

2. Reimbursement Class Actions by Providers and Patients

a. Coast Plaza Doctors Hospital. v. Wellpoint, Case No. BC 360235, Los Angeles Sup. Ct., Central Civil West (Complex Division), Dept. 16 (filed Oct. 12, 2006)

- California Hospital filed class action lawsuit against Wellpoint and its subsidiaries, Blue Cross of California and Blue Cross Health & Life, challenging business practice of rescinding member coverage on grounds that it violates statutes (a) precluding post-claims underwriting; (b) requiring payment for authorized services; and (c) requiring payment for emergency services.

- In December 2006, motions were filed by Coast Plaza and the California Medical Association to intervene in Horton v. Wellpoint, et al., BC 341823, Los Angeles Sup. Ct., which is a class action by patients alleging that Wellpoint and its Blue Cross subsidiaries violated the rights of patients by rescinding policies based on post-claims underwriting. The intervention motion is based on the position that the patient class action is seeking payments from these plans to cover the costs of services rendered by the providers. The plans oppose the intervention.

- In January 2006, the Los Angeles Sup. Ct. deemed the Coast Plaza and Horton cases related, transferred the patient class to the complex department handling the provider class, and stayed the cases to permit settlement negotiations.

b. Edward Collins, M.D., et al. v. Anthem Health Plans Inc., No. X06CV990156198S, Conn. Super., Waterbury Jud. Dist., Complex Litigation Docket (Feb. 7, 2007)

- Court dismissed class action claims filed against an insurer by a group of orthopedic surgeons, finding that the individuals lacked standing to sue and that the physicians groups actually signing the participating provider agreements were in a better position to seek redress of the reimbursement injuries alleged

- Plaintiffs alleged that they entered into participating provider agreements with Blue Cross and Blue Shield of Connecticut, that Anthem became the successor of Blue Cross following a merger in August 1997, and

that Anthem violated those agreements through unfair reimbursement methods.

- Anthem moved to dismiss the complaint, arguing that the individual providers lacked standing because their medical practice groups contracted with Anthem, not the individuals.

- The individual providers claimed that common law requires only a minimal injury for them to have standing, and alleged direct personal harm different than that of the professional groups because Anthem's actions allegedly affected their ability to practice medicine and protect their employment interests.

- The court held that the harm allegedly suffered by the plaintiffs was indirect and that any duties owed by Anthem were owed to the physicians groups and not the individual physicians

- The physicians groups of the other plaintiffs were members of a managed care class action lawsuit in which a settlement was reached.

3. Quality of care and related terminations

a. Washington State Medical Association v. Regence Blue Shield, (Wash. Super. Ct., No. 06-230665-1SEA (complaint filed Sep. 21, 2006))

- Washington State Medical Association filed a complaint against Regence Blue Shield, alleging unfair and deceptive business practices, defamation, libel, intentional interference with commerce, and breach of contract.

- The association sued after the insurer's decision to exclude nearly 500 doctors from its "Select Network," which provided services to 8,000 employees and their families.

- In November 2006, the American Medical Association's Litigation Center, a coalition of the AMA

and state medical societies, joined the lawsuit as a co-plaintiff.

- In the complaint, the Association, on behalf of six of its physician members, alleges that Regence used "flawed methodology" to determine that several hundred physicians did not meet the company's quality and efficiency standards.

- The Association further alleged that Regence used old data from a small number of patient files and focused on the amount charged, rather than medical records, to deem physicians "inefficient."

- The lawsuit seeks an injunction against Regence to prevent it from implementing the Select Network Program and monetary damages for the insurer's alleged improper and inaccurate statements to patients that certain physicians failed to meet certain quality and efficiency standards.

b. New York Attorney General Action (July 13, 2007)

- Letter to UnitedHealthcare indicates that NY AG is prepared to seek an injunction against the introduction of any program "which would rank physicians according to alleged quality and cost-effectiveness." NY AG reveals concern that a program that would utilize financial inducements to steer patients to doctors ranked on such bases could:

    - Be based on faulty data and criteria;

    - Encourage patients to use inexpensive doctors, not good doctors, which could undermine the doctor-patient relationship;

    - Be driven by United's profit motive, a purported conflict of interest; and

    - Could publicly rank physicians in an erroneous manner, leading to "irreparable harm."

- AG also requests documentation concerning United's development and operation of the program, due "at your earliest convenience"

B. Class Action Fairness Act of 2005 – Immediate Results?

1. Intentions of Class Action Fairness Act ("CAFA")

- Correct perceived abuses in the prosecution of class actions, e.g.,
- Keep cases of national importance in federal court
- Protect against bias towards out-of-state defendants
- CAFA allows removal of class actions with state law claims

2. Removal

Norem *et al.* v. Aetna Health Inc., No. 06-1007, W.D. Mo. (removal filed Dec. 12, 2006)

- Plaintiff alleged Aetna improperly required a co-pay in excess of that allowed by a Missouri regulation.
- Plaintiff filed motion seeking certification of a class of Missouri enrollees defined as: "All individuals who were enrolled in defendant's HMO plan/s in which defendants have imposed co-payment charges in excess of 50% of the total cost of providing any single service to the enrollee."
- Dec. 12, Aetna successfully removed the case to the U.S. District Court for the Western District of Missouri, arguing that ERISA preempts Norem's claims and that removal was appropriate based on CAFA.
- Aetna's motion to dismiss granted March, 2007 (preempted by ERISA).

3. The "Relation Back" Doctrine

Eavenson v. Selective Insurance Co. of America, S.D. Il., No. 06-731 (Feb. 12, 2007)

- In 2004, Eavenson, a chiropractor, filed a nationwide class action complaint against Selective Insurance Company ("Selective") in Illinois State court, alleging that Selective improperly paid out-of-network providers (such as Eavenson) at in-network, i.e., discount rates, in violation of Illinois statutory and common law.

- In August, 2006 (post-CAFA), Eavenson amended his complaint to further allege that Selective improperly paid discounted rates to such "preferred" providers without properly steering patients to the providers.

- Selective attempted to remove the case to federal court, claiming that since Eavenson's amended complaint was filed after the effective date of CAFA, the CAFA provision granting class action jurisdiction to federal courts applied.

- U.S. District Court for the Southern District of Illinois denied Selective's motion and remanded the case back to state court. Specifically, the court determined that Eavenson's further allegations were not "sufficiently distinct" from the original allegations so as to be treated as a new piece of litigation, or so as to prevent Selective from mounting an appropriate defense. Accordingly, the court found that Eavenson's amendments "related back" to the original complaint, and that CAFA did not apply.

C. Enforcement Of Arbitration Clauses In Class Actions

- ADR methods, such as arbitration and mediation, are increasingly used as means of resolving health care disputes. Prevalent litigation issues include whether arbitration clauses in participating provider contracts may be enforced.

1. Physicians' Class Action Claims Not Subject to Arbitration

Kansas City Urology Care, P.A., v. Blue Cross and Blue Shield of Kansas City, Inc., (Cir. Ct. of Jackson County, Mo., 0516-CV04219, Dec. 4, 2006)

- Plaintiffs, a group of doctors and doctor organizations, brought class action claims against various health insurance

providers, alleging price fixing and conspiracy to monopolize in violation of Kansas law.

- Defendant health insurance companies moved to compel arbitration based on arbitration clauses in the various participating provide agreements. Special Master recommended that the motion to compel arbitration be sustained, but that provisions in some of the arbitration clauses that preclude joinder or class action be stricken and that the parties proceed with a single unitary arbitration.

- Despite this recommendation, the court refused to order arbitration of plaintiffs' claims. In analyzing the motion to compel arbitration, the court addressed three issues: 1) whether arbitration clauses exist in the contracts; 2) if they do exist, whether they apply in the instant case; and 3) if the arbitration clauses do apply, whether they agreements are enforceable as a matter of law.

- The court segregated the arbitration claims into two categories (1) broadly-worded arbitration agreements that do not specifically address the issue of joinder or class action; and (2) narrowly-worded arbitration provisions that intend to preclude class action litigation or joinder of other parties.

    - As to the first category, the court determined that these arbitration clauses did not apply to the instant case because there was no language specific to antitrust and class action claims. As a result, the court refused to compel arbitration under those agreements.

    - The court also declined to compel arbitration under the second category of arbitration agreements. Although the court admitted that the narrow provisions applied to the dispute of the parties because they specifically referenced antitrust actions and precluded class action claims, the court ruled that these provisions were unenforceable and void as against public policy.

    - The court held that enforcing these arbitration agreements would be "tantamount to granting immunity to these defendants regarding any kind of

claim touching upon conspiracy or relief as part of a class action."

- Claiming that the Plaintiffs would be unable to try – let alone prove – their allegation that the insurers acted in concert without being able to join all parties in litigation, the court found "a factual perfect storm that makes these contracts unconscionable and against the public policy."

o In anticipation of an immediate appeal by the defendant insurers, the court stayed the entirety of the litigation to allow an appellate court to review the case on an interlocutory basis, and posed specific questions to the appellate court for its review, including whether the issues in the litigation were appropriate for arbitration rather than a court, and whether the case should be considered by the Missouri Supreme Court because of the importance of the issues to the State of Missouri.

Kruger Clinic Orthopaedics v. Regence BlueShield, 157 W.2d 290, 138 P.3d 936 (Wash., July 13, 2006)

- This case arose out of two consolidated appeals brought by providers. In both cases, the providers unsuccessfully argued in the Washington Court of Appeals that the arbitration clause in Regence BlueShield's provider agreements was unconscionable and unenforceable.

- The providers filed petitions for review with the Washington Supreme Court, arguing that the arbitration clauses in their provider agreements violated a Washington statute that required insurers to provide a "fair review" of provider complaints because the clauses required binding arbitration, thereby precluding judicial review of the providers' complaints. In July 2006, the high court reversed the appeals courts' decisions and denied the plan's motion to compel arbitration.

- The Washington Supreme Court rejected Regence's argument that the Federal Arbitration Act ("FAA") preempted the Washington statute, finding that the McCarran-Ferguson Act – under which state laws regulating the business of

insurance are protected from preemption by the federal laws – shielded the state law from preemption by the FAA. Because the arbitration provisions at issue precluded judicial remedies, they were invalid under the Washington state law requiring fair review of provider complaints.

2. Physicians' Class Action Claims Subjected to Arbitration

Rosenberg v. Blue Cross Blue Shield of Tenn., Tenn. Ct. App. No. M2005-01070-COA-R9-CV (Nov. 29, 2006)

- Two physicians sued Blue Cross Blue Shield of Tennessee ("BCBST") alleging, among other claims, breach of contract and unfair or deceptive business practices arising out of BCBST's reimbursement practices. They sought not only damages for claims denied, but punitive damages on behalf of a class of all BCBST participating providers.

- The doctors had entered into participating provider agreements with BCBST that required submission of unresolved claims to binding arbitration. After the suit was filed, BCBST moved to compel arbitration in accordance with the participating provider agreements. In response, the doctors argued that the arbitration provision was unenforceable because (1) it was part of a contract of adhesion and (2) the arbitration of small claims was cost prohibitive. The trial court rejected both arguments and, on interlocutory appeal, the Court of Appeals of Tennessee agreed.

- The appellate court noted that "[a] party challenging the arbitration provisions of a contract, particularly when those provisions are clear and unambiguous, faces a figurative tsunami of case law, both federal and state, ever strengthening and reinforcing the favored status of arbitration."

    - As to the argument that the contract was a contract of adhesion, the court ruled that the contract had to be shown to be "beyond the reasonable expectations of an ordinary person, or oppressive or unconscionable," and that the contracts at issue did not meet that standard.

- As to the argument that arbitration is cost prohibitive, the court noted that while arbitration of individual claims might be cost prohibitive, the doctors in this case had asserted more than individual claims: the complaint alleged a pattern of deceptive conduct and practices that deprived a class of doctors of "millions of dollars" in reimbursements, and the doctors sought punitive damages. The court noted that "[w]hat might be cost prohibitive when a [small] claim is in issue would certainly not be prohibitive when millions of dollars and vast injunctive relief are actually in issue," and thus the doctors failed to meet their burden of proving that arbitration was cost prohibitive.

- In April 2007, the U.S. Supreme Court denied permission to appeal the appellate court's decision.

- Class arbitrations filed by providers against insurers have been increasing in number every year since the Supreme Court's decision in *Green Tree Financial Corp. v. Bazzle*, 539 U.S. 555 (2003), in which the Supreme Court held that arbitration should be compelled when it is not clear whether an arbitration clause prohibits class arbitration. At least eight such class arbitrations have been filed with the American Arbitration Association in the past four years.

II. Non-Participating Provider Lawsuits

Reimbursement to participating providers is always a major issue in managed care litigation, but increasingly non-participating physicians are filing suit over the rate of reimbursement they receive from plans.

Non-participating providers argue that plans undercompensate them, forcing members to pay the difference in the plans' payments and the providers' charges. Most state laws (and certainly plan terms) prohibit participating providers from collecting from plan members beyond plan co-pays and deductibles, and some state laws prohibit *non*-participating providers from balance billing plan members, even though the providers have no relationship with the plan (e.g., Connecticut, Maryland).

A. Does state law create an implied contractual relationship between the plan and the non-participating provider?

Prospect Medical Group v. Northridge Emergency Medical Group, No. B172737 (Cal. App. 4th, Feb. 17, 2006)

- California appellate court held that out-of-network emergency physicians may bill plan members for the balance of the physician charges that are not paid by plans

- At issue is a provision of the Knox-Keene Act (§1379) that provides that patients shall not be liable to a health care provider for sums due under contracts between the provider and a health plan, and that the provider shall not attempt to collect from the patient.

- Plaintiff, an agent of a health plan, sued an emergency physician group, seeking a declaration that non-participating physicians are entitled to reasonable compensation (defined by Plaintiff as 100% of Medicare) and that §1379 prohibits non-participating physicians from balance billing plan members.

- Plaintiff claimed that the statutory scheme creates an implied contract between plans and the non-participating emergency physicians.

- Court held that there is no implied contract, that non-participating physicians are not required to accept Medicare rates, and that non-participating physicians may contest in court whether the reimbursement rates being paid are "reasonable."

- California Supreme Court will review. Amicus briefs have been filed, and the California Department of Managed Health Care would further the argument that the Knox-Keene Act (a "consumer protectionist statute") creates an implied contractual relationship, specifically because out-of-network ER doctors expect to receive some payment from plans, do in fact receive some payment from plans, and further accept the California Department of Managed Health Care's assistance in retrieving certain payments from plans.

B. What are the appropriate levels of reimbursement to non-participating providers?

1. Medicare

- Medicare regulations establish criteria for determining "reasonable and customary." See 42 CFR §§405.502, 503.

2. California

- Six-part test to determine "reasonable and customary" rate for paying non-contracted physicians, based upon "statistically credible information that is updated at least annually" and that takes into consideration:
    1. provider's qualifications
    2. nature of services
    3. provider's typical fees
    4. prevailing provider rates in the same area
    5. economics of the provider's practice that are relevant
    6. unusual circumstances in the case

3. Maryland

- Statutory law governs reimbursement to non-participating physicians that treat HMO plan members for emergency and trauma services. The statute directs HMOs to pay non-participating providers 125% of the rate a contracted physician receives for a given service, who is similarly licensed and in the same geographic region as the non-participating provider seeking reimbursement.

- The purpose of the statute is to reimburse a non-participating physicians at least 25% more than a contracted provider is paid.

- Areas of dispute: What constitutes similarly licensed? Is the rate based on one similarly licensed provider's rates, or an average of the rates paid in the region? If it is one provider's rates, who gets to choose?

4. Florida

- Statute governing non-participating provider reimbursement requires HMOs to reimburse non-participating providers for "usual and customary provider charges for similar services" or the provider's actual charges, whichever is less. The statute also allows HMOs and providers to negotiate a mutually-agreeable charge within 60 days of the claim submission.

- Merkle v. Health Options, Inc., 940 S.2d 1190 (Fla. App., Oct. 18, 2006).

    - Dr. Merkle, a physician providing emergency orthopedic services, filed four class action complaints against several HMOs. Dr. Merkle, a non-participating provider, alleged that the HMOs underpaid non-participating providers in contravention of Florida statutory law by paying class members 120% of Medicare reimbursement rates, rather than the usual and customary provider charges.

    - The HMOs moved to dismiss, arguing that the statute does not authorize a private cause of action. The trial court consolidated the cases, granted the motions to dismiss with prejudice, and entered final judgment in favor of the HMOs.

    - Upon appeal, the appellate court reversed, holding that the applicable statute clearly imposes a duty on HMOs to reimburse non-participating providers according to the statute's dictates, not based on Medicare reimbursement rates. The court further stated that the statute is aimed at protecting non-participating providers who must provide emergency medical services to HMO subscribers, ensuring they are compensated fairly. The question, the court stated, is not whether the HMOs are liable under the statute, but what is the appropriate method for determining the extent of their liability. Accordingly, the court remanded the case for further proceedings.

    - The court also rejected the HMOs' argument that there is no private right of action under the statute. Noting that parties have the right to maintain a private cause of action as the persons the legislature intended to protect,

the court found that the legislature intended for this law to protect not only health plan members, but also the non-participating providers.

- Electrostim Medical Services Inc. v. Aetna Life Insurance Co., M.D. Florida, No. 8:06-cv-14-T-24TBM (Feb. 13, 2007)

    - Electrostim Medical Services, Inc. ("EMS"), a pain management medical device supplier, provides devices directly to patients and, upon delivery, submits claims for reimbursement directly to insurers, including Aetna Life Insurance Co. ("Aetna").

    - EMS alleged that Aetna failed to process in excess of $1,000,000 of claims as required by the patients' health plans, ERISA, and Florida law. EMS also alleged that Aetna's conduct constituted unfair or deceptive trade practices in violation of Florida's HMO Act (the "Act").

    - Aetna moved to dismiss the latter claim, arguing that the Act does not provide a private cause of action, but rather only permits the Florida Department of Insurance to enforce the Act. The U.S. District Court for the Middle District of Florida agreed and dismissed EMS' unfair and deceptive trade practices claims.

    - However, the court noted that the Act's statutory provisions can be incorporated and converted into contractual obligations, and thus a failure to adhere to the Act's provisions may be the subject of a common law breach of contract claim, including a third-party beneficiary breach of contract claim.

5. Usual, Customary and Reasonable

- American Medical Ass'n v. United Healthcare Corp., S.D.N.Y., No. 00 Civ. 2800 (LMM) (June 18, 2007)

    - AMA determined to lack associational standing to challenge United's method of determining "usual, customary and reasonable" rates of payment for out-of-network providers.

- Court determines that (a) AMA failed to demonstrate that its members exhausted their ERISA administrative remedies before filing suit, and that (b) United had demonstrated that it would *not* have been futile for the providers to do so, as appealing providers had been awarded greater reimbursement.

- United dismissed as defendants vis-à-vis three of four health plans at issue; the plan sponsors, not United, were determined to be the plan administrators, and thus the proper defendants.

C. Prompt Payment to Non-Participating Providers, as Third-Party Beneficiaries of Plan Members' Policies

Westside EKG Associates v. Foundation Health, 944 S.2d 188 (Fla. Oct. 19, 2006)

- Non-participating physician group that read EKGs and stress tests sued seven HMOs for failing, under Florida's prompt pay act, to timely pay for both emergency and non-emergency services provide to HMO members.

- The trial court ruled for the HMO, stating that the providers had no standing absent a contract. The appeals court reversed, holding that the providers could bring a claim as third party beneficiaries of the HMO members' contracts, and certified the following question to the Florida Supreme Court: Could a provider sue for breach of a third-party beneficiary contract for an HMO's alleged violations of the prompt pay act?

- The high court concluded that the prompt pay statute should be considered incorporated into the HMO contracts, and that providers have long been considered the intended beneficiaries of insurance contracts under Florida law.

- The HMOs argued, as has been argued in other suits across the country, that the prompt pay statute is enforceable only by the department of insurance – and allows no private right of action by providers. The Florida Supreme Court rejected this argument, stating that "[i]f providers cannot enforce the very statute that the Florida legislature passed to ensure the prompt payment of provider claims, they are left, as Voltaire said, like the proverbial blind men in a dark room looking for a black cat that isn't there."

III. Upsurge in Federal Healthcare Programs Litigation

A. Medicare Advantage and Part D Preemption

1. Uhm et al. v. Humana, Inc. et al., W.D. Wa., No. C06-0185-RSM (June 5, 2006)

   - In perhaps the first written opinion to analyze Medicare Part D law and regulations, a federal district court determined that Medicare Part D preempts state law claims that Part D beneficiaries brought against their Part D plan for allegedly failing to provide them forms needed to obtain reimbursement for prescription drugs.

   - Uhm allegedly enrolled in a Medicare Part D prescription drug plan (the "Plan") sponsored by Humana, paid monthly premiums to Humana, repeatedly requested mail-order forms that the Plan required for Uhm to obtain prescription drugs, but never received the forms, requiring Uhm to pay for the drugs out-of-pocket at retail prices.

   - Individually and on behalf of similarly situated enrollees, Uhm sued Humana, claiming breach of contract, violation of state consumer protection laws, unjust enrichment, fraud and fraud in the inducement.

   - The district court determined that Medicare Part D, specifically 42 U.S.C. §1395w-26(b)(3), preempts such state law claims, finding that "if Part D establishes standards that cover plaintiffs' claims, then those standards supersede state law, and plaintiffs' state law claims are preempted."

   - The court then found that the Medicare Part D regulations set standards for marketing materials, coverage determination procedures and appeals processes, and grievance procedures. The combination of these standards operated to preempt Uhm's state law claims.

   - Uhm argued that under the court's analysis, nearly all state law causes of action against PDP sponsors would be preempted. In a response indicative of the breadth of the Medicare Part D preemption provision, the court stated that Medicare Part D, which "creates an exceedingly complex national program which requires administration by agencies

with expertise in the area," specifically provides that "state laws are *presumed to be preempted* unless they relate to licensure or solvency" (emphasis added).

- Uhm has appealed to the Ninth Circuit Court of Appeals.

2. Matthews v. Leavitt, 2nd Cir., No. 05-4853 (July 31, 2006)

   - The Second Circuit Court of Appeals ruled that the Medicare + Choice (now Medicare Advantage) administrative appeals process does not provide a forum for the resolution of a claim that a benefit determination triggered a premature discharge that, in turn, proximately caused an injury-producing fall.

   - Plaintiff Matthews, a beneficiary of Senior Choice, a Medicare + Choice plan administered by Excellus Health Plan, Inc., was hospitalized and subsequently stayed at three skilled nursing facilities in a 6-month period. During his stay at the second facility, Senior Choice informed Matthews that coverage of SNF services at that facility would cease, as Senior Choice had made the organizational determination that Matthews had achieved his rehabilitation goals. Matthews was discharged while appealing this determination, but fell at his home, requiring the third SNF stay.

   - Matthews ultimately spent 138 days in the three SNFs, and challenged Senior Choice's second determination to refuse to cover more than 100 total days of SNF services. Matthews alleged that he would not have needed to stay the extra 38 days in the third facility if not for Senior Choice's decision to cease coverage at the second facility, i.e., that that organizational determination caused the second facility to prematurely discharge him, which in turn caused the fall and the need to stay at the third SNF.

   - An Administrative Law Judge dismissed Matthews' appeal for lack of jurisdiction, stating that Matthews' argument, akin to a medical malpractice claim, is not subject to the M+C administrative appeal process.

   - After the ALJ dismissed his appeal, Matthews exercised his statutory right to file an action in the U.S. District Court for the Southern District of New York, alleging that Senior

Choice had breached the covenant of good faith and fair dealing implied in his subscriber agreement. However, the District Court determined that an ALJ does not have statutory authority to entertain a state law breach of contract claim.

- Upon appeal, the Second Circuit Court of Appeals affirmed.

B. TRICARE

1. Board of Trustees of Bay Medical Center et al. v. Humana Military Healthcare Services, Inc., Fed. Circ. No. 05-1501 (May 4, 2006)

   - In 1996, Humana and the U.S. Department of Defense entered into a contract whereby Humana provided managed care support services to all CHAMPUS (now TRICARE) beneficiaries residing in parts of the southeast U.S. For three years, Humana paid hospitals at agreed-upon rates for outpatient non-surgical services, but in 1999 and as a result of the government's adoption of a payment policy, Humana began capping payment for such services at the CHAMPUS Maximum Allowable Charge. In 2003, Bay Medical Center and another hospital sued the government for declaratory relief (that the policy was invalid), and sued Humana for breach of contract.

   - On grounds that the hospitals didn't have standing to sue it for breach of contract, the government successfully moved to dismiss the claims against it. Humana, however, unsuccessfully moved to have the case transferred to the Court of Federal Claims on grounds that the government was the true party in interest. Humana appealed to the Federal Circuit Court of Appeals.

   - The Federal Circuit affirmed the lower court's decision, finding that Humana was the proper defendant: the "network provider contracts are private agreements between the Hospitals and Humana. The government was not a party to those contracts, and the Hospitals have no direct relationship with the government." The appellate court further stated that "the Hospitals are not in privity of contract with the government and have not sought monetary relief from the

government." The case was remanded to the U.S. District Court for the Northern District of Florida.

2. Baptist Physician Hospital Organization, Inc. v. Humana Military Healthcare Services, Inc., E.D. Tenn., No. 3:01-cv-588 (Feb. 13, 2006)

- Baptist PHO and Baptist Hospital (collectively, "Baptist") had previously sued Humana for breach of contract, claiming that Humana owed Baptist the difference between the discounted charges for certain high-dollar services rendered to CHAMPUS beneficiaries and the amounts actually paid. Humana counterclaimed, alleging that it overpaid Baptist.
  - Humana argued that federal regulations, incorporated by reference into its agreement with Baptist, only required it to pay what CHAMPUS was required to pay for the services at issue. The Sixth Circuit did not agree.
- On remand, Humana claimed that Baptist's actions operated as a constructive acceptance of CHAMPUS levels of payment. After examining communications relayed during and after the parties' execution of the agreement at issue, as well as oral testimony from both parties, the district court determined that Baptist did not expressly or impliedly accept CHAMPUS rates of payment for high-dollar services.
- With respect to the high-dollar services, the court determined that Humana underpaid Baptist by $1,277,872.89. While the court indicated that Humana had overpaid Baptist for certain other services, it indicated that a portion of the total overpayment was owed to patients because of various patient cost shares and co-insurance issues. As Humana did not submit evidence on these patient cost shares, the court declined to find any award for Humana.
- The court ordered Humana to pay to Baptist $1,277,872.89, plus prejudgment interest of 10% per annum, i.e., a total of $2,009,361.40.

C. Federal Employee Health Benefits Program and Preemption

1. Empire HealthChoice Assurance Inc. d/b/a Empire Blue Cross Blue Shield v. McVeigh, U.S. No. 05-200 (June 15, 2006)

   - Last summer, the United States Supreme Court ruled that the Federal Employees Health Benefits Act ("FEHBA") does not provide federal jurisdiction for a carrier's reimbursement action against an insured.

   - McVeigh, an enrollee in Empire's Federal Employees Program plan, filed a state tort action against parties who had caused his injuries. Though Empire was aware of the suit, it declined to participate. Once Empire learned of the lawsuit's settlement, it filed suit in federal district court for reimbursement of the $157,309 it had paid for McVeigh's medical care.

   - The Supreme Court held that the FEHBA provides for federal jurisdiction only in actions against the United States, and that nothing in the statute's text gave carriers a federal forum for the carrier's claims against either its insured or an alleged tortfeasor to share in the proceeds of a state-court tort action. Empire argued that the reimbursement claim was a federal cause of action, because Congress intended all rights and duties stemming from Empire's contract with the Office of Personnel Management (the federal agency that administers FEHBA) to be federal in nature. The Court disagreed, holding that Empire had not demonstrated a significant conflict between an identifiable federal interest and the operation of contractual reimbursement provisions and state subrogation law. In the absence of such a conflict, the Court saw no reason to displace state law or to decide this type of case in federal court.

2. GHS HMO, Inc. v. U.S., Ct. Fed. Claims, Nos. 01-517C, 05-371C, 5-0963C (Apr. 17, 2007)

   - Court of Federal Claims granted summary judgment to three health benefits carriers that participate in the FEHBP. The plans sought a declaration that an Office of Personnel Management ("OPM") regulation involving premium rates conflicted with the governing statute, the FEHBA.

- OPM requires plans to participate in an annual rate reconciliation process. The carriers reconcile the current year's estimated premium rates with the actual rates the carrier should have been paid. If it is determined that the estimated rates were lower than the actual rates, the government pays the carrier the difference, and vice versa.

- At issue was the validity of an OPM regulation that forbade the recoupment or reimbursement of premium payments in the final year of participation in the program. In addition to seeking declaratory relief, the plans sought reimbursement of substantial sums owed in their final year of participation in the FEHBP.

- The court held that, despite OPM's expertise with the program and the discretion it has to interpret FEHBA, OPM's refusal to reconcile rates in the last year of participation in the FEHBP "ignores, invalidates and conflicts with the intent of the FEHBA," which requires rates charged by FEHBP carriers to "reasonably and equitably reflect the cost of the benefits provided."

- The court rejected OPM's assertion that it would be difficult to obtain accurate plan data to perform rate reconciliations in the last year of participation, and determined that OPM's evidence that two health plans failed to provide sufficient information in their last years of participation were isolated situations that occurred too far in the past to be relevant.

- The court also rejected OPM's contention that, because the regulation was incorporated into the plans' contracts, the plans were bound by the contracts, even if the court were to invalidate the regulation. The court held that the contractual provisions are not binding where a statute invalidates a regulation and mandatory contract clause.