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**Current Legal Issues
Facing Managed Care**

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Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

A. Background

- Plans generally utilize Special Investigations Units ("SIUs") to detect, prevent and improve processes to address health insurance fraud, waste and abuse.
- SIUs are governed by various Federal and State Statutes. See, e.g., S. 817.234, Florida Statutes.
- SIUs Identify and Attempt to Recoup \$100s of millions in consumer and provider fraud each year.

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

B. Issues Addressed by SIUs

1. Submitting Claims for services not rendered
2. Misrepresenting diagnosis information
3. Utilizing split billing schemes
4. Duplicate billing
5. Misuse of member ID cards
6. Member/Group Enrollment Fraud

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

C. SIU Practices That Providers Dispute

1. Retroactive Denial of Claims
 - Governed By Contract and State Law
2. Offsets on Future Claims
 - Governed By Contract, Provider Manuals and State Law
3. Reimbursement Adjustments Based on Claim Audits
 - Contract—based Remedy
4. Retroactive Denials of Provider Claims Based on Subscriber or Employer Group Fraud

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

D. Significant Litigation Arising Out Of SIU/Member Fraud Issues

1. Pennsylvania Chiropractic Association et al. v. Blue Cross Blue Shield Association, Case No. 1:09-cv-05619 (N.D. Ill. 2009)

Allegations in the Complaint:

- The twenty-five defendants include: (a) twenty-four companies that use the Blue Cross® and Blue Shield® names and marks (the "Blue Marks") that offer health insurance or other health care financing services, which the Complaint dubs "BCBS Entities" (exclusive of BCBSA); and (b) BCBSA.
- With one exception, each of the Individual Plaintiffs purports to have or have had a contract ("Participating Provider Agreement" or "Par Agreement") with one RICO Defendant.

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

- Plaintiffs allege that they have been harmed by supposed retroactive requests for the return of benefit payments. The complaint asserts that the RICO Defendants are advancing a “Recoupment Enterprise” comprising themselves, all the other defendants, IBM, and a national anti-fraud organization that includes the FBI and many governmental law enforcement agencies, by using anti-fraud and overpayment recovery measures as a pretext to deprive the plaintiffs of money they claim they should receive for treating patients.
- The Complaint cites a wide variety of individualized episodes, each involving one “Individual Plaintiff” and one RICO Defendant, in which the RICO Defendant supposedly committed mail or wire fraud, or stole from an employee benefit plan, to recoup money in furtherance of the supposed enterprise.
- Finally, the complaint alleges a claim for benefits under group plans governed by ERISA and failure to provide a full and fair review as required by ERISA.

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

Procedural Status:

- Defendants have filed several motions to dismiss based on RICO, ERISA, the Florida Insurance Code, and accord and satisfaction. The plaintiffs have filed responses to these briefs, and the defendants have filed replies. As of today, the judge has not ruled on any of these motions.

ERISA Motion to Dismiss:

- Count I (claim for benefits under ERISA) should be dismissed because the Blue Defendants are not the proper defendants under Section 502(a)(1)(B), plaintiffs have failed to state a claim under section 502(a)(11)(B) by failing to allege any facts showing that the terms of any ERISA plan were violated; and plaintiffs have neither exhausted administrative remedies nor demonstrated that exhaustion would be futile.

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

RICO Motion to Dismiss

- The complaint does not state a plausible section 1962(c) claim because the allegations are entirely consistent with lawful activity. The complaint does not allege any predicate acts committed by BCBSA, does not allege any predicate acts directed against the association plaintiffs, and cannot support injunctive or declaratory relief.

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

Invia Bet Joseph v. Health Net, Inc. et al., LASC Case No. BC 388634 (2008); California Hospital Association v. Health Net, Inc. et al., BC 44389 (2009)

- Case brought by CA hospitals where claims were allegedly denied as the result of rescissions of health plan contracts administered by Health Net.
- Rescissions were carried out by SIUs, allegedly resulting in claims denials to the CA Hospitals for services rendered to rescinded members.
- Plaintiffs bring claims under CA Bus. & Prof. Code Section 7200, Health & Safety Code Section 1371.4, Breach of Contract and Breach of the Duty of Good Faith and Fair Dealing

Provider Disputes Arising Out Of SIUs And Anti-Fraud Efforts

- Result: The case settled on May 22, 2009, pursuant to which Health Net paid \$1,935,000 to the hospitals for denied claims of the rescinded members.
 - Each hospital entitled to its pro rata share of the settlement funds.

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**Litigation Impacts
Arising Out of
Health Care Reform**

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape

- **Broader Definition of “Adverse Benefit Determination”**

- A. Group health plans (both insured and self-insured) as well as individual health insurance issuers (with a few exceptions) are now subject to the DOL claims procedure regulations. Under the regulation an “adverse benefit determination” includes:
 - 1. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, (pre- and post-service, including any action based on:
 - Eligibility
 - A determination that a benefit is not a covered benefit;
 - Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
 - A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.
 - A denial due to issues relating to copayments, deductibles, or other cost-sharing requirements.
 - 2. Any rescission of coverage (essentially, a cancellation with retroactive effect), whether or not there is an adverse effect on any particular benefit at that time.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

Practical Impact

1. All insureds are now entitled to external review for rescission decisions as well as benefit determinations.
2. Both “clinical” as well as “administrative” determinations are now subject to external review procedures.
3. Greater chance of class actions based on administrative issues being referred to external review.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape

- Post-Claims Rescission

- A. Prohibited Rescissions

1. A group health plan, or a health insurance issuer offering group or individual health insurance coverage must not rescind coverage except in the case of **fraud or an intentional misrepresentation of a material fact:**
2. A rescission is a cancellation of discontinuance of coverage that has retroactive effect.
 - Examples of rescissions include:
 - A cancellation that treats a policy as void from the time of the individual's or group's enrollment
 - A cancellation that voids benefits paid up to a year before the cancellation

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- Practical Impact

- Rescissions much less likely to occur given burden of proof
- Should result in less litigation

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- Impact of External Review

- A. Plans must state there is an opportunity for external review in both the plan documents as well as in notices of final adverse benefit determinations:
 - 1. **Plan Documents**: issuers must “include a description of the external review process in the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to claimants, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.”
 - 2. **Final Adverse Benefit Determination Notice**: “[T]he plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.”
- B. The decision of an independent external reviewer is “binding on the plan or issuer, as well as the claimant, except to the extent that other remedies are available under State or Federal law.”

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- Practical Impact

- A. Significant reduction in claims litigation.
- B. Burden of overcoming an external review decision.
- C. Potential hurdle to class litigation.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- Out-of-Network Reimbursement

A. Members can be balance billed for out-of-network emergency services, but the ability of insurers to do so is more limited than before based on cost-sharing limitations:

1. Copayments or coinsurance imposed for out-of-network emergency services cannot exceed cost-sharing for services provided in-network.
2. Out-of-network providers may, however, balance bill patients for the difference between the providers' charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- The insurer must pay a reasonable amount before a patient becomes responsible for a balance billing amount. The “objective standard” used to determine what amount is reasonable requires that insurers pay the greater of the following:
 - A. The amount negotiated with in-network providers for the emergency service furnished;
 - B. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services; or
 - C. The amount that would be paid under Medicare for the emergency service.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- Practical Impact
 - A. Out-of-network formulas spawn litigation.
 - B. No differentiation between PPO and HMO members.
 - C. Administrative challenge of members turning to plans for help with balance billing.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- **Strict Adherence**

- A. For a plan or issuer that fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process, regardless of whether the plan or issuer asserts that it substantially complied with these requirements or that any error it committed was de minimis.
- B. Accordingly, upon such a failure, the claimant may initiate an external review and pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process.

Healthcare Reform Regulatory Changes that Affect the Litigation Landscape (cont'd)

- Practical Impact

- A. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances [i.e., judicial review], the claim or appeal is deemed denied on review *without the exercise of discretion by an appropriate fiduciary.*
- B. Major change in standard of review.
- C. If the non-compliance is systemic, takes away a major hurdle to ERISA class litigation.