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Managed Care Litigation: Recent Developments and Future Trends for Payors and Providers

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I. INTRODUCTION

This paper discusses the recent case law regarding the following managed care litigation topics:

- Payor Actions for Alleged Provider Fraud and Abuse;
- Civil Actions Involving Health Care Data Privacy Breaches;
- Member and Patient Class Actions Against Payors and Providers; and
- Medicare Preemption of Member and Provider Claims.

II. PAYOR ACTIONS FOR ALLEGED PROVIDER FRAUD AND ABUSE

A. Payor Actions for Providers' Waivers of Members' Cost-Sharing

1. Background

Health plans steer their members to in-network providers by negotiating lower rates with the in-network providers, and offering lower co-payments or co-insurance to the members. The cost-sharing also creates an incentive for the members to use the in-network health care services judiciously. The members' selection of in-network providers and efficient use of health care services enables the plans to control health care costs.

Because member cost-sharing is a cornerstone of the health network system, Congress has prohibited providers from routinely waiving member co-payments or deductibles in federal programs. 42 U.S.C. § 1320a-7b(b) (authorizing criminal prosecution); 42 U.S.C. § 1320a-7(b)(7) (authorizing program exclusion). Federal courts have likewise recognized that providers which do not collect co-payments may forfeit the right to payment from a health plan. *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701-02 (7th Cir. 1991) Despite these well-settled principles, some in-network providers have tried to inflate their patient volume by waiving members' co-payments or deductibles. Increasingly, providers have tried to

circumvent the system altogether by going out of network and then waiving members' co-insurance. The waivers eliminate the immediate, short-term costs of the out-of-network services, allowing the out-of-network providers to siphon members away from in-network providers. The out-of-network providers then recoup the foregone co-insurance through increased charges to the payors funding the health plans.

Private payors have responded to the waivers of in-network and out-of-network member cost-sharing by suing the providers. In some instances, providers have even sued their competitors under the same theories. Most of the litigation has occurred in Illinois, New Jersey, and New York, under those states' deceptive trade practices and insurance fraud statutes. The plaintiffs have achieved varying degrees of success.

2. Illinois Litigation

a) *Elements of Claim for Violation of Illinois Consumer Fraud and Deceptive Business Practices Act ("ICFA"):*

- (i) A deceptive or unfair act or practice by the defendants;
- (ii) The defendant's intent that the plaintiff rely on the deceptive or unfair practice; and
- (iii) The unfair or deceptive practice occurred during a course of conduct involving trade or commerce.

Siegel v. Shell Oil Co., 612 F.3d 932, 935 (7th Cir. 2010)

b) *Dimensions Med. Ctr., Ltd. v. Principal Fin. Grp., Ltd.*, No. 93-C-6264, 1996 WL 494229 (N.D. Ill. Aug. 21, 1996)

The providers in *Dimensions Medical Center* sued the payor to recover alleged underpayments, and the payor counterclaimed for violations of the Employee Retirement Income Security Act ("ERISA"), the ICFA, and the Illinois Insurance Act, as well as for fraud. *Id.* at *1, *8. The payor alleged that the providers were liable for waiving patients' co-payments and deductibles. *Id.* at *8. The Northern District of Illinois held that the ICFA and common law fraud claims were preempted by ERISA because they related to the members' benefit plans. *Id.* at *11-*12. The Illinois Insurance Act also related to the benefit plans, but the Northern District concluded that it fell within ERISA's insurance savings clause and was not preempted. *Id.* The Northern District denied summary judgment on the ERISA claim because the payor raised genuine issues of material fact

regarding the provider's authority to waive co-payments and deductibles under the benefit plans. *Id.* at *8-*9.

- c) Report & Recommendation, *OSF Healthcare Sys. v. Banno*, No. 1:08-cv-01096, ECF No. 29 (C.D. Ill. Sept. 24, 2008) ; ECF No. 42 (Dec. 10, 2008) (adopting report of magistrate in part); ECF No. 61 (Mar. 30, 2009) (final order on motion to dismiss following re-pleading)

In *OSF Healthcare*, the plaintiff ambulatory surgery practice entered into an exclusive agreement with Caterpillar to provide healthcare to the company's employees. Order Adopting Report in Part at p. 2. The plaintiff agreed to discount its rates in return for the exclusive right to provide non-urological services to Caterpillar employees. *Id.* The defendants (a urologist and several medical practice entities) had the right to provide urological services under the agreement. *Id.* To induce Caterpillar employees to use their other services (which were out-of-network), the defendants waived the employees' co-insurance. *Id.* at 3. They did so despite being told multiple times by Caterpillar that the co-insurance was mandatory. Report & Recommendation at p. 5.

The plaintiff brought federal RICO claims against the defendants. Order Adopting Report in Part at p. 3. The plaintiff alleged that the defendants were a RICO "enterprise" that had engaged in a pattern of racketeering activity by fraudulently billing Caterpillar, in violation of the federal mail and wire fraud statutes. *Id.* at 3. The plaintiff alleged that the same conduct violated the ICFA. *Id.*

The Central District of Illinois ultimately held that the plaintiff had sufficiently alleged a legal duty to charge and collect the co-insurance, and had therefore sufficiently pled mail and wire fraud. Final Order on Motion to Dismiss at p. 3. Consequently, the Central District partially denied the defendant's motion to dismiss the RICO counts. *Id.* at 3. The Central District also denied the defendant's motion to dismiss the ICFA claim because the defendant's conduct increased the amount which Caterpillar paid for healthcare, and therefore had the effect of increasing consumers' health care costs. *Id.* at 5-6.

- d) *Pa. Chiropractic Ass'n v. Blue Cross Blue Shield Ass'n*, No. 09-C-5619, 2011 WL 1626546 (N.D. Ill. Apr. 28, 2011)

The plaintiffs in *Pa. Chiropractic* included chiropractors who sued the defendant payors for alleged improper recoupments. *Id.* at *1. One of the payors counterclaimed against one of the chiropractors under their contract,

alleging that the chiropractor had failed to charge and make reasonable attempts to collect the members' co-insurance. *Id.* The chiropractor moved to dismiss the counterclaim on the grounds that it was preempted by ERISA, and that it failed to state a claim. *Id.* at *2. The Northern District of Illinois denied the motion, reasoning that the counterclaim arose from the contract, and did not "relate to" an employee benefit plan. *Id.* at *4-*5. The Northern District also found that the payor had stated a claim by sufficiently pleading an obligation to collect the co-insurance. *Id.* at *5-*6. Nonetheless, the Northern District directed the payor to re-plead the counterclaim and identify the specific patients for whom co-insurance was waived. *Id.*

3. New Jersey Litigation

a) *Elements of Claim for Violation of New Jersey Insurance Fraud Protection Act ("IFPA"):*

- (i) Presenting or causing to be presented any statement as part of, or in support of a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or
- (ii) preparing or making any statement that is intended to be presented to any insurance company, in connection with, or in support of any claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; and
- (iii) causation; and
- (iv) actual damages.

See N.J. Stat. §§ 17:33A-4(a)(1)-(2), 17:33A-7(a).

b) *Aetna Health, Inc. v. Carabasi Chiropractic Ctr., Inc.*, No. A-3185-04T1, 2006 WL 66460 (N.J. Super. Ct. App. Div. Jan. 13, 2006) (per curiam)

In *Aetna Health*, the New Jersey Appellate Division held that a payor states an IFPA claim by alleging that a provider waived member co-insurance, failed to disclose the waiver on claim forms, and inflated the actual charges on the claim forms. *Id.* at *3. The Appellate Division also held that a payor states a claim for tortious interference against a provider by alleging that

the provider waived the member's co-insurance obligations. *Id.* The Appellate Division, however, concluded that the payor's unjust enrichment claim had "no merit" because the payor did not except remuneration from the provider when it paid the claims. *Id.* at *4.

c) *Garcia v. Health Net of N.J., Inc.*, No. C-37-06, 2007 WL 5253484 (N.J. Super. Ct. Ch. Div. Nov. 20, 2007), *aff'd* No. A-2430-07T3, 2009 WL 3849685 (N.J. Super. Ct. App. Div. Nov. 17, 2009)

The payor in *Garcia* alleged that out-of-network providers violated the IFPA by waiving members' co-insurance. 2007 WL 5253484, at *14-*15. The trial court granted summary judgment to the providers on the IFPA claim and distinguished *Aetna Health* on the ground that the providers lacked the requisite scienter, as New Jersey law does not prohibit co-insurance waivers by out-of-network providers. *Id.* The Superior Court also granted summary judgment to the providers on the payor's tortious interference claim, reasoning that the providers: (1) received assignments of the members' contracts with the payor, (2) had no contractual or other duty to collect co-insurance from the members, and (3) thus had no motive to harm the payor. *Id.*

The Appellate Division affirmed the Superior Court, reasoning that the payor failed to establish that the providers submitted claims knowing that the claims were false and misleading. 2009 WL 3849685, at *3. Notably, there "was no statute, regulation, or regulatory directive from any licensing agency barring the waiver of a contractual right to collect co-insurance," so it would have been inappropriate to impute knowledge of illegality to the providers. *Id.* at *4.

d) *Horizon Blue Cross Blue Shield of N.J. v. E. Brunswick Surgery Ctr.*, 623 F. Supp. 2d 568 (D.N.J. 2009)

The payor in *Horizon BCBS* sued the defendant out-of-network provider in New Jersey state court, alleging that the defendant waived members' co-insurance, and was therefore liable for IFPA violations, common law fraud, misrepresentation, and tortious interference. *Id.* at 572. The defendant removed the action to federal court, arguing that the state law claims were completely preempted by ERISA's enforcement provisions under section 502(a). *Id.*

The plaintiff conceded that most of the disputed claims were paid by ERISA employee benefit plans, but the district court remanded. *Id.* at 573. The district court concluded that the plaintiff's claims had an independent

basis in New Jersey state law. *Id.* at 576-77. Also, the plaintiff was suing on its own behalf, in order to protect its contractual agreements with in-network providers. *Id.* at 577. The plaintiff was not suing for beneficiaries, nor was it acting like a provider by trying to recover benefits under an assignment. *See id.* Ultimately, remand was appropriate because the plaintiff's action did not predicate on an alleged failure to provide full benefits to a beneficiary. *Id.* at 578.

4. New York Litigation

- a) *Oxford Health Ins., Inc. v. Josephson*, No. 106655/04, 2010 WL 3068027 (N.Y. Sup. Ct. Jul. 23, 2010)

The plaintiff payor in *Oxford Health* sued the defendant physician for breach of contract, common law fraud, and unjust enrichment. *Id.* at *2-*3. The plaintiff alleged that the physician was an out-of-network provider who routinely waived co-insurance for the plaintiff's members. *See id.* The trial court granted summary judgment to the defendant on the breach of contract claim because the defendant had no contract with the plaintiff, and did not assume any obligations relating to co-insurance when the members assigned their rights to payment. *Id.* at *4-*5. The court also granted summary judgment to the defendant on the fraud claim because the plaintiff did not show that the defendant's practice was to routinely waive co-insurance. *Id.* at *6-*8. The plaintiff's unjust enrichment claim survived summary judgment because there was evidence that the defendant had waived co-insurance for members on at least some claims, and proof of routine waivers was not necessary to prevail. *Id.* at *8.

B. Payor Actions for Alleged Pharmacy Fraud and Abuse

1. *Pirelli Armstrong Tire Corp. Retiree Med. Benefits Trust v. Walgreen Co.*, 631 F.3d 436 (7th Cir. 2011)

In *Pirelli*, a third-party payor alleged that Walgreens pharmacies violated the ICFA by systematically taking prescriptions written for less expensive forms of two drugs and illegally filling those prescriptions with more expensive forms. 631 F.3d at 437-38. The payor relied primarily on allegations of fraud from other lawsuits, and referenced only a handful of improperly filled prescriptions from its own pharmacy data. *Id.* at 444-47. The Seventh Circuit affirmed the dismissal of the complaint because the payor's de minimis showing did not satisfy Federal Rule of Civil Procedure 9(b). *Id.* at 446-47.

III. CIVIL ACTIONS INVOLVING HEALTH CARE DATA PRIVACY BREACHES

A. Common Law and Statutory Claims

1. Claims for health care data privacy breaches under state common law and statutory theories have failed for lack of an injury and insufficient pleading. In *Resnick v. AvMed, Inc.*, the defendant managed care organization (“MCO”) had several laptop computers stolen from its corporate offices. No. 1:10-cv-24513-JLK, 2011 WL 1303217, at *1 (S.D. Fla. Apr. 5, 2011). The computers contained the health care data for more than one million customers. *Id.* Some of the customers sued, alleging that the MCO’s breach exposed them to an “increased risk of identity theft.” *Id.* They pled claims for (1) negligence, (2) breach of contract, (3) breach of implied contracts, (4) restitution/unjust enrichment, (5) violation of state statutes prohibiting misleading advertising, (6) negligence per se, (7) breach of fiduciary duty, (8) breach of the implied covenant of good faith and fair dealing, and (9) invasion of privacy. *Id.* The Southern District of Florida dismissed the claims because the mere risk of future identity theft was not a legally cognizable injury. *Id.* Additionally, the Southern District dismissed the claims by one plaintiff who alleged actual identity theft, as her allegations attempting to tie the alleged identify theft to the data breach were not sufficient to satisfy Rule 12(b)(6)’s plausibility standard. *Id.*
2. The federal courts have repeatedly held that there is no private right of action under the Health Insurance Portability and Accountability Act (“HIPAA”). *See, e.g., Sneed v. Pan Am. Hosp.*, 370 F. App’x. 47, 50, 2010 WL 971894, at *2 (11th Cir. Mar. 18, 2010); *Warren Pearl Constr. Corp. v. Guardian Life Ins. Co. of Am.*, 639 F. Supp. 2d 371, 376 (S.D.N.Y. 2009).
3. At least two federal courts have dismissed claims under the Racketeer Influenced and Corrupt Organizations Act (RICO) based on violations of HIPAA because such violations are not predicate acts for purposes of civil RICO liability. *Wheeler v. Hilo Med. Ctr.*, No. 09-00533 JMSKSC, 2010 WL 1711993, at *8, n.11 (D.Haw. Apr. 27, 2010); *Vavro v. Albers*, No. 2:05CV321, 2006 WL 2547350, at *18-*20 (W.D. Pa. Aug. 31, 2006).

B. Federal Civil RICO Identity Theft Litigation

1. Several independent pharmacies recently filed a putative RICO class action against CVS Caremark to enjoin and recover damages for the alleged use of member’s pharmacy data in violation of the Identity Theft Assumption and Deterrence Act. Complaint, *Muecke Co., Inc. v. CVS Caremark Corp.*, No. 6:10-cv-00078, ECF No. 1, at ¶¶ 95 - 122 (S.D. Tex. Sept. 30, 2010). CVS

Caremark operates a chain of retail pharmacies along with a pharmacy benefit manager (“PBM”) business. *Id.* at ¶¶ 25-35. Plaintiffs do not participate in CVS Caremark’s PBM network. *Id.* at ¶ 109.

- a) The Identity Theft Act makes it a federal crime to
 - (i) knowingly transfer, possess, or use,
 - (ii) without lawful authority,
 - (iii) “a means of identification of another person,”
 - (iv) with the intent to commit, or to aid or abet, or in connection with,
 - (v) any unlawful activity that constitutes a violation of Federal Law, or that constitutes a felony under any applicable State or local law.

See 18 U.S.C. § 1028(a)(7). Importantly, violations of the Identity Theft Act are RICO predicate acts. 18 U.S.C. § 1961(1).

- b) The Identity Theft Act defines the term “means of identification” as any name or number that may be used, along with any other information, to identify a specific individual, including any:
 - A. [N]ame, social security number, date of birth, official State or government issued driver’s license or identification number, alien registration number, government passport number, employer or tax identification number;
 - B. [U]nique biometric data, such as fingerprint, voice print, retina or iris image, or other unique physical representation; [or]
 - C. [U]nique electronic identification number, address, or routing code
....

18 U.S.C. § 1028(d)(7)(A)-(C). “The [term] means simply a means of identification (an identifier or combination of identifiers) that may be used to identify a specific individual.” *United States v. Mitchell*, 518 F.3d 230, 234-35 (4th Cir. 2008).

- c) Plaintiffs’ primary theory is that CVS Caremark violated the Identity Theft Act (and RICO) by receiving PBM members’ protected health information (“PHI”) from Plaintiffs, and then using the information in connection with criminal HIPAA violations. *Muecke* Complaint at ¶¶109-116.

2. Essentially, the plaintiffs are trying to use RICO and the Identify Theft Act to make an end-run around well-settled case law holding that HIPAA does not create a private right of action. The plaintiff's theory has a good-faith, reasonable legal basis, as RICO can be used to pursue violations of statutes which do not create private rights of action. *See, e.g., Leskinen v. Halsey*, No. 2:10-cv-03363 MCE, 2011 WL 837111, at *2 (E.D. Cal. Mar. 7, 2011) ("Although plaintiff cannot directly sue any defendants under the federal mail and wire fraud statutes, a violation of those provisions may serve as predicate acts in support of a claim brought pursuant to [RICO]."). RICO, however, is not a vehicle for pursuing statutory violations which are enforced through an administrative process. *McCulloch v. PNC Bank Inc.*, 298 F.3d 1217, 1227 (11th Cir. 2002) (no RICO claim based on alleged mail and wire fraud in connection with Higher Education Act because Sec. of Education was authorized to impose civil penalties on lenders). Here, Congress empowered the U.S. Department of Health and Human Services to enforce HIPAA by investigating consumers' complaints of HIPAA violations and conducting administrative enforcement actions. *See* 45 C.F.R. §§ 160.300 – 160.316 (complaint procedures); §§ 160.400 – 160.426 (enforcement and civil penalties). A threshold legal issue in *Muecke* will likely be whether Plaintiffs can use RICO to pursue HIPAA violations indirectly, through the Identity Theft Act.

IV. MEMBER AND PATIENT CLASS ACTIONS

A. Member Class Actions Against Payors

1. Health Plan Marketing:

The plaintiffs in *Levine v. Blue Shield of Cal.*, 117 Cal.Rptr.3d 262, 265-66 (Cal. Ct. App. 2010) were a husband and wife who sued the defendant payor for fraudulent concealment, negligent misrepresentation, breach of the implied covenant of good faith and fair dealing, unjust enrichment, and unfair competition. The plaintiffs' claims were based on the allegation that the defendant failed to disclose that the plaintiff's premiums would have been lower had they designated the wife as the primary insured instead of the husband. *Id.* The duty to disclose allegedly arose from the common law, as well as a California Insurance Code provision requiring insurers to affirmatively disclose known material facts which the other side has no other means to ascertain. *See Id.* at 267, n.4. The trial court sustained the defendant's demurrer on the grounds that there was no common law duty of disclosure, and the statutory duty did not apply because the defendant was regulated as a health plan and not an insurer. *Id.* at 268. The Court of Appeal affirmed, reasoning that not even an insurer would have a common

law or statutory duty to disclose information about premium pricing to a potential policy holder. *Id.* at 270-77.

2. Balance Billing:

In *Clark v. Grp. Hospitalization & Med. Servs., Inc.*, No. 10-CV-333, 2010 WL 5093629, at *2 (S.D. Cal. Dec. 7, 2010), the plaintiff's son was treated at the emergency department, and the plaintiff's ERISA plan paid for 100% of the facility's charges, but not 100% of the physicians' charges. The plan documents stated that the plaintiff was responsible for amounts exceeding the plan's allowable for the physicians' charges. *Id.* at *3. The plaintiff filed an appeal with the plan regarding the refusal to pay 100% of the physicians' charges, and the plan denied the appeal. *Id.* at *2.

The plaintiff responded by bringing putative class claims under ERISA and California's Unfair Competition Law ("UCL") against the plan's third-party administrator ("TPA"). *Id.* The ERISA claim sought full payment of the plan benefits and clarification of rights to future benefits under the plan. *Id.* at *3. The defendant moved to dismiss the ERISA claim on the ground that it complied with the terms of the plan, and the Southern District of California denied the motion on the ground that compliance with the plan presented a fact issue. *Id.*

In support of the UCL claim, the plaintiff alleged that the plan documents amounted to an "unfair" practice because they placed him in the middle of a billing dispute between physicians and the plan concerning the claim balance, when a California statute expressly prohibited balance billing by providers. *Id.* at *7-8. The defendant argued that the UCL claim was preempted by ERISA, and that the plaintiff had failed to state a claim under the UCL because California's prohibition on balance billing applied only to providers. *Id.* at *4, 6. The Southern District rejected the preemption argument, reasoning that the balance-billing statute fell within ERISA's savings clause, and the UCL claim presented an independent legal duty that was separate from ERISA's remedial scheme. *Id.* at *6. The Southern District also agreed with the plaintiff that the UCL claim was viable because the plan documents placed the plaintiff in the middle of a billing dispute that was prohibited by California law. *Id.* at *7-8.

3. Co-Payments and Co-Insurance:

- a) Order preliminarily approving class action settlement, *Casey v. Coventry Healthcare of Kan., Inc.*, No. 4:08-cv-00201, ECF No. 129 (W.D. Mo. May 4, 2011)

The plaintiff in *Casey* brought putative class claims against the defendant health maintenance organization (“HMO”) under ERISA and Missouri law, alleging that the defendant violated the plan documents and a Missouri insurance regulation by collecting both co-payments (flat fees) and co-insurance (percentage fees) on the same claims. No. 4:08-cv-00201, 2009 WL 1616636, at *4-5 (E.D. Mo. Jun. 9, 2009). The Western District of Missouri granted summary judgment to the plaintiff on the issue of whether collecting co-payments and co-insurance on the same claim violated the regulation. *Id.* at *4-6. The Western District granted summary judgment despite the fact that the Missouri Department of Insurance had approved the defendant’s Statement of Benefits (which disclosed that both co-payments and co-insurance would be collected). *Id.* at *5-6. The Western District then certified the class, despite the individualized nature of the alleged damages and the availability of statutory attorney’s fees (which supported the defendant’s superiority argument). No. 4:08-cv-00201, 2010 WL 3636140, at *5-6 (W.D. Mo. Sept. 10, 2010). The Western District preliminarily approved a settlement and provisionally certified a settlement class on May 4, 2011. No. 4:08-cv-00201, ECF No. 129.

- b) Final order regarding class certification notice, *Holling-Fry v. Coventry Healthcare of Kan., Inc.*, No. 07- 00092. ECR No. 137 (W.D. Mo. May 11, 2011)

The plaintiff in *Holling-Fry* brought putative class claims against the defendant HMO under ERISA, alleging that the defendant violated a Missouri insurance regulation by collecting copayments at the point of service on prescription drugs that exceeded 50% of the cost of the drugs. No. 07-0092, 2010 WL 3636156, at *1 (W.D. Mo. Sept. 10, 2010). The Western District held that the defendant’s practice of collecting the copayments at the point of service, but later refunding amounts in excess of 50%, was a violation of the regulation. *Id.* The Western District then certified the class after determining that a class action was a superior means for resolving the dispute, despite the individualized nature of the damages. *Id.* at *5. The Western District later granted summary judgment to the defendant on the issue of whether the defendant’s reimbursement practice complied with the plaintiff’s plan. No. 07-0092, 2010 WL 4867598, at *4 (W.D. Mo. Nov. 23, 2010). The parties are scheduled to try the merits of

the plaintiff's individual claims, as well as class-wide damages issues (*e.g.*, whether amounts exceeding 50% remain to be reimbursed), in November 2011. No. 07-00092, ECF No. 137 at ¶ 5.

4. Mental Health Parity:

- a) *Johns v. Blue Cross Blue Shield of Mich.*, No. 2:08-12272, 2009 WL 646636 (E.D. Mich. Mar. 10, 2009)

The plaintiff in *Johns* brought putative class claims against the defendant TPA under ERISA, alleging that the defendant wrongfully denied claims for an autism treatment known as Applied Behavioral Analysis (“ABA”). *Id.* at *1. The plaintiff contended that the defendant systematically denied coverage of ABA as “experimental” or “investigative” without explaining or providing evidence in support of that status. *Id.* The defendant moved to dismiss the plaintiff's ERISA claim for breach of fiduciary duty under 29 U.S.C. § 1132(a)(2) on the ground that the plaintiff failed to plead injury to the plan. *Id.* at *7. The defendant also moved to dismiss the plaintiff's ERISA claim for breach of fiduciary duty under § 1132(a)(3) on the ground that it was cognizable only as a claim for a denial of benefits under § 1132(a)(1)(B). *Id.* at *4-6. The Eastern District of Michigan granted the defendant's motion on the § 1132(a)(2) claim, but only granted the motion on the § 1132(a)(3) claim in part. *Id.* at *7. The Eastern District determined that the § 1132(a)(3) claim was viable only to the extent that it predicated on the defendant's alleged refusal to provide a full and fair review of the denial of the claim for ABA coverage. *Id.* at *6.

- b) *Arce v. Kaiser Found. Health Plan, Inc.*, 104 Cal.Rptr.3d 545 (Cal. Ct. App. 2010)

The plaintiff in *Arce* brought putative class claims against the defendant health plan under the UCL after the defendant denied coverage of certain therapies for treatment of his autism. *Id.* at 552-53. The plaintiff alleged that the denials were wrongful under California's Mental Health Parity (“MHP”) Act, which requires that health plan contracts cover the diagnosis and medically necessary treatment of severe mental illness under the same terms and conditions applied to other medical conditions. *Id.* at 554. The defendant demurred, arguing that the plaintiff could not establish commonality of interest because resolution of the UCL claim would require the trial court to make individualized medical necessity determinations. *Id.* at 554-55. The defendant also argued that the trial court should equitably abstain from deciding which forms of autism therapy are properly excluded from coverage, as economic and health policy determinations are made by

the legislature or California's Department of Managed Health Care ("DMHC"). *Id.* The trial court agreed with the defendant and granted the demurrer. *Id.*

The Court of Appeal reversed, reasoning that the plaintiff alleged a violation of the MHP Act through a policy of excluding coverage for the autism therapies, without regard to whether the therapies might be medically necessary for the particular patient. *Id.* at 565. The uniform nature of the policy presented common issues of contractual and statutory interpretation which the trial court would decide without ever reaching individualized issues of medical necessity. *Id.* at 562-63, 567. Such issues of law were appropriate for adjudication by the court, and weighed against equitable abstention, because they did not require the court to decide complex issues of economic or health policy. *Id.* at 570-73.

c) *Graddy v. Blue Cross Blue Shield of Tenn., Inc.*, No. 4:09-cv-84, 2010 WL 670081 (E.D. Tenn. Feb. 19, 2010)

The plaintiff in *Graddy* brought putative class claims against the defendant insurer and TPA under ERISA and state law, alleging that the defendant wrongfully refused to cover Applied Behavior Analysis ("ABA") treatment for his child's autism. *Id.* at *2-3. The plaintiff asserted that the defendant maintained a policy of denying all coverage for autism treatments without regard to the terms of the plan, medical necessity, or the scientific validity of the treatments. *Id.* at *4-5. The defendant moved the Eastern District of Tennessee to dismiss the claims on the ground that the plaintiff improperly pled them as a class action. *Id.* at *7. At the same time, the plaintiff moved for certification of the class. *Id.*

The Eastern District denied the plaintiff's motion, finding that individualized issues predominated and that the typicality requirement was not met. *Id.* at *9. The Eastern District reasoned that even if all class members were subjected to the alleged uniform policy, questions of causation and damages would be particularly dependent upon the equities of each class member's claim. *Id.* Also, the common issue of whether the ABA treatment is experimental "per se" did not predominate, because the experimental nature of the treatment depends partly on the extent of each class member's autism. *Id.* at *10.

d) *Daniel v. Blue Shield of Cal.*, No. 09-2037, 2011 WL 830623 (N.D. Cal. Mar. 3, 2011)

The plaintiffs in *Daniel* sued the defendant claims administrator after the defendant denied coverage of a residential mental health treatment program for their child. *Id.* at *1. The plaintiffs alleged that the denial of coverage breached the terms of the plan (which was subject to California's MHP Act). *Id.* The defendant moved for summary judgment on the ground that the plan did not cover residential care, and the Northern District of California granted the motion. *Id.* at *7. The Northern District observed that the MHP Act does not require coverage for all medically necessary health care services, and only requires parity for coverage of outpatient, inpatient hospital, and partial hospital services. *Id.* at *8. Because the plan did not cover residential care, and residential care did not fit within the categories of services subject to the MHP Act, there was no breach of the plan or any violation of the MHP Act. *Id.* at *9.

B. Uninsured Patient Class Actions Against Providers

1. *Durell v. Sharp Healthcare*, 108 Cal.Rptr.3d 682 (Cal. Ct. App. 2010)

The plaintiff in *Durell* was an uninsured patient who received treatment from the defendant hospital, and agreed to pay the defendant's "usual and customary charges" when he presented. *Id.* at 687-88. The defendant charged the plaintiff its chargemaster rates, which were 412% of Medicare. *Id.* at 688. The plaintiff refused to pay the charges, and brought putative class claims against the defendant for violations of the UCL and Consumer Legal Remedies Act ("CLRA"), as well as unjust enrichment and breach of contract. *Id.* at 688. The defendant demurred and the trial court dismissed the complaint, but allowed the patient to amend after paying part of the charges. *Id.* at 689. On reconsideration, the trial court affirmed. *Id.*

The Court of Appeal affirmed the dismissal of the UCL claim because the plaintiff failed to plead reliance on a misrepresentation under the UCL's "unlawful" prong, and failed to plead an "unfair" practice under the UCL as a matter of law. *Id.* at 694, 696. The Court of Appeal also affirmed the dismissal of the CLRA claim for failure to plead reliance on a misrepresentation. *Id.* at 697. Finally, the Court of Appeal affirmed the dismissal of the breach of contract and unjust enrichment claims because the plaintiff had not paid the full charges, had no excuse for his nonperformance, and could not show that the defendant's retention of the partial payments was unjust. *Id.* at 697-98, 699-700.

2. *Baptist Health v. Hutson*, 2011 Ark. 210 (Ark. 2011) (page citations unavailable)

The defendant hospital in *Baptist Health* appealed the trial court's certification of the plaintiff uninsured's class action for breach of contract. The plaintiff's theory was that the defendant had breached its contractual obligation to assess charges at no more than its regular rates by assessing charges to the class members at the full chargemaster rate. The defendant argued that the trial court erred by defining the class to include persons who remain legally liable on their patient accounts, since that class definition necessarily required the resolution of individualized issues. The Supreme Court of Arkansas affirmed, reasoning that the common liability issue of billing the full chargemaster rate was predominant. The Supreme Court also determined that individualized issues of damages could be addressed through bifurcated proceedings in the event that the plaintiff prevailed on the common liability issue.

V. MEDICARE PREEMPTION OF MEMBER AND PROVIDER CLAIMS

A. Background: Preemption of Claims Regarding Medicare Marketing

1. The Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA") contains a broad preemption clause which, on its face, preempts all but two areas of state law concerning the marketing of Medicare Advantage ("MA") plans. The clause states: "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under [Part C]." 42 U.S.C. § 1395w-26(b)(3).¹ This plain language seems to depart from the prior statute, which preempted only those state laws that actually conflicted with specific federal standards, such as Medicare "requirements relating to marketing materials and summaries and schedules of benefits." 42 U.S.C. §§ 1395w-26(b)(3)(B)(iv) (2002).
2. The first district judge to construe the preemption clause found that it supported both complete and ordinary preemption. Since then, multiple district judges have found that it only supports ordinary preemption.
 - a) *Dial v. Healthspring of Ala., Inc.*, 501 F. Supp. 2d 1348 (S.D. Ala. 2007)

¹ Medicare Part D incorporates the express preemption provision contained in Medicare Part C. *Uhm v. Humana, Inc.*, 620 F.3d 1134, 1149 (9th Cir. 2010) (citing 42 U.S.C. § 1395w-112(g)).

In *Dial*, members of a MA plan sued the MA organization and its marketing agents in Alabama state court. The members alleged that the defendants induced them to enroll in the MA plan by misrepresenting benefits levels. *Id.* at 1350. The misrepresentations supposedly resulted in the members losing their richer, pre-existing benefits under Medicare Parts A and B. *Id.* The members asserted numerous state law causes of action against the defendants, including: fraud, negligent hiring and supervision, civil conspiracy, unjust enrichment, breach of contract, breach of fiduciary duty, and infliction of emotional distress. *Id.* The defendants removed the case to Southern District of Alabama, and the members moved to remand. *Id.*

The interpretation of the MMA's preemption clause presented an issue of first impression for the *Dial* court, which held that the clause created federal jurisdiction by completely preempting state law in the area of MA marketing. *Id.* at 1352. The *Dial* court found complete preemption based on the plain language of the preemption clause, as well as the MMA's structure and purpose. *Id.* at 1356. These considerations showed that Congress' intent was for the MMA to preempt state laws in areas in which Congress either established standards, or authorized CMS to establish standards. *Id.* at 1356.

The *Dial* court reviewed CMS's standards for MA marketing. *Id.* at 1357-58 (citing 42 C.F.R. § 422.80). Because CMS's standards applied to the MA marketing practices about which the members complained, the court held that the MMA and CMS's standards completely *and* ordinarily preempted the claims. *Id.* at 1358. The *Dial* court rejected the argument that CMS's Final Rule on MA marketing standards furnished "a blanket reprieve from preemption for all state tort claims." *Id.* at 1359.

b) *Bolden v. Healthspring of Ala., Inc.*, No. CV07-0413CGB, 2007 WL 4403588 (S.D. Ala. Oct. 2, 2007)

In *Bolden*, another district judge from the Southern District of Alabama declined to follow *Dial* when considering nearly identical claims against the same defendant. The *Bolden* court found no complete preemption after evaluating (1) the scope of the preemption under the MMA's preemption clause, and (2) Congress' substitution of a federal civil remedy for putative state law claims. *Id.* The *Bolden* court assumed that the "ordinary" preemptive effect of the MMA's preemption clause was sufficiently broad to satisfy the first prong of the test. *Id.* at *9. Then the *Bolden* court compared Part C's administrative grievance procedures to the federal civil remedies available under ERISA (which completely preempt state law

claims). *Id.* Because Part C's grievance procedures do not furnish a federal civil remedy in the mold of an ERISA claim, the *Bolden* court remanded the case to state court. *Id.*²

3. *Dial v. Healthspring of Ala., Inc.*, 541 F.3d 1044 (11th Cir. 2008)

The Eleventh Circuit eventually reversed the Southern District's decision in *Dial*, holding that the Medicare Act strips the federal courts of primary federal question jurisdiction over claims arising under the Act, and instead vests jurisdiction in the Secretary of the Department of Health and Human Services. *Id.* at 1047-1048. In other words, the Eleventh Circuit determined that the Southern District never had removal jurisdiction, as it was not reviewing an administrative decision issued by the Secretary. *See Id.* Following the Eleventh Circuit's decision in *Dial*, numerous district courts remanded actions involving MA organizations to state court. *See, e.g., Spencer v. Coventry Health and Life Ins.*, No. 07-0847, 2008 WL 4186161, at *1 (S.D.Ala. Sept. 8, 2008).

B. Recent Developments in Medicare Preemption of Member Claims

1. *Uhm v. Humana, Inc.*, 620 F.3d 1134 (9th Cir. 2010)

The plaintiffs in *Uhm* applied to enroll in the defendant's Medicare Part D prescription drug plan, and paid premiums to the defendant, but never received the materials from the defendant which were necessary to exercise the benefits under the plan. *Id.* at 1138-39. Consequently, the plaintiffs had to buy their prescription medications at higher costs. *Id.* at 1139. The plaintiffs sued for breach of contract, violation of consumer protection statutes, unjust enrichment, and fraud under Washington law. *Id.* The defendant moved to dismiss on the grounds that the plaintiffs had failed to exhaust their administrative remedies or, in the alternative, the plaintiffs' claims were preempted. *Id.* The plaintiffs responded that their state law claims were neither subject to administrative exhaustion nor preempted because the claims did not "arise under" the Medicare Act, as the claims arose before any enrollment in the program. *Id.* at 1141.

The Ninth Circuit found that the claims arose under the Medicare Act

² The U.S. District Court for the Middle District of Alabama subsequently reached similar decisions in three cases involving analogous allegations and claims. *Williams v. Viva Health, Inc.*, No. 2:07-CV-321-WKW, 2008 WL 220799, at *2-*3 (M.D. Ala. Jan. 25, 2008); *Lassiter v. PacifiCare Life & Health Ins. Co.*, No. 2:07-CV-583-MEF, 2007 WL 4404051, at *2-*3 (M.D. Ala. Dec. 13, 2007); *Harris v. PacifiCare Life & Health Ins. Co.*, 514 F. Supp. 2d 1280, 1292-97 (M.D. Ala. 2007).

because they were, “at bottom,” complaints for the denial of Medicare benefits. *Id.* at 1142-43. The contract and unjust enrichment claims were subject to administrative exhaustion because the plaintiffs did not allege that the contract imposed any obligations above and beyond those imposed by the Act. *Id.* at 1143. Consequently, the plaintiffs’ alleged injuries could be remedied by the retroactive payment of Medicare drug benefits, compelled through the administrative process. *Id.* at 1144.

The Ninth Circuit also found that the defendant’s alleged misrepresentations tracked the language of the defendant’s marketing materials. *Id.* at 1150-52. Those materials were prepared to comply with federal regulations and approved by the federal government. *Id.* Since the defendant’s consumer protection claim would have imposed inconsistent standards for the marketing materials, the Ninth Circuit held that it was preempted. *Id.* The Ninth Circuit concluded that the fraud claims were preempted for the same reason. *Id.* at 1156-57.

2. *Kovach v. Coventry Health Care, Inc.*, No. 02:10-cv-00536, 2011 WL 284174 (W.D. Pa. Jan. 25, 2011)

The Medicare beneficiary in *Kovach* developed respiratory and kidney failure following a heart bypass surgery. *Id.* at *1. The beneficiary’s physicians recommended transfer to an acute long term care facility, and the beneficiary’s MA organization denied coverage. *Id.* at *2. The beneficiary died of respiratory failure, and his wife sued the MA organization for consumer protection law violations, breach of contract, and wrongful death. *Id.* The Western District of Pennsylvania rejected the defendant’s preemption defense, reasoning that the plaintiff was seeking damages caused by the defendant’s wrongful conduct, and was not seeking declaratory or injunctive relief regarding Medicare benefits, or payment of wrongfully denied Medicare benefits. *Id.* at *4-*5.

3. *Mann v. Reeder*, No. 1:10-cv-00133-JHM, 2011 WL 665749 (W.D. Ky. Feb. 15, 2011)

The plaintiffs in *Mann* purchased a MA plan from the defendant MA organization and its agent. *Id.* at *1. The agent allegedly guaranteed that premiums would not increase by more than \$3.00 per month. *Id.* at *1. The premiums increased above that level and the plaintiffs tried to cancel, but their requests were untimely. *Id.* When the plaintiffs found out that the cancellation window had lapsed, they sued for fraud and breach of contract. *Id.* at *2. The defendants moved to dismiss on the grounds that the plaintiffs failed to exhaust their administrative remedies and that the

Medicare Act preempted the plaintiffs' claims. *Id.*

The Western District of Kentucky held that the fraud and breach of contract claims did not “arise under” the Medicare Act, and were not subject to the exhaustion of administrative remedies defense. *Id.* at *3. The Western District further held that the fraud claim was not, “at bottom,” a claim for benefits, but was instead a claim for the damages allegedly caused by the defendants' misrepresentations. *Id.* at *3. Likewise, the breach of contract claim was not “merely [a] creatively disguised claim[] for benefits,” as the plaintiffs alleged that the defendants had contracted to provide more than what the Medicare Act required. *Id.*

The Western District also rejected the preemption defense, finding that the alleged misrepresentations were “ad hoc enrollee communications” that were excluded from the regulatory definition of “marketing materials.” *Id.* at *5. The Western District emphasized that the alleged misrepresentations were substantively different from the MA organization's marketing materials and were also not systematic in nature. *Id.*

C. Recent Developments in Medicare Preemption of Provider Claims

1. *Main & Assoc, Inc. v. Blue Cross & Blue Shield of Ala.*, No. 2:10-cv-00326, Slip op. (M.D. Ala. Mar. 22, 2011), ECF No. 34.

The plaintiff in *Main* is a skilled nursing facility that alleges that the defendant MA organization wrongfully and tortiously failed to pay for Medicare-covered services in accordance with Medicare's Resources Utilization Group (“RUG”) Guidelines. *Id.* at *3-4. The plaintiff brought putative class claims against the defendant for breach of contract, intentional interference with business relations, wantonness, unjust enrichment, and injunctive relief. *Id.* at 4. The plaintiff sued in Alabama state court, and the defendant removed on the ground that certain claims arose under the Medicare Act. *Id.*

The Middle District of Alabama found that the claims did not arise under the Medicare Act, and remanded. *Id.* at 14. The Middle District reasoned that no MA enrollees were suing the defendant and the federal government had no continuing financial interest in the case because it had already made its capitated payment to the defendant. *Id.* at 15-16. Additionally, the Middle District rejected the argument that the remedial provisions of the Medicare Act were sufficient to support federal jurisdiction based on complete preemption. *Id.* at 20.

2. *N.Y. City Health & Hosps. Corp. v. WellCare of N.Y., Inc.*, No. 10 Civ. 6748 SAS, 2011 WL 1842396 (S.D.N.Y. May 10, 2011).

In *N.Y. City Health & Hosps.*, the plaintiff public hospital corporation sued the defendant MA organization for third-party breach of contract and unjust enrichment, alleging that its policy of paying for out-of-network services at the lesser of Posted Charges or the DRG amount caused underpayments. *Id.* at *2. Before filing suit, the plaintiff asked the Centers for Medicare & Medicaid Services (“CMS”) to help resolve the dispute. *Id.* CMS advised that the defendant’s policy was permissible if the parties agreed to it, and referred the parties to CMS’ voluntary dispute resolution program. *Id.*

The defendant moved to dismiss on the grounds that (1) the plaintiff was impermissibly trying to enforce a federal law with no private right of action, (2) the claims were preempted by the Medicare Act, and (3) the claims failed as a matter of law. *Id.* at *1. The Southern District of New York agreed that the plaintiff could not enforce the defendant’s contract with CMS through a third-party breach of contract claim in light of CMS’ voluntary dispute resolution process. *Id.* at *7. The Southern District, however, permitted the unjust enrichment claim because the plaintiff’s theory “would not upset” any regulations or guidance issued by CMS during the relevant time period. *Id.* at *8-*9. Since federal jurisdiction was based on the third-party breach of contract claim, the Southern District remanded the case to state court. *Id.* at *9.