

LITIGATION TRENDS IN MANAGED CARE

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Why Is Litigation Important to Compliance Office?

- May give early warning on regulatory issue that creates compliance risk
- Company may be disclosing compliance risk in a public forum
- Potential significance of compliance issue may not be appreciated by litigation counsel

Compliance Monitoring of Litigation

- Should this be done?
- How?
- At what point is Compliance Office overstepping its bounds?
 - Invading province of General Counsel's Office?

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Compliance Monitoring of Litigation

- What types of litigation should be monitored?
 - employment?
 - medical malpractice?
 - business disputes?
- Be mindful of attorney-client privilege and work-product protection
 - routine “monitoring” could weaken the company's privilege position

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Provider/Payor Litigation

- Non-participating providers in today's challenging economic environment are suing health plans with greater frequency
- Non-participating providers typically sue for billed charges or reasonable value
- Plans assert defenses which can vary greatly from state-to-state and by type of plan (e.g. government v. commercial)
- Provider may also seek to recover from patient

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Balance Billing: Patient Issues

- What can non-par provider collect from patient?
 - nothing?
 - co-pay/deductible?
 - balance of bill?
- Can be regulated by state statute
- A patient's receipt of a "balance bill" can lead to patient inquiries, patient complaints or even complaints to state regulatory officials

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Balance Billing: Recent Case Law

- California Department of Managed Health Care v. Prime Healthcare Services (Cal. 2008)
 - California Department of Managed Health Care sued hospital organization (Prime) to bar it from balance billing insured patients
 - Lawsuit seeks penalties of \$2500 per violation
- Kaiser obtained TRO in May 2008 prohibiting balance billing of its members
- In response, Prime sued Kaiser in five lawsuits alleging various improper practices

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Balance Billing: Recent Case Law

- California Medical Association v. California Department of Managed Health Care (Cal. 2008)
 - Lawsuit by California Hospital Association and several physician associations to block the enforcement of 28 C.C.R.S. §1300.71.39
 - This regulation bars hospitals and their physicians from billing patients for emergency services that are the responsibility of insurers
- See also Prospect Medical Group v. Northridge Emergency Medical Group (Cal. 2006)
 - “HMO members are not liable to pay for emergency care.”

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Provider v. Payor Litigation: Medicaid Managed Care

- Midwest Emergency Associates – Elgin Ltd. v. Harmony Health Plan of Illinois (Ill. 2008)
 - Illinois appellate court held that Medicaid managed care organization entitled to reimburse non-par provider at the Medicaid fee-for-service rate rather than billed charges.

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Provider v. Payor Litigation: Emerging Florida Law

- Several provider v. payor cases decided by Florida courts in recent years. Issues considered include:
 - Are providers third-party beneficiaries of payor/member contracts?
 - Are non-par providers permitted to recover billed charges in actions against plans?
 - Do billed charges constitute reasonable value?

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Payment for Out-of-Network Emergency Services

- Several states have statutes requiring HMOs to pay out-of-network hospitals for the provision of emergency services to HMO members
- These statutes have various payment requirements. Here are two examples:
 - Reasonably necessary costs (Pennsylvania)
 - Lower of hospital's billed charges or usual and customary charges for similar services in the community (Florida)

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Ingenix-Related Investigation

- In February 2008 New York Attorney General Cuomo announced a large-scale investigation into healthcare billing information provided by United subsidiary Ingenix. AG Cuomo contended that several large health plans and/or Ingenix kept out-of-network payments unreasonably low by relying on faulty methods for determining usual and customary ("U&C") rates.
- According to AG Cuomo, the alleged improper conduct caused consumers to absorb a higher share of healthcare costs

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Settlement of Ingenix-Related Investigation

- AG Cuomo's office issued subpoenas to 16 large health insurance companies seeking information on the calculations of U&C rates and communications with Ingenix on the issue.
- On January 13, 2009, AG Cuomo announced a settlement with United providing for termination of the Ingenix database. Certain insurers have also agreed to fund a qualified nonprofit organization to establish a new independent database to determine out-of-network rates.

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Settlement of Ingenix-Related Investigation

- American Medical Association v. United Healthcare Corp. (N.Y. 2009)
 - \$350 million settlement with United to resolve the class action lawsuit by physicians challenging United's out-of-network payment determinations
 - Settlement came two days after New York AG Cuomo's prospective settlement regarding Ingenix
- See also prior Health Net settlement (2007)

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Physician Tiering Programs

- Rank physicians based on performance standards
- Higher scoring physicians typically are placed into an elite plan with a limited network or lower cost-sharing

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Physician Tiering Programs

- Critics of tiering programs argue there must be assurance that:
 - 1) tiering is based on quality rather than cost;
 - 2) tiering process is open to review;
 - 3) methodology is appropriate; and
 - 4) there is adequate disclosure to consumers on the basis for tiering decisions.

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Physician Tiering Programs

- Tiering can expose health plans to litigation risks. Potential causes of action include:
 - Defamation
 - Breach of contract
 - Violation of unfair trade practices and consumer protection statutes
- Litigation has occurred in Washington and Massachusetts and a wide-scale investigation has occurred in New York

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Physician Tiering Programs

- Washington State Medical Associates v. Regence Blue Shield (Wash. 2006)
 - Washington State Medical Association (“WSMA”) and others sued Regence alleging unfair and deceptive business practices, defamation, libel, intentional interference with commerce, and breach of contract in connection with Regence’s exclusion of approximately 500 physicians from the “Select Network Program”
 - In November 2006 the American Medical Association Litigation Center (a coalition of the AMA and state medical associations) joined the lawsuit as co-plaintiff.

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Physician Tiering Programs

- Case settled in August 2007. Key terms were:
 - Advance disclosure to WSMA prior to implementation of any new rating/performance program and its methodology
 - Ten days' notice to WSMA prior to release of physician performance scores
 - Reasonable efforts to notify physicians that scores are being released
 - Posting of scores on Regence website along with explanation of methodology and data used, including identification of patients.

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Physician Tiering Programs

- Massachusetts Medical Society, et al. v. Group Insurance Commission, et al. (Mass. 2008)
 - Defamation and fraud action relating to “Clinical Performance Improvement Initiative”
 - Case pending

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Physician Tiering Programs

- In 2007 New York Attorney General Cuomo announced investigation of physician tiering programs of several major insurers. AG identified 3 key concerns:
 - Consumers may be steered towards doctors based on faulty data and criteria
 - Potential undermining of doctor-patient relationship due to emphasis on lower cost rather than quality of care
 - Insurers' profit motive could affect accuracy of rankings

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Physician Tiering Programs

- New York investigation settled in November 2007. Under the settlement agreements, the insurers agreed to implement model standards developed by AG's office in conjunction with AMA, the Medical Society of New York and other advocacy groups.
- Standards focus on accuracy of data, transparency of process and oversight by a nationally-recognized standard-setting organization

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ERISA Conflict of Interest

- Metropolitan Life Ins. Co. v. Glenn (U.S. Supreme Ct. 2008)
 - Insurers that both fund and administer employee benefit plans operate under a conflict of interest
 - Conflict must be considered by a court reviewing whether plan administrator abused its discretion in denying a benefit claim.
 - But, the conflict does not automatically convert the traditional deference standard of review to a *de novo* one

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Arbitration Clauses

- States may regulate the use of arbitration clauses in health plans member contracts
 - E.g. a California statute provides for certain disclosure requirements
- Disclosure requirements can be very technical, creating potential for non-compliance and litigation
- Several decisions in California regarding alleged non-compliance

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Post-Claims Underwriting

- What is it? Where insurer reexamines policy coverage after filing of claim by the insured and limits or revokes the coverage
- Subject of extensive litigation and administrative proceedings in California

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Post-Claims Underwriting

- General Rule: Insurer may rescind coverage retroactively if the insurer later learns that insured misrepresented information in the application.
- Exception to General Rule: Insurer is required to investigate applicant information during application process if the information provided is suspect.
- But, is there an obligation for insurer to investigate where there is no suspect information?

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Post-Claims Underwriting

- California Health & Safety Code § 1389.3
 - prohibits insurers from engaging in post-claims underwriting “due to the plan’s failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the plan contract.”

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Post-Claims Underwriting

- What must insurer do “to complete medical underwriting” ?
- Haley v. California Physicians’ Serv. (Cal. 2007)
 - Insurer has a duty to take steps to ensure accuracy and completeness of information even when there is no indication that the information submitted is suspect.

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Post-Claims Underwriting

- In April 2008 the California Department of Managed Health Care announced its review of all California health insurance rescissions since 2004.
- The review resulted in settlements with the five largest plans in California.
 - Settlements involved substantial fines and required corrective action

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Pharmacy Benefit Managers: Fiduciary Duties

- Several cases address whether PBMs are ERISA fiduciaries.
 - Most cases involve allegations that PBM is receiving discounts and rebates from drug manufacturers without disclosing or passing along the financial benefit
 - Results have generally favored PBMs

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Pharmacy Benefit Managers: Drug Switching Settlements

- Two large PBMs entered into settlements in 2008 to resolve allegations of “drug switching”
 - “Drug switching” is where PBM allegedly contacts patient’s physician without patient’s knowledge and replaces prescribed drug with a different one for financial reasons
 - Settlements were with 28 states and District of Columbia and provided for payments totaling \$75 million along with certain procedural and disclosure requirements

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Coverage Issues: Eating Disorders

- Recent large class action settlements relating to denial of claims for reimbursement of medical expenses associated with treatment of eating disorders
- Settlement terms involve commitment that insurers will treat eating disorder claims the same as biologically-based illnesses

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Coverage Issues: Obesity

- Several recent cases on this subject
 - Issue is whether plan denial of benefits was arbitrary and capricious
 - Decisions go both ways

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Coverage Issues: Investigational/Experimental

- Cases apply arbitrary and capricious standard of review to determine whether claims properly denied as investigational or experimental
 - Results vary based on specific facts of case
 - Issue continues to be litigated often

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False Claims Act: Allison Engine

- Allison Engine Co. v. United States ex rel. Sanders (U.S. Supreme Court 2008): May have implications for health plans involving Medicare or Medicaid coverage.
- Specific holding: A claim brought under 31 U.S.C. §3729(a)(2) requires proof that the defendant created the false record or made the false statement with the intent to get the government to pay or reimburse a claim.
- Proof of presentment of the claim to the government is not required (but such presentment is required under § 3729(a)(1)).

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False Claims Act

- United States ex rel. Sterling v. Health Insurance Plans of Greater New York (N.Y. 2008)
 - Relator alleged that health plan's alleged false statements to NCQA enabled plan to secure accreditation which thereby enabled plan to obtain payment from government healthcare programs.
 - Court dismissed, holding that presentment of false information to NCQA is not equivalent or analogous to presentment to the government.

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Blue Cross Class Action Settlement

- 2008 settlement between Blue Cross Blue Shield Association and national class of 90,000 physicians. Key non-monetary terms include:
 - Greater availability of fee schedules
 - Reduced precertification requirements
 - Increased notice of policy and procedure changes
 - Increased transparency for claims payment practices
 - New processes for resolution of billing and coverage issues

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