

MANAGED CARE LIABILITY UPDATE

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I. Introduction and Overview of Managed Care Liability Exposures

Given the wide divergence in interests between employers, their employees, health plans and providers, it is not surprising that there are many areas of tension, which spill over into managed care legislation, regulation and litigation.

Types of common allegations against MCOs:

- A. Vicarious liability for medical negligence (ostensible or apparent agency theory utilized to impose liability for the malpractice of a contracted or independent provider)
- B. Direct liability for medical negligence
- C. Negligent credentialing (claims by harmed enrollees)
- D. Negligence or other wrongful acts in provider contracting or peer review/credentialing (practitioner exclusion, termination, unfair terms)
- E. Liability for antitrust violations or other unfair competition
- F. Libel, slander, defamation
- G. Breach of contract and bad faith claims based upon denials of health benefits
- H. Negligence or other wrongful acts in utilization review
- I. Utilization management / medical malpractice
- J. Adverse financial incentives / breach of fiduciary obligations
- K. Advertising / marketing claims
- L. Misrepresentation or breach of warrantee or guarantee
- M. Trademark / slogan infringement

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II. Noteworthy Judicial Trends

A. 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, 2002 WL 265023 (E.D. Pa 2002), 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 court 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 Preemption¹, 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

¹ 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.

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distinction between the financing and the delivery of healthcare is blurred in the context of managed care, leading to endless debate 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 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

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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) finding 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 unanimous panel 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 5th 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).

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(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.

Pryzbowski v. U.S. Healthcare, 2001 WL 292997 (3rd Cir. 2001)(New Jersey law) (Court 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, Marks v. West Virginia Department of Health Human Resources, 322 F. 3d 316 (4th Cir. 2003) (Court found that ERISA preempts claims concerning eligibility decisions by independent utilization review agent); 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

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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.

Haynes v. Prudential Health Care, 313 F. 3d 330 (5th Cir. 2002) (Court held ERISA preempts 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).

(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

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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 decision², the Isaac court noted:

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*

² 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.

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- 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 law³ 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).⁴ 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.⁵ 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)⁶.

While the Illinois law at issue clearly "relates to" ERISA within the meaning of Section 514, the U.S. Supreme Court found that the

³ 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.

⁴ 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 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.

⁵ 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."

⁶ 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.

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law is nonetheless saved from ERISA preemption because, from a “common sense view,” it regulates the insurance industry⁷. 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 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

⁷ 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.”

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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. ***In the Wake of Moran Decision, Two Federal Court Judges in Same District Reach Differing Conclusions On ERISA Preemption of Pennsylvania Statutory Bad Faith Actions Against Insurers***

- a. In Rosenbaum v. Unum Life Insurance Company of America, 2002 WL 1769899 (E.D. Pa July 29, 2002), Senior U.S. District Court Judge Clarence Newcomer held that ERISA does not preempt an employee's statutory bad faith claim against his long term disability carrier for its wrongful denial of benefits. While District Courts in Pennsylvania have consistently held that Pennsylvania's bad faith statute is preempted by ERISA, Judge Newcomer reexamined the issue in light of a "new trend in federal law." In a pair of recent decisions from the high court—Unum Life Insurance Co. of America v. Ward in 1999 and Rush Prudential HMO Inc. v. Moran in 2002—Judge Newcomer found that the U.S. Supreme Court justices significantly changed the test for assessing whether a state law qualifies for ERISA's Savings Clause, which exempts from preemption "any law of any state which regulates insurance." According to Judge Newcomer, the savings clause can now protect a state law from preemption even if the law does not meet all three factors of the McCarran-Ferguson Act which include whether the practice: (1) has the effect of transferring or spreading a policyholder's risk; (2) is an integral part of the policy relationship between the insurer and the insured; (3) is limited to entities within the insurance industry. While the Pennsylvania bad faith statute may not satisfy the first factor in that it does not have the effect of transferring or spreading a policyholder's risk since it is special damages section, the Rosenbaum court found that it satisfies the second and third factors. According to Judge Newcomer, the bad faith statute plays

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an integral part in the policy relationship between the insurer and the insured as it creates the right of an insured to pursue punitive damages, attorneys fees and interest⁸ and it is limited to entities within the insurance industry.

- b. Less than one month later, in Sprecher v. Aetna U.S. Healthcare Inc., 2002 WL 1917711 (E.D. Pa. August 19, 2002), U.S. District Judge Ronald Buckwalter reached the opposite conclusion and held that the bad faith statute was preempted.⁹ Judge Buckwalter disagreed with Judge Newcomer on two key points. On the second factor of the McCarran-Ferguson test, Judge Buckwalter found that the bad-faith statute does not serve as “an integral part of the policy relationship between the insurer and the insured” because it doesn’t “change the bargain between an insurer and insured.” According to the Sprecher court, insurers already have the obligation to act in good faith and “a state statute providing a remedy for breach of this obligation does not have the effect of creating a new, mandatory contract term.” Instead, the Sprecher court found the bad faith statute simply creates an opportunity for a policyholder whose claim has been improperly handled by the insurer, to seek punitive damages and interest penalties.

Secondly, Judge Buckwalter found that, even if he were to hold that the bad faith law qualified for protection from preemption under ERISA’s savings clause, the law would nonetheless be preempted because “its provision for interest penalties and punitive damages, is more akin to an “alternative remedy” which is categorically preempted by ERISA.” Because Pennsylvania’s bad faith statute provides a form of ultimate relief in a judicial forum that adds to the judicial remedies provided by ERISA, Judge Buckwalter found it is incompatible with ERISA’s exclusive enforcement scheme.

In Kirkhuff v. Lincoln Technical Institute, Inc. 221 F. Supp. 2d 572 (E.D. Pa. 2002), Judge Bartle agreed with Judge Buckwalter, holding that the Pennsylvania bad faith statute was preempted by ERISA and not “saved” by ERISA’s “savings clause” because it

⁸ 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. However, Pilot Life dealt with common law claims of bad faith unspecific to the insurance industry, while the bad faith claim before the Court in Rosenbaum derived from a statute specific to the insurance industry.

⁹ In Sprecher, the plaintiff, an enrollee under an ERISA benefits plan, filed suit against his health insurer for its partial failure to pay hospital expenses he incurred after suffering a heart attack. Count I of plaintiffs complaint was filed under ERISA to recover benefits while Count II is a state statutory bad faith claim.

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amounts to an alternate enforcement mechanism outside of the exclusive remedial scheme.

In Bell v. Unum Provident Corp., 222 F. Supp. 2d 692 (E.D. Pa. 2002), Judge Baylson also ruled that the Pennsylvania bad faith statute was preempted and not “saved by ERISA’s “savings clause” because it conflicts with ERISA’s exclusive remedies. Judge Baylson noted that while Ward and Rush addressed claims dealing with the processing of a claim for benefits, neither provided an alternative enforcement remedy to those set forth by ERISA §502(a)(1)(b).

See, also, Caffey v. Unum Life Insurance Co., 2002 WL 2001526 (6th Cir. Tenn)(Sept. 3, 2002)(In finding that ERISA preempts Indiana tort of bad faith by an insurer, the Caffey court, made note of the U.S. Supreme Court decision in Rush:

In its most recent pronouncement on the subject, the Supreme Court again confirmed that any state law “providing a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA . . . patently violates ERISA’s policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and wards when a violation has occurred.”

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

In Kentucky Association of Health Plans v. Miller, U.S. No. 00-147 (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 McCarren-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.”

B. Decline in “Shock” 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

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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).¹⁰

Additionally, 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 \$33 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.

C. **Large U.S. Health Insurers and Managed Care Organizations Continue to Be Plagued With Costly Provider and Subscriber Class Action Lawsuits Challenging the Propriety of Fundamental Managed Care Methodologies**

1. *Subscriber Class Actions*

a. RICO Violations:

- (i) Humana v. Forsyth, 119 S.Ct. 710 (1999) (U.S. Supreme Court held that the McCarran-Ferguson Act did not preempt a subscriber class action against a health insurer alleging its failure to disclose provider discounts in marketing to healthcare subscribers violated RICO. Suit subsequently settled for \$28.8 million).
- (ii) Maio v. Aetna, 221 F.3d 472 3d Cir. (2000) (U.S. Court of Appeals for the Third Circuit upheld a lower court's dismissal of a purported RICO class action by subscribers on standing grounds. The subscribers essentially alleged

¹⁰ 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.

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that defendants made misrepresentations in marketing their health plans to subscribers by failing to disclose internal managed care cost control mechanisms. The subscribers alleged that the hidden cost control measures rendered the health plans worth less than those for which the subscribers bargained. None of the subscribers alleged actual denial of benefits, delay in care or other concrete injury).

(iii) Multi-District Litigation. Purported subscriber class actions have been filed against the largest for-profit health insurers and HMOs, alleging RICO violations similar to those in Maio as well as ERISA violations. These actions have been consolidated for pre-trial purposes in In re: Humana Managed Care Litigation, No. 00-1334 (S.D. Fla. 2001).

(a) On February 20, 2002 Judge Moreno refused to dismiss the subscribers' RICO claims for lack of standing. (In re Managed Care Litigation, S.D. Florida, No. 1334, ruling February 20, 2002). Judge Moreno declined to follow the Third Circuit Court of Appeals' no-standing ruling in Maio v. Aetna, Inc. In concluding that the plaintiffs have standing to sue under RICO, Judge Moreno likened the plaintiffs' racketeering claims to the tort of fraudulent inducement which he found may be filed independently of any contract claim. Despite this pronouncement, Judge Moreno concluded that the McCarran-Ferguson Act barred the RICO claims of 10 of the 16 subscriber plaintiffs.¹¹ These 10 subscribers resided in states that had enacted insurance fraud laws. On March 25, 2002, Judge Moreno granted the defendant managed care organizations the right to seek immediate review of his standing ruling by the U.S.

¹¹ The court ruled that the McCarran-Ferguson Act, a law that Congress passed to prohibit federal lawsuits that encroach upon each state's right to regulate insurance, barred the ten plaintiffs from California, Florida, New Jersey and Virginia from maintaining their RICO suits. In support, the court pointed to the insurance fraud laws in these four states that do not allow individuals to maintain private causes of action. Rather, these actions must be filed by the appropriate government regulatory body. Thus, the court found that the state insurance fraud laws barred the subscriber's federal RICO claims since such claims would encroach upon each state's regulatory decision to not allow private causes of action.

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Court of Appeals for the 11th Circuit stating that immediate review of the RICO issue could “materially advance the termination of the litigation.” However, on June 11, 2002, Judge Moreno denied the defendants’ Motion for Reconsideration of his February 20, 2002 opinion.

- (b) On September 26, 2002, Judge Moreno denied the subscriber plaintiffs’ motions for class certification. In Re Managed Care Litigation, 209 F.R.D. 678 (S.D. 2002). Judge Moreno held that the certification of the proposed subscriber class was inappropriate because common issues of law and fact did not predominate over individual ones and litigating plaintiffs’ claims as a class comprised of 145 million members would be unmanageable. The subscriber plaintiffs have chosen not to appeal the court’s ruling denying class certification.

b. ERISA Violations:

- (i) In Doe v. Blue Cross Blue Shield of Maryland, 173 F. Supp. 2d 398 (D. Md. 2001), the U.S. District Court for the District of Maryland dismissed a lawsuit by a purported class of individuals insured by employer-sponsored policies issued by Blue Cross Blue Shield of Maryland alleging ERISA violations through failure to disclose cost controls. The District Court based its dismissal decision on lack of standing.
- (ii) In the Multi-District litigation, the plaintiff subscribers allege that the defendants breached their fiduciary duty under ERISA by misrepresenting benefits in plan summaries, determining “medical necessity” using financial criteria and not disclosing that criteria, and interfering with communication between doctors and patients. As a result, the plaintiffs claim to have sustained injury in that they paid more for insurance coverage than they would have absent the HMO’s alleged misrepresentation and exaggerations of plan benefits. The

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plaintiff subscribers asserted all of their breach of fiduciary duty claims under ERISA's "catch all" claim provision which allows subscribers and, in some cases, former subscribers to bring a civil action to enjoin any act which violates the term of the Plan or any provision of ERISA and to obtain appropriate equitable (including restitution and monetary damages) and injunctive relief.

- (iii) In his February 20, 2002 ruling, Judge Moreno dismissed a number of the subscribers' ERISA claims, including the ERISA medical necessity fiduciary duty claims by subscribers who are still enrolled in their health plans under the ERISA catch all claim section. Since the subscribers are essentially alleging fraudulent inducement to purchase an insurance contract by misrepresenting medical necessity criteria, Judge Moreno held that their claims should be characterized as an ERISA claim for benefits rather than as an ERISA breach of fiduciary duty claim.¹² The ruling is significant as it drastically restricts the remedies available to those plaintiffs to health benefits, and possibly plaintiffs' attorneys' fees. However, Judge Moreno allowed all subscribers to maintain their claims that the defendants breached their fiduciary duties under ERISA by "improperly interfering with physician-patient communication by imposing "gag orders" on doctors" and not discharging their duties "solely in the interest" of the participants and beneficiaries. While most managed care organizations no longer utilize gag orders in their contracts with providers, the subscriber suits challenge managed care methodologies employed by the defendants dating back to 1991.

2. *Provider Class Actions*

¹² As to the subscribers who are no longer members of a plan, Judge Moreno noted that they have no adequate remedy under ERISA's claim for benefits provision for their breach of medical necessity fiduciary duty claims since this section of ERISA limits those who can seek recourse to current subscribers only. Thus, the former plaintiff subscribers' only recourse to recover for the defendants' alleged misrepresentation is under the ERISA catch all claim provision which presumably allows the plaintiff former subscribers to pursue restitutionary and other equitable relief. Judge Moreno cautioned the former subscribers that their medical necessity misrepresentation claims must conform with his prior rulings that neither the summary plan document requirements nor ERISA's general fiduciary duty obligations require a plan administrator to disclose financial incentives paid to physicians or employees. He stated: "*If, in the end, the plaintiffs' misrepresentation claim boils down to an allegation that the Defendants mislead their subscribers by failing to give enough information about cost-suppression incentives to place the medical necessity terminology in proper context, it would be precisely the sort of omission-based claim that this Court has already rejected. . . Such a claim would be fatally imprecise and subject to dismissal.*"

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a. RICO Violations:

- (i) Healthcare providers and several state medical associations have filed class actions against the largest for-profit health insurers and HMOs alleging RICO violations through fraudulent and extortionate predicate acts. The provider RICO class actions have been consolidated in In Re: Humana Managed Care Litigation. The providers generally assert that, contrary to defendants' contracts and representations, defendants implemented internal policies and procedures secretly designed to systematically obstruct, reduce, delay and deny healthcare payments to the providers.¹³ 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 November 20, 2002, the U.S. Court of Appeals for the 11th Circuit granted the defendants' Motion for Appellate review. The parties filed their appellate briefs but the 11th Circuit has not yet scheduled oral arguments.
- (iii) Although many of the provider contracts with the defendant managed care organizations contain arbitration clauses, on March 14, 2002, the 11th Circuit Court of Appeals ruled that *the providers' 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

¹³ As discussed in Section D3 below, many providers have also been alleging antitrust violations and unfair trade practices.

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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' RICO claims. Pacificare Health Systems, Inc. v. Book, 538 U.S. ____ (2003). 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.

b. ERISA Violations

- (i) The providers in the In Re Humana Managed Care Litigation 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

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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.

D. Increased Frequency of Individual Provider Suits and Attorney General Suits Against Managed Care Organizations Arising Out of Claim Payment Practices

1. Violations of Prompt Payment Statutes

- a. Most states have prompt or clean payment statutes which require health insurers to timely pay undisputed health benefit claims within 30 to 45 days of receipt of all necessary claim documentation. Individual healthcare providers, their medical associations, and the state attorney generals are filing complaints against managed care organizations, challenging the timing and/or amount of provider claim reimbursement payments. For example, last year the Texas Attorney General announced agreements requiring 17 insurance carriers and health maintenance organizations to pay tens of millions of dollars in restitution to providers and \$9.25 million in fines to resolve complaints about claim processing under the Clean Claim Act, which requires claim payments on undisputed claims within 45 days.¹⁴

Pacificare has filed suit challenging the constitutionality of the Clean Care Act.

III. Noteworthy Legislative Developments

A. The Patient Bill of Rights

For some time prior to the events of September 11, 2001, Congress debated passage of patient protection legislation. The Senate and House passed differing versions of the legislation in June and August 2001, respectively. *See*, S. 1052 and *H.R. 2463*. Both measures would have amended ERISA to allow subscriber-patients to sue health insurers for injuries caused by their wrongful denial of benefits to the extent the insurer exercised medical judgment. The bills differed with respect to the scope of the patient-subscriber's available remedies.¹⁵ President

¹⁴ Among the insurers and HMOs agreeing to the settlement were: Blue Cross and Blue Shield of Texas, Cigna Healthcare of Texas, Humana Health Plan of Texas and United Healthcare Insurance Co.

¹⁵ In denial of benefit cases involving medical judgment, the Senate bill would have permitted a subscriber that has suffered injury or death to pursue all available relief under state law, including extra-contractual relief. However, the House version of the bill would have capped non-economic damages at \$1.5 million and punitive

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Bush indicated that he would veto the Senate passed bill. While Senate aides and White House representatives were reportedly negotiating the terms of compromise legislation on the liability portion of the bills, efforts have apparently been abandoned, in part, because of the House of Representative's recent passage of the Medical Malpractice Liability Act, discussed below.

However, on March 3, 2003, Representative Charlie Norwood introduced into the House of Representatives Patient Protection legislation (H.R. 597) which incorporates the non-controversial provisions of the 2001 patient protection legislation with respect to a health insurers' provision of (1) emergency care; (2) obstetric and gynecologic care; (3) specialists care; (4) prescription drugs; (5) participation in approved clinical trials; and (6) health plan information. The newly proposed patient rights legislation would also, among other things, amend ERISA to require MCOs to have approved utilization review programs, internal and external claims procedures, etc. Significantly, H.R. 597 does not address the liability of MCO's for wrongful denial of benefit claims in cases where the MCO employs medical judgment.

B. Medical Malpractice Liability Act

On March 13, 2003, the House of Representatives passed legislation (H.R. 5) which, among other things, places a federal limit of \$250,000 on non-economic (pain and suffering) damages in health care lawsuits and caps 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 Act¹⁶. 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."

President Bush has endorsed the bill and urged Senate action on it, but commentators believe that it will be tough to navigate the bill through the Senate. Republicans in the Senate are reportedly preparing similar legislation but Senator Judd Gregg (R-N.H.), Chairman of the Senate Health, Education, Labor and Pensions Committee advises that the range of lawsuits covered in the Senate GOP bill would not be as broad as in the House measure which extends to health care liability suits filed against pharmaceutical makers. Moreover, commentators anticipate pressure

damages at \$1.5 million. Moreover, under the House version of the bill, punitive damages would only have been available if a health plan failed to comply with the independent medical reviewer's decision that the claim for health benefits should be granted.

¹⁶ 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."

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in the Senate to increase the House bill's \$250,000 cap on non-economic damages and to provide for exceptions from the cap in cases where medical malpractice results in death or dismemberment.

1. Comments: 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 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.