Managed Care Litigation: Emerging Trends in Provider-Plan Disputes
Pursuing and Defending Lawsuits Involving Balance Billing, Reimbursement, Physician Tiering and Other Claims

A Live 90-Minute Teleconference/Webinar with Interactive Q&A

Today's panel features:
Christopher Flynn, Partner, Crowell & Moring, Washington, D.C.
James W Boswell, III, Partner, King & Spalding, Atlanta
Robert T. Rhoad, Partner, Crowell & Moring, Washington, D.C.

Thursday, March 11, 2010

The conference begins at:
1 pm Eastern
12 pm Central
11 am Mountain
10 am Pacific

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MANAGED CARE LITIGATION: EMERGING TRENDS IN PROVIDER-PLAN DISPUTES

James W. Boswell
HISTORICAL OVERVIEW OF MANAGED CARE LITIGATION TRENDS
Historical Themes In Managed Care Litigation

**Individual Subscriber Disputes**

- Wrongful denial of benefits
- Malpractice of contracted providers
- Consumer fraud claims related to payor’s business practices such as billing, payment, marketing and enrollment
Historical Themes In Managed Care Litigation

Individual Provider Disputes

- Payment Practices Claims
  - prompt payment claims
  - failure to pay based on undisclosed criteria
  - downcoding or bundling
- Antitrust Claims
  - refusal to contract with certain providers
  - payor influence over healthcare pricing
- Unfair Business Practices
  - restricting access to payor networks
  - payor’s influencing providers to join particular practices
Historical Themes In Managed Care Litigation

Large Scale Investigations & Class Actions

– Ingenix Investigation

– In Re Managed Care Litigation

– California Dept. Managed Healthcare & Anthem Blue Cross
Ingenix 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.
Settlement of Ingenix 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 a discontinuation 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.
Settlement of Ingenix 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
In Re Managed Care Litigation

- Patients (in a “subscriber” class) and Physicians (in a “provider class”) filed class action against 10 managed care organizations representing 90% of the managed care industry, including Cigna, Aetna, Humana, Pacificare, Prudential, Wellpoint, Anthem, and United.

- Alleged RICO and ERISA violations on behalf of the subscriber class and RICO, unfair competition, breach of contract, unjust enrichment and prompt payment claims on behalf of the provider class.

- Southern District of Florida certifies provider class alleging: unlawful denial of codes; downcoding; grouping; ignoring modifiers calling for higher reimbursements; and misrepresentations in EOBs

- Large-scale cash settlement reached between providers and seven of the insurance companies over a series of years. Court heard the last settlement fairness appeal in the case in 2009.
## In Re Managed Care Litigation: Settlement

<table>
<thead>
<tr>
<th>HEALTH PLAN SETTLEMENTS OVERVIEW: SETTLEMENT VALUES AND IMPORTANT DATES</th>
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<tr>
<th></th>
<th>AETNA</th>
<th>CIGNA</th>
<th>HEALTH NET</th>
<th>PRUDENTIAL</th>
<th>ANTHEM AND WELLPOINT</th>
<th>HUMANA</th>
<th>COMBINED SETTLEMENT TOTALS</th>
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<tr>
<td>Physician Cash Recovery</td>
<td>$100 Million</td>
<td>&gt;$70 Million</td>
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<td>Physicians’ Foundation Funds</td>
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<td>$23 Million</td>
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<td>Changes in Health Plan Business Practices</td>
<td>&gt;$300 Million</td>
<td>&gt;$400 Million</td>
<td>&gt;$80 Million</td>
<td>N/A</td>
<td>&gt;$250 Million</td>
<td>&gt;$75 Million</td>
<td>&gt;$1.1 Billion</td>
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<tr>
<td>Total Physician Damages</td>
<td>&gt;$420 Million</td>
<td>&gt;$485 Million</td>
<td>&gt;$120 Million</td>
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<td>&gt;$390 Million</td>
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<td>Attorneys’ Fees*</td>
<td>$50 Million</td>
<td>$55 Million</td>
<td>$20 Million</td>
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<td>$38 Million</td>
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<td>Settlement Approval Dates</td>
<td>11/6/03 (Final Approval)</td>
<td>4/22/04 (Final Approval)</td>
<td>9/26/05 (Judge Approved; Appeal Pending)</td>
<td>9/26/05 Hearing Scheduled: 12/2/05</td>
<td>Hearing Scheduled: 3/6/06</td>
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# In Re Managed Care Litigation Settlement

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<th>HUMANA</th>
<th>TOTALS</th>
</tr>
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<tr>
<td>Opt Out Deadline</td>
<td>8/29/03</td>
<td>11/20/03</td>
<td>8/22/05</td>
<td>8/5/05</td>
<td>10/18/05</td>
<td>1/18/06</td>
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<td>Deadline to Submit Claim Forms for Compensation</td>
<td>9/30/03</td>
<td>2/18/05</td>
<td>9/21/05</td>
<td>N/A</td>
<td>11/17/05</td>
<td>2/17/06</td>
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*Attorneys’ fees reflect approximately 10% of the value of the settlements.

Note: Trial against remaining defendants (Pacificare, United, and Coventry) is scheduled to begin 9/18/06.
Current Themes In Managed Care Litigation

- Balance Billing
- Reimbursement and Recoupment
- Physician Tiering
- Coverage Issues
- Silent PPOs
- Post-Claim Underwriting
- Scope of ERISA Preemption
- Patient Responsibility Waivers By Providers
- Network Exclusion
- Out-Of-Network Reimbursement
Current Trends in Managed Care Litigation

Presented by
Chris Flynn

March 11, 2010
Balance Billing Issues
Background

“Balance billing” occurs when an insurer submits a payment lower than the amount billed by the provider, and the provider then charges the patient directly for the remaining balance.

Background

- Many state statutes prohibit HMOs from allowing providers to balance bill members, yet some providers continue this practice.

- Providers maintain they have the right to be compensated for the services they provide and should not be forced to accept reimbursement levels unilaterally set by health plans.

- Plans, on the other hand, contend that they are not required to pay providers whatever they bill and that providers cannot balance bill an HMO member for a covered service.

- In light of recent rulings, it is likely that there will be more consumer class actions against both payors and providers.
Consumer Class Actions Against Providers

- In many states, courts have made clear that providers are prohibited from balance billing HMO members.


    - "Billing disputes over emergency medical care must be resolved solely between the emergency room doctors, who are entitled to a reasonable payment for their services, and the HMO, which is obligated to make that payment. A patient who is a member of an HMO may not be injected into the dispute. Emergency room doctors may not bill the patient for the disputed amount."


    - "[A] hospital-based, but non-contracted, provider of health care services to the subscribers of a health maintenance organization plan may not "balance bill the subscribers for the unpaid portion of its statements for medical services that have not been paid by the health maintenance organization.""
Ramifications of Recent Decisions for Suits Against Providers

- If recent judicial decisions against providers merely confirm what state laws already required, providers could face class actions brought by, or on behalf of, members who were balance billed years or decades ago.

    - Putative class of patients allege violations of California state law against providers for balance billing for ER services *over the past four years and up to the point of trial*.

    - Putative class of providers and subscribers (some of whom had been balance billed) allege ERISA, RICO, Sherman Act and state law violations against plans for improper UCR determinations based on the Ingenix database.
    - Defendants moved to dismiss based on lack standing, ERISA preemption and failure to state a claim.
It is considerably less clear whether consumers can proceed against payors that do not affirmatively authorize providers to balance bill members.

- Do payors have an affirmative duty to prevent balance billing?
Reimbursement Issues in Managed Care Litigation
• The UCR reimbursement framework is employed in many statutory and other regulatory reimbursement frameworks, including outside of the traditional commercial managed care context, and has been the subject of numerous suits brought directly by members and providers.

• Courts have varied in determining which criteria should be used in the development of UCR rates, although they have been nearly unanimous in rejecting discounted “in-network” rates as an approximation of UCR.

- BCMS sued health plans to determine the rates it was entitled to receive for services provided to subscribers seeking emergency medical services at BCMS under Florida law.
- Statute provides that plans must reimburse OON providers at rates equal to the lesser of the provider's charges or the "usual and customary provider charges for similar services in the community where the services were provided."
- BCMS is OON, and bills the plans the charge master rates. The plans discount the charges and remit checks to BCMS marked "payment in full."
- BCMS argued the statute requires defendants to pay the amount billed or the charge master rates.

Courtholds: "It is clear what is called for is the fair market value of the services provided. Fair market value is the price that a willing buyer will pay and a willing seller will accept in an arm's-length transaction. In determining the fair market value of the services, it is appropriate to consider the amounts billed and the amounts accepted by providers..."

- Putative class action against health plans alleging ERISA, RICO, Sherman Act, and common law claims for systematic reduction of reimbursement (for providers) and health benefits (for individual subscribers) based on flawed and invalid data for services provided by non-par providers.

- Defendants filed a Motion to Dismiss (9/9/09), arguing that claims exceeding allegations relating to use of Ingenix database are too broad and should be stricken, failure to plead fraud with particularity, failure to exhaust administrative remedies and lack of standing.
In Re Wellpoint, Inc., Out-of-Network "UCR" Rates Litig, No. 2:09-ml-02074-PSG-CT, MDL No. 09-2074 (C.D. Cal.)

- Plaintiffs (individual subscribers and providers) assert various federal and state law claims relating to the use of Ingenix to calculate the usual and customary rates ("UCR") for out-of-network services provided to WellPoint’s members.

- Defendants filed a Motion to Dismiss (12/15/09), framing UCR issue as governed by terms of the contract and arguing failure to state a claim, failure to exhaust administrative remedies and lack of standing.
Pennsylvania Chiropractic Ass’n v. Blue Cross Blue Shield Ass’n, No. 09-cv-05619, complaint filed Nov. 16, 2009 (N.D. Ill.)

- Putative class action brought on behalf of a chiropractor association as well as individual providers against health plans alleging ERISA, RICO and Florida Equity Law violations.

- Class alleges defendants engaged in concerted action to unlawfully obtain monies from provider class by accusing them of fraud, demanding recoupment, and withholding current or future benefits based on the alleged past fraud.

- Defendants filed a Motion to Dismiss (12/31/09), arguing failure to state a claim, failure to exhaust administrative remedies and lack of standing.
PHYSICIAN TIERING
Physician Tiering

– Payor practice of rating physicians based on specific performance standards such as cost and quality of care provided

– Higher rated physicians typically are placed in an elite plan with a limited network or lower cost-sharing
**CIGNA’s Cost-Efficiency Rating**

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>CIGNA Care Designation</th>
<th>Address Phone</th>
<th>Group Practice</th>
<th>Location Only</th>
<th>Location: Within 25.0 miles of Atlanta GA 30309</th>
<th>Cost Value Rating</th>
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</thead>
<tbody>
<tr>
<td>Epstein, Jacob, MD</td>
<td>Yes</td>
<td>1175 W Peachtree St NW #1208 Atlanta, GA 30309 (404) 892-8875</td>
<td>Peachtree Per OB/GYN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moyer, Leroy N, MD</td>
<td>Yes</td>
<td>1175 W Peachtree St NW #1209 Atlanta, GA 30309 (404) 892-8875</td>
<td>Peachtree Perimeter OB/GYN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brown, Morris E, MD</td>
<td>Yes</td>
<td>550 Peachtree St NE #1550 Atlanta, GA 30303 (404) 892-2131</td>
<td>Laureate Medical Group PC</td>
<td>1.2 Miles</td>
<td>Map</td>
<td>Endocrinology And Metabolism</td>
</tr>
</tbody>
</table>

*Compare Selected*
Select at least 2 Providers

This Physician Quality and Efficiency Profile reflects a partial assessment of quality and cost efficiency based on the criteria described below. It should not be used as the sole basis for decision-making, as such measures have a risk of error. We encourage you to consider all relevant factors and consult with your treating physician as you select a specialist for your care.

Ratings Key:
- CIGNA Care Designation
- ★★★ Top Score for Cost Efficiency Measures
CIGNA’s Cost-Efficiency Rating

Cost-Efficiency Evaluation

CIGNA’s approach is based on what we believe individuals care most about; the total cost of their care, including inpatient and outpatient, for an episode of illness. As individuals assume greater financial responsibility for their care, the total cost of care impacts the amount they pay, affordability and possibly the accessibility of care. Because cost-efficiency is important to individuals with CIGNA administered plans, we determine how a physician or physician group’s cost-efficiency compares to that of other physicians in the same specialty in their market. For this assessment, CIGNA evaluates claims using the Episode Treatment Group (ETG) methodology available through INGENIX® Symmetry Health Data Systems Inc. This ETG methodology is commonly used in the industry. Claims are clustered into over 500 different episodes of care. The ETG methodology incorporates case mix and severity adjustment. The claims used for the assessment are HMO, POS, OAP and PPO claims from January 2007 through December 2008. For additional information about the INGENIX® Symmetry Episode Treatment Groups and a complete listing of the ETGs Please refer to the INGENIX web site at www.ingenix.com/transparency.
UniCare’s Physician Tiering Criteria

Frequently Asked Questions about Physician Tiering

How does physician tiering work?
Under the Plan’s physician tiering program, Massachusetts physicians are assigned to tiers based on an evaluation of various quality measures and cost-efficiency measures. The Plan has three tiers for physicians: Tier 1, Tier 2 and Tier 3. You pay different office visit copays, based on the physician’s tier level and whether the physician is a primary care physician or a specialty care physician. **(Please note you are not required to choose a primary care physician.)** You will pay lower office visit copays when you use physicians assigned to Tier 1 or Tier 2 than with physicians assigned to Tier 3.

Based on our evaluation of the quality and efficiency measures, as compared to their peers in the same specialties on these measures, individual physicians are assigned to one of three tiers, as described below. The names of the tiers have been assigned by the Group Insurance Commission (GIC) for use uniformly across all of its participating health plans.

- **Tier 1*** (Excellent) – Tier 1 physicians are those who met or exceeded the quality assessment threshold established for all physicians, and ranked at the highest level of cost-efficiency, as compared to their peers according to our scoring system. Tier 1 is designed to acknowledge the high performance of these physicians in terms of both quality and cost-efficiency measures, as determined by the available data.

- **Tier 2** (Good) – Tier 2 physicians are those who demonstrate good practice patterns. They have met or exceeded the quality assessment threshold established for all physicians, and have met the cost-efficiency threshold established by the Plan, but did not achieve scores as high as Tier 1 physicians.

- **Tier 3* (Standard)** – Tier 3 physicians are those who did not meet the quality threshold established for all physicians, or they did not meet the cost-efficiency threshold established by the Plan, or both.
Physician Tiering From Payor Perspective:

– Cost containment while improving quality of care
– Encourages and rewards providers for improving efficiency and quality
– Rewards members with lower out-of-pocket costs for choosing more efficient physicians
– Members able to choose providers
– Employers reduce costs by offering employees tiered plan options
Physician Tiering From Provider Perspective:

- Insufficient/inadequate claims data for measuring performance
- Lack of transparency in rating methodology
- Inadequate disclosure to consumers on the basis for tiering decisions
- Emphasis on cost rather than quality of care to detriment of provider/patient relationship
Physician Tiering Litigation Risks

– 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, Massachusetts, Texas and a wide-scale investigation has occurred in New York
Recent Litigation: Physician Tiering


New York Attorney General Investigation

− In 2007 New York Attorney General Cuomo announced investigation of physician tiering programs of several major insurers. AG Cuomo identified three 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
New York Attorney General Investigation

- New York investigation settled in November 2007. Under the settlement agreements, the insurers agreed to implement nationwide model standards developed by AG’s office in conjunction with AMA, the Medical Society of New York and other advocacy groups.

- Model standards focus on accuracy of data, transparency of process, oversight by a nationally-recognized standard-setting organization and providing a grievance/appeal process.

- Model standards now industry standard on tiering.
Treatment/Coverage Issues
  - ERISA beneficiaries brought putative class action suits against insurer, challenging denial of benefit claims for treatment of eating disorders under coverage for biologically based mental illnesses (BBMI).
  - Court holds ERISA preempts the New Jersey Parity law claims.

  - Plan members enrolled in both ERISA and non-ERISA plans sued their health plans, alleging the plans improperly classified eating disorders as non-BBMINs and consequently denied or limited coverage.
  - Court holds ERISA preempts the N.J. Parity Act claims because the plan terms directly tracked the statutory language and thus any private cause of action that might be created would be duplicative of ERISA.

  - Putative class action relating to denial of residential treatment coverage for eating disorders.
  - Motions for Summary Judgment filed:
    - Plaintiffs seeks summary judgment on their breach of contract claims.
    - Defendant argues its decision is supported by the administrative record and that ERISA plaintiffs should be dismissed for failing to exhaust administrative remedies.

- Putative class action alleging defendant violated the California Mental Health Parity Act (and thus the Unfair Competition Law (UCL)) and breached individual health plan contracts by “categorically denying coverage for behavioral therapy and speech therapy to plan members with autism spectrum disorders.”

- Court reversed lower court which had dismissed the UCL count of the lawsuit
  - “We conclude . . . there is a reasonable possibility that Arce can establish the requisite community of interest for a class action suit under the UCL, and resolution of the UCL claim would not require the court to make individualized determinations of medical necessity or to decide complex issues of economic policy or other matters over which an administrative agency has exclusive jurisdiction.”

- ERISA beneficiary seeks reimbursement for an autism treatment known as Applied Behavioral Analysis therapy. The Summary Plan Description (SPD) granted the administrator discretion to determine eligibility for benefits under the plan, but the Group Policy was silent on this issue. The SPD stated the Policy would control in the event of a conflict.

- Court applies de novo standard of review to denial, reasoning that a SPD cannot expand the terms of an ERISA Policy and thus the omission of the discretionary provision in the Policy created a material conflict between the two documents. In light of the policy favoring beneficiaries when construing ERISA plans, the conflict required the court to review the plan determination de novo.
Smith v. Blue Cross Blue Shield of Mass., Inc.,

- Plaintiff had a history of significant substance abuse beginning at 12 as well as various mental illnesses (OCD, schizophrenia, etc.). He had been admitted to hospitals and other therapeutic communities, but his parents and doctors felt an inpatient RTC would best treat him.

- The Plan covered BBMIIs such as schizophrenia and substance abuse, but only if “medically necessary” in the discretion of the Plan.

- Defendant denied plaintiff's claim for RTC benefits as not “medically necessary” because there was no indication of an “immediate safety risk” or that the plaintiff was “unstable,” elements in treatment guidelines used by the Plan and the independent reviewer, respectively.

- Court upheld denial, finding that the denial was supported by substantial evidence because three separate physicians had concluded RTC treatment was not medically necessary.
Silent PPOs
Silent PPOs

– Payor negotiates reimbursement discounts with Provider and then sells/rents access to discounts to third-party payor absent an explicit authorization from Provider to do so.

– Silent third-party payor then compensates providers at the contractual discounted rate negotiated by the original payor and provider, even though patient is not a member of the original payor.
Typical Rental Network PPO Scenario

1. Physician submits claim to payer.
2. Payer submits claim to network broker.
3. Network broker runs claim through its database and assigns the lowest payment rate from contractual agreements the physician has with various payers.
4. Physician receives explanation of benefits (EOB) with a payment rate unrelated to the contract with the payer.
Traditional PPO Industry
King & Spalding

The Tangled Web
The Leased PPO Network Industry

Employer A
Employer B
Employer C
Pension Fund

Benefit Services
Third Party Administrator

PPO A
PPO B

Rental Network PPO A
Rental Network PPO B
Rental Network PPO C

Independent Practice Association A
Independent Practice Association B

Repricer
TPAs/PPOs

IPAs
Physician/Groups

Group A
Group B

Physician A
Physician B
Physician C
Physician D
Appropriate Rental Network Agreements

– Not all third-party payors that rent databases of provider discounts from primary payers are silent PPOs.
– Legitimate rental network arrangements exist (e.g. “Network Access Agreements”).
– Legitimate rental network agreements exist when original payor-provider contract explicitly allows payor to rent discounts to third-party payors.
  • Generally require provider notice and additional consideration.
Rental Network Agreements

– Contractual language allowing third-party rental agreements should:
  • contain broad definition of Payor such as: “an individual, organization, firm or governmental entity, or self-insured account that has executed an agreement with [original-payor]”
  • explicitly provide for third-party agreements with other payors
  • describe process for billing and accepting patients of non-contracted payors
Rental Network Agreements

– Contractual language prohibiting third-party rental agreements should:

- prohibit first-party payor from contracting with third-party payors without express consent of network providers
- limit definition of payor to original payor
- state that negotiated discounts not available to any party other than defined payor
- limit negotiated discounts to members presenting identification cards with original payor logo
- require payment rate confidentiality
- prohibit assignments of the provider agreement
NCOIL Model Act

– 2008: The American Medical Association (AMA), American Association of Preferred Provider Organizations (AAPPO) and the National Conference of Insurance Legislators (NCOIL) developed “Rental Network Contract Arrangements Model Act.”

– Model act prohibits payors from assigning PPO network contractual benefits to third parties without providers’ knowledge and consent.

– Attempt at increasing transparency in how providers are compensated by payors.
Requirement of NCOIL Model Act

- Requires all businesses that contract with providers to deliver health care services to register with the state and prohibits those contracting entities from granting access to providers’ contractual discounts unless:
  - (1) the provider network contract specifically states that third-party agreements are allowed; or
  - (2) the third-party accessing the network contract is obligated to comply with all terms, limitations, and conditions of the original network contract.
State Adoption of NCOIL Model Act

– Colorado, Connecticut, Florida, Indiana, and Ohio adopted versions of the NCOIL Model Act
– Arkansas, California, Kentucky, Louisiana, Maryland, Minnesota, North Carolina, Oklahoma, South Carolina, Texas, and Virginia passed laws restricting silent PPOs.

• Minnesota Statute § 62Q.74(2)(a): “No health plan company shall require a health care provider to participate in a network under a category of coverage that differs from the category … of coverage to which the existing contract between the health plan company and the provider applies, without the affirmative consent of the provider…”
HCA Health Services

- HCA Health Services of Ga., Inc. v. Employers Health Ins. Co.,
  240 F.3d 982 (11th Cir. 2001).
  - No provider contract with down-the-chain bill repricer
  - Claim analyzed under ERISA heightened arbitrary and capricious standard: Parkway sued as assignee of benefits; insurer determined to be conflicted fiduciary
  - Parkway has agreed discount with PPO MedView
  - MedView leased network to Health Strategies, Inc.
  - HSI leased right to access discounts to insurer, EHI
  - HSI retained right to percentage of EHI savings
HCA Health Services, cont.

- Insurer’s plan interpretation held by 11th Circuit to be wrong:
- “Even if, as a general matter, EHI could use undisclosed outside agreements not in existence at the time EHI issued its policy to [the member] … the outside agreements in this case (i.e., the series of contracts linking EHI to Parkway) do not entitle EHI to the discounted fee because Parkway does not receive the benefit of the bargain.” 240 F.3d 997.

- Court’s analysis centers on whether the participant benefited as a result of reduced co-pay.
Recent Litigation: Roche v. Travelers


  - Provider Roche sued Travelers for taking PPO discount rate Roche negotiated with First Health PPN.
  - Travelers, a third-party payor with First Health, submitted payment to Roche at First Health PPO discounted rate, unbeknownst to Roche.
  - Roche claims breach of contract, unjust enrichment, and violation of state consumer fraud act.
  - Court dismisses breach of contract claim for Roche’s lack of privity or third party beneficiary status as well as her consumer fraud claim because her pleadings did not properly allege unfair or deceptive practices.
  - Unjust enrichment claim later dismissed in subsequent unpublished order dated March 31, 2009 for failure to allege that Travelers retained a benefit to Roche’s detriment.
  - No appeal filed.
Recent Litigation: Christie Clinic

  
  • Central District of Illinois refused to certify class of physicians working for Christie Clinic and other providers across the nation with respect to their claims of “silent PPO” fraud against a PPO, MultiPlan, and two insurers, Unicare and United Health Care.
  
  • Christie alleged that MultiPlan contracted with 500,000 providers and agreed to accept reduced reimbursement rates in consideration for incentives to increase the number of patients that would seek treatment from the providers.
Christie Clinic, cont.

- Insurers allegedly imposed higher member copayments for treatment provided by Christie.

- Insurers countered that Christie agreed that MultiPlan could add “complimentary network clients” that could bill their members at higher, out-of-network copayment levels.

- District Court denied class certification, finding that Christie Clinic’s claims were not typical of the proposed class, because Christie Clinic’s contract with MultiPlan was different from contracts reached with other providers.
Post-Claims Rescission Issues
What is Post-Claims Underwriting?

  - When an insurer waits until after the insured makes a claim to determine whether the claimant is eligible for insurance according to the risk he presents.

  - When an insurer determines whether an individual meets underwriting criteria after the receipt of a claim and voids coverage or denying the claim based upon that determination.

  - The rescinding, canceling, or limiting of a plan contract 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.
Recent Cases

  
  Insurers are required to investigate every aspect of information available to verify the accuracy of the applicant’s statements on the application to avoid allegations of post-claims underwriting.

  
  State law prohibits a health plan from “rescinding a contract for a material misrepresentation or omission unless the plan can demonstrate:
  
  - The misrepresentation or omission was willful; or
  - The plan made reasonable efforts to ensure the subscriber’s application was accurate and complete during the pre-contract underwriting process.
Recent Cases – Enter Nieto


  - Declined to follow *Ticconi*. Held that an insurer need not attach or endorse an application in order to rescind a policy when “the only reasonable inference from the undisputed facts is that [the plaintiff’s] misrepresentations were the result of both fraud and deceit on her part.”

  - “We conclude that *Hailey* is both legally and factually inapposite and agree with the trial court that the undisputed evidence showed that Blue Shield conducted a reasonable investigation and its rescission was not due to any failure to resolve reasonable questions arising from the application.”
Pending Cases

  - Putative class action alleging violation of unfair competition law, declaratory relief and breach of contract, among other claims.
  - Plaintiff alleges Blue Cross improperly rescinded his coverage.
  - Currently awaiting class certification ruling.

- **Horton v. WellPoint**, No. BC341823 (Cal. Super. Ct.), *motion for class certification filed Nov. 24, 2009*
  - Putative class action alleging improper post-claims rescission.
  - In 2006, the AMA moved to intervene, alleging that when a plan rescinds an individual policy, it also refuses to pay providers after they have provided treatment.
  - Currently awaiting class certification ruling.

- The City of Los Angeles sued Blue Cross and Health Net, alleging the defendants violated the Knox-Keene Act by engaging in post-claims underwriting.
- The suit seeks $1 billion in restitution and penalties.
- Although seeking to enforce the Knox-Keene Act prohibition on post-claims underwriting, the suit also alleged violations of the Unfair Competition Law (UCL) and False Advertising Law (FAL).
- Trial court ruled the City Attorney had standing to bring the suit under the UCL and FAL on behalf of the people, and the defendants appealed.

Court affirms: City is not precluded from pursuing the UCL and FAL claims because those statutes authorize the City to bring such claims provided no other statute provides to the contrary, and there is no provision in the Knox-Keene Act explicitly prohibiting a city attorney from enforcing its provisions (even if indirectly through other statutes).
ERISA PREEMPTION
Employee Retirement Income Security Act

– **General Rule:** ERISA applies to employee benefit plans established or maintained by an employer or by an employee organization or both for the purpose of providing medical, surgical or hospital care or benefits.

– ERISA applies to insured or self-funded employee welfare benefit plans that meet these criteria.

– Certain types of employee benefit plans are not ERISA plans.
Overview: ERISA Preemption

– Why does it matter?

• Since the 1980’s ERISA has been used by HMOs as an effective liability shield against state law claims for wrongful denial of benefits, wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith.


• Benefits determinations under “arbitrary and capricious” standard of review

• No jury trial right

• Restricted remedies

  • No common law money damages or consequential damages
Provider Assignee v. Provider Direct Claims

- It is established that the provider can “stand in the shoes” of a participant or beneficiary.

- A claim for benefits is likely to fall within the scope of ERISA § 502(a)(1)(B), 29 USC § 1132(a)(1)(B).

- Direct (non-assignee) claims that do not involve interpretation of plan terms likely not subject to complete preemption.
Two Types of ERISA Preemption

- **Complete (or Super) Preemption**: A principle of subject matter jurisdiction

- **Defensive (or Express or Conflict) Preemption**: An affirmative defense to certain state law claims
ERISA Preemption Requirements

**Complete Preemption (Davila)**

**Requirements:**

- A relevant ERISA plan
- A plaintiff with standing to sue under ERISA (*see* 29 U.S.C. § 1132) (e.g. a participant)
- A state law complaint seeking relief that could have been obtained under 29 U.S.C. § 502(a)(1)(B)

**Defensive Preemption**

**Requirements:**

- A relevant ERISA plan
- State law claims that “relate to” the ERISA plan (29 U.S.C. § 1144(a))
Recent Litigation: ERISA Preemption

- **Complete Preemption**

- **Scope of Complete Preemption after Davila**
  - *Quality Infusion Care v. Humana Health Plan of Texas*, 2008 WL 3471861 (5th Cir. 2008).

- **Finding Complete and Defensive Preemption after Davila**

- **Standard of Review for Plan Administrator Conflict of Interest**

– Davila made a claim against Aetna under the Texas Health Care Liability Act alleging violation of Aetna’s duty to exercise ordinary care after the HMO denied his coverage for Vioxx medication, allegedly causing a complication requiring hospitalization.

– **Doctrine:** “[A]ny state law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted.” 542 U.S. at 209.
Aetna v. Davila, cont.

– **The Test for Preemption:** An individual’s cause of action is completely preempted if:
  - An individual at some point in time could have brought a claim under ERISA § 502(a)(1)(B) AND
  - There is no other independent legal duty implicated by the defendant’s actions.

– **What does the participant or his assignee get from an ERISA claim for benefits?**
  - recover benefits due; “enforce his rights under the terms of the plan”; “clarify his rights to future benefits under the terms of the plan.” ERISA § 502(a)(1)(B)
  - § 502(a)(3) provides for “appropriate equitable relief.”
Quality Infusion Care v. Humana Health Plan of Texas, 2008 WL 3471861 (5th Cir. 2008).

- Dismissed home pharmacy provider’s state law claim that two ERISA health plans violated the Texas AWP law by refusing to pay for out-of-network services provided to plan participants.

- Relied exclusively on Davila preemption analysis.

- Held that provider’s claims could have been brought as a claim for benefits as participants’ assignee under § 502(a) and were therefore completely preempted because claims “not only involve participants and assignments, [but also] rely on Plan ‘terms and requirements.’”

- Distinguished Kentucky Assn. of Health Plans Inc. v. Miller, 538 U.S. 329 (2003) because that case focused only on defensive preemption under ERISA § 514.

- Participants in employee benefit plan filed a class action against prescription drug plans and a pharmacy benefits manager, claiming unjust enrichment due to the required payment of higher co-payments as a result of the alleged misclassification of a generic drug as a brand name drug.

- Held that the PBM’s cause of action was: (1) defensively preempted under ERISA § 514(a) because resolution “entirely dependent on the language and terms of the Plaintiff’s ERISA plans”; AND (2) completely preempted because plaintiffs’ could have brought action under ERISA § 502(a)(1)(B).

- “Where a state law tort action is “based on alleged improper processing of a claim for benefits [under a covered plan],” that claim absolutely “relates to” the plan.”

– MetLife denied a claim for long-term disability benefits for a Sears employee with a heart condition after initially approving short term benefits.

– Held that insurers that both fund and administer ERISA benefit plans operate under a conflict of interest that reviewing courts must consider in determining whether a plan administrator abused its discretion in denying a benefit claim.

– If facts show an insurer’s history of biased claims administration or there is other evidence that a conflict of interest affected a benefits decision, the existence of a conflict of interest should be weighed as a factor in whether an administrator abused its discretion.
PROVIDER NETWORK EXCLUSION
Suits Regarding Provider Exclusion and Expulsion from PPNs

– Providers historically make four types of claims against MCOs to contest exclusion or expulsion from preferred networks:

• State and federal law antitrust claims
• State law unfair business practice or common law unfair trade practice claims
• Common law due process claims
• State law “any willing provider” or “freedom of choice” claims against MCOs.
Generally No ERISA Preemption of Wrongful Exclusion Claims

– The United States Supreme Court case Kentucky Association of Health Plans v. Miller, 538 U.S. 329 (2003) paved the way for provider wrongful exclusion claims by holding that these types of state law insurance company regulation claims were not preempted by ERISA.

– See also Napoletano v. Cigna, 238 Conn. 216 (1996)
Antitrust and Exclusion from PPNs

– In the 1980’s the American Chiropractic Association successfully pursued antitrust litigation against several medical organizations, proving that this type of claim could be successful if a court was convinced that a market-dominant organization’s act amounted to a complete boycott of a particular type of provider, and if the boycott has no objective relationship to patient care or safety.

• Wilk v. American Medical Association, 895 F.2d 352 (7th Cir. 1990).
Antitrust Claims


  • Health care providers sued insurance companies seeking injunctive and other equitable relief under Oregon’s antitrust statute, Or. Rev. Stat. § 646.725, alleging that the insurance companies conspired to refuse to deal with them, thereby denying access to a market necessary for effective competition.

  • The appeals court affirmed an order of the trial court, which denied the providers’ request for an injunction and other equitable relief.

  • Under federal and state law, the insurance companies’ conduct, although a joint venture, was not illegal per se because there was no adverse effect on market competition.
Recent Litigation: Antitrust Claims

- Little Rock Cardiology Clinic PA v. Baptist Health, No. 08-3158 (8th Cir. Dec. 29, 2009)
  - The Eighth Circuit dismissed claims brought by a cardiology group against an Arkansas hospital claiming that it illegally conspired with health insurers to defeat competition from a specialty hospital affiliated with the group.
  - The court found that the plaintiff clinic failed to properly identify the product and geographic markets at the heart of its antitrust claims. The court determined that those markets were too narrowly defined by the plaintiff clinic and should not have been restricted to include only privately-insured patients in Little Rock.
Common Law Physician Due Process Claims


  • When an MCO or insurer possesses market power so substantial such that the removal of a provider from its PPN would significantly impair the ability of an ordinary, competent physician to practice medicine in a particular geographic area, its removal decision affects an important economic interest of the provider such that the provider has a common law due process right to a fair procedure to contest its removal.

  • Common law due process right is so important it “overrides” fact that the insurer and provider had contracted for a “without cause” termination clause.
Recent Litigation: Physician Due Process

- Palm Medical Group, Inc. v. State Compensation Insurance Fund, Cal., No. S163235 (June 18, 2008).

  • California Supreme Court denied review of case limiting the rights of insurers and MCOs to exclude providers from PPNs.

  • California Court of Appeals reinstated a $1.1 million jury verdict for Palm (after the trial court’s judgment notwithstanding the verdict for SCIF), that accused SCIF of violating the common law due process doctrine by denying admission to its PPN.

  • Court of Appeals held that SCIF “possessed power so substantial over the market” that the exclusion of Palm from its PPN significantly impaired the provider’s ability to practice medicine in the Fresno area. SCIF, therefore, “owed Palm a duty of fair procedure in acting on its application to the PPN.”
Treatment of Potvin Outside of California

- Pannozzo v. Anthem Blue Cross and Blue Shield, 152 Ohio App. 3d 235 (Ohio App. 2003):
  - Appellate Court determined that it would not adopt Potvin as Ohio law without the necessary finding that the insurer’s market power was so great that the removal from a provider from its PPN would spell disastrous economic hardship for the provider.

- Other states’ courts have also used the “market power” gatekeeping rule of Potvin to refuse to find a common law right of due process for terminated providers.
Any Willing Provider (AWP) Claims

- Approximately half of the fifty states including Alabama, Arkansas, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, for example, have enacted laws that restrict PPOs from excluding some or all providers from their networks if the providers are willing and able to participate in the plan under its rules.
- These laws have been challenged on the basis that they are preempted by ERISA, but the U.S. Supreme Court held in Kentucky Assn. of Health Plans Inc. v. Miller, 538 U.S. 329 (2003) that ERISA’s insurance “savings” clause applied to Kentucky’s AWP law because the law regulated insurance by imposing conditions on the right to engage in the business of insurance.
Recent Litigation: AWP Claims

Arkansas Blue Cross and Blue Shield v. Little Rock Cardiology Clinic PA, No. 08-1442 (8th Cir. January 7, 2009).

- The Eighth Circuit held that an injunction that at one time blocked enforcement of the state’s AWP law provided no basis for federal court jurisdiction over an action that Arkansas BCBS brought to block a damages lawsuit filed in state court by providers that BCBS excluded from its networks.

- After the decision in Miller, the district court dissolved an injunction against enforcing the Arkansas law. As a result of the injunction’s dissolution, there was no basis for ancillary federal subject matter jurisdiction over the action and the cardiology clinic should be allowed to pursue damages in state court.
Issues: Any Willing Provider Laws

– Example: Kentucky Rev. Stat. § 304.17A-270
  
  • “A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.”

– Should state “Any Willing Provider” laws apply only to insurers or should they have a broader scope?
  
  • Pharmacy benefit managers
  
  • Third-party administrators
AFFIRMATIVE HEALTH CARE COST RECOVERY LITIGATION AGAINST THIRD PARTIES

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• The Government’s Lead:
  – In the late 1980s and early 1990s, the Government pursued an aggressive campaign to fight fraud in the Defense Contracting Industry.
  
  – Stories of $1,000 toilets and $500 hammers were widespread. The Government responded to public outcry for reform.
THE GOVERNMENT’S “WEAPONS” AGAINST DEFENSE FRAUD

• Criminal Prosecution
  – False Claims Act ("FCA")
  – Racketeer Influenced and Corrupt Organizations Act ("RICO")
  – Fraud
  – Money Laundering

• Civil Fraud Enforcement
  – FCA
  – RICO
  – Fraud

• Debarment and Suspension
• Hundreds of Criminal Convictions and Billions of Dollars in Fines, Penalties, and Civil Damages Awards;

... and ...

• Hundreds of Contractors Suspended or Debarred;
• Hundreds of Corporate Integrity Agreements (“CIAs”);
• Restoration of Government Agency Program Integrity;
• Institution of Compliance Programs
• With its appetite whetted through its successful campaign against Defense contractors, the Government moved next to the health care industry and has achieved similar results.
The Government’s “Weapons” Against Health Care Fraud

- Criminal Prosecution
  - FCA
  - Anti-Kickback Statute
  - RICO
  - Fraud Money Laundering

- Civil Fraud Enforcement
  - FCA
  - Stark
  - RICO
  - Fraud

- Debarment and Suspension
In addition to the enforcement efforts of the Department of Justice ("DoJ") to pursue health care fraud, the Federal Trade Commission ("FTC"), and Attorneys General of the states and territories began to pursue their own.
• The FTC
  – Antitrust Enforcement
  – Antitrust Actions Seeking Injunctive Relief, Including Disgorgement

• State AGs
  – Antitrust Actions
  – False Claim Law Enforcement
  – Fraud and Abuse Enforcement
• Anticompetitive Conduct in the Pharmaceutical, Medical Device, and Laboratory Services Industries:
  – Monopolization/Attempted Monopolization ("reverse payment" agreements and otherwise)
  – Market Allocation
  – Price-Fixing

• Fraud and Abuse
  – Upcoding
  – Unbundling
  – Charges for Services not performed
  – Off-Label Promotion
  – AWP/Marketing the Spread
• Taking the Government’s lead, private entities (payors, plans, managed care organizations) began to wonder:

“Why not us?”
• Anticompetitive Conduct in the pharmaceutical, medical device, and laboratory services industries:
  – Monopolization/Attempted Monopolization (through “reverse payment” agreements and otherwise)
  – Market Allocation/Price-Fixing

• Fraud and Abuse
  – Upcoding, Unbundling
  – Charges for Services not performed
  – Off-Label Promotion
  – AWP/Marketing the Spread
  – Consumer Fraud/Unfair Business Practices
WHAT LEGAL “WEAPONS” DO PRIVATE PAYORS HAVE?

- Federal Antitrust Laws (for direct purchasers)
- State Antitrust Laws (for indirect purchasers)
- State Product Liability, Consumer Fraud, Unfair Business Practices Statutes
- State Fraud and Abuse Laws
- RICO
- Common Law (e.g., Unjust Enrichment)
- Medicaid/Medicare Provisions (e.g., 42 U.S.C. § 1395y(b)(3)(A))*
Blue Cross of California, et al. v. SmithKline Beecham Clinical Laboratories, Inc., et al., Case No. 97-cv-01795 (D. Conn.)

- Early case brought on behalf of 37 third-party payors (“TPPs”).
- **Alleged**: Upcoding, Unbundling, Charges For Services Not Rendered through:
  - RICO
  - ERISA
  - Pennsylvania Insurance Fraud Statute
  - Common Law (Fraud and Unjust Enrichment)
- **Result**: Settlement (Confidential).
In re: Lorazepam & Clorazepate Antitrust Litig., MDL No. 1290; Misc. No. 99-ms-00276 (D.D.C.)

- Representation of 19 TPPs (an FTC action, class action and opt-out case).
- **Alleged:** Mylan engaged in anticompetitive conduct by entering into exclusive supplier contracts for the raw materials for two drugs – Lorazepam and Clorazepate – and then raised its prices between 1,500% and 3,200%.
- **Result:** Class Settlement for TPPs of approximately $35 million. Settlement provided for pennies on the dollar and client group objected. 13 TPP clients accepted the settlement. HCSC (then BCBSIL, BCBSTX, and BCBSNM) as well as BCBSMA, BCBSMN, and Federated Mutual Insurance Co. opted-out and litigated.
Health Care Service Corp., et al. v. Mylan Laboratories, Inc., et al., Case No. 02-cv-01299 (D.D.C.)

- Representation of HCSC (BCBSIL, BCBSTX, and BCBSNM).
- **Result:** Fully litigated and tried to verdict on behalf of HCSC on all claims and for all damages alleged. Judgment ultimately entered in favor of opt-out plaintiffs in the amount of approximately $80 million, exclusive of pre-judgment interest and attorneys’ fees and costs. **Roughly double nationwide class settlement.** (Appeal pending).
- To Date **ONLY** indirect purchaser antitrust case on behalf of TPPs fully litigated/ tried to verdict.
In re: Cardizem CD Antitrust Litigation, MDL No. 1278 (E.D. Mich.)

- Representation of 7 TPPs. (class action).
- Brought in federal court in the Eastern District of Michigan.
- **Alleged**: Unlawful patent settlement agreement ("reverse payment settlement") designed to suppress generic competition.
- **Result**: Class settlements of **$100 million** with direct purchasers and **$80 million** with TPPs and state A.G.s. Several Blues plans litigated on their own.

- Representation of 4 TPPs.
- **Alleged**: Unlawful patent settlement agreement to designed to suppress generic competition (antitrust and unjust enrichment).
- **Result**: Aggressively litigated to multi-million dollar settlement well in excess of potential class settlement recovery.
In re: Synthroid® Marketing Litig., Case No. 1:97-cv-06017 (EEB) (N.D. Ill.)

- Early Case involving representation of 18 TPPs.
- **Alleged:** Knoll wrongfully suppressed study determining a number of less expensive thyroid hormone products were bioequivalent to Synthroid®, and could therefore be substituted at substantial cost savings. Knoll denied the author’s permission to publish the study. Did not allege that Synthroid® was unsafe or ineffective in treating thyroid disorders.
- **Result:** Class Settlement of approximately $87 million. Three Blues (BCBSMA, BCBSMI, BCBSMN) opted-out and separately settled their individual claims.

- Consolidated class action filed in federal court for the District of Massachusetts against 23 pharmaceutical companies.
- **Alleged:** Pharmaceutical companies inflated prices of physician administered drugs using Average Wholesale Price ("AWP").
- **Result:**

- Class action lawsuit against Pfizer on behalf of individual consumers and TPPs.
- **Alleged:** Fraudulent marketing and sale of Bextra®.
- **Result:** $2.3 Billion Settlement.
In re: Vioxx Marketing Fraud Litigation, Case Nos. L-4354-08, L-4355-08, L-4356 (619-TPP) (N.J. Sup. Ct. - Atlantic County Division).

- Representation of numerous TPPs.
- Brought in state court in New Jersey under the New Jersey Consumer Fraud Statute and other state statutory and common law provisions.
- **Alleged:** Fraudulent marketing and sale of Vioxx®, which led to great sales/utilization of Vioxx® when other safer, equally or more efficacious, and cheaper alternatives were available.
- **Result:** $85 million settlement of marketing fraud claims. In addition, multi-million subrogation effort underway in $4.85 billion personal injury settlement MDL in federal court in Louisiana.
In re: Zyprexa Product Liability Litigation, MDL 1596 (E.D.N.Y.)

- Class action lawsuit filed on behalf of TPPs in federal court in the Eastern District of New York.
- **Allegations**: Civil RICO and state consumer fraud, unfair trade practices and common laws claims related to off-label marketing of Zyprexa®.
- **Result**: Class of TPP certified as to Civil RICO claims, but not others. Pending.
HISTORICAL AND EMERGING DEFENSES

- **Antitrust**
  - Standing (Illinois Brick)
  - Standing (Subrogation v. Direct Recovery)
  - Damages (Down-Stream or Pass-On)
- **Consumer Fraud/Unfair Trade Practices**
  - Standing/Pre-Emption
  - Standing (Subrogation v. Direct Recovery)
  - Rule 9(b) (for fraud actions)
- **Miscellaneous**
  - Rule 12(b)
  - ASO/Self-Funded Issue
Five Approaches:

1. Do Nothing
2. “Business” Resolution
3. Monitor Ongoing/Class Litigation
4. File Suit
5. Participate In Ongoing/Class Litigation Using “Hybrid” Approach