Current and Emerging Trends in Managed Care Litigation

Presented By:

Julie Barnes
William Flanagan
Christopher Flynn
David Florin
Jeffrey Poston

HOOPS 2007 - Washington, DC October 15-16

NON-PARTICIPATING PROVIDER REIMBURSEMENT LITIGATION

Non-Participating Provider Lawsuits

- **Reimbursement of non-contracting providers is the focus of several lawsuits and regulatory action**
- **Providers argue that plans undercompensate them**
- **Issue is how to decide a fair rate of compensation – typically what is "usual and customary" – absent a contractual agreement**

Traditional Methods of Non-Participating Provider Reimbursement

- **Billed Charges**
- **Health Plan Fee Schedules**
- **Usual, Customary & Reasonable Charges**
- **Percentage of Medicare Rates for Same Service**
- **State-Mandated Methods**
  - Percentage of Fee Schedule
  - Percentage of UCR
  - Percentage of Medicare Rates
- **Negotiated Rates**

Allegations in Non-Par Actions

- **Plans improperly deflate levels of reimbursement paid to non-participating providers.**
- **Plans conspire with third party vendors that provide data necessary to establish UCR charges.**
- **Plans under-report claims experience when attempting to establish UCR charges.**
- **Plans violate statutory methods of compensating non-participating providers by interpreting statutory methodologies in the manner that yields the lowers level of reimbursement.**

Plaintiffs' Theories of Recovery In Recent Non-Par Litigation

- Breach of Implied Contract
- Quantum Meruit
- Unjust Enrichment
- Unfair Claims Settlement Practices Acts
- Statutory Causes of Action Under Relevant Insurance Codes
- ERISA Violations

Non-Participating Provider Reimbursement

- **Laws Establish Non-Par Reimbursement**
- **Medicare**
  - Medicare regulations establish criteria for determining "reasonable and customary"
- **Maryland**
  - HMOs must pay non-pars 125% of the rate a similarly licensed contracted physician receives for same service in the same geographic region
- **Florida**
  - "Usual and customary provider charges for similar services" or provider's actual charges

Non-Participating Provider Cases

- ***Merkle v. Health Options*, 940 S.2d 1190 (Fla. App. Oct. 18, 2006)**
  - Class action alleging health plans violated statute by paying 120% of Medicare rather than UCR
  - Court held that statute provided a private right of action under the statute and remanded the case for further proceedings
  - Court denied rehearing
  - Supreme Court of Florida denied plans' petition for review in June 2007
  - Case continues

Non-Participating Provider Cases

- ***Cooper v. Aetna Health Inc.,* No. 07-3541 (D.N.J. Complaint Filed on July 30, 2007)**
  - Class action alleging insurer systematically reduced reimbursement for services provided by nonparticipating providers
  - Case keys off of $10 million fine by New Jersey Insurance Department for setting UCR at a percentage of Medicare rates

Non-Participating Provider Cases

- ***American Medical Association v. United Healthcare*, S.D.N.Y.**
  - UCR is based on inappropriate data
  - Discovery, procedural issues since April 2000
  - June 2007, Court granted plans' summary judgment motion that providers failed to exhaust their administrative remedies and that certain plaintiffs didn't have standing
  - Court granted Plaintiffs' motion for reconsideration, but Court affirmed its decision upon reconsideration
  - Case continues on remaining issues

Non-Participating Provider Cases

- **TRICARE Non-par Underpayment Litigation**
  - Plaintiffs are non-network participating hospitals who provide services to TRICARE beneficiaries
  - Defendants contract with DOD to provide managed care services for the TRICARE program
  - Reimbursement of Plaintiffs is governed by TRICARE regulations, 32 CFR § 199.14
  - Plaintiffs allege that Defendants failed to pay facility charges for outpatient services in violation of TRICARE regulations

Avoiding Liability In Non-Participating Provider Cases

- Consider paying billed charges for non-par services rendered to HMO members only
- Negotiate rates on high dollar non-par claims at the time of the services
- Utilize accepted sources/vendors of UCR data
- Strictly adhere to statutorily mandated methods of compensating providers for non-par services
- Assert ERISA and FEHBA preemption where applicable
- Demand proof of assignment of benefits

Challenges to Measuring Quality

Potential Litigation in
Pay-for-Performance Implementation

and

Challenges to Tiering / Quality Indicators

Pay for Performance

- **P4P includes any type of performance-based provider payment arrangement.**
- **Typically, P4P refers to the attempt to offer financial incentives to encourage high quality of care.**
- **P4P usually includes paying providers based on their cost efficiency.**

Pay for Performance

- **Payors provide financial incentives to providers for meeting performance goals.**
- **May be as simple as setting a fixed benchmark: if provider meets or exceeds a certain goal, the MCO will make an incentive payment.**

P4P Example

- **Aetna and NYU Medical Center**
- **On August 7, 2007, Aetna announced a three-year P4P pilot program with the NYU Medical Center that will be the model for future Aetna NY hospital contracts**

P4P Example

- **Under the new hospital services compensation schedule, Aetna will financially reward NYU Medical Center for:**
  - superior performance, and/or
  - continuous improvement on nationally recognized measures of patient safety and quality of care, and
  - efficient delivery of medical services

P4P Example

- **50% of the Aetna/NYU criteria is based on 5 CMS Quality of Care Measures:**
  - Patients given appropriate beta blockers at discharge
  - Patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction
  - Pneumonia patients given initial antibiotics within 4 hours after arrival at the hospital
  - Surgery patients who receive preventive antibiotics one hour before incision
  - Preventive antibiotics for surgery patients are stopped within 24 hours after surgery

P4P Example

- **30% of the Aetna/NYU criteria involve clinical performance measures such as length of stay and hospital readmission rates**
- **20% of the Aetna/NYU criteria are based on patient-safety yardsticks developed by the Leapfrog Group**

Provider Tiering

- **What is Provider Tiering?**
  - Health plans are ranking providers on certain quality and efficiency measures.
  - Health plans analyze claims data to assess network physicians on the basis of efficiency (costs per episode of care, such as treatment of low back pain) and on measures of quality that can be assessed with claims data (blood testing for a diabetic).
  - Goal: influence enrollees to shift to high-performing providers, so physicians are motivated to improve efficiency and quality to better compete.

Provider Tiering

- **THIS IS NOT A NEW CONCEPT**
  - Plans have credentialed and used quality measurements for network physicians for years.
  - Physician tiering is the latest structural approach to quality performance measurement as efforts to link practice quality to financing have increased.
  - Conditioning membership in an organization on quality measurements.

Provider Tiering

- **Why does provider tiering pose new legal challenges?**
  - Tiering is very public now.
  - Plans are actively using tiering in marketing to employers.
  - Renewed concern about negligent credentialing.
  - Physicians are concerned about interference with physician-patient relationships and impairment to their livelihood.

Litigation Risks in P4P/Tiering

- Errors in data / wrong data used
- Providers dispute rankings/report cards
- Alleged improper financial incentives or withholding bonuses
- Quality measurement methodology is questioned

Litigation Risks in P4P/Tiering

- **Wrongful inclusion or exclusion in tiered provider network based on quality rankings**
- **Lack of transparency in measurement methodology and process**
- **Lack of dispute remedies**
- **Issues in Federal health programs (COP, gainsharing, etc.)**

Challenges to Quality Performance Measurement Case

- ***Washington State Medical Association v. Regence Blue Shield*, (Wash. Super. Ct., No. 06-230665-1SEA (complaint filed Sep. 21, 2006))**
- **Issue: Creating a tiered provider network that rates physicians based on quality / cost considerations.**
- **WSMA sued after Plan excluded nearly 500 doctors from its "Select Network," which provided services to 8,000 Boeing employees and their families.**
- **Complaint alleged unfair and deceptive business practices, defamation, libel, intentional interference with commerce, and breach of contract.**

Washington State Medical Association Case

- **Allegation: Health plan used "flawed methodology" to determine that several hundred physicians did not meet the company's quality and efficiency standards.**
- **Allegation: Health plan used old data from a small number of patient files and focused on the amount charged, rather than medical records, to deem physicians "inefficient."**
- **Relief sought: An injunction to prevent plan from implementing program and monetary damages.**

Washington State Medical Association Case

- 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 December 2006, Health Plan said that it had decided to discontinue the Select Network plan.
- Case settled on August 8, 2007.

Washington State Medical Association Case

- **Settlement:**
  - Physicians will have “meaningful” input into the performance measurement program BEFORE it is implemented
  - Physician input will be sought on timeliness of data, comparability of physician practices and patient populations and patient noncompliance

Washington State Medical Association case

- **Settlement:**
  - Health Plan will give advance notice to the state medical association of the release of new physician performance scores
  - Physician reports and scores will be posted on Plan's provider website and will include an explanation of the methodology and data that was relied on to calculate the score
  - Physicians will have an opportunity to appeal their scores

Challenge to Tiered Network

- ***Fairfield County Medical Association v. CIGNA*, Conn. Super. Ct. , Complaint filed 7/26/07**
  - Connecticut doctors allege that plans violated the State's unfair trade law by encouraging plan members to seek treatment from a subset of handpicked specialists
  - Plaintiffs claim that tiered network conveys impression that specialists who were not designated provide lower quality of care
  - Plaintiffs say that the plan's elite designations are based on inaccurate data

Attorney General Investigates Physician Quality Ranking Programs

- New York Attorney General Andrew Cuomo issued warnings to United Healthcare, Aetna and CIGNA about their plan to rank physicians on quality and cost criteria
- AG letters cite concerns about consumer confusion, data accuracy and profit motive

Ounce of Prevention

- **HOW TO AVOID DISPUTES ABOUT QUALITY MEASUREMENT PROGRAMS**
  - Transparency
  - Invite physician input
  - Take care in development of design
  - Adhere to design
  - Correct errors quickly
  - Provide due process / appeal procedures
  - Monitor program
- **MOST IMPORTANT: TRANSPARENCY AND COMMUNICATION**

Supreme Court Revisits ERISA Remedies

LaRue v. DeWolff, Boberg & Associates,

450 F.3d 570 (4th Cir. 2006),
***cert. granted* 2007 WL 1730445**

Supreme Court Revisits ERISA Remedies

- **ISSUE: To what extent can an ERISA plan participant who has been harmed by a breach of fiduciary duty receive recovery of individual money damages either because:**
  - the money damages are funneled to the participant through the plan; or
  - the money damages are a recovery under the equitable theory of "surcharge"

Supreme Court Revisits ERISA Remedies

- **ERISA Background**
  - ERISA governs most domestic private employee benefit plans and permits plan participants to enforce both the terms of the plan and requirements of the law
  - ERISA's enforcement provisions are "complex and reticulated"
  - Need to choose both the right cause of action and the right remedy

Supreme Court Revisits ERISA Remedies

- **Relevant Remedial Provisions**
  - ERISA § 502(a)(1)(B)
    - Recovery of denied benefits or clarification of rights under the plan
    - Monetary recovery limited solely to value of benefits under the plan
  - ERISA § 502(a)(2)
    - Suit by participant when a fiduciary breach has resulted in a "loss to the plan"
    - *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) – Section 502(a)(2) permits suits for damages only when the recovery is paid to the plan; individual recovery of damages not permitted

Supreme Court Revisits ERISA Remedies

- **Relevant Remedial Provisions**
  - ERISA § 502(a)(3)
    - Participant suits for "other appropriate equitable relief"
    - *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993) – Justice Scalia declares that 502(a)(3) permits only relief that is itself equitable in nature

Supreme Court Revisits ERISA Remedies

- **Difficulties Following Mertens**
  - Supreme Court on an almost annual basis wrestled with ERISA's enforcement and remedial provisions
  - Two salient points have emerged
    - ERISA does not provide a "make whole" remedy for participants harmed by fiduciary breach
    - Doctrine of "Complete Preemption" makes state law remedies unavailable

Supreme Court Revisits ERISA Remedies

- **Factual Background**
  - 9/10/01 – LaRue claims he directed plan administrator to switch his 401k account investment from one mutual fund to another
  - 9/11/01 – Switch never made, markets plummet

Supreme Court Revisits ERISA Remedies

- **6/2/04 – LaRue sues the Plan (and the employer as Plan Administrator) alleging that the failure to implement his investment direction caused the value of his account to decrease by $150,000**
  - Complaint included only cause of action under 502(a)(3)
  - Requested "appropriate "make whole" or other equitable relief pursuant to [ERISA § 502(a)(3)]"
- **District Court dismisses for failure to state a claim**

Supreme Court Revisits ERISA Remedies

- Appeal to 4th Circuit – LaRue first raises 502(a)(2) argument
- 4th Circuit affirms – regarding 502(a)(2), Court states that this argument was probably waived, but in any event, recovery would be precluded by Russell
- LaRue and Department of Labor petition for rehearing – denied
- Cert. granted 6/18/07

Supreme Court Revisits ERISA Remedies

Argument I – Resurrecting Russell

- **Supported by the Solicitor General and a host of amici, LaRue asks the Court to reconsider *Russell* –**
  - Russell's prohibition of individual damages recoveries should apply only to extra-plan recoveries (punitive damages, exemplary damages, etc.)
  - So long as damages recovery is at some point treated as "plan assets" it should be permitted under § 502(a)(2) even if it ends up benefiting only one participant – "Unitary Trust" argument

Supreme Court Revisits ERISA Remedies

Argument I (cont'd)

- **DeWolff Boberg's argument**
  - Waiver
  - *Russell* settled law
  - Effect of Court's prior preemption analyses
  - Subtext – Speculative nature of loss and LaRue's withdrawal from the plan

Supreme Court Revisits ERISA Remedies

Argument II – "Surcharge" as Silver Bullet

- **Solicitor General -- "Surcharge" available under § 502(a)(3)**
  - At equity, if a trustee breached a duty owed to a beneficiary, the court could impose a "surcharge" on the trustee that was in the nature of a penalty payable to the beneficiary to compensate the beneficiary for the fact that there was a breach of trust
  - § 199 Restatement (2d) of Trusts (1959) – surcharge identified as an equitable remedy intended to compel the trustee to manage the trust correctly

Supreme Court Revisits ERISA Remedies

Argument II (cont'd)

- **DeWolff Boberg's response – All cases cited by LaRue indicate that "surcharge" was the term applied whenever a court at equity was awarding damages**
  - Under Scalia's reasoning in *Mertens*, as adopted by the Court in five subsequent cases, the fact that a court at equity could award damages did not cause the damages award to be "equitable" relief

Supreme Court Revisits ERISA Remedies

Potential Ramification for Health Care Plans, Insurers and Providers

- No reason that a decision would be restricted to pension plans
- "Surcharge" as a new equitable remedy that mimics damages

Supreme Court Revisits ERISA Remedies

- **Potential increased fiduciary exposure whenever recovery can be treated as "plan assets" funneled through the plan under § 502(a)(2)**
  - Premium rebates
  - Pharmacy charges
  - Recovery of servicing fees/commissions
- **Additional avenue to impose personal fiduciary liability under ERISA**

QUESTIONS??