Managed Care Litigation: Latest Developments
Litigating Issues Involving Healthcare Reform, Payment Practices, Most Favored Nations Clauses and More

TUESDAY, FEBRUARY 7, 2012
1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today’s faculty features:
James W Boswell, III, Partner, King & Spalding, Atlanta
Jesica M. Eames, King & Spalding, Atlanta

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Managed Care Litigation: Latest Developments

James W. Boswell
jboswell@kslaw.com

Jesica M. Eames
jeames@kslaw.com
Overview

• PPACA Litigation Topics
  – Constitutional Challenges to Healthcare Reform
  – Areas for Potential PPACA Litigation

• Managed Care Litigation Update
  – Most Favored Nations Clauses
  – ERISA Recoupment Class Actions
  – “Usual, Customary, and Reasonable” Reimbursement
  – Open Access Plans
  – ERISA Update

• Q & A
CONSTITUTIONAL CHALLENGES TO HEALTHCARE REFORM
High-Profile Constitutional Challenges To PPACA


• **Supreme Court Grants Certiorari: November 14, 2011 (Florida)**

• **3 days Oral Argument: March 26-28, 2012**

• **Decision Expected: June 2012**
Claims at Issue

1. Whether Anti-Injunction Act -- prohibiting *pre*-enforcement challenges to any “tax” -- bars the challenges.

2. Whether Minimum Coverage Requirement is permissible under Commerce Clause.
   - U.S. Constitution, Article 1, Section 8: “Congress shall have Power To . . . regulate Commerce . . . among the several states . . .”

3. If the Minimum Coverage Requirement is unconstitutional, is it severable from the remainder of PPACA?

4. Whether PPACA’s expansion of Medicaid is unconstitutionally coercive (Florida Action Only).
   - PPACA expands Medicaid eligibility to those under 65 with income at or below 133% of federal poverty line.
   - Project increase of 16 million Medicaid beneficiaries by 2016.
## Commerce Clause

<table>
<thead>
<tr>
<th>States</th>
<th>Federal Government</th>
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</thead>
<tbody>
<tr>
<td>Congress can only regulate commercial “activity.”</td>
<td>Congress can regulate individual behavior that impacts commerce among the states.</td>
</tr>
<tr>
<td>Government does not have authority to force people to purchase a commercial product, like health insurance, that they may not want or need.</td>
<td>This is not any commercial product. This is different. Everyone will need health care at some point -- no one can opt-out of health care market.</td>
</tr>
<tr>
<td>When an person declines to purchase health insurance, that is a decision <strong>not</strong> to engage in commerce. It is “inactivity” and cannot be regulated.</td>
<td>Decision to forego health coverage now is economic decision to pay for health care services later -- the individual decision collectively impacts interstate health care market.</td>
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Medicaid Expansion

<table>
<thead>
<tr>
<th>States</th>
<th>Federal Government</th>
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</thead>
<tbody>
<tr>
<td>Medicaid Expansion unconstitutionally coercive</td>
<td>Congress can specify conditions on spending federal money</td>
</tr>
<tr>
<td>States Left With No Real Choice:</td>
<td>Amendments will cause no financial harm</td>
</tr>
<tr>
<td>Accept the expansion and crush strained state budgets; or</td>
<td>Increase in State’s Medicaid spending offset through other federal spending &amp; reduction in the uninsured</td>
</tr>
<tr>
<td>Withdraw from Medicaid, lose millions in federal funding and leave poorest residents without adequate care</td>
<td>State Participation Voluntary</td>
</tr>
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</table>
The Michigan Action

Plaintiffs

• Thomas More Law Center - Non-profit public interest law firm.
• Four Individuals

Lower Court Ruling

• United States District Court for Eastern District of Michigan:
  – Individual Mandate Constitutional
Mandate Constitutional (2-1)

- **Mandate = Proper Regulation of Commercial Activity**
  - “Call this mandate what you will -- an affront to individual autonomy or an imperative to national health care -- it meets the requirement of regulating activities that substantially affect interstate commerce.”
  - Self-insuring is activity that substantially impacts commerce by driving up health care expenses and shifting costs to third parties.

- **Action v. Inaction (To Buy or Not To Buy)**
  “Each requires affirmative choices; one is no less active than the other; and both affect commerce.”

- **Power Limited: Forcing Citizens to Purchase A Product**
  “Regulating how citizens pay for what they already receive (health care), never quite know when they will need, and in the case of severe illness and emergencies generally will not be able to afford, has few (if any) parallels in modern life.”
The Florida Action

Plaintiffs

• 26 States, Private Individuals, and National Federation of Independent Business

Lower Court Ruling

• United States District Court for Northern District of Florida
  – Individual Mandate Unconstitutional
  – Medicaid Expansion Constitutional
  – Mandate Not severable - Declared Entire Act Invalid
• People Cannot Be Forced Into Commercial Contracts
  – “[C]annot mandate that individuals enter into contracts with private insurance companies for the purchase of an expensive product from the time they are born until the time they die.”

• Individual Mandate “Breathtaking In Its Expansive Scope”
  – “Unprecedented”
  – “Lacks Cognizable Limits”
  – “Imperils Our Federalist Structure” of Limited Powers

• Power Under Commerce Clause Would Be Limitless
  – “[W]e are unable to conceive of any product whose purchase Congress could not mandate” under Government’s theory.
  – Uniqueness of health care and health insurance markets not enough to save the mandate.

• Mandate Can Be Severed From Rest of Act
Medicaid Expansion Constitutional (3-0)

- Expansion is proper exercise of Congress’s Spending Power
  - Congress reserved the right with States to change Medicaid
  - Federal Government will bear nearly all costs associated with the Medicaid Expansion
  - States given plenty of notice -- time to make other plans should they elect to withdraw from Medicaid
  - States have power to tax and raise revenue to create and fund different program.
The Virginia Actions


- Individual Mandate Unconstitutional
- The Commerce Clause cannot “compel an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market.”


- Individual Mandate Constitutional
- A decision to forego purchasing health insurance is economic activity. Such decisions, in the aggregate, has “a substantial impact on the national market for health care” and can be regulated.
4th Circuit Dismisses

- 4th Circuit Did Not Reach The Constitutional Questions
- Dismissed Both Actions on Procedural Grounds
  - *Commonwealth of Virginia v. Sebelius* (3-0)
    - State of Virginia did not have “standing” to file the lawsuit.
    - “[T]he sole provision challenged - the individual mandate - imposes no obligation on the sole plaintiff, Virginia.”
  - *Liberty Univ. Inc. v. Geithner* (2-1)
    - Challenge to the individual mandate premature
    - Barred by the Anti-Injunction Act, which prohibits *pre*-enforcement challenge to any “tax,” which court said encompasses the “penalty” in the individual mandate.
Supreme Court Grants *Certiorari*
To Review 11th Circuit Decision
3 Days of Oral Argument - March 2012
Court to Consider 4 Issues

• (1) Applicability of Anti-Injunction Act (1 hour argument)
  – DOJ & States contend AIA does not apply
  – Sct appoints *amicus curiae* to brief and argue in favor of applicability

• (2) Constitutionality of Individual Mandate (2 hours)

• (3) Severability of Individual Mandate from rest of PPACA (1.5 hours)

• (4) Constitutionality of Medicaid Expansion (1 hour)
Areas of Potential PPACA Litigation
PPACA Effects on Managed Care Litigation

- Claims Appeals
  - Including rescission
- Medical Loss Ratio
- Provider Non-Discrimination
- Out of Network Emergency Services
PPACA Effects on Managed Care Litigation: Claims Appeals

• What Existed Before PPACA
  – ERISA Claims Procedure Regulation
  – Applied to Group Health Plans
  – Contains such terms as:
    • No more than 2 internal appeals required
    • How plans must notify claimants of adverse benefit determinations (e.g., 72 hours after receipt for urgent care claims)
    • Requirements for the contents of EOBs (e.g., must disclose the specific plan provisions on which determination is based)
PPACA Effects on Managed Care Litigation: Claims Appeals

• How PPACA Changed Claims Appeal Rules
  – New 2719 of the Public Health Service Act (effective policy years beginning on or after 9/23/2010 - does not apply to grandfathered plans)
  – DOL Claims Procedure Regulation greatly expanded; not just ERISA plans, but also:
    • to health insurance issuers offering group health insurance coverage
    • issuers involving individual health insurance coverage
PPACA Effects on Managed Care Litigation: Claims Appeals

• EXPANSION of ERISA Claims Procedure Regulation
  – Broader definition of “adverse benefit determination”
  – Includes the same elements from ERISA Claims Procedure Regulation (denial of benefit because it is determined to be experimental or not medically necessary, for example) but also more
PPACA Effects on Managed Care Litigation: Claims Appeals

- EXPANSION of ERISA Claims Procedure Regulation
  - Also includes, however, “any rescission of coverage . . . whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.”
  - Turns what was largely a clinical process into a quasi-legal investigation into whether “fraud” or “an intentional misrepresentation of material fact” occurred
  - PPACA changes the substantive standards for an insurer/health plan to void or rescind coverage: only permitted in the case of “an act, practice or omission that constitutes fraud, or an intentional misrepresentation of material fact”
PPACA Effects on Managed Care Litigation: Claims Appeals

• External Review Broadly Available Following PPACA
  – After PPACA, group health plans and health insurance issuers must comply with state or federal external review standards
  – Departments of Treasury, Labor and HHS jointly promulgated Interim Final Regulations 7/23/2010; amendment and further request for comments published 6/24/2011
  – Health insurance issuers must comply with state external review requirements so long as those State processes contain minimum requirements (selected from the NAIC Uniform Model Act)
PPACA Effects on Managed Care Litigation: Claims Appeals

- External Review (cont’d)
  - If the state external review process does not meet the minimum requirements, or if the plan is not subject to state regulation (i.e., it is an ERISA plan), then the plan is subject to the federal external review process
PPACA Effects on Managed Care Litigation: Claims Appeals

• How the Claims Interim Final Regulation Is Enforced
• “Deemed Exhaustion”: If the plan or health insurance issuer “fails to strictly adhere” to the DOL-mandated internal claims and appeals process, the claimant:
  – Is deemed to have exhausted the internal claims and appeals process
  – May initiate external review immediately OR may proceed directly to federal court to bring an ERISA claim for benefits (or equivalent state action)
  – Under section 502(a) of ERISA, a civil action may be brought by a participant to recover benefits due under the plan
PPACA Effects on Managed Care Litigation: Claims Appeals

• “Deemed Exhaustion” Further Changed by Amendment on 6/24/2011
• Originally - plan must “strictly adhere” to all regulatory requirements for claims appeals and processes; otherwise those processes “deemed exhausted”; substantial compliance irrelevant
PPACA Effects on Managed Care Litigation: Claims Appeals

• “Deemed Exhaustion” Further Changed by Amendment on 6/24/2011
• Now, an exception for “minor” errors in process
• Opens the door for more litigation over whether errors in process were de minimis, non-prejudicial, for good cause or beyond the plan’s control and while plan/issuer and claimant were engaged in a “good faith exchange of information”
PPACA Effects on Managed Care Litigation: Claims Appeals

• More member litigation or less?
  – Initially, perhaps more
    • Strict compliance may push more claims out of internal claims and appeals and straight into court
    • Significant potential for litigation over exhaustion
  – Over time, perhaps less
    • As insurers and plans perfect their procedures, how likely that individual claims will proceed beyond external review and into court?
    • Plowing rescission claims into internal claims appeals and external review likely to reduce the incidence of rescission litigation, including class actions
PPACA Effects on Managed Care Litigation: Medical Loss Ratio

- 2718 of the PHSA requires (beginning June 1, 2011) that a certain percentage of money collected by insurance companies be spent on healthcare services and quality improvement, and not administrative costs.
- MLRs must be publicly reported each plan year.
- Minimum MLR for large group market: 85%.
- Minimum MLR for individual/small group market: 80%.
- States are free to adopt higher MLRs.
- HHS Secretary can adjust the minimum MLR for individual market to prevent destabilization.
PPACA Effects on Managed Care Litigation: Medical Loss Ratio

Rebates

• Health insurance issuers that fail to meet the minimum MLR standard are required to provide rebates to enrollees proportional to the premium paid (and also must report to HHS that rebates were provided)

• For group health plans, issuers must pay rebates to the group policyholder, but the benefit of the rebate must be passed on to the enrollees. There are separate criteria for how the rebate benefits are to be passed on to enrollees, depending on the type of group health plan.

• First set of rebates due August 1, 2012
PPACA Effects on Managed Care Litigation: Medical Loss Ratio

- HHS will enforce the reporting and rebating requirements (30 days advance notice of audits)
- Failing to comply with the rebate requirements could lead to civil penalties up to $100 per day per individual affected
PPACA Effects on Managed Care Litigation: Medical Loss Ratio

Litigation Risks

• Potential (class action) lawsuits
  – alleging that the MLR was calculated incorrectly
  – or that the plan or issuer issued incorrect rebate amounts

• Potential qui tam/False Claims Act cases
  – alleging that the plan or issuer reclassified costs as medical treatment instead of overhead/admin costs
  – or disputes over what constitutes admin costs
    • for instance, broker commissions are admin costs
SEC. 2706 NON-DISCRIMINATION IN HEALTHCARE

(a) PROVIDERS. — A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate 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. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.
PPACA Effects on Managed Care Litigation: Prohibition on Discrimination Against Providers

What’s Not Required

- Plans and issuers are not required to permit participation to every provider willing to accept plan terms
- Coverage of a service is not required if the service is not covered regardless of who provides the service
- Varying reimbursement rates based on quality or performance measures are NOT prohibited
PPACA Effects on Managed Care Litigation: Out of Network Emergency Care

• If a group health plan or health insurance issuer offering group or individual health insurance provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency (ER) services consistent with the following rules:
  – must provide coverage without the need for any prior authorization determination, even if the ER services are provided on an out-of-network basis
  – must provide coverage without regard to whether the health care provider furnishing the ER services is a participating network provider with respect to the services
  – if the ER services are provided out of network, must not impose any administrative requirement/limitation on coverage that is more restrictive than the requirements/limitations applicable to ER services received from in-network providers
PPACA Effects on Managed Care Litigation: Out of Network Emergency Care

• If the ER services are provided out of network, must comply with cost-sharing requirements
  – cost-sharing requirements expressed as a copayment amount or coinsurance rate imposed for out of network ER services cannot exceed the cost-sharing requirements that would be imposed if the services were provided in network.
  – however, out of network providers may balance bill patients for the difference between the providers’ charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount
PPACA Effects on Managed Care Litigation: Out of Network Emergency Care

- A “reasonable amount” must be paid before a patient becomes responsible for a balance billing amount. HHS says that a group health plan or health insurance issuer complies with that requirement if it provides benefits with respect to an ER service in an amount equal to the greatest of the 3 amounts below:
  - 1. the amount negotiated with in-network providers for the ER service furnished (if more than one amount negotiated, use the median)
  - 2. the amount for the ER service calculated using the same method the plan generally uses to determine payments for out of network services (such as UCR) but substituting the in-network cost-sharing provisions for the out of network cost-sharing provisions
  - 3. the amount that would be paid under Medicare for the ER service
PPACA Effects on Managed Care Litigation: Out of Network Emergency Care

• Other cost-sharing requirements
  – Anything other than a copayment or coinsurance requirement (such as a deductible or out of pocket maximum) may be imposed with respect to ER services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits
  – A deductible may be imposed with respect to out-of-network ER services only as part of a deductible that generally applies to out-of-network benefits
  – If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network ER services
PPACA Effects on Managed Care Litigation: Out of Network Emergency Care

**PPACA Example**

- **Facts:** a group health plan imposes a $60 copayment on ER services without preauthorization, whether provided in or out of network. If ER services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition.

- **Conclusion:** by requiring an individual to pay more for ER services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover ER services without the need for any prior authorization determination.
PPACA Effects on Managed Care Litigation: Out of Network Emergency Care

PPACA Example

- Facts: a group health plan covers individuals who receive ER services with respect to an emergency medical condition from an out-of-network provider. The plan has agreements with in-network providers with respect to a certain ER service. Each provider has agreed to provide the service for a certain amount: 1 has agreed to accept $85, 2 have agreed to accept $100, 2 have agreed to accept $110, 3 have agreed to accept $120, and 1 has agreed to accept $150. Under the agreement, the plan agrees to pay the providers 80% of the agreed amount, with the individual receiving the service responsible for the remaining 20%.

- Conclusion: the median amount among those agreed to for the ER service is $110. Thus, the amount is 80% of $110 = $88.
Managed Care
Litigation Update
Most Favored Nation Clause
Litigation and DOJ Investigation
DOJ, Michigan Lawsuit Against Blue Cross Blue Shield of Michigan is Proceeding

- August 12, 2011 E.D. Mich. issues opinion denying motion to dismiss
- DOJ and State AGs are investigating other Blues plans’ use of MFN clauses
What is the DOJ lawsuit against BCBSMI about?

- BCBSMI alleged to have over 60% of commercially insured business
- Largest non-governmental purchaser
- MFN agreements with 70 of Michigan’s 131 general acute care hospitals [40% of beds]
- 2 types
  - MFN-plus
  - Equal-to MFNs
What is the root concern?

• The Michigan situation
  – The MFN-plus clauses require hospitals to charge other commercial health plans more - up to 40%
  – Raises competitors’ costs, increases premiums, directly increases costs to self-insured employers
MFN Litigation and Enforcement: What other activity is underway?

- Combination of DOJ and State AGs: CID to Blue Cross plans in Missouri, Ohio, Kansas, West Virginia, North Carolina, South Carolina, D.C.
- In Michigan:
  - At least 3 private lawsuits in federal court against Blue Cross Blue Shield of Michigan
  - City of Pontiac lawsuit joins hospitals, including Ascension Health
- In December 2011, Aetna filed a lawsuit for damages against Blue Cross BCBS of Mich. alleging that BCBS of Mich. used MFN language to “strangle its nascent competitor (Aetna)”
- BCBS of Mich. appealed the denial of its motion to dismiss to the 6th Circuit but it is questionable whether the appeal is procedurally proper
ERISA RECOUPEMENT CLASS ACTIONS
ERISA Class Actions: Recoupment of Previously Paid Benefits

Overview

• Providers and provider associations pursuing nationwide class actions against certain health insurers and plans, alleging ERISA and RICO violations based on recoupment of previously paid benefits.
Overview, continued

• Health plans/insurers reimbursed providers for covered services and then later decided the claims were in error and sought repayment through demand letters.

• If providers refuse to repay, the health plans/insurers allegedly force recoupment by withholding payment on unrelated or future claims.
Three Pending Class Action Suits

- **Pennsylvania Chiropractic Ass’n v. Blue Cross Blue Shield Ass’n, et al., No. 09-c-5619 (N.D. Ill. 2009)**
- **Premier Health Center v. UnitedHealth Group, et al., No. 11-0425 (D.N.J. 2011)**

**Status:**
- **Aetna** and **BCBS**: RICO claims fail on MTD and ERISA claims allowed to proceed.
- Class certification denied in **BCBS**.
- Motions to dismiss pending in **UnitedHealth Group**.
Case Study: Aetna

- Plaintiffs are individual providers and chiropractic professional associations. Aetna’s “Special Investigation Unit” detects potential fraud through use of “Post Payment Audits.” Aetna attempts to recoup previously paid benefits through demand letters to providers.

- Plaintiffs contend recoupment efforts are “adverse benefit determinations” or “retrospective denial of benefits” under ERISA → Aetna must comply with ERISA’s requirements (notice and appeal) in seeking repayment.

- Additionally allege that Aetna’s prepayment review practice is unlawful: Aetna reviews records before paying claims from providers where Aetna has sought recoupment. Contend the practice is a “sham” and/or “pretext” for blanket benefit denial without complying with ERISA procedures.

- Plaintiffs argue that Aetna is a “plan administrator” and violated ERISA by failing to give a full and fair review of denied claims.
Case Study: Aetna

• Aetna’s response:
  – The overpayment letters are not adverse benefit determinations and thus do not trigger ERISA protections.
  – Recoupment letters arise out of Aetna’s independent duties under state statutes and regulations to prevent insurance fraud.
  – Plaintiffs fail to identify any injury to an ERISA beneficiary arising out of the demand letter.
  – ERISA permits prepayment review. Plaintiffs’ challenge to Aetna’s denial of benefits resulting from the prepayment review process is factually unsupported.
  – Plaintiffs did not exhaust administrative remedies - did not appeal prepayment denials prior to litigation.
Aetna Motion to Dismiss Ruling

• On ERISA: “While Aetna has raised questions as to the viability of Plaintiffs’ ERISA claims, the Court concludes that a more complete factual picture regarding Aetna’s “recoupment”/anti-fraud efforts is necessary to ultimately resolve the issue.”

• Plaintiffs failed to state a RICO claim.
BCBS’ Motion to Dismiss

• BCBS argued that BCBS entities were not appropriate ERISA defendants since they are not ERISA plans but “plan administrators.”
  – Court disagreed: BCBS entities had the sole authority to make the decisions that give rise to Plaintiffs’ claims. They are intertwined with the plans themselves and are appropriate ERISA defendants.

• BCBS also argued that Plaintiffs failed to exhaust administrative plan remedies before filing suit.
  – Court disagreed: Plaintiffs’ complaint alleges lack of meaningful access to review procedures, and thus asserts a sufficient basis to excuse the exhaustion requirement.
Other points…

**BCBS - Class Certification Defeated on 12/28/2011**

- **Proposed Provider Class**
  - Court holds too many individualized questions:
    - Different plans conducted dealings with providers & participants in different ways
    - Different plans had different practices regarding whether/how they complied with ERISA’s notice and review requirements
    - Any injunctive relief would differ on a plan-by-plan basis
Update on “Usual, Customary and Reasonable” Reimbursement, Including the Fair Health Database and Ingenix
UCR Database Timeline

- 1973 - Health Insurance Association of America (HIAA) created Prevailing Health Charges System (PHCS) database
- 1998 - HIAA sold PHCS to Ingenix
- 2008 - Andrew Cuomo while NY AG launched investigation directed toward United and Ingenix
- 2009 - NY AG Investigation Settled
  - United/Ingenix agree to shut down PHCS and MDR
  - FAIRHealth created
- 2011 - FAIRHealth released Ingenix replacements
Significant UCR Litigation

• Settled
Pending UCR Litigation

- In re WellPoint, Inc. Out-of-Network “UCR” Rates Litigation, No. MDL 09-2074 (C.D. Cal.)
- Franco v. CIGNA, No. 2:07-cv-06039 (D.N.J.)
- In re Aetna UCR Litigation, No. MDL 2020 (D.N.J.)
- American Medical Ass’n et al. v. CIGNA, No. 1-12-cv-00128 (N.D. Ga.)
Who are plaintiffs in UCR cases and what claims are they alleging?

- **Plaintiffs**
  - Subscribers
  - Providers
  - State medical societies

- **Claims**
  - ERISA - multiple, including claims for benefits and breach of fiduciary duty
  - Sherman Act
  - RICO
Factual basis for the claims

- After HIAA members sold PHCS database to Ingenix, they remain involved in “Ingenix PHCS Advisory Committee”
- Wellpoint, Aetna and CIGNA are participating insurers
- 10-year Cooperation Agreement between HIAA and Ingenix
Factual basis for the claims

- Plaintiffs allege “flawed data”. Allegations:
  - Participating insurers “scrub” their data by removing high-value claims
  - Ingenix removes “high-end” values as statistical outliers
  - Ingenix fails to tabulate data accurately according to geographic area
  - Insurers do not verify the accuracy of the data
Factual basis for the claims

- Plaintiffs reach two conclusions:
  - Insurers violated contractual obligations to pay UCR
  - Insurers knowingly participated in the manipulation of UCR data
## Judicial reception of the claims

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<thead>
<tr>
<th>Date</th>
<th>Decision 1</th>
<th>Decision 2</th>
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<tbody>
<tr>
<td>08/11/2011</td>
<td>C.D. Cal. (Wellpoint)</td>
<td>9/23/2011 D.N.J. (CIGNA)</td>
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### Standing
- Subscribers, Providers, Associations all have standing, except with respect to “ONS Benefit Reductions"
- No provider standing; No association standing; subscribers alone have standing (except one group lacks standing for RICO)

### Antitrust
- Defendant motion denied: Per se and rule of reason Sherman Act claims will go forward
- Defendant motion granted; antitrust claims dismissed
Judicial reception of the claims

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<tr>
<td>RICO</td>
<td>Defendant motion granted but plaintiffs given leave to re-plead [Plaintiffs failed to allege: [1] RICO conduct; [2] A RICO pattern as to UHC; [3] reliance]</td>
<td>Defendant motion granted in part; one group of subscriber plaintiffs can proceed on RICO claim premised on mail and wire fraud</td>
</tr>
<tr>
<td>ERISA - proper defendant</td>
<td>Wellpoint can be sued even though it is insurer and not plan administrator</td>
<td>Same with respect to CIGNA</td>
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# Judicial reception of the claims

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<td>Defendant motion denied; ERISA claim for benefits under 502 (a)(1)(B) will proceed; Providers can proceed via assignments</td>
<td>Defendant motion denied - Using Ingenix to determine UCR fails to comply with plan definition of UCR; granted as to providers</td>
<td></td>
</tr>
<tr>
<td>ERISA - breach of fiduciary duty</td>
<td>Defendant motion denied</td>
<td>Dismissed claims under ERISA 502(a)(3) - non-disclosure of UCR Data</td>
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Status of Wellpoint and Cigna Cases

• Wellpoint: Plaintiffs filed a third consolidated amended complaint on 10/17/11. Defendants filed a motion to dismiss on 12/22/11.

• Cigna: Plaintiffs filed a motion for class certification on 12/19/11. Defendants filed a motion for judgment on the pleadings, which the court granted as to the civil conspiracy claim on 1/24/12.
Status of Aetna Case

- Motions to dismiss and motion and opposition to class certification have been re-filed
- Case transferred in June 2011 from Judge Hochberg to Judge Chesler
- Claims against United and Ingenix by plaintiffs who were members of the AMA class dismissed 9/9/2011
- Case appears to be in active settlement talks
New CIGNA Case

- Filed 1/12/12 by the American Medical Association, multiple state medical societies, and 1 physician and 1 non-physician provider, in Northern District of GA
- Complaint alleges violations of various ERISA provisions
- Similar to other UCR cases - CIGNA allegedly contracted with Ingenix to provide out of network services data claims & uniform pricing schedules that are used to calculate reimbursements at artificially low rates that are presented as UCR
- CIGNA allegedly failed to disclose critical facts about Ingenix & its methodology that CIGNA used to make reimbursement decisions
- Alleged problems with Ingenix: inadequate data points; flawed “geo-zips”; data “scrubbing”; flawed methodology
Conclusions from UCR Litigation

• Compare to Managed Care MDL
  – RICO claim against payors no longer shocking
  – Here the MDLs are single payor
  – Some of the same plaintiff lawyers and medical societies
  – What will next issue be?
• What a difference the judge makes
OPEN ACCESS PLANS
PPO
Higher Provider Reimbursement

Higher Premiums
OON Benefits

Higher Out of Pocket
No PCP Gatekeeper

HMO
Lower Provider Reimbursement

Lower Premiums
No OON Benefits

Lower Out of Pocket
PCP Gatekeeper

REIMBURSEMENT?

OPEN ACCESS

May have larger provider panel

OON Benefits
Gatekeeper not required

Premiums =

Higher HMO
Lower PPO
Plan Changes January 1, 2010

- The PPO options going forward will be referred to as the Open Access Plans (OAP).

- Benefits are the same as under a PPO and provide in-network and out-of-network benefits.
Provider Impact?

• Payors Tie Open Access Plans To HMO/POS Rates

• When Managed Care Agreement Has 2 Fee Schedules, Payors Link Open Access Plans To What Are Traditionally Considered HMO Schedules
<table>
<thead>
<tr>
<th>Description of Plans</th>
<th>Plan Provisions and Benefits Georgia In-Network</th>
<th>Plan Provisions and Benefits Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Lifetime Benefits</td>
<td>- Major medical coverage, including diagnosis and/or treatment of illness, injury or medical conditions. Benefits include physician, hospital, surgical, ConditionCare, pharmacy benefit management, behavioral health (mental health/substance abuse), and transplant services. Members who elect to use the services of out-of-network doctors and hospitals will receive a lower level of benefit coverage and are subject to balance billing.</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Maximum Annual Deductible</td>
<td>Individual $300</td>
<td>$400</td>
</tr>
<tr>
<td></td>
<td>Family (3 or more covered members) $900</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

Members who use both BlueCard National Network providers and out-of-network providers will be responsible for two separate deductibles and for two separate maximum out-of-pocket limits (stop loss). Annual deductibles, annual maximum out-of-pocket limits (stop loss), and annual visit limitations, will be based on a January 1 - December 31 plan year.

| Maximum Annual Out-of-Pocket Limit (Stop Loss) | Individual $1,000 | $2,000 |
| | Family (3 or more covered members) $2,000 | $4,000 |

Member copayments for physician office visits, for emergency room services, and/or for prescription drugs do not apply toward the annual deductible(s) or toward the maximum annual out-of-pocket (stop loss) limit(s). Member costs incurred for balance billing will not apply toward the annual deductible(s) or toward the maximum annual out-of-pocket (stop loss) limit(s).

| Pre-Existing Conditions | None |

### Physician Services Provided in An Office Setting

#### Physician Office Visit
For treatment of illness or injury
100% of network rate after $20 copayment per visit; applies to non-surgical services; not subject to deductible. The $20 copayment applies to the physician's office visit only.
60% of network rate for non-surgical services; subject to deductible and balance billing.

#### Wellness Care/Preventive Healthcare
No limit; paid at 100% of network rate; not subject to deductible; no copayment for office visit.
Not covered; Non-covered charges do not apply to annual deductible or annual out-of-pocket maximum.

#### Behavioral Health/Substance Abuse Services
90% of network rate; subject to deductible.
60% of network rate; subject to deductible and balance billing.

#### Laboratory Services
90% of network rate; subject to deductible.
60% of network rate; subject to deductible and balance billing.

#### Maternity Care
(Routine prenatal care, delivery and postnatal)
90% of network rate after an initial visit copayment of $20; not subject to deductible. There will be no copayments charged for subsequent visits.
60% of network rate; subject to deductible and balance billing.

#### Outpatient Surgery
Pre-certification may be required.
90% of network rate; subject to deductible.
60% of network rate; subject to deductible and balance billing.

#### Second Surgical Opinion
(Elective Surgery)
100% of network rate after a $20 copayment per visit; not subject to deductible.
60% of network rate; subject to deductible and balance billing.

#### Allergy Testing
90% of network rate; subject to deductible
60% of network rate; subject to deductible and balance billing.

#### Allergy Shots & Serum
100% for allergy shots & serum; not subject to deductible. If a physician is seen, the visit is treated as an office visit and is subject to a $20 copayment per visit.
60% of network rate; subject to deductible and balance billing.
How to locate Georgia Providers for PPO

1. Go to
2. Click on “Find a Doctor.”
3. Click on “Locate Georgia Providers.”
4. Select Preferred Provider Organization (PPO).”

You will then be linked to the ProviderFinder. Follow prompts to locate a provider.

Under “Plan Information,” select Preferred Provider Organization (PPO)” again.

How to locate Georgia Providers for PPO Alternative Network

1. Go to
2. Click on “Find a Doctor.”
3. Click on “Locate Georgia Providers.”
4. Select Access HMO & Open Access POS.”

You will then be linked to the ProviderFinder. Follow prompts to locate a provider

Under Plan Information select Open Access POS”
Key ERISA Decisions
Cyr v. Reliance Standard Life Insurance (9th Cir.) (en banc)

- June 2011 - Court decides that proper defendants in an ERISA 502(a)(1)(B) claim for benefits not limited to the plan and plan administrator
- Court notes that “the plan administrator can be an entity that has no authority to resolve benefit claims or any responsibility to pay them. In this case, for example, CTI [the employer] was identified as the plan administrator, but it had nothing to do with denying Cyr’s [the plaintiff’s] claim for increased benefits.”
- Held, the insurer is therefore a logical defendant in an action to enforce plan rights under ERISA 502(a)(1)(B)
- Will affect insurers who are not named fiduciaries but who contract with ERISA plans
CIGNA v. Amara (U.S. May 2011)

• Question: Was it appropriate for a district court to reform an ERISA plan to conform to statements made in a SPD?
• 8-0 decision: No
• Majority opinion, authored by Breyer, makes interesting law on the proper interpretation of the “appropriate equitable relief” language in 502
CIGNA v. Amara

• Facts
  – CIGNA pension plan transitioned from a defined-benefit plan to cash balance plan based on defined annual contribution from CIGNA
  – Plaintiffs sued on behalf of putative class alleging that the SPD misinformed them
  – The district court had reformed the plan, holding that the class members were “likely harmed” by the SPD disclosure
  – The district court based its ruling on the civil enforcement provision of ERISA contained in 502(a)(1)(B)
CIGNA v. Amara

• Holding
  – 502(a)(1)(B) did not permit the court to change the plan terms [Court said: “the summary documents, important as they are, provide communications with beneficiaries about the plan, but . . . their statements do not themselves constitute the terms of the plan”]
  – Remanded so that the lower courts could determine whether 502(a)(3) [providing for a civil action by a participant or beneficiary to obtain “other appropriate equitable relief” might provide a remedy]
  – Other statements about the potential remedy
    • a money remedy “requir[ing] the plan administrator to pay to already retired beneficiaries money owed them under the plan” would still be “equitable”
    • In a court of equity, “there is no general principle that ‘detrimental reliance’ must be proved before a remedy is decreed”
CIGNA v. Amara: implications

• Case decided in pension context
• Statements about how SPDs and plan language interrelate - obvious implications in welfare benefit plan context
• Concern on the part of some Justices about the limitation of remedies in court’s jurisprudence under 502(a)(1)(B)
• Is emphasis on 502(a)(3), trust law and equity a way to make inroads on the ERISA protections employers and health plans enjoy?
Thanks.

• James W. Boswell
  jboswell@kslaw.com

• Jesica M. Eames
  jeames@kslaw.com