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I. Noteworthy Judicial Trends

A. Decline in “Shock” Managed Care Verdicts in Non-ERISA Bodily Injury Cases

Fortunately for the managed care industry and its insurers, there have been no new reported “shock verdicts” against managed care organizations in the last several years, and the previous shock managed care verdicts (i.e., the \$80 million verdict in Chipps v. Humana; the \$120 million verdict in Goodrich v. Aetna; and the \$89 million verdict in Fox v. HealthNet) have either been reduced or settled for considerably less money on appeal. We attribute this favorable development largely to the fact that managed care organization defendants have discontinued utilizing many controversial managed care methodologies, implemented external appeals and other risk management techniques, and stepped up their efforts to settle potentially dangerous managed care cases prior to trial. Nevertheless, *the risk of run-away managed care verdicts still exists in the expanding pool of cases not governed by the Employee Retirement Income Security Act (ERISA).*¹

B. Does *Dardinger* Signal A Judicial Trend Towards Sustaining Catastrophic Punitive Damages Awards?

The Ohio Supreme Court’s recent decision in Dardinger v. Anthem, 2002 WL 31895279 (Ohio) demonstrates that appellate courts are not always willing to reverse or substantially reduce punitive damage awards in utilization review cases. While that court did reduce the punitive damages award from \$49 to \$30 million, the reduced verdict is still deliberately substantial as evidenced by the court’s scathing opinion. Moreover, the court, on its own motion and in the absence of express statutory authorization, reallocated two thirds of the reduced punitive damages award to the state medical facility which had treated the plaintiff. *Dardinger may signal a judicial trend towards sustaining catastrophic punitive damages awards and reallocating a portion of those awards to the public good.*

¹ ERISA governs most private employer sponsored health insurance and does *not* currently permit jury trials or awards of extra-contractual damages to ERISA plan participants who allege wrongful denial of health insurance benefits.

C. The *State Farm* Decision and Its Impact on Managed Care Cases

While the United States Supreme Court's April 7, 2003 decision in State Farm Mutual Automobile Ins. Co. v. Campbell appears to place new limits on state court punitive damage awards (e.g. it suggests that "few [punitive damage] awards exceeding a single-digit ratio between punitive and compensatory damages ... will satisfy due process"), the plaintiffs' bar is seizing upon certain language in the opinion to suggest that it does not apply to personal injury cases. However, since it issued the State Farm decision, the United States Supreme Court has ordered lower courts to reconsider multi-million dollar punitive damages verdicts against Ford Motor Company in two personal injury cases. This suggests that the new limits on punitive damages announced in State Farm apply to cases involving personal as well as economic injury.

The Supreme Court's holding in State Farm that punitive damages should not be based upon evidence of the defendant's *dissimilar* conduct in *other states* should apply to all cases, including bodily injury cases.

D. "Shock Verdicts" Continue to be Rendered Against Healthcare Providers in Medical Malpractice Cases; Managed Care Organizations Continue to Face Vicarious Medical Malpractice Liability Exposure

"Shock verdicts" continue to be rendered against healthcare providers in medical malpractice cases. For example, last month, New York's highest court affirmed an award of \$140 million in compensatory damages against a hospital in a medical malpractice case involving devastating brain injury. Desiderio v. Ochs, et al., 2003 WL 1818120 (2003). The New York Court of Appeals held that it was bound to uphold the verdict because it resulted from application of a statutory formula concerning long-term care required as a result of medical malpractice. Also, in October of 2002, a Suffolk County New York jury awarded \$80 million in a case against physicians involving medical malpractice during preterm labor. The hospital settled out prior to trial for \$2.9 million. Brenner v. Spector, Klein, Docket No. 1581/95 (October 2002).

These shock verdicts in medical malpractice cases are noteworthy to managed care organizations which face increasing vicarious medical malpractice liability exposure. In light of the medical malpractice insurance crisis and anticipated tort reforms benefiting providers, in the future, more medical malpractice liability may shift to managed care organizations.

E. Good News and Bad News on the ERISA Front: Courts Have Been Reluctant to Expand Fiduciary Duties and Liabilities under ERISA, But Continue to Narrow the Scope of ERISA Preemption Protection

1. Breach of Fiduciary Duty Under ERISA

In Pegram v. Herdrich, 530 U.S. 211 (2000), the U.S. Supreme Court refused to find that an HMO making “mixed eligibility and treatment decisions” through its physician owners was acting as an ERISA fiduciary. Thus, it dismissed the plaintiff’s breach of fiduciary duty claims under ERISA.

2. *Duty to Disclose Financial Incentives Under ERISA*

Absent a specific inquiry or some other compelling circumstance, the majority of courts appear unwilling to impose upon a health plan an affirmative duty under ERISA to disclose provider compensation/financial incentives. See, Horvath v. Keystone Health Plan East, 333 F.2d 450 (2003), *aff’d*, 2002 WL 265023 (E.D. Pa 2002) (Third Circuit held that the plaintiff lacked standing to seek restitution of healthcare premiums under ERISA on the grounds that Keystone failed to disclose provider financial incentives which could potentially impact her future healthcare. She conceded that she had suffered no actual individual loss and that hers was a diminished value case. However, the court indicated that Horvath had standing to seek injunctive relief under ERISA). Peterson v. Connecticut General Life Insurance, 2000 WL 1708787 (E.D. Pa) and Ehlmann v. Kaiser Foundation Health Plan of Texas, 198 F.3d 552 (5th Cir. 2000); But see, Shea v. Esensten, 107 F.3d 625, (8th Cir.), cert. denied, 522 U.S. 914 (1997), appeal after remand, 208 F.3d 712 (8th Cir. 2000) (Eighth Circuit held that an HMO had a fiduciary duty to plan participants to disclose fully any compensation arrangements with providers that discourage referrals to medical specialists because those are material facts that could adversely affect the participant’s interest)

3. *Continued Erosion of ERISA Preemption², Particularly In Cases Involving Mixed Benefit and Treatment Decisions*

a. *ERISA Preemption Standard:*

Activities relating to the *administration of healthcare benefits* are preempted by ERISA, whereas activities relating to the *quality of healthcare* are not preempted by ERISA (See, Dukes v. U.S. Healthcare, Inc. 57 F.3d 350 (3d Cir. 1995)). However, the distinction between the financing and the delivery of healthcare is blurred in the context of managed care, leading to endless debate

² ERISA preemption is significant because ERISA’s civil enforcement provisions do not provide the range of remedies typically available under state law. ERISA effectively restricts a claimant’s recourse to benefits due under the plan and equitable relief to enforce the plan terms. 29 U.S.C. sec. 1132 (a)(1)(B). Attorneys fees and costs may also be awarded at the court’s discretion. Extra-contractual and punitive damages are not available to claimants alleging violation of ERISA plans.

over whether lawsuits challenging managed care activities, such as utilization review are preempted.

b. ***The U.S. Supreme Court Implied A New ERISA Preemption Standard For ‘Mixed Eligibility and Treatment’ Decisions in Pegram v. Herdrich, 530 U.S.211 (2000).***

c. ***Conflicting Post-Pegram ERISA Preemption Cases:***

(i) ***Cases Finding ERISA Does Not Preempt Challenges to Managed Care Activities***

In the wake of Pegram v. Herdrich, some courts are more reluctant to find ERISA preemption when managed care organizations or healthcare providers employ medical judgment in determining benefit eligibility. For example, see Cicio v. Does, 321 F. 3d 83 (2nd Cir. 2003) where the Second Circuit Court of Appeals held that an enrollee in an ERISA governed health plan may state a medical malpractice cause of action under state law against a health plan and its medical director based on their utilization review determinations if those determinations are alleged to involve medical decisions or ‘mixed eligibility and treatment’ decisions. The court stated: “By denying one treatment and authorizing another that had not been specifically requested, Dr. Spears [the medical director] at least seems to have engaged in patient-specific prescription of an appropriate treatment, and, ultimately, a medical decision.”

See also, Land v. CIGNA Healthcare of Florida, 11th Cir. No. 02-15549 (July 30, 2003), where the Eleventh Circuit Court of Appeals held that ERISA does not preempt a lawsuit alleging that an HMO nurse’s denial of authorization for inpatient treatment (as opposed to outpatient care) on medical necessity grounds. Citing Pegram and Cicio, the court concluded that the nurse’s decision was a ‘mixed eligibility and treatment decision.’

See also Pappas v. Asbel, 564 Pa 407, 768, A.2d 1089 (2001) where the Pennsylvania Supreme Court ruled that ERISA does not preempt a state law claim asserting that an HMO was negligent in providing medical benefits to a plan member when it refused to authorize coverage at a non-

HMO hospital recommended by the treating physician, stating:

Instead of referring Pappas [the HMO enrollee] to Jefferson, a non-HMO hospital, as [his treating physician] recommended, Dr. Leibowitz [the HMO Medical Director] referred Pappas to one of three other facilities for medical care. He did not, in the Supreme Court's words, only make a "simple yes or no" decision as to whether Pappas' condition was covered; it clearly was. Rather, Dr. Leibowitz also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as Pegram teaches, through state medical malpractice law.

See also, Lazorko v. U.S. Healthcare et al., 237 F.3d 242 (3rd Cir. 2000), cert. denied, 533 U.S. 930 (2001) where the Third Circuit Court of Appeals held that ERISA did not preempt a Plaintiffs' claim that U.S. Healthcare's financial incentives caused the premature discharge of their newborn from the hospital.

See also, Villazon v. Prudential Health Care Plan, No. Civ. 2003 WL 1561528 (S. Ct. Fla. March 27, 2003). Following Cicio, the court ruled that ERISA does not preempt plaintiff's claim against an IPA model HMO alleging direct and vicarious liability for the medical malpractice of the HMO's contracting physician. Villazon asserted that the HMO failed to provide his wife with adequate medical treatment for her cancer.

See also, Roark v. Humana, Inc. 307 F. 3d 298 (5th Cir. 2002) where the Fifth Circuit Court of Appeals ruled that several consolidated claims against health plans based on the Texas Healthcare Liability Act were not preempted by ERISA because they were based on a statutorily imposed duty of care running from the plan's physicians to the plan participants. (The Fifth Circuit did affirm the dismissal of one of the consolidated claims because it challenged the plan's denial of benefits allegedly due and was therefore preempted by ERISA pursuant to the Fifth Circuit's prior ruling in Corcoran v. United Healthcare, Inc., 965 F. 2d 1321 (5th Cir. 1991); cert. denied.466 U.S. 1033 (1992). The panel added that, if not for this prior precedent, it would have reversed).

On June 20, 2003, Aetna Health, Inc. filed a petition for certiorari challenging the 5th Circuit Court of Appeals ruling in Roark which allowed the Texas Health Care Liability Act claims brought by Juan Davila who alleged that he was injured (i.e., developed a bleeding ulcer) as a result of the HMO's requirement that he comply with its "step program" and use a less-expensive generic pharmaceutical before being permitted to obtain the drug actually prescribed by his treating physician. Aetna argues that the high court review is required because the Fifth Circuit opinion conflicts with the court's ruling in Pilot Life v. Dedeaux, 481 U.S. 41 (1987), and would lead to "development of conflicting and overlapping state remedial schemes for ERISA benefit determinations."

On June 3, 2003, Roark filed a petition for certiorari challenging a ruling contained in Roark which dismissed as preempted her claims alleging that the HMO's failure to allow her use of a vacuum assisted closure device at home to treat her spider bite resulted in development of a serious leg infection and amputation. The Roark petition claimed the court's decision erroneously perpetuated legal reasoning on what state laws "relate to" employee benefit plans that has largely been abandoned by the high court in recent cases.

(ii) ***Cases Finding ERISA Preempts State Law Challenges to Managed Care Activities***

However, other post-Pegram courts have held that ERISA preempts challenges to managed care activities under ERISA governed plans.

See Marks v. West Virginia Department of Health Human Resources, 322 F. 3d 316 (4th Cir. 2003) where the court found that ERISA preempts claims concerning eligibility decisions by independent utilization review agent; Haynes v. Prudential Health Care, 313 F. 3d 330 (5th Cir. 2002) where the court held ERISA preempts an HMO's "purely" administrative decision that a physician was not authorized to treat the plaintiff because he was not a primary care physician under the Plan.

See also Bui v. American Telephone and Telegraph Co., Inc., 310 F.3d 1143 (9th Cir. 2002) (Holding that the

important distinction for ERISA preemption purposes is whether a medical decision by the plan is made in the course of the direct provision of medical services to a participant. Tort claims based on such decisions are not preempted. Claims challenging denial of benefits are still preempted).

See also, Pryzbowski v. U.S. Healthcare, 2001 WL 292997 (3rd Cir. 2001)(New Jersey law) where the Third Circuit Court of Appeal's found that Plaintiff's claim that her HMO delayed approving treatment by an out-of-network doctor was preempted by ERISA. It noted that determinations of whether requested treatment is covered under a health plan relate to plan administration. According to the Pryzbowski court, holding that the plaintiff's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g. the policy of favoring in-network specialists over out-of-network specialists) which the Pegram Court rejected in light of congressional policy of promoting HMOs.

See also, Shusteric v. United Healthcare Ins. Co. of Illinois, 2000 WL 1263581 (N.D. Ill. 2000)(Court found that claim challenging HMO's delay in agreeing to pay for physical therapy following dental surgery on grounds of lack of medical necessity was completely preempted by ERISA. The court rejected the plaintiff's argument that, since the HMO employed medical judgment in rejecting the plaintiff subscriber's request for therapy, Pegram v. Herdrich required the court to conclude that her suit was not preempted by ERISA. The Schusteric court rejected this contention and found that: "Pegram's discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA says nothing about whether a negligence claim of the type alleged is completely preempted by sec. 502(a)[of ERISA]." See also, Rubin-Schneiderman v. Merit Behavioral Care and Empire Blue Cross and Blue Shield, 2001 WL 363050 (S.D. N.Y. April 10, 2001) (Court held that ERISA completely preempts Plaintiff's claim for wrongful refusal to authorize coverage for in-patient care for Plaintiff's psychiatric illness. Significantly, the court distinguished Pegram and certain Third Circuit cases on the grounds that they: "involved UR determinations by an HMO's doctors or administrators, not by independent UR

agents for a more traditional fee-for-service plan. An HMO, as a managed care entity, takes on the role of medical provider *and* plan administrator . . . courts rely on the fact that the HMO was acting as “medical provider” rather than “administrator” in finding that negligence claims are not completely preempted.” The court further stated:

Unlike an HMO, Empire Blue Cross never sought to undertake responsibility for Plaintiff’s treatment. In providing UR services, Merit’s role was confined to informing a patient *before* receiving treatment whether that treatment would be covered under the plan. Merit’s doctors were not Plaintiff’s treating physicians, nor did Merit purport to provide Plaintiff with medical services. Thus, the UR determination involved plan administration, not provision of medical services. *See Dukes*, 57 F.3d at 360-61. As such, *Pegram*’s suggestion that an HMO’s negligent mixed eligibility decision may not be completely preempted is inapposite.

(iii) *Can These Apparently Conflicting ERISA Preemption Decisions Be Reconciled?*

Central to the Pryzbowski and other court decisions finding ERISA preempts utilization review decisions was the fact that, unlike the HMO at issue in Pegram, the defendant HMO had not assumed the dual role of an administrator of benefits and a provider of medical services. However, in Isaac v. Seabury & Smith, 2002 WL 1461710 (S.D. Ind.)(July 5, 2002), the U.S. District Court for the Southern District of Indiana rejected the notion that the nature of the enterprise – HMO or third party administrator – was a determinative factor as to whether ERISA would preempt a mixed eligibility and treatment decision. Significantly, in holding that ERISA does not completely preempt a state law tort action arising from a third party administrator’s mixed eligibility and treatment decision³, the Isaac court noted:

³ The plaintiff-employee was a beneficiary of an ERISA governed “fee for service” health plan. The plan was funded by a health insurance policy issued to the plaintiff’s employer by an insurance company which retained a separate third party administrator to make benefit decisions. Plaintiff-employee contracted leukemia and on August 10, 1999, her treating physician requested authorization to perform a bone marrow transplantation. By letter dated August 25, 1999, the third party administrator denied coverage since it was not “medically necessary.” This initial decision was modified on September 23, 1999, when the third party administrator gave “conditional approval” for the transplant. The plaintiff-employee died on October 7, 1999, before any transplant was undertaken.

First, the *Pegram* court did not focus on the treatment of covered beneficiaries or on who provided the treatment. It focused on *decisions*: eligibility *decisions*, treatment *decisions*, and mixed *decisions* of treatment and eligibility. Regardless of who makes these decisions, they are all decisions which affect beneficiaries. We find no principled way to distinguish between a mixed decision of eligibility and treatment rendered by a physician employed by an HMO (as in *Pegram*) and a mixed decision eligibility and treatment rendered by a physician engaged by a third-party administrator to make such decisions (as in the instant case). . . [W]e fail to see how, under the *Pegram* regime, the nature of the enterprise—HMO or third party administrator—is a pertinent factor in determining whether ERISA completely occupies the field.

In *Cicio*, the Second Circuit Court of Appeals also rejected the notion that the nature of the enterprise (i.e. HMO or third party administrator) makes any difference, in evaluating whether particular activities constitute mixed eligibility and treatment decisions.

4. ***Divided U.S. Supreme Court Finds Illinois State Law Requiring Independent Review of Health Plan Benefit Decisions is Not Preempted by ERISA***

- a. Currently 41 states and the District of Columbia provide patients with the right to an independent, outside review of a managed care organization's denial of health care benefits. The external review programs vary significantly from one state to another. The Illinois Health Maintenance Organization Act (hereinafter "HMO Act") is one state external review law⁴ which the U.S. Supreme Court recently reviewed in light of the federal circuit court split on whether ERISA preempts a state's external review provisions. See, Rush Prudential HMO Inc. v. Moran, 122 S.Ct. 2151 (2002).⁵

⁴ Section 4-10 of the HMO Act requires an HMO to submit for independent physician review any dispute between a patient's primary care physician and the HMO that involves treatment being refused on the grounds of "medical necessity." In the event the independent reviewer determines that treatment is medically necessary, the HMO Act requires the insurer to cover the treatment.

⁵ The plaintiff in Moran requested that her HMO, Rush Prudential, cover a particular kind of surgery that an out-of-network physician had recommended to treat the decreased mobility that she was experiencing in her right shoulder. Rush denied coverage for that surgery and instead offered to cover all of the costs associated with a different type of surgery to be performed by an HMO affiliated doctor. Moran sought external review of Rush's denial of coverage, and in the meantime, paid for the surgery recommended by the out-of-network physician herself at a cost of \$95,000. An independent reviewer found the services provided to Moran by the out-of-network physician were medically necessary, but Rush still denied Moran's claim. Moran then sought reimbursement under Section 4-10 of the Illinois HMO Act by bringing an action in state court. Rush removed the action to federal court

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On June 20, 2002, a divided U.S. Supreme Court upheld a decision by the U.S. Court of Appeals for the Seventh Circuit which held that the Illinois external review provision was not preempted by ERISA, because it regulates insurance.⁶ According to the Court of Appeals, HMOs are “insurance vehicles under Illinois law.” Moran v. Rush Prudential HMO, Inc., 230 F.3d 959 (7th Circuit 2000)⁷.

While the Illinois law at issue clearly “relates to” ERISA within the meaning of Section 514, the U.S. Supreme Court found that the law is nonetheless saved from ERISA preemption because, from a “common sense view,” it regulates the insurance industry⁸. According to the court, the Illinois law clearly regulates integral parts of policy relationships between insurers and the insured by adding “an extra layer of review when there is internal disagreement about an HMO’s denial of coverage.” While the state law may “settle the fate of a benefit claim,” the Court held that the law “does not enlarge the claim beyond the benefits available in any action under ERISA’s civil enforcement provision.”

The majority in Moran also found that the state law did not interfere with Congress’ intention to provide a uniform regime under ERISA. The court distinguished the independent review statute from arbitration provisions, saying the independent review provisions were more similar to a doctor’s “second opinion” than a binding arbitral decision. “The Act does not give the independent review a free-ranging power to construe contract terms, but

on ERISA preemption grounds. Eventually, the U.S. District Court for the Northern District of Illinois determined that Moran made a claim for benefits that was preempted by ERISA.

⁶ While ERISA preemption invalidates any state law that “relates to” a covered employee benefits plan, the most notable exception is the savings clause, which holds that a state law “relat[ing] to” an ERISA plan may avoid preemption if the state law “regulates insurance.”

⁷ Four months prior to the Seventh Circuit’s decision in Moran, the U.S. Court of Appeals for the Fifth Circuit reached the opposite conclusion and held that the independent review provisions of the Texas Health Care Liability Act are preempted by ERISA. See, Corporate Health Insurance Inc. v. Texas Department of Insurance, 215 F.3d 526 (5th Cir. 2000). On June 24, 2002, the high court vacated and remanded the Fifth Circuit decision in Corporate Health for reconsideration in light of its Rush decision.

⁸ In rejecting Rush’s argument that HMOs should be immune from state regulation as members of the insurance industry since HMOs also provide health care, the Court held that “nothing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, as long as providing insurance fairly accounts for the application of state law, the savings clause may apply.” Likewise, the majority rejected Rush’s argument that the Illinois HMO Act “sweeps too broadly within the definitions capturing organizations that provide no insurance, and by regulating non-insurance activities of HMOs that do.”

instead, confines review to a single term; the phrase “medical necessity” used to define the services covered under the contract.”

- b. The Moran decision is a mixed bag for HMOs. The Moran decision is favorable to HMOs in that that it reaffirms an expansive reading of the “relate to” provision in ERISA’s express preemption provision. The members of the Court agreed that, if the state independent review law was not an insurance regulation, it would be preempted as a provision related to an ERISA plan. Also, the ruling arguably reaffirms that a state law purporting to regulate insurance may nonetheless be preempted by ERISA if it conflicts with remedies established under the federal law. The decision is unfavorable for HMOs because: (1) it confirms that they must comply with a patchwork quilt of state independent review laws; and (2) fails to address whether a state could supplant health plan language by adopting a new or different definition of “medical necessity” or standard of review for the second opinion. Some commentators have suggested that it would have been better if the court had upheld the independent review law with the caveat that the reviewer is to use the definition of medical necessity contained in the health plan.

Note, the impact of Moran will be limited since it only applies to insured plans and has no effect on self-funded health benefit plans. See, Corporate Health v. Texas Department of Insurance, 314 F. 3d 784 (5th Cir. 2002)(on remand from the Supreme Court, the Fifth Circuit modified its earlier opinion concerning ERISA preemption of laws mandating independent external review, but only for insured plans. The Fifth Circuit maintained that *ERISA still preempts the independent review law for self-funded plans because the savings clause does not apply to save the state statute as it applies to self-funded plans.*

5. U.S. Supreme Court Rules That Kentucky’s Any Willing Provider Law Is Saved From Preemption

In Kentucky Association of Health Plans v. Miller, 123 S. Ct. 1471 (2003) (April 2, 2003), the United States Supreme Court held that Kentucky’s any willing provider law is saved from ERISA preemption because it regulates the business of insurance. Justice Scalia announced that the Supreme Court was making a “clean break” from the McCarran-Ferguson Act test previously utilized by federal courts to determine if a state law regulates the business of insurance. Justice Scalia stated that, to regulate insurance within the meaning of ERISA’s savings clause, a state law must: (1) be specifically directed towards entities engaged in the business of insurance

and (2) “substantially affect the risk pooling arrangement between the insurer and the insured.”

6. In the Wake of Miller and the Newly Announced U.S. Supreme Court McCarran-Ferguson Act test, Federal Court Judges Spar Over Whether ERISA Preempts Pennsylvania Statutory Bad Faith Actions Against *Insurers*

- a. The sparring match over ERISA’s preemptive effect on the Pennsylvania bad faith statute, sec. 8371, continues in the wake of Miller. Two Eastern District Court Judges have applied the Miller two-prong test and have concluded that ERISA preempts sec. 8371 because the bad faith statute does not substantially affect the risk pooling arrangement between insurers and insureds, thereby failing to satisfy the second prong of the Miller test. In McGuigan v. Reliance Standard Life Insurance Co., 256 F. Supp.2d 345 (E.D. Pa. 2003), Senior District Court Judge Robert F. Kelly found that, while section 8371 concerned the policy relationship between insurer and insured, the law which imposes damages upon an insurer as punishment for acting in bad faith towards its insured does not substantially affect the risk pooling arrangement between the insurer and the insured. Even if Section 8371 did satisfy both prongs of the Miller test, Judge Kelly found that the law would nonetheless be preempted because its provision for interest, penalties and punitive damages is an alternative remedy which is categorically preempted by ERISA. Relying on the U.S. Supreme Court decision in Pilot Life Ins. Co v. Dedeaux, 481 U.S. 107 (1987) ⁹ and Rush Prudential HMO Inc. v. Moran (discussed above), Judge Kelly found that section 8371 allows an ERISA plan participant to recover punitive damages for bad faith conduct which is incompatible with ERISA’s enforcement scheme. See also, Morales-Ceballos v. First UNUM Life Ins. Co of America, No. 03-295, slip op. (E.D. Pa. May 27, 2003) (J.M. Kelly, J) (ERISA preempts sec. 8371 bad faith claim);
- b. On September 8, 2003, Senior U.S. District Judge Clarence C. Newcomer refused to reconsider his July 2002 ruling that cleared the way for an ERISA plaintiff to pursue a bad faith claim against

⁹ In Pilot Life Ins. Co v. Dedeaux, 481 U.S. 107 (1987) the U.S. Supreme Court found that the Mississippi law of bad faith did not satisfy the second factor of the McCarran –Ferguson test. The Pilot Life court held that punitive damages constitutes an additional remedy and that “the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.”

his long term disability carrier for its wrongful denial of benefits.¹⁰ Rosenbaum v. Unum Life Insurance Co. of America, 2003 WL 22078557 (E.D. Pa 2003). Judge Newcomer found that his original decision was proven correct when the U.S. Supreme Court handed down the Miller decision earlier this year because the justices “significantly altered the applicable test for determining whether state legislation qualifies for protection under ERISA’s savings clause.” According to Judge Newcomer, the Miller test “replaces the McCarran-Ferguson three prong test approach in determining whether a state law regulates insurance, and is, therefore, exempt from ERISA’s preemptive effect.” Judge Newcomer concluded that the Pennsylvania bad-faith statute, sec. 8371, easily satisfies the first prong of the Miller test (i.e., it is specifically directed toward entities engaged in insurance). Turning to the second prong, Newcomer said it is “critically important to note that this test differs significantly from the first of the now defunct McCarran-Ferguson factors which asks “whether the law has the effect of transferring or spreading policyholders risk.” As Justice Antonin Scalia explained, the Miller test “requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk.” Applying the new test himself, Judge Newcomer concluded that sec. 8371 qualifies for the savings clause because it has an effect on the pooling arrangement between an insurer and an insured.” (i.e., by dissuading insurers from denying claims in bad faith).

Judge Newcomer dismissed rulings by his colleagues that found that, even if the state statute falls within the savings clause, it is, nonetheless, subject to conflict preemption. (Under this approach, if the state statute provides for an alternative remedy outside of ERISA’s enforcement scheme, then the statute is categorically preempted by ERISA). According to Judge Newcomer, as long as the law regulates insurance, it is saved from preemption and it is wrong to take the analysis to the second step to determine if the law was subject to conflict preemption. In his order, Judge Newcomer granted Unum Life Insurance Company the right to take the issue to the 3rd Circuit in an interlocutory appeal.

¹⁰ The original Rosenbaum decision, Rosenbaum v. Unum Life Insurance Company of America, 2002 WL 1769899 (E.D. Pa July 29, 2002), led to a flurry of litigation as plaintiffs’ lawyers across Pennsylvania moved to amend their ERISA lawsuits to add bad faith claims. But the initial excitement among plaintiffs’ lawyers fizzled as, one by one, Judge Newcomer’s colleagues rejected his view. Since the original Rosenbaum decision, nine Eastern District judges have concluded that ERISA does not preempt a claim under Pennsylvania’s bad faith statute sec. 8371, because Congress intended that ERISA’s remedies be “exclusive” and the state law provides additional remedies, most notably punitive damages.

Unfortunately, it does not appear that the 3rd Circuit will have an opportunity to review Judge Newcomer's latest decision in Rosenbaum as the lawyers on both sides in Rosenbaum informed the court on September 15, 2003 that they had settled the case.

F. Large U.S. Health Insurers and Managed Care Organizations Continue to Be Plagued With Costly Provider Class Action Lawsuits Challenging Managed Care Methodologies

1. Provider Class Actions

a. MDL Litigation: In Re: Humana Managed Care Litigation

- (i) Healthcare providers and several state medical associations filed class actions against the largest health insurers and HMOs (i.e., Aetna, CIGNA, Anthem Inc., PacifiCare Health Systems Inc., United Health Group, Inc., and Wellpoint Health Networks, Inc.) alleging RICO violations through fraudulent and extortionate predicate acts. On October 23, 2000, the Judicial Panel on Multi-district Litigation transferred these lawsuits to Judge Federico Moreno in the U.S. District Court for the Southern District of Florida and consolidated them into a single class action proceeding in In Re: Humana Managed Care Litigation, S.D. Fla., MDL NO 1334-MDL-Moreno (hereinafter the "MDL"). The providers assert that, contrary to defendants' contracts and representations, the defendants implemented internal policies and procedures secretly designed to systematically obstruct, reduce, delay and deny healthcare payments to the providers. The providers also allege that the defendants extorted them into participating in their managed care health plans and into rationing medical care through economic coercion (e.g., 'all products' requirements and wielding their dominant market power). The providers claim to have sustained substantial economic losses as a result of the defendants' alleged misconduct. The court found that *the providers have standing to sue under RICO because they sufficiently pled injury to their business or property*. However, the defendant MCOs renewed Motions to Dismiss plaintiffs' RICO claims are pending. Oral arguments were heard on March 27, 2003. The defendants argued that a recent U.S. Supreme Court decision on RICO requires dismissal of the providers' RICO claims.

- (ii) On September 26, 2002, Judge Moreno granted class certification as to the proposed provider class. On September 11, 2003, the U.S. Court of Appeals for the 11th Circuit heard oral arguments on the defendants' appeal of the class certification ruling. While the defendants' counsel previously expressed optimism that the 11th Circuit will decertify the provider class, one Judge's commentary at oral argument suggested that the Panel may not decertify the class. The 11th Circuit is not expected to rule on this significant issue until late 2003 or early 2004.

- (iii) On December 11, 2000, Judge Moreno entered an Order granting in part and denying in part the various defendants' Motion to Compel Arbitration holding that the quantum meruit, unjust enrichment, breach of contract and prompt pay claims of all doctors with arbitration clauses were arbitrable; the direct RICO claims of physicians with arbitration clauses were arbitrable; and plaintiffs' RICO conspiracy and aiding and abetting claims against defendants with whom they had no arbitration agreement were not arbitrable.

- (iv) On March 14, 2002, the 11th Circuit Court of Appeals ruled that *the providers' direct RICO claims are not subject to arbitration if the applicable arbitration provisions preclude extra-contractual or punitive damage awards. In re Humana Inc. Managed Care Litigation*, 11th Cir., NO. 01-10247. The managed care defendants' petition for certiorari was granted and the U.S. Supreme Court heard oral arguments on February 24, 2003. The plaintiff providers argued that, since treble damages under RICO are punitive in nature and the provider arbitration agreements preclude an award of punitive damages, the arbitration agreements are unenforceable as they restrict the physician plaintiffs' ability to vindicate their RICO claims. However, the defendants argued that the provider agreements are enforceable and the RICO Claims should be arbitrated since the arbitration agreements limitation on punitive damages would not prevent an award of RICO treble damages.

On April 7, 2003, the U.S. Supreme Court reversed the judgment of the 11th Circuit Court of Appeals finding that *the proper course was to compel arbitration of the providers' direct RICO claims. Pacificare Health Systems,*

Inc. v. Book, 123 S.Ct. 1531. The Pacificare Court found that it was premature for it to address the question of whether the remedial limitations require invalidation of the arbitration agreements. In delivering the opinion of the Court, Justice Scalia recognized that the U.S. Supreme Court cases have placed different statutory treble damage provisions on different points along the spectrum between purely compensatory and strictly punitive awards. Thus, it is unclear whether the agreements actually prevent an arbitrator from awarding treble damages under RICO. Since the Court did not know how the arbitrator would construe the remedial limitations and whether such remedial limitations would render the parties' agreement unenforceable, it declined to address these issues and held that the arbitration clause is, at least, initially enforceable.

Prior to the U.S. Supreme Court's decision in Pacificare, on November 6, 2002, Judge Moreno issued an Order in the MDL enjoining arbitration of the provider claims since the providers filed a Notice of Dismissal which purported to dismiss from the Complaint all arbitrable claims. Pacificare and United Healthcare have appealed this order to the 11th Circuit which heard oral arguments on the issue on September 11, 2003. According to Pacificare and United, Judge Moreno erred in enjoining the arbitrations because, among other things: (1) the plaintiffs' Notice of Dismissal did not dismiss all arbitrable causes of action; and (2) where arbitrable (breach of contract and quantum meruit and direct RICO claims of physicians with arbitration clauses) and non-arbitrable claims (RICO conspiracy and aiding abetting against MCOs with no arbitration agreements) involve overlapping factual issues, the correct procedure for a court to follow is not to enjoin resolution of the arbitrable claims, but instead to allow those claims to be arbitrated and then, after the arbitration is completed, to determine what preclusive effect the arbitration will have on the non-arbitrable claims that remain in court.

- (v) Two of the MDL defendants –Aetna and CIGNA- have negotiated settlements. On May 22, 2003, Aetna announced that it had reached a \$470 million settlement with the plaintiff providers. Aetna agreed to (1) pay \$100 million in cash to be divided by the roughly 600,000

physician class members; (2) pay \$50 million in plaintiffs' legal fees; (3) pay \$20 million to establish an independent foundation for studying critical health care issues; and (4) make improvements to its claims systems valued at \$300 million. A final approval hearing of the proposed Aetna settlement is scheduled for October 13, 2003. On September 4, 2003, Judge Moreno preliminarily approved CIGNA's \$550 million settlement in the MDL. CIGNA agreed to: (1) establish a \$30 million settlement fund out of which physicians may opt for a fixed amount on a per capita basis; (2) establish a \$40 million fund out of which physicians may resubmit previously denied claims; (3) pay as much as \$10 million in administrative fees relating to the settlement; (4) pay \$15 million to a charitable foundation to foster public health initiatives; (4) pay as much as \$55 million in legal fees; (5) make improvements to its claims systems and business processes valued at \$400 million.

- (vi) The providers in the MDL also made a claim for "unpaid benefits" under ERISA. (Their ERISA claim was asserted in the alternative to their state law breach of provider contract claims which the defendants asserted were preempted by ERISA.) The defendants moved to dismiss the providers' ERISA claims for lack of standing (the providers were suing in their own rights, not under assignments of the rights of plan participants or beneficiaries) and for failure to exhaust administrative remedies. The court has not addressed these arguments because it held that the providers' breach of contract claims are not preempted by ERISA.

b. Thomas RICO Class Action Litigation

- (i) A RICO class action lawsuit was recently filed against the Blue Cross Blue Shield Association (BCBSA) and sixty-six (66) Blue Cross Blue Shield Plans in the U.S. District Court for the Southern District of Florida (hereinafter "the Thomas litigation"). The plaintiffs—four doctors from Connecticut, Florida and Georgia, and medical societies based in Connecticut, Florida and Virginia – allege that, since **May of 1993**, each of the defendants, on their own and as part of a common fraudulent scheme and conspiracy, has systematically denied, delayed, and diminished claim payments due to plaintiffs for medical services rendered to members of health plans insured or administered by the

defendants. The plaintiffs allege that the defendants perpetrated their scheme through violations of criminal mail and wire fraud statutes in violation of the Racketeer Influenced and Corrupt Organization Act (RICO). Plaintiffs seek: (1) class certification; (2) recovery of treble the amount of damages suffered by reason of payments due them for services rendered on a fee for service or capitation basis having been wrongfully withheld, denied or reduced plus interest due on the wrongfully delayed or withheld payments; (3) injunctive relief; and (4) attorneys fees and costs.

- (ii) The Plans' liability exposure in Thomas is presently unclear. The Plans' liability exposure will depend to a large extent upon the outcome of the various motions pending before the court (discussed below) as well as the pending appeal of the class certification ruling in the MDL pending against the largest for-profit health insurers. If the 11th Circuit reverses the lower court's granting of class certification, the providers' claims in Thomas would be severely undermined.
- (iii) The plaintiffs have filed a Motion to Transfer the *Thomas* litigation to Judge Moreno, the judge currently presiding over MDL. The RICO allegations in the *MDL* provider litigation are virtually identical to those alleged against the Blue Cross Blue Shield Plans in *Thomas*. In light of several unfavorable rulings by Judge Moreno in the MDL, including his certification of a provider class and his refusal to dismiss the RICO causes of action for lack of standing, a number of defendant Plans and the BCBSA have filed a Motion to Oppose Transfer of *Thomas* to Judge Moreno.
- (iv) On September 2, 2003, the defendant Plans in Thomas filed a Joint Motion to Dismiss based on numerous grounds, including failure to:
 - 1. allege a coherent RICO "enterprise" as the statute requires (instead the "enterprise" they allege is a sprawling collection of separate Blue Cross and Blue Shield licensees, the BCBSA and a wide variety of independent third parties which do not share any of the joint decision making and common control that a RICO enterprise requires);

2. allege any “predicate acts” under RICO because the acts of mail and wire fraud forming the basis of their complaint are not pled with particularity; and
3. allege facts to support conclusory allegations that the dozens of companies that they name as defendants “conspired” with each other to violate the racketeering laws.

In addition, the defendant Plans argue that there are numerous defects in the Complaint. According to the Plans,

- Plaintiffs’ attempt to allege that defendants are liable for “aiding and abetting” the RICO violations of other defendants under 18 U.S.C. §2 must be rejected since the U.S. Supreme Court has found that this section of the U.S. Code does not support a civil claim for aiding and abetting liability.
 - Plaintiffs are not entitled to seek the declaratory or injunctive relief they request since the plain text of RICO’s remedial provisions vest only the U.S. government with authority to seek an injunction against RICO violations.
 - Major portions of the plaintiffs’ claims – in particular, the claims brought by the Florida doctors and the medical societies in Florida, Virginia, and Colorado – are barred by the McCarran Ferguson Act and their home states’ comprehensive state regulation of health insurers.
 - Plaintiffs’ attempts to avoid the four-year statute of limitations applicable to RICO actions must be rejected due to their failure to allege any specific acts of fraudulent concealment by the defendants.
- (v) A number of defendant Plans have filed Motions to Compel arbitration.
- (vi) The BCBS Association has filed a separate Motion to Dismiss plaintiffs’ claims to the extent they seek relief for Defendants’ actions in paying claims under the Service

Benefit Plan¹¹ because: (1) the statute governing the Service Benefit Plan, namely FEHBA, preempts RICO; (2) plaintiffs' claims are barred by sovereign immunity, since the federal government would be financially responsible for any underpayment about which Plaintiffs complain and thus is the real party in interest; (3) plaintiffs' case as it concerns the Service Benefit Plan is barred by the doctrine of official immunity, which extends to private entities carrying out government functions; and (4) Plaintiffs' claims must be dismissed as falling within OPM's primary jurisdiction, because Congress expected OPM in the first instance to address disputes involving FEHBA plans and to oversee the conduct of the entities administering the plans.

II. Noteworthy Legislative Developments

A. Federal Legislation

1. Federal Medical Malpractice Liability Act

On March 13, 2003, the House of Representatives passed legislation (H.R. 5) which, among other things, would place a federal limit of \$250,000 on non-economic (pain and suffering) damages in health care lawsuits and cap punitive damages at the greater of twice the amount of non-economic damages or \$250,000. Health care lawsuits are defined to include a demand by any person against a health care provider or health care organization which are based upon the provision of, use of, or payment for (or the failure to provide, use or pay for) health services, regardless of the theory of liability on which the claim is based and whether it is brought in state or federal court. The proposed legislation would apply to managed care organizations and administrators of health benefits plans since these entities would arguably qualify as Health Care Organizations under the Act¹². However, H.R. 5 would not preempt any state law enacted before or after it that sets higher or lower damage caps for health care lawsuits; it only applies in states with no caps on damages. Moreover, H.R. 5 would not supersede any state or federal law "that imposes greater procedural or substantive protections for health care providers or organizations from liability, loss, or damages than those provided by this Act or create a cause of action."

Under the proposed Medical Malpractice Act, MCOs would not be precluded from raising ERISA preemption to claims challenging its administration of healthcare benefits. However, to the extent ERISA does not preempt a claimant's state law claim asserting wrongful denial of

¹¹ The Service Benefit Plan is one of the federal government's fee-for-service health benefit plans for federal employees, retirees, and their dependents. It is established through a federal government contract between the United States Office of Personal Management ("OPM") and BCBSA; pursuant to that contract, independent licensees of BCBSA process benefits in all 50 states and U.S. territories.

¹² The Act defines Health Care Organization as "any person or entity which is obligated to provide or pay for health benefits under any health plan, including any person or entity acting under contract or arrangement with a health care organization to provide or administer any health benefit."

benefits against an MCO based upon its mixed eligibility and treatment decision, the MCO would arguably obtain the benefit of the \$250,000 cap on non-economic and punitive damages in the absence of any applicable state medical malpractice liability caps.

President Bush endorsed the bill and urged Senate action on it, but the Senate blocked the legislation. For a summary of recent legislative activity related to this Act see Exhibit A.

2. Class Action Fairness Act

On June 12, 2003, the U.S. House of Representatives passed the Class Action Fairness Act, H.R. 1115, widely referred to as the “Consumer Class Action Bill of Rights.” H.R. 1115 attempts to curb perceived class action abuses which many believe result in the imposition of a “hidden litigation tax” on U.S. consumers. Currently, many plaintiffs’ attorneys abuse the system by filing nationwide class actions in notoriously plaintiff-friendly “magnet jurisdictions” such as Madison County, Illinois, home of the recent \$12 billion verdict against Phillip Morris in a tobacco case. H.R. 1115 would expand federal diversity jurisdiction for large national or interstate class actions, making it easier for them to be heard in federal courts. Under H.R. 1115, federal district courts would have jurisdiction over interstate class actions where (1) any defendant and plaintiff live in different states; (2) the amount in controversy exceeds \$5 million; and (3) the suit is on behalf of 100 or more putative plaintiffs. The federal courts would have discretion to remand intrastate class actions to state court if between one-third and two-thirds of the plaintiffs are citizens of the same state as the primary defendants. In exercising such discretion, the federal courts would weigh several factors set forth in H.R. 1115, such as whether or not the claims are governed by local law and whether they involve national or interstate interests. If two-thirds or more of the proposed class members and the primary defendants reside in the state where the litigation was filed, H.R. 1115 would not apply.

H.R. 1115 would also: subject coupon settlements to higher judicial scrutiny; protect against settlements that would result in a net monetary loss to plaintiffs; prohibit the payment of bounties to class representatives; and protect out-of-state class members against geographic discrimination.

In addition, H.R. 1115 provides that all district court decisions on class certification could be immediately appealed, and that discovery would be stayed during the pendency of such appeals unless the court determines specific discovery is necessary to preserve evidence or prevent undue prejudice to the party seeking the discovery.

H.R. 1115 would apply retroactively to any pending class action where the class certification order is entered after the date of enactment of H.R. 1115.

H.R. 1115 now heads to the Senate for consideration. Commentators suggest that, among other things, members of the Senate will seek to impose a higher amount-in-controversy threshold (e.g. \$15 million) for removal of class actions to federal court.

B. State Legislation

The states have been very active on the healthcare liability reform front. In response to the medical malpractice crisis, many states have passed tort reforms placing limits on non-economic and/or punitive damages. See Exhibit B, which summarizes recent state healthcare liability reforms.