Current Topics and Emerging Trends in Managed Care Litigation

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Topics

- Coverage for Mental Health Benefits
  - ACA and Essential Health Benefits
  - Mental Health Parity
  - Autism and Parity Act Litigation

- Key Developments in ERISA Litigation
  - Overpayment Recovery Actions
  - Attorney-Client Privilege under ERISA

- Provider Non-Discrimination
- UCR Class Action Litigation
- Medical Loss Ratio
- Fee Forgiveness Litigation
Recent Sources Addressing the Scope of Coverage for Mental Health Benefits

- **Affordable Care Act**
  - Creates Essential Health Benefits, which include habilitative services as well as Mental Health & Substance Abuse, including behavioral health treatment
  - Expands requirements of FedMHPA
  - Abrogates annual and lifetime limits for “essential health benefits”

- **Federal Mental Health Parity Act**
- **State Mental Health Parity Acts**
- **Mental Health Parity Act Litigation**
- **Autism Litigation and State Autism Legislative Mandates**
Essential Health Benefits

- ACA sets ten broad categories of essential health benefits:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity & newborn care
  - Mental Health & substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative & habilitative services and devices
  - Laboratory Services
  - Preventive & wellness services and chronic disease management
  - Pediatric services, including oral & vision care
Essential Health Benefits

- EHB coverage requirements mandatory 1/1/2014 for:
  - All health plans offered through Health Insurance Exchanges
  - Small group and individual products offered outside the exchanges, except “grandfathered plans” — an existing group health plan or health insurance coverage in which a person was enrolled on the date of ACA's enactment
  - Large employer and self-insured plans
    - Do not need to provide essential health benefits
    - But if they fail to provide plans with minimum value, their employees may go to the insurance exchange and receive premium tax credits. PPACA, Pub. Law No. 111-148, § 1401(a), 124 Stat. 119 (2010)
    - Employers may have to pay penalties to the IRS if its full-time employees receive these tax credits. ld. § 1411(e)(4)(B)(iii)
    - A plan provides minimum value if the total allowed costs of the benefits provided under the plan is at least 60 percent. ld. § 1401(a)
      - Issuers may calculate minimum value using a minimum value calculator to be made available by HHS and the Internal Revenue Service, complying with any safe harbor established, or certification by an actuary. ld.
Essential Health Benefits
November 26, 2012, HHS Proposed Rule (45 CFR §§ 147, 155, 156)

- States choose one of four benchmark plans to serve as reference that reflects scope of services and benefits limits for plans that cover EHBs:
  - The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market
  - One of the three largest state employee health plans
  - One of the three largest federal employee health plans
  - The largest HMO plan offered in the state’s commercial market

- Default plan if state fails to exercise option: Largest plan by enrollment in the largest product in the state’s small group market
Supplementation of benchmark plan

- If benchmark plan lacks any of the ten categories, State or HHS directed to supplement benchmark plan in that category

State mandates beyond EHB categories

- States may require Qualified Health Plan to cover additional benefits beyond the ten EHB categories
- The state must defray the cost to issuer of additional benefit mandates enacted after December 31, 2011
- Protects states from having to subsidize the cost of state mandated benefits enacted before 2012 that go beyond federally mandated minimum benefits
Prescription Drug Coverage

Plans must offer the greater of

- One drug in every U.S. Pharmacopeia (USP) category or class; or
- The same number of drugs in each category and class as the essential health benefits benchmark plan

Health plan providing essential health benefits must have procedures that allow enrollee to request clinically appropriate drugs not covered by the plan
Essential Health Benefits

November 26, 2012, HHS Proposed Rule (45 CFR §§ 147, 155, 156)

_actuarial value

For purposes of determining whether a plan offers essential health benefits, the proposed rule contains requirements for health insurance issuers to determine actuarial value.

Actuarial value (AV) is a measure of the percentage of expected health care costs a health plan will cover for a standard population. Id. § 156.20. For example, if plan has an AV of 60 percent, patient would be responsible for 40 percent of the cost of benefits covered by the plan.

Beginning in 2014, health plans must meet an AV that matches up to a specified level of coverage – _bronze (60 percent), silver (70 percent), gold (80 percent), or platinum (90 percent)._ Id. §156.140(b)

The proposed rule permits a plan to qualify for a particular "metal level" if the difference in the true dollar value is within 2 percentage points. _Id._ (c)
Non-Discrimination in Essential Health Benefits

Proposed rule: prohibits benefit designs that could discriminate against potential or current enrollees based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Id. § 156.125(a)

PHSA § 1302: In defining essential health benefits, the Secretary shall:

- “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life”
- “ensure that health benefits established as essential not be subject to denial . . . on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life”
Essential Health Benefits

- What about Utilization Review Criteria?
  - Alcoholism as a criteria for liver transplants?
  - Advanced age as a criteria for transplants or major surgery?
  - Expected length of survival or quality of life as criteria for transplants?
  - End of life decisions such as DNR?

- Permissible to use improvement as basis for medical necessity?
- Will the Act alter criteria used in the practice of medicine and in utilization review?
- Permissible to distinguish “coverage” as an insurance policy term versus individual medical/utilization decisions?
Habilitative services

- Many plans do not identify habilitative services
- States may define these services if they are not included in benchmark plan
- If state does not define habilitative services, issuers must provide coverage at parity with rehabilitative services or as determined by the issuer and reported to HHS

Example of Habilitative Services Definition: California SB 951

- Medically necessary health care services that assist in acquiring or improving skills and functioning necessary to address a health condition, and needed for functioning in interaction with an individual’s environment
- Excluding: respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training

- Effective January 1, 1998
- Applied to employer-sponsored group health plans
- Did not apply to individual insurance market, small employers between 2 and 50 employees, group plans that experienced at least a 1% cost increase from compliance
- Required parity in annual and lifetime limits between medical/surgical and mental health benefits for plans that offered both types of benefits
- Did not mandate that plans offer coverage for mental health benefits at all
State Mental Health Parity Acts

- States enacted their own parity legislation
- Parity acts varied by state
  - Some limited parity to certain enumerated mental health conditions
  - Annual and lifetime limits
  - Financial and non-financial treatment limitations
  - Exclusion of certain plan types
2008 FedMHPA expands coverage mandates

- 2008 Mental Health Parity And Addiction Equity Act (26 USC § 9812; 29 USC § 1185a; 42 USC § 300gg-26) (Effective October 3, 2009)

- Applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured and fully-insured arrangements, and health insurance issuers who offer or provide coverage to employers with more than 50 employees

- Exempt: individual insurance market; employers with 50 or fewer employees

- As with the 1996 MHPA, does not require group health plan to provide mental health benefits

- Extends parity to substance use disorder benefits

- Required that treatment limitations and financial requirements for mental health and substance use disorder benefits be no more restrictive than those for medical and surgical benefits
  - Treatment limitations: limits on frequency of treatment, number of visits, days of coverage, or other limits on scope and duration of treatment
  - Financial requirements: deductibles, co-payments, coinsurance, and out-of-pocket expenses, excluding annual and lifetime limits

- Required parity in coverage by out-of-network providers for med/surg and mental health/substance use disorder benefits
FedMHPA Joint regulations broaden concept of “treatment limitations” (75 FR 5410, Feb. 2, 2010)

- Statute: Treatment limitation includes limits on the frequency of treatment, number of visits, days of coverage or similar limits on the scope or duration of treatment

- Regulations expand treatment limitations to nonqualitative treatment limitations, 45 CFR § 146.136(c)(4)(ii):
  - Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitations with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference

- Potentially problematic nonquantitative treatment limitations:
  - Different standards for determining medical necessity or whether the treatment is experimental or investigative
  - Requiring concurrent review for mental health conditions, but only retrospective review of med/surg conditions
  - Different standards for provider admission to network
ACA abrogates lifetime and annual limits beginning in 2010

- ACA prohibits lifetime limits on essential health benefits for group health plans and a health insurance issuer offering group or individual health insurance coverage issued or renewed on or after September 23, 2010. 42 USC §300gg-11
- ACA restricts and phases out annual limits for essential health benefits for all group health plans and health insurance issuers offering group or individual health insurance coverage issued or renewed after March 23, 2010
  - Plan year or policy year 9/23/10 to 9/22/11: Annual limit less than $750,000 prohibited
  - Plan year or policy year 9/23/11 to 9/22/12: Annual limit less than $1.25 million prohibited
  - Plan year or policy year 9/23/12 to 1/1/14: Annual limit less than $2 million prohibited
  - January 1, 2014: Annual dollar limit prohibited
  - Does not apply to “grandfathered” individual plans

- Eliminates FedMHPA rules permitting parity in annual and lifetime limits for any essential health benefits
Autism and other behavioral health services suits

- Medical services for ASDs are covered
- ABA often excluded as:
  - Experimental
  - Habilitative/non-restorative
  - Non health care (educational)
  - Not provided by licensed providers
- ST/OT treatments for ASD often excluded as:
  - Habilitative/non-restorative
  - Non health care (educational)

- **Johns v. Blue Cross Blue Shield of Michigan, E.D. Mich, No. 08-12272**
  - ABA Coverage denied as experimental
  - Court denied class certification for lack of evidence of typicality and adequacy, as plan terms on exclusions could differ among putative class members’ plans (March 2009)
  - Settled in June 2009, but provided no prospective relief, and settlement class redefined. Reimbursement of all class members who paid for ABA from May 2003 through June 2009. Nearly 100 families received almost $1 million in aggregate reimbursement

- **Potter v. Blue Cross Blue Shield of Michigan, E.D. Mich., No. 10-14981**
  - ABA Coverage denied as experimental
  - Court rejected BCBS’s failure to exhaust argument, because of BCBS’s alleged policy that ABA treatment is experimental
  - Court certified entire requested class, finding that the common issue for the class, whether ABA could be denied as experimental, predominated over individual damages issues
  - Cross-motions for SJ filed on whether ABA is experimental
Additional ASD class actions

- **Arce v. Kaiser Foundation Health Plan**, Superior Court of the State of California, County of Los Angeles, JCCP 4585: Certification granted. Kaiser MSJs pending based on (1) mootness in light of newly enacted ASD services mandate bill (SB 946) and (2) exclusion of members of government plans subject to exclusive administrative remedies. Motion for preliminary approval of class settlement filed.

- **Churchill v. CIGNA Corp.**, 2011 WL 356489 (E.D. Pa. 2011): Certification granted for class of persons actually denied ABA on the grounds that it is experimental.

ASD merits ruling: Denial of ABA on experimental & non-licensure bases: *D.F., et al. v. Washington State Health Care Authority*, Superior Court of Washington for King County, No. 10-2-29400-7 SEA

- Washington State Health Care Authority (HCA) contended that there was no scientific evidence establishing a significant improvement in children who have undergone ABA therapy, and it is not covered because it is provided by unlicensed providers.

- Class action suit brought under Washington MHPA, which provides that *all health benefit plans* offered by health maintenance organizations that provide coverage for medical and surgical services *shall provide*: . . . (c) For all health benefit plans delivered, issued for delivery, or renewed on or after July 1, 2010, *coverage for* (i) *Mental health services*. . . .

- Suit sought declaratory and injunctive relief requiring HCA to cover ABA for children with autism when medically necessary.

- Court found:
  - ABA is beneficial for *some* children.
  - HCA not in compliance with Washington MHPA insofar as it imposes a blanket exclusion of ABA, even when provided by licensed therapists.
  - Court could not determine as matter of law that HCS is required to cover ABA provided by certified or registered providers, because it was not clear from record if HCA covers health services provided by counselors or therapists who hold certifications or registrations, but not licenses.
  - It was also not clear whether a national certification by ABA providers is equivalent to certifications for providers of mental health services covered by HCA.

- ERISA plan administrator denied coverage for ABA based on plan exclusion for experimental treatments, and academic or social skills training, and because the ABA provider, a BCBA, was not a medically trained clinician
- Court held that ABA “is not an experimental or investigational procedure” and rejected denial on that ground
- Court found that exclusion for educational intervention did not apply because it only applied if provided by a school or halfway house, and plaintiff’s services were provided by a private company
- Court found that ABA is not primarily academic or social skills training, and rejected denial on that ground
- BUT: Court upheld denial of coverage because there was no evidence that a non-licensed, but BCBA-certified provider, qualified as an eligible provider authorized for reimbursement under Oregon law
ASD merits ruling: Denial of ABA as educational, not medically necessary, and not medical service: *Hummel v. Ohio Dept. of Job & Family Serv.*, 844 N.E.2d 360 (Ohio Ct. App. 2005)

- Plaintiff with autism eligible to receive benefits through Medicaid program administered by Ohio Department of Job & Family Services
- Treating physician found that ABA was medically necessary
- Local provider rejected request for ABA as neither medically necessary nor a medical service. State hearing upheld local provider
- Common pleas court reversed, and State department appealed on grounds that ABA was not a reimbursable “medical service” but rather an educational program or behavior modification technique
- Court of Appeal affirmed common pleas court:
  - Treating physician classified ABA as medically necessary, and other reports and articles suggested that ABA was generally accepted and appropriate for treating autism
  - Medical service is a synonym for medically necessary service. Alternatively, meaning assigned to “medical services” through ordinary usage would be an act helpful to healing or treatment
  - “Medically necessary service” encompasses “medical service,” and court of common pleases did not err in determining that ABA qualified for reimbursement

- Cases concerned denial by State Health Benefits Commission ("SHBC") of ST, PT and OT for two children, one with autism and one with PPD-NOS, on grounds that services were excluded as educational, developmental, or non-restorative.
- State 1999 MHPA required SHBC to cover biologically-based mental illness ("BBMI") under the same terms as provided for any other sickness under contract.
- Court rejected SHBC’s position that coverage for PT, OT and ST could be excluded as educational, developmental or non-restorative services on grounds that such exclusions applied equally to mental and physical conditions.
- Court held that parity act mandated coverage for ST, PT and OT for autism and PPD.
  - Court found persuasive insurance regulation under private insurer parity law, which regulation prohibited carriers from applying any exclusion in a health insurance policy for services medically necessary for the treatment of covered persons with BBMIs, specifically listing exclusions for non-restorative PT, OT and ST, and for treatment of developmental disorders or developmental delay.
  - Court found that denying coverage would be unreasonable and contrary to purpose of the parity act.
ASD merits rulings – Denial of ST as habilitative/non-restorative:  


- Class action against Group Health Options, which insures and administers Washington ERISA plans. GHO denied coverage for ST for plaintiff, who had speech delays, at age 7
- Plan covered therapy to “restore function following illness, injury or surgery”
- Plan excluded therapy for “degenerative or static conditions when the expected outcome is primarily to maintain the Member’s level of functioning,” excepting coverage under the “Neurodevelopmental Therapies for Children Age Six (6) and Under” Subsection
- Court granted SJ for plaintiff. (June 1, 2012). State MHPA “plainly imposes a baseline coverage requirement” requiring coverage for medically necessary treatment for DSM mental health conditions “without any regard for whether that treatment is restorative or non-restorative.”

- Florida Medicaid agency (AHCA) denied ABA as experimental and non-restorative/habitatative
  - Suit based on Medicaid mandate for “early and periodic screening, diagnostic and treatment services” (EPSDT) for children under age 21. 42 U.S.C. § 1396a(a)(10)(A)
    - EPSDT catchall provisions requires coverage of “other necessary health care, diagnostic services, treatment, and other measures [described in § 1396d(a)] to correct or ameliorate defects and physical and mental illnesses.” 42 U.S.C. § 1396d(r)(5)
    - §1396d(a)(13) requires coverage of “other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial service . . . recommended by a physician or other licensed practitioner . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”
  - Court found plaintiff had regressed and ABA was needed to restore to prior functional level
    - However, citing *Parents League for Effective Autism Services*, 565 F.Supp.2d 905 (S.D. Ohio 2008), court noted that other courts interpreting §1396d(a)(13) found that it does not require restoration of previously achieved functional level, but only requires that licensed clinician find service medically necessary to help improve functional level
  - AHCA acted unreasonably in determining that ABA is experimental
  - Court granted injunction requiring AHCA to provide ABA
Non-ASD merits rulings: State parity acts broadly construed: Harlick v. Blue Shield of California, 686 F.3d 699 (9th Cir. 2012)

- Plaintiff diagnosed with anorexia nervosa. Was denied coverage for residential treatment under an exclusion in ERISA plan that applied to both physical and mental care.
- Ninth Circuit found that the residential exclusion was unambiguous, so that coverage was not available under the Plan document.
- However, Ninth Circuit found coverage under the California MHPA by concluding that the MHPA “mandates that a plan provide all medically necessary treatment,” even if such treatment is not covered for physical conditions. 686 F.3d at 712-13, 715-16.
- The only “parity” that MHPA requires is for the financial limitations like copays and deductibles.
- Harlick rejected by one California state court: Rea v. Blue Shield of California, Superior Court of the State of California, County of Los Angeles, No. BC468900, Order Sustaining Defendant’s Demurrer to First Amended Complaint (June 13, 2012)
Many Sources Acting Collectively to Expand Coverage of Mental Health Benefits

- **Affordable Care Act**
  - Creates Essential Health Benefits that mandates coverage for
    - mental health and substance use disorder services, including behavioral health treatment
    - habilitative services and devices
  - Abrogates annual and lifetime limits for “essential health benefits,” effectively eliminating FedMHPA rules permitting parity in annual and lifetime limits for any “essential health benefits”

- State and Federal Mental Health Parity Acts and Related Litigation

- Autism Litigation and State Autism Legislative Mandates

- Questions raised regarding types of services:
  - Residential treatment facilities; unlicensed providers; custodial care
Key ERISA Decisions: Class Actions Based on Recoupment Practices

- Provider and provider organizations have brought putative class actions based on alleged recoupment practices
  - Allege that organizations seek to recoup previously paid benefits that post claims audits determine were non-covered, excessive, fraudulent, unsupported by pertinent documentation, or the result of improper billing practices
  - Allege that if benefit not returned organization deducts or offsets the amount from future unrelated claims

- Allege recoupment practices violate RICO and ERISA
  - Decisions allegedly constitute “adverse benefit determination” under ERISA without “full and fair review” (disclosure of plan terms, reason for denial, documentation supporting decision)
  - Alleged breach of fiduciary duties under ERISA

- Chiropractic associations and individual chiropractors filed putative class action against Aetna in July 2010
- Allege that Aetna’s SIU would recoup overpayments identified in “Post Payment Audits,” in violation of RICO and ERISA, the latter because they allegedly constitute “adverse benefit determinations” made without complying with ERISA
  - Court dismissed RICO claims (June 20, 2011)
  - Court denied motion to dismiss ERISA claims, noting that “Aetna has raised questions as to the viability of Plaintiffs’ ERISA claims,” but “that a more complete factual picture . . . is necessary to . . . resolve the issue”
- Aetna filed cross-complaint for fraud and misrepresentation – survived Plaintiffs’ motion to dismiss
- Case is stayed pending outcome of appeal in *Tri3 Enterprises, LLC v. Aetna, Inc., et al.*, No. 11-3981, D.N.J.
ERISA Recoupment Class Actions: *Pennsylvania Chiropractic Ass’n., et al. v. Blue Cross Blue Shield Ass’n.*, No. 09C5619, N.D. Ill.

- Plaintiffs chiropractic physician associations and individual chiropractors filed putative class action on Sept. 10, 2009 against various Blue Cross and Blue Shield entities alleging recoupment practices violate RICO and ERISA
- Defendants filed three motions to dismiss, which were granted as to the RICO claims but denied as to the ERISA claims
  - As to RICO claims, the Court held plaintiffs failed to plead predicate acts of racketeering and proximate cause
  - Defendants moved to dismiss ERISA claims on various grounds, including that Blue entities were not proper ERISA defendants, failure to identify plan or participants at issue, and failure to exhaust. Court denied motions to dismiss the ERISA claims
- Summary judgment granted in favor of defendants on subscriber claims by order dated January 23, 2012
- Provider classes and Florida chiropractor discrimination class denied by order on October 12, 2012
- Order granting in part and denying in part defendants’ motion for summary judgment and denying motion for judgment on the pleadings entered October 12, 2012
- Bench trial set for December 2, 2013
ERISA Recoupment Class Actions:  *Premier Health Ctr., et al. v. United Health Grp., Inc.*, No. 11-0425, D.N.J.

- Plaintiffs chiropractors, chiropractic health care facilities, and chiropractic associations filed First Amended Complaint on April 1, 2011 against UnitedHealth entities, OptumHealth, Health Net of Northeast and Health Net of New York

- **Recoupment Practices**: Plaintiffs allege that recoupment practices constitute adverse benefit determinations and allegedly violate ERISA, and that fiduciary duties under ERISA were breached

- **Utilization Review**: Plaintiffs allege OptumHealth’s pre-authorization and provider tiering practices violate ERISA as “adverse benefit determinations” without “full and fair review” and because pre-authorizations are allegedly not permitted under plan documents

- UnitedHealth and Health Net filed motions to dismiss. On 3/30/12 the court denied UnitedHealth’s motion to dismiss as to all claims, but granted it as to two subsidiaries of UnitedHealth

- Motion for class certification pending

- Motion for summary judgment against named representatives of purposed “ERISA Chiropractor Class” pending
Key ERISA Decisions: Attorney Client Privilege under ERISA

- *Stephan v Unum, Ninth Circuit, Sept 12, 2012*
  - “Fiduciary Exception” to AC Privilege
  - Insurer is a claims fiduciary under ERISA
  - Attorney’s duty extends to beneficiaries of the ERISA plan
  - Therefore beneficiaries can discover attorney client communications of the plan (insurer)
Stephan v Unum, Ninth Circuit, Sept 12, 2012

The AC Privilege applies only after the insurer and beneficiary are sufficiently “adverse”

At the least this means after the completion of all internal appeals

Receipt of a demand letter from the beneficiary’s attorney does NOT make the situation sufficiently adverse to protect the insurer’s AC privilege
Key ERISA Decisions: Attorney Client Privilege under ERISA

- A conflict exists between the 3rd and 9th Circuits
- Wachtel v Health Net (3d Cir. 2007)
  - Whatever could be said of traditional trusts and their beneficiaries, an insurance company is sufficiently adverse to its insureds to support the AC privilege
Key ERISA Decisions: Attorney Client Privilege under ERISA

- Sensitize in-house counsel to lack of privilege
- Does using outside counsel make a difference?
- Is this good “policy” under the law?
  - Will it discourage seeking counsel opinion?
  - Will it have a chilling effect on opinions given by counsel?
Provider Non-Discrimination

- PPACA prohibits group health plans and health insurance issuers “from discriminating with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.”
- Does NOT require plan to contract with any provider willing to accept plan terms
- Does NOT prevent the plan from varying reimbursement rates based on quality or performance measures

Statutory Provision: PHSA § 2706
Regulations will be promulgated in 2014
Provider Non-Discrimination: Practical Impact

- First federal provider non-discrimination law applicable to non-government programs and self-insured ERISA plans. It applies across all categories of providers:
  - Self-insured employee health benefit plans
  - Group health insurance
  - Individual health insurance
  - Products sold via health insurance “Exchanges” starting in 2014
  - Likely includes Federal Employees Health Benefits Programs

- Effective January 1, 2014 except for “grandfathered plans”
Provider Non-Discrimination

- By rejecting “any willing provider,” the law recognizes that a Plan may refuse to contract with individual providers. The refusal of an individual contract should not be improper discrimination.

- **What, then, is prohibited discrimination?**
  - The exclusion of or discrimination against classes of providers
    - Osteopaths
    - Podiatrists
    - Chiropractors
    - Optometrists
    - Acupuncturists

- **What else will be prohibited discrimination?**
Provider Non-Discrimination

- Discrimination against Non-Pars as a class?
- Could this be discrimination based on “participation”?
- Is it “discrimination” to pay non-pars differently from par-providers?
Provider Non-Discrimination – Unknowns?

- Discrimination based on different negotiated rates?
  - Resulting from different market power?
  - The “marquee practice” problem

- Must the same “service” always be paid the same?
  - Paying optometrist less than ophthalmologist for the same service?
  - Physicians vs Nurses vs Physician Assistants?
  - Is this “varying reimbursement rates based on quality or performance measures”?

- Having a “closed panel” benefit for optometrists, podiatrists or chiropractors but an “open access” benefit for ophthalmologists and orthopedists?
Provider Non-Discrimination – Unknowns?

- Borrowing employment law discrimination theories
- “Disparate Impact” theory
- A facially neutral policy that has a discriminatory effect (statistical proof of discrimination)
- Adopting a new, stricter credentialing standard but grandfathering in the existing network
- Uniform credentialing criteria that are more difficult for non-MDs to satisfy than MDs
- Uniform “malpractice criteria” that fails to account for different malpractice experience for different specialties
Provider Non-Discrimination – Unknowns?

Pay-for-Performance Programs

Will differential payments be challenged as a “subterfuge” for discrimination?

Is this “varying reimbursement rates based on quality or performance measures”

Need objective measures and statistical validity
Provider Non-Discrimination

Plan liability for discrimination by delegated entities?

Check IPA & Medical Group Contracts regarding indemnity/insurance for this kind of liability
UCR Class Action Litigation

- Genesis of Litigation: Investigation of Ingenix, Inc. by New York Attorney General
- Billed charges vs. UCR or allowed amount
- “Reasonableness” is Benchmark
- Courts determine reasonableness on a case by case basis
UCR Class Action Litigation

Common Provider Themes

- Use of flawed, corrupted data base
- Contribution by insurance companies of inaccurate data regarding billed charges
- Scrubbing of data to remove high-end charges, but not low-end charges
- Grouping geographic areas that do not reflect comparable charging patterns
- Using outdated or old charges
- Collection of insufficient data from contributors
UCR Class Action Litigation

- Provider Theories
  - ERISA Claims
  - State Law Claims
    - Quantum Meruit
    - Equitable Estoppel
    - Promissory Estoppel
    - Third-Party Beneficiary
  - RICO
  - Sherman Act
  - Unfair and Deceptive Trade Practices
UCR Class Action Litigation

Defense Strategies

ERISA

- Preemption
- Lack of Standing – Enforcement of Anti-Assignment Clauses
- Failure to Plead Assignment
- Failure to Exhaust Administrative Remedies
- Merits – Determination of UCR not arbitrary and capricious
UCR Class Action Litigation

  - Settled 2009
- **2001**: *Wachtel v. HealthNet, et al.* (District of New Jersey)
  - Settled
  - Rico class had been certified
- **2004**: *Franco v. CIGNA, et al.* (District of New Jersey)
  - By order of September 23, 2011, the Court granted in part and denied in part motions to dismiss of CIGNA, United Health and Ingenix. 818 F.Supp.2d 792 (D.N.J. 2011)
  - By order of January 24, 2012, the Court dismissed plaintiff Nelson’s civil conspiracy claim as being preempted by ERISA.
  - Class certification motion pending
UCR Class Action Litigation

- **2007:** 
  - **MDL 2020:** *In re Aetna UCR Litigation* (District of New Jersey)
  - Settled
  - Hearing on Motion for Preliminary Approval of Settlement set for January 23, 2013.

- **2009:** 
  - **MDL 2074:** *In re Wellpoint UCR Litigation* (Central District of California)
  - Order of September 6, 2012 dismissed ERISA, RICO and antitrust claims.
  - Fourth Consolidated Amended Complaint filed November 5, 2012.
  - Motions to Dismiss Fourth Amended Complaint Pending Hearing, April 8, 2013.
2009: *McDonough v. Horizon Blue Cross* (District of New Jersey)

By order of September 23, 2011, district court granted in part Horizon’s motion to dismiss. 2011 WL 4455994.

Surviving Claims

- ERISA Benefits, §502(a)(1)(B)
- ERISA Breach of Fiduciary Duty, §502(a)(3)
- Based on calculation of out of network benefits using Ingenix
- Summary Judgment pending.
Medical Loss Ratio under ACA

- ACA MLR Summary:
  - Health insurance issuers offering group or individual health insurance coverage are required to report their MLR each year
  - Minimum MLR for large group market – 85%
  - Minimum MLR for individual market and small group market – 80%
  - States are free to adopt higher minimum MLRs
  - HHS Secretary may adjust the minimum MLR for individual market to prevent destabilization
  - Health insurance issuers that fail to meet the minimum MLR required to provide rebates to employer (or policyholder)

Statutory Provision: PHSA § 2718
Key Regulations: 45 CFR §§ 158.110-606
MLR Rebate Paid to Whom?

- Rebates for group policies will generally be to “policyholders” and not directly to “consumers”
  - ERISA and State Government Group Health Plans
    - Rebates paid to policyholders, who must use rebate for benefit of subscribers to either
      - Reduce premium for subsequent policy year (reduces taxes)
      - Provide cash refund
    - Rebates to policyholders of ERISA group health plans may be plan assets, which must be handled in accordance with ERISA’s fiduciary responsibility provisions
      - Policyholder may be the plan or plan sponsor (employer)
        - If the plan or trust is policyholder, entire rebate is plan asset
        - If plan sponsor is policyholder, determining plan’s portion depends on plan provisions, the policy, or manner in which sponsor or participants shared in cost

MLR Rebate Paid to Whom?

- Non-ERISA and Non-Governmental Group Health Plans

- Rebates paid to the policyholder only if issuer receives written assurance that rebate will be used to benefit enrollees

- Absent assurance, issuer must distribute in equal amounts to all subscribers without regard to how much each actually paid
Medical Loss Ratio: National Trends

- HHS Secretary may adjust the minimum 80% MLR for individual market if necessary to prevent destabilization

- Waivers Rejected
  - Ten states and one territory (Wisconsin, Delaware, Florida, Indiana, Kansas, Louisiana, Michigan, North Dakota, Oklahoma, Texas, and Guam) had their requests for waivers rejected on grounds that medical loss ratio would not destabilize states’ individual insurance markets

- Waivers Granted
  - Seven states (Georgia, Iowa, Kentucky, Maine, Nevada, New Hampshire, and North Carolina) had waiver requests granted or partially granted

- HHS announced June 21, 2012 that rebates of $1.1 billion would be paid to 12.8 million policyholders by August 1, 2012
Medical Loss Ratio – Potential Issues

- Examples of MLR Issues:
  - Broker commission practices
  - Mid-year Premium holidays to avoid end of year rebates
  - Mid-year provider contract rate adjustments
  - Provider risk sharing measured by MLR stats
  - Selective (discriminatory) premium adjustments driven by perceived market positioning
  - Compensation bonuses for employees that may incentivize achievement of results not requiring MLR rebate payments
  - Appropriate identification of Quality Improvement expenses
  - Rebate distribution practices
  - Accounting for
    - Pharmacy benefit expenditures
    - Capitated Providers
    - Vendors
MLR & Rate Regulation - Liability Risks

- “Rebate” requirement creates potentially high dollar damages for class actions by
  - Insurance Regulators
  - Attorneys General
  - Class Action lawyers
  - “Consumer Watchdog” organization

- Plaintiffs will exploit errors and ambiguities in MLR filings to claim fraud
  - Internally, be wary of “creative” or overly aggressive accounting
  - Look for clear regulatory guidance/direction on MLR calculations
  - Administrative MLR Hearings?
  - Judicial review proceedings of agency MLR decisions?
Medical Loss Ratio

- **Key Defenses to Private Litigation**
  - **Filed Rate Doctrine**
    - Are the rebates a “rate”?
    - “Rebates are essentially a retrospective adjustment or correction to premiums”
    - MLR allocations used in initial rate review?
    - Is there agency review and approval of rebates?
  - **Abstention**
  - **Primary Jurisdiction**
  - **No Private Right of Action**
MLR Case Study:
U.S. v. Farha, et al. (M.D. Fla., 2011)

- March 2011: Five former Wellcare executives indicted
- Allegations involve Florida Medicaid’s 80% MLR Rebate Requirement for behavioral health care services provided by managed care plans
- Executives alleged to have fraudulently reduced MLR refund by:
  - Including fraudulent information in worksheets submitted to Medicaid
  - Improperly including expenditures for certain types of health care services in Behavioral Health Care Worksheet submitted to Medicaid
  - Creating a wholly-owned, capitated provider to conceal costs and increase expenditures reported to Medicaid
  - Issuing approx. $1 million rebate based on inconsistent and improper methodologies across various reporting periods to avoid scrutiny
  - Failing to respond truthfully to the Medicaid program’s request for information regarding MLR
  - Submitting executed policies and procedures that falsely represented that aforementioned worksheets were prepared according to appropriate standards
Indictments of executives follow:

- **2008 plea agreement** by a former WellCare employee and
- **2009 Deferred Prosecution Agreement** entered into by WellCare with United States Attorney
  - $40 million in restitution
  - Forfeited an additional $40 million
  - Executed Corporate Integrity Agreement with OIG that places compliance obligations for five years
Fee Forgiveness Litigation

**Payor Themes**

- “Out-of-Network” Strategy
- Cherry Pick (target and siphon) high-value patients from in-network, full service hospitals or providers and refer to out-of-network facilities in which referring physician has financial interest
- Out-of-network facility discounts or waivers of co-payments and other out-of-pocket costs
- Results in higher plan costs
Fee Forgiveness Litigation

➢ Payor Themes

➢ Providers submitting charges for medical treatments that are improper, unreasonable, or medically or clinically unnecessary
Fee Forgiveness Litigation

Payor Theories

- Violations of State Occupation Codes
- Violations of Ethical Standards
- Violations of Medical Ethics of the American and State Medical Associations
Fee Forgiveness Litigation

- Claims
  - Fraud
  - Money Had and Received
  - Unjust Enrichment
  - Injunctive Relief
  - Declaratory Judgment
  - ERISA § 502(a)(3) relief
    - constructive trust
    - injunction
    - return of plan assets
Fee Forgiveness Litigation

- **Aetna v. Bay Area Surgical Management LLC, N.D. Cal., No 5:12-CV-05829**
  - Lawsuit originally filed in Superior Court, Santa Clara County (Case No. 1:12-CV-217943)
  - Removed to N.D. Cal on November 14, 2012
  - Stipulated Order entered on December 21, 2012. Aetna intends to file Motion to Remand.
Fee Forgiveness Litigation

- **Aetna Life Insurance Co. v. Bay Area Surgical Management LLC, No. 112CV217943, Santa Clara Superior Court (filed Feb. 2, 2012)**
  - Defendants are 7 non-par surgery centers and related individuals
  - **Allegations:**
    - Surgery centers illegally induced Aetna’s in-network physicians (who are also investors in out-of-network surgery centers) to refer patients to out-of-network centers
    - Physicians’ ownership interest provides incentive or referral fees for out-of-network referrals
    - Surgery center management cherry picks patients for referral based on high insurance coverage
    - Surgery center seeks non-par reimbursement from insurer at rates that are much higher than contracted facility rates
    - Surgery center waives or reduces copayment so that patient does not pay more than an in-network copayment
    - Physicians fail to adequately disclose to members their ownership/financial interest/incentive to refer
Fee Forgiveness Litigation:
Aetna Life Insurance Co. v. Bay Area Surgical Management LLC

Examples from complaint:
- Physician received an annual bonus of $980,000
- Physicians promised 805% annualized return on investment
- Surgery center charge for “correction of bunion”: $66,100
- Aetna paid $23 million for 1900 procedures that should have cost only $3 million – a 771% increase
- Payments from 513% to 1135% higher (percentage varied for each center) than Aetna paid its in-network providers in same geographic area for same procedures

Waiver of Copayment:
- $66,100 for “correction of bunion” procedure represented as reasonable charge
- Surgery center never collects $10,576 (20% of $52,880) (total allowed amount) from member as coinsurance or other compensation
- Surgery center submits claim for $66,100 with intent that Aetna would remit 80% of $66,100
- Aetna pays $52,880 based on the misrepresentation
- Aetna should have been charged or paid more than $42,304 ($52,880 (allowed amount) x Aetna’s 80% responsibility)
- Aetna damaged $10,576: ($52,880 (amount paid) less $42,304 (most should have paid))
Fee Forgiveness Litigation:
Aetna Life Insurance Co. v. Bay Area Surgical Management LLC

Relief Sought:
Aetna asserts causes of action for:
- Unfair business practices/B&P § 17200 based on, *inter alia* (1) offering compensation for referral of patients, (2) referring patients to organization in which physicians have beneficial interest without disclosing interest in writing, (3) submitting false claim, and (4) corporate practice of medicine
- Intentional interference with contractual relations with its members and with its in-network participating providers
- Fraud
- Declaratory judgment
- Unjust enrichment

Aetna seeks
- $23 million in damages
- Disgorgement of profits
- Attorneys’ fees
- Injunction, and
- Declaration that "fee-forgiving" practices are illegal
Court overrules Demurrer & Motion to Strike (September 28, 2012):

- Aetna adequately pleads a UCL violation based on illegal referrals (B&P Code 650) because alleges that remuneration is based on value or volume of referrals, not proportional to investment or ownership.
- UCL is also supported by alleged fraudulent waiver of copayments (distinguishing a 1981 AG Opinion and the Duz-Mor Case).
- Failure to disclose waiver of copayment to insurer can be fraudulent.
- Aetna has standing to allege illegal corporate practice of medicine based on surgicenters “cherrypicking” the patients for referral.
- Aetna adequately pleads a cause of action for unjust enrichment.
- Demurrer to claim for “interference with contract” sustained with leave to amend to clarify how member’s or provider’s contracts were affected.
Fee Forgiveness Litigation

- **Aetna v. Humble Surgical Hospital, S.D. Tex., No. 4:12-cv-01206**
  - Complaint filed April 18, 2012
  - Provider’s Motion to Compel Arbitration and Motion to Dismiss denied by Order dated July 9, 2012
  - Interlocutory Appeal to 5th Circuit pending. Motion to Stay denied.
Fee Forgiveness Litigation

- Similar suits filed by Aetna against nine New Jersey and two New York doctors, along with Long Island-based surgery center
Fee Forgiveness Litigation

- **North Cypress Medical Center Operating Co., Ltd. v. CIGNA Healthcare, S.D. Tex, No. 4:09-CV-2556**
  - North Cypress filed complaint for alleged $20 million in UCR denials under ERISA
  - CIGNA counterclaimed, alleging an ongoing scheme to defraud CIGNA through “fee forgiveness”
  - Final Judgment entered December 12, 2012. Court disposed of all claims of both parties through this order and prior orders
  - North Cypress filed Notice of Appeal to Fifth Circuit on December 14, 2012
Fee Forgiveness Litigation:

*United Healthcare Services, Inc. v. Bay Area Surgical Management, LLC, No. 112CV226686, Santa Clara Superior Court (filed June 18, 2012)*

- Defendants include 6 out-of-network surgery centers and related individuals
- Causes of action for Fraud and Unfair Business Practices/B&P § 17200
- Allegations:
  - Defendants submitted inflated and fraudulent bills that were greater than the amount actually charged to United members
  - Defendants failed to disclose their routine waiver of coinsurance, copayment and other amounts of member responsibility
  - Defendants incentivized physicians to refer patients with favorable out-of-network benefits to the facility defendants by providing discounted ownership shares and above-market rates of return on ownership
  - Defendants violated the federal Stark law, federal anti-kickback law, and federal prohibitions on waiver of copayment and deductible amounts for claims involving Medicare patients
  - Defendants fraudulently induced United to pay approx. $39,045,539 based on the alleged misrepresentations and unlawful conduct