

Managed Care Litigation in the Age of Health Care Exchanges and Value-Based Payment

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I. Introduction

The adoption of the federal Affordable Care Act (“ACA”) accelerated the migration of the health care industry from traditional fee-for-service (“FFS”) contracts to new, value-based arrangements that create incentives for delivering higher-quality care at lower costs through population health management. Such value-based arrangements run the gamut from FFS contracts with pay-for-performance components, to narrow networks or Accountable Care Organizations (“ACOs”) with shared savings features, to full capitation. Whatever form value-based payment takes, it hinges on administrative and clinical alignment. While some hope that better alignment will reduce disputes, others are less sanguine. As Modern Healthcare reported just last week:

Experts largely agree that value-based contracting ***will not*** be a panacea for healthcare payment spats What will change will be the sticking points between insurers and providers—issues such as per-member, per-month fees and performance measures, for example.

...

Experts predict that determining lump-sum payments, quality metrics to be used for bonuses or penalties, and arrangements for how shared savings should be split will be the new payment bargaining chips.¹

¹ Bob Herman, *Value-based care not likely to end payer/provider financial spats*, Modern Healthcare (Jan. 22, 2015) (emphasis added).

In this paper, we review recent narrow network litigation, assess the precedent for future litigation involving ACOs, and offer perspectives on ethics in multi-jurisdictional arbitration practice. We also review recent out-of-network litigation, which continues unabated despite the ongoing migration to value-based payment.

II. Narrow Network Litigation: Breaking efforts to bend the cost curve?

A “narrow network” is essentially a provider network consisting of a smaller number of providers than a conventional Preferred Provider Organization (“PPO”). Narrow networks are intended to increase patient volume and revenue for providers while also lowering costs through reduced rates, increased quality, or some combination of both.² Health insurance issuers and Medicare Advantage Organizations (“MAOs”) have increasingly turned to narrow networks as tools for helping slow increases in premiums (which are subject to review under the ACA),³ and mitigating reductions in the funding for the Medicare Advantage (“MA”) program,⁴ respectively.

The proliferation of narrow networks has implications for patients and providers alike. Patient advocacy groups fear that the ACA will flood the market with newly-insured patients in narrow network plans, which will reduce quality by increasing patient-

² David Blumenthal, *Reflecting on Health Reform - Narrow Networks: Boon or Bane?* The Commonwealth Fund Blog (Feb. 24, 2014), available at <http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane>.

³ *Narrower Networks Expected in 2015 ACA Plans*, Healthcare Financial Management Association, (September 23, 2014), available at <http://www.hfma.org/Content.aspx?id=25330>.

⁴ Press Release, The Commonwealth Fund, *Affordable Care Act Policies Will Equalize Payments for Traditional Medicare and Medicare Advantage Plans, Ending More Than \$12.7 Billion in Annual Excess Payments to Plans*, (Oct. 16, 2012), available at <http://www.commonwealthfund.org/publications/press-releases/2012/oct/policies-will-equalize-payments>.

to-provider ratios, wait times, and the distances that patients travel for care.⁵ But increased patient volume will benefit the providers serving the narrow networks, so long as those networks survive legal challenges. If the legal challenges succeed, then in-network providers may find themselves locked into lower rates without increased patient volume. Such a scenario may well converge with fears of reduced access.

A. Health plan members are seeking relief from the roll-out of narrow networks and challenging the adequacy of those networks in California

In 2014, health plan members in California filed at least six separate actions (including five putative class actions) challenging the narrow network features of their plans. The actions are new and many health plan defendants have not yet had an opportunity to contest the merits. But the members' factual allegations, theories of recovery, and claims for relief are instructive.

1. The health plan members seek sweeping equitable relief that may be difficult to obtain but would potentially benefit out-of-network providers

The health plan members in the California actions typically allege that they intended to buy a PPO plan with a broad provider network and a low deductible, but received an Exclusive Provider Organization ("EPO") plan with a narrow provider network and a high deductible. Some allege that they received a PPO plan that had a smaller provider network or higher deductible than expected.

Many members were enrolled in non-grandfathered PPO plans, and selected narrow network plans because their non-grandfathered PPO plans did not comply with the ACA and were cancelled. They attribute their selections to improper conduct or

⁵ Jeff Overley, *Lawsuits Over Narrow Insurer Networks Threaten ACA Goals*, Law360 (July 28, 2014), available at <http://www.law360.com/articles/556980>.

errors by the health insurance issuers during the market transition. For example, they contend that their physicians were listed in the provider directory during the open enrollment period and were cut from the network after open enrollment ended.

Health insurance issuers can correct provider manuals and similar operational problems during future open enrollment periods. Some members, however, allege that new narrow network plans are inherently deficient because they do not comply with state network adequacy standards. The remedy for network adequacy violations would be to add providers. But the addition of providers would potentially dilute patient volume, increase costs, and unravel the narrow network.

The predominant theories of recovery in the California actions are fraud, negligent misrepresentation, breach of contract, and violations of state consumer protection statutes. For remedies, the members primarily seek:

- Injunctive Relief: Certain members seek injunctions compelling the defendant issuer to correct its provider guides, cease misleading advertising regarding the size or scope of its provider networks, and, in some instances, comply with state network adequacy requirements. The members may have difficulty obtaining such broad injunctions because some components of the injunctions would be mandatory.⁶ If the members are successful, out-of-network providers may benefit from expansions of narrow networks.
- Restitution: Certain members seek restitution equal to: (1) the difference in the value of the plans with the provider networks listed during open enrollment and the value of those plans with narrowed networks; or (2) premiums paid by consumers for the periods before they received ID cards from issuers.

The members may have difficulty showing an objective diminution in plan value if the plan was priced to a narrow network and the issuer simply failed reflect the

⁶ *People ex rel. Herrera v. Stender*, 212 Cal. App. 4th 614, 630, 152 Cal. Rptr. 3d 16, 31 (2012) (recognizing that mandatory injunctions are “rarely granted”); *but see Consumers Union of U.S., Inc. v. Alta-Dena Certified Dairy*, 4 Cal. App. 4th 963, 972-74, 6 Cal. Rptr. 2d 193 (1992) (granting mandatory injunction).

narrowed network in its provider directory during open enrollment. The proof would differ if the narrow network was shown to violate network adequacy standards. Of course, proving diminished value due to noncompliance with network adequacy standards would present its own set of challenges, particularly on a class-wide basis. The putative class members would have purchased different plans in different geographical areas of the state, with varying networks and alleged deficiencies. Absent common deficiencies across all networks in the state, it would be challenging for a court to craft an order of restitution that would apply across all putative class members statewide.

With these themes in mind, the six patient actions are surveyed below.

2. Survey of California Narrow Network Cases

- a. *Felser v. Blue Cross of Cal.*, No. BC550739, 2014 WL 3361745 (Cal. Super. Ct. L.A. County, filed July 9, 2014);

Davidson v. Cigna Health & Life, No. BC558566, 2014 WL 4980307 (Cal. Super. Ct. L.A. County, filed Sept. 24, 2014); and

Lehman v. Health Net of Cal., No. BC567361 (Cal. Super. Ct. L.A. County, filed Dec. 21, 2014)

The putative class action complaints in *Felser*, *Davidson*, and *Lehman* are substantially similar and were filed by the same attorneys. In *Felser*, seven health plan members sued Anthem Blue Cross after transitioning to individual, ACA-compliant health plans that Anthem offered both inside and outside of the Covered California health exchange. They allege that Anthem, in connection with the ACA transition:

- Misrepresented to consumers that their physicians and hospitals were participating in Anthem's health plans;
- Misrepresented that EPO plans with no out-of-network benefits were PPO plans with out-of-network benefits;
- Misrepresented and concealed that new PPO health service plans imposed much higher deductibles for out-of-network providers than advertised;
- Subjected the named plaintiffs to inadequate provider networks; and

- Delayed the named plaintiffs' enrollment in the plans notwithstanding the collection of premiums.

The *Felser* plaintiffs plead individual claims for fraud by intentional misrepresentation and fraud by concealment. They also plead class claims for violations of the California Unfair Competition Law ("UCL"), False Advertising Law ("FAL"), and Consumers Legal Remedies Act ("CLRA"), plus a class claim for declaratory judgment. For remedies, they seek injunctive relief, restitution, and damages.

The named plaintiff in *Davidson* is a single Cigna member. In addition to the claims pleaded in *Felser*, the plaintiff in *Davidson* alleges that Cigna breached its individual contracts with the putative class by denying coverage for medical services as out-of-network after representing that the services were in-network.

The named plaintiffs in *Lehman* are two Health Net members. They allege that Health Net fraudulently induced them to purchase a plan by falsely representing that certain physicians and hospitals would be in-network. They allege the same basic theories of recovery and pray for the same remedies as the plaintiff in *Davidson*.

- b. *Roberts v. United Healthcare Servs., Inc.*, No. BC540910, 2014 WL 1335630 (Cal. Super. Ct. L.A. County, filed Mar. 28, 2014)

The putative class representative in *Roberts* alleges that she enrolled in a MA plan offered by United based on allegedly misleading advertising about United's MA provider network. According to the plaintiff, United represented that it had a large MA provider network in California. Because United allegedly has no in-network urgent care clinics in California, the plaintiff allegedly had to obtain urgent care from out-of-network providers

and pay higher co-pays.⁷

The plaintiff has pleaded claims for violations of the UCL, unjust enrichment, and financial elder abuse. Financial elder abuse occurs when a person or entity takes, secretes, appropriates, obtains, or retains real or personal property of an elder for a wrongful use or with intent to defraud.⁸ The issue of whether personal property includes money paid towards MA premiums has not been addressed by California courts.

c. *Harrington v. Blue Shield of Cal.*, No. CGC-14-539283, 2014 WL 1921999 (Cal. Super. Ct. S.F. County, filed May 14, 2014)

In *Harrington*, two health plan members filed a putative class action alleging that Blue Shield induced them to purchase health plans by making misrepresentations and concealing material facts about the scope of its provider network. Both plaintiffs were previously uninsured and purchased their health plans to comply with the ACA. They purport to sue on behalf of previously-insured members who were denied coverage for services rendered by providers excluded from Blue Shield's "lesser network."

The plaintiffs allege claims for concealment under the Cal. Ins. Code § 332, violations of the CLRA and UCL, and breach of contract. The concealment claim is unique: plaintiffs allege that Blue Shield had a statutory duty to disclose material facts about its provider network. To prevail on that claim, Plaintiffs must prove that Blue Shield knew that the facts were material.⁹

⁷ The case was removed to federal court by United, but then remanded in August 2014. There have been no substantive actions taken in the case since it was remanded.

⁸ Cal. Welf. & Inst. Code § 15610.30(a)(1) (West 2014)

⁹ *Hartford Accident & Indem. Co. v. Emp'rs Ins. of Wausau*, No. 847212, 1995 WL 870851, at * 17 (Cal. Super. Ct. May 26, 1995).

- d. *Brown, et al. v. Blue Cross of Cal.*, No. BC554949 (Cal. Super. Ct. L.A. County, filed Aug. 19, 2014)

The 33 individual health plan members in *Brown* allege that Anthem “tricked” them when transferring them from their existing health plans to “skinny” network plans required by the ACA. Anthem supposedly misrepresented that out-of-network providers were in-network and then issued ID cards showing incorrectly that EPO plan members were PPO plan members. At the same time, Anthem allegedly reduced access by excluding costly providers from its network, and offering low rates to other providers that were rejected out of hand. The *Brown* plaintiffs plead claims for breach of contract, negligent misrepresentation, and violations of the UCL.

B. California regulators have taken actions to address health plan members’ concerns about narrow networks in that State

After a five-month investigation, the California Department of Managed Health Care (“DMHC”) issued reports on November 19, 2014 in which it found that Blue Shield’s and Anthem’s provider directories were inaccurate and insufficient.¹⁰ The DMHC determined that 18 percent of physicians listed by Blue Shield were not at the location listed and, of those, 8.8 percent would not accept members of Blue Shield’s exchange products.¹¹ Similarly, 12.5 percent of Anthem physicians were not at the

¹⁰ Tracy Seipel, *Two Covered California health insurance plans misled consumers, regulators say*, The San Jose Mercury News, (Nov. 19, 2014), *available at* http://www.mercurynews.com/health/ci_26965329/two-covered-california-health-insurance-plans-misled-consumers.

¹¹ Dep’t of Managed Health Care, Final Report: Non-Routine Survey of Blue Shield of California at p. 3, (issued to the public on Nov. 18, 2014), *available at* <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf>.

location listed and, of those, 12.8 percent were not willing to accept Anthem patients.¹² The DMHC has referred the results of its investigation to its Office of Enforcement for corrective action and financial penalties.

On January 5, 2015, the California Department of Insurance issued an emergency regulation regarding health care access in narrow networks. The regulation requires issuers to comply with new standards for appointment wait times, ensure adequate numbers of physicians and clinics, maintain an accurate list of in-network providers, and provide out-of-network care options for the same price as in-network care when in-network care is insufficient.¹³ The DMHC has similar regulations.

C. Connecticut MA providers have challenged United's narrowing of its MA provider networks under a breach of contract theory

The Fairfield County (Connecticut) Medical Association sued United Healthcare of New England and its affiliates (“United”) in 2013 on behalf of its member physicians, alleging that United breached its contracts with the physicians by removing them from its MA network.¹⁴ The Association argued that United’s removal of the physicians from the MA network would adversely affect quality of care and patient rights. The district court enjoined United from removing the physicians, finding a likelihood of irreparable harm to patient-provider relationships and to the ability of providers to compete for Medicare

¹² Dep’t of Managed Health Care, Final Report: Non-Routine Survey of Anthem Blue Cross at p. 3, (issued to the public on Nov. 18, 2014), *available at* <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf>.

¹³ Press Release, Cal. Dep’t of Ins., (released January 5, 2015), *available at* <http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/release001-15.cfm>.

¹⁴ *Fairfield Cnty. Med. Ass’n v. United Healthcare of New England*, 985 F. Supp. 2d 262 (D. Conn. 2013) *aff’d as modified sub nom.*, *Fairfield Cnty. Med. Ass’n v. United Healthcare of New England, Inc.*, 557 F. App’x 53 (2d Cir. 2014).

patients. The district court also concluded that the contract language was unlikely to support United's position. After issuing the injunction, the district court referred the individual physicians to arbitration pursuant to their respective contracts with United. Any outcomes of those arbitrations are nonpublic.¹⁵

D. The Centers for Medicare & Medicaid ("CMS") have updated their guidance to address MA members' concerns about narrow MA networks

Beginning in 2014, CMS may authorize MA members to enroll in new MA plans if they lose network access to their health care providers as a result of a "significant" network change occurring outside the course of routine contract initiation and renewal cycles. CMS determines whether a network change is "significant" on a case-by-case basis. If CMS finds a "significant" change, then it will open a three-month special enrollment period ("SEP") and notify MA members. Individual MA members cannot request the opening of a SEP.¹⁶

II. ACOs: The next litigation frontier?

The ACA encouraged providers to form ACOs by directing the U.S. Department of Health & Human Services ("HHS") to create a "shared savings" program.¹⁷ Under that program, any ACOs meeting HHS's quality standards and savings benchmark qualify for additional payment.¹⁸ While similar commercial ACOs are proliferating,

¹⁵ A cardiology practice filed a similar action against United's affiliate in North Carolina. That lawsuit was voluntarily dismissed before any substantive legal rulings. See *Ferncreek Cardiology v. UnitedHealthcare of N. Carolina*, 3:14-cv-00432, Stipulation of Dismissal (W.D.N.C. Sept. 10, 2014) ECF 24.

¹⁶ Medicare Managed Care Manual, Ch. 2 at 30.4.6 (updated Aug. 14, 2014 and effective Jan. 1, 2015), available at <http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY-2015-MA-Enrollment-and-Disenrollment-Guidance.pdf>.

¹⁷ 42 U.S.C.A. § 1395jjj(a)(1)

¹⁸ 42 U.S.C.A. §§ 1395jjj(d)(1)(A)(i)-(ii), (d)(1)(B)(i), (d)(2).

there is no uniform ACO model. Commercial ACOs can vary structurally by ownership, providers, financial incentives, and risk-sharing. For instance, a commercial ACO may either reward providers with shared savings, or penalize providers by withholding or recouping payment when quality or savings goals are not met.¹⁹

There has been little reported ACO litigation in the past year. But given the clinical services that ACOs provide—and the compensation structures upon which they are built—ACOs may eventually encounter litigation similar to what Health Maintenance Organizations (“HMOs”) faced in the 1990s and early 2000s.

A. Are ACOs ripe for litigation related to provider compensation?

As noted, some ACOs compensate providers based on their satisfaction of quality and cost measures when treating attributed patients. Patient attribution and performance measurement were hotly contested in *Grider v. Keystone Health Plan Central, Inc.*, where physicians sued an HMO for wrongfully denying or delaying the payment of compensation under capitation and fee-for-service agreements.²⁰ The agreements allegedly contained misrepresentations and omissions about the attainability of the performance measures for physician compensation, which supposedly induced the plaintiffs to contract with the HMO. The plaintiffs further alleged that the HMO “shaved” its capitation payments by underreporting the patients who were attributable to the plaintiffs. These allegations were sufficient to state claims for fraud.²¹ ACO

¹⁹ Stephanie Barr and Mark Dennehey, *A Historical Look At the ACO Concept and Future Liabilities: What Does Accountability Really Mean?*, 2014 HEALTH L. HANDBOOK 7 (June 2014)

²⁰ No. CIV.A.2001-CV-05641, 2003 WL 22182905, at *2 (E.D. Pa. Sept. 18, 2003).

²¹ *Id.* at *4.

providers could conceivably assert the same theories against ACOs with similar compensation structures.

B. Could patients sue ACOs for failing to disclose financial incentives?

Patients have repeatedly sued HMOs for supposed breaches of fiduciary duty based on failures to disclose provider compensation arrangements. Such actions have typically failed. For example, the district court in *Horvath v. Keystone Health Plan East, Inc.* granted summary judgment on the plaintiff's claim that an HMO breached its fiduciary duties under the Employee Retirement Income Security Act of 1974 ("ERISA") by failing to disclose its "cost containment procedures."²² The U.S. Court of Appeals for the Third Circuit affirmed, finding that no duty to disclose existed absent: (i) a request for such information by plaintiff; (ii) circumstances which put defendant on notice that plaintiff needed such information to prevent plaintiff from making a harmful decision with respect to plaintiff's healthcare coverage; or (iii) evidence that plaintiff was harmed as a result of not having the information.²³ In a similar case, state law claims for bad faith and fraud were preempted by ERISA.²⁴

State courts have recognized that providers owe fiduciary duties to patients.²⁵ They could conceivably extend those fiduciary duties to require the disclosure of

²² 333 F.3d 450, 454 (3d Cir. 2003). The HMO's cost-containment procedures included "financial incentives to physicians, rewarding [physicians] for decreasing utilization of health-care services, and penalizing them for what may be found to be excessive treatment." *Id.*

²³ *Id.* at 463; see also *Ehlmann v. Kaiser Found. Health Plan of Tex.*, 198 F.3d 552, 557 (5th Cir. 2000).

²⁴ *Toledo v. Kaiser Permanente Med. Grp.*, 987 F.Supp. 1174, 1179 (N.D.Cal. 1997).

²⁵ See, e.g., *Moore v. Regents of the Univ. of Cal.*, 51 Cal.3d 120, 129, 483, 271 Cal.Rptr. 146, 150 (1990) ("[A] physician must disclose personal interests unrelated to the patient's head, whether research or economic, that may affect the physician's professional judgment").

commercial arrangements affecting the delivery of care.²⁶ If ACOs owe fiduciary or tort duties to disclose provider compensation arrangements, then they may have greater exposure than HMOs in years past. This is because an ACO that contracts with a health plan to serve patients would simply be a participating provider, and not an ERISA plan sponsor or fiduciary that can assert an ERISA preemption defense.

C. ACOs may face malpractice exposure due to administrative and clinical integration and the use of quality measures to determine compensation

The ACA encourages ACOs to participate directly in population health management in order to increase efficiency and the quality of patient care.²⁷ But such integration may expose ACOs to malpractice liability if cost-containment measures overlap with poor outcomes.²⁸ In the past, HMOs litigated state law tort claims based on their alleged exercise of clinical control through cost-containment measures.²⁹ Unlike HMOs, ACOs would not have ERISA preemption defenses to similar claims.³⁰

²⁶ *Id.* at 486 (finding that physician had fiduciary duty to disclose financial self-interest in patient's spleen); *but see Neade v. Portes*, 193 Ill. 2d 433, 444-45, 739 N.E.2d 496, 503 (2000) (declining to recognize breach of fiduciary duty claim separate from medical negligence claim); *Jezek v. Carecredit, LLC*, No. 10 C 7360, 2011 WL 2837492, at *3-4 (N.D. Ill. July 18, 2011) (declining to find that physicians owed fiduciary duty to patient to disclose financial self-interest in patients' enrollment in credit card program).

²⁷ See 42 U.S.C. § 1899(b)(2)(G), (H); Medicare Program, Medicare Shared Savings Program: Accountable Care Organizations, 76 FED. REG. 67802-01, 67,803 (Nov. 2, 2011) (to be codified at 42 C.F.R. pt. 425).

²⁸ Benjamin Harvey and Glenn Cohen, *The Looming Threat of Liability for Accountable Care Organizations and What to Do About It*, 310 J. AMER. MED. ASSOC. 140, 141 (July 10, 2013).

²⁹ See e.g., *Petrovich v. Share Health Plan of Illinois*, 188 Ill. 2d 17, 49, 719 N.E.2d 756, 774-75 (1999) (recognizing that HMO that exerts sufficient control over physicians' medical practice may be held vicariously liable for physicians' malpractice because the physicians are no longer independent contractors of HMO). Similar claims may be brought for institutional negligence. See e.g., *Jones v. Chicago HMO, Ltd.*, 191 Ill.2d 278,293,730 N.E.2d 1119, 1128 (2000) (finding that an HMO could be liable for negligently assigning too many patients to a physician given its "expansive role in arranging for and providing health care services to their members.").

³⁰ 310 J. AMER. MED. ASSOC. at 141.

III. Ethics in Multi-Jurisdictional Arbitration Practice

Representing large providers or multi-state payors in health care payment disputes inevitably involves out-of-state arbitrations. An important but perhaps underappreciated issue in such arbitrations is the risk of the unauthorized practice of law (“UPL”). The American Bar Association addresses the UPL issue in Model Rule of Professional Conduct 5.5(c), which permits an out-of-state lawyer to arbitrate in another jurisdiction on a temporary basis when the services “arise out of or are reasonably related to the lawyer’s practice in a jurisdiction in which the lawyer is admitted to practice and are not services for which the forum requires *pro hac vice* admission.”

Most states have adopted ABA Model Rule 5.5(c) and do not require *pro hac vice* admission for arbitrations.³¹ In New York, for example, Rule of Professional Conduct 5.5 does not address arbitrations, and the state courts have found that participating in arbitration does not constitute the practice of law.³² Illinois is similar.³³

A smaller number of states, including California and Florida, have adopted a modified version of Rule 5.5(c) or a *pro hac vice* or filing requirement. California permits out-of-state representation if the lawyer (i) timely serves a certificate required by

³¹ For a 50-state survey, see Rachel Cash, *The Other Fifty Shades of Grey: Multijurisdictional Practice in Private Arbitrations*, 37 AM. J. TRIAL ADVOC. 1 (2013).

³² See *Williamson, P.A. v. John D. Quinn Constr. Corp.*, 537 F. Supp. 613, 616 (S.D.N.Y. 1982) (“An arbitration tribunal ... has no provision for the admission *pro hac vice* of local or out-of-state attorneys.”). A report by the New York Ethics Committee reinforces this position. *Recommendation and Report on the Right of Non-New York Lawyers to Represent Parties in International and Interstate Arbitrations Conducted in New York*, 49 REC. ASS’N B. CITY N.Y. 1 (1991).

³³ ILL. RULE OF PROF’L CONDUCT R. 5.5; Ill. State Bar. Op. 12-17 (July 2012) (available at <http://www.isba.org/sites/default/files/ethicsopinions/12-17.pdf>); *Colmar, Ltd. v. Fremantlemedia, N. Am., Inc.*, 344 Ill. App.3d 977, 801 N.E.2d 1017, 1026 (2003), *appeal denied*, 208 Ill.2d 535, 809 N.E.2d 1285 (2004).

the State Bar; (ii) the lawyer's appearance is approved in writing on that certificate by the arbitrator; and (iii) the approved certificate is filed with the California Bar and served on the parties.³⁴ California has not adopted ABA Model Rule 5.5(c).

In Florida, early judicial decisions held that participation in arbitration by out-of-state attorneys was the unauthorized practice of law.³⁵ Florida now allows out-of-state representation if (i) the appearance is for a client who resides or has an office in the lawyer's home state, or (ii) the appearance arises out of or is reasonably related to the lawyer's practice in a jurisdiction where the lawyer is admitted to practice.³⁶ Out-of-state attorneys may not participate in more than three arbitrations per 365 days.³⁷

Because the state rules can vary greatly, the best practice is to review the bar rules, statutes, and case law of the state where the arbitration hearing will occur. By reviewing all sources of authority, an out-of-state attorney can help ensure compliance with any filing requirements and avoid running afoul of state UPL rules.

IV. Out-of-Network Litigation: provider and payor actions on the rise?

The classic out-of-network dispute involves an individual, non-contracted provider that contests the sufficiency of a health plan's benefit payments for services rendered. The provider, lacking a contract, sues the plan under an assignment of benefits and direct theories of recovery (*e.g.*, misrepresentation, third-party breach of contract, unjust enrichment). In the 2000s, providers began litigating such disputes on a grand

³⁴ CAL. CIV. PROC. CODE § 1282.4(b)(1)-(3).

³⁵ *Fla. Bar v. Rapoport*, 845 So. 2d 874, 877 (Fla. 2003); D. Ryan Nayar, Unauthorized Practice of Law in Private Arbitral Proceedings: A Jurisdictional Survey, 6 J. AM. ARB. 1, 10 (2007).

³⁶ FLA. RULES OF PROF'L CONDUCT R. 5.5 (2013); FLA. BAR. REG. R. 4-5.5 (2006).

³⁷ FLA. BAR. REG. R. 1-3.11(d) (2006).

scale by filing putative class actions challenging the industry-wide use of the Ingenix databases³⁸ to determine the usual, customary and reasonable amounts (“UCR”) payable for out-of-network services. Several of the major Ingenix cases have resolved. The remaining Ingenix cases are far along and appear to be nearing conclusion.

The maturation of the Ingenix litigation has not curtailed out-of-network litigation. Anecdotally, several factors may account for this:

- Smaller providers are integrating with the larger providers (e.g., health systems) that are the cornerstones of narrow networks and ACOs. Providers that do not integrate may find out-of-network billing more appealing.³⁹
- Health plans are deploying new strategies to reduce out-of-network payments and control leakage. Some now pay a percentage of the Medicare allowable instead of the UCR.⁴⁰ Others are suing out-of-network providers for allegedly inflating charges and waiving members’ cost-sharing obligations.
- Patients are more sensitive to cost due to high-deductible health plans.⁴¹ Complaints about out-of-pocket costs are generating media coverage and prompting legislative and regulatory scrutiny of balance billing. New York, for example, enacted legislation in 2014 that regulates out-of-network billing.

These developments are explored in greater detail below.

³⁸ Ingenix was an affiliate of UnitedHealth Group, Inc., that created databases using data reported by third-party payors. See, e.g., *McDonough v. Horizon Blue Cross Blue Shield of N.J.*, No. 09-cv-571, 2011 WL 4455994, at *2 (D.N.J. Sept. 23, 2011).

³⁹ Geoff C. Cockrell, et al., *The Unique Risks of Investing in Out-of-Network Providers*, Law360 (Dec. 3, 2014), available at <http://www.law360.com/articles/601005/the-unique-risks-of-investing-in-out-of-network-providers>.

⁴⁰ *The Role of Medicare in Out-of-Network Reimbursement*, Fair Health Consumer, <http://fairhealthconsumer.org/reimbursementseries.php?id=33> (last visited Jan. 11, 2015); Nina Bernstein, *Insurers Alter Cost Formula, and Patients Pay More*, N.Y. Times (Apr. 23, 2012), available at http://www.nytimes.com/2012/04/24/nyregion/health-insurers-switch-baseline-for-out-of-network-charges.html?pagewanted=all&_r=0.

⁴¹ Michelle Andrews, *Large Companies are Increasingly Offering Workers Only High Deductible Health Plans*, Kaiser Health News (Mar. 26, 2013), available at <http://kaiserhealthnews.org/news/032613-michelle-andrews-on-high-deductible-plans-and-large-employers>.

A. The Ingenix litigation is ongoing but seemingly nearing its end

In the 2000s, various medical associations, out-of-network providers, and patients filed putative class actions against major payors—including United Healthcare, Health Net, Aetna, Cigna, and WellPoint—alleging that they paid less than the correct UCR by using the Ingenix databases to calculate UCR payments.

The first significant Ingenix case was filed by the American Medical Association, state medical societies, out-of-network providers, and benefit plan members in 2000. They named United Healthcare and Ingenix as defendants and alleged that the Ingenix databases used flawed or inadequate data. They also alleged that United conspired with health insurance trade associations to use the Ingenix databases to restrain trade, and concealed the flaws in the databases.⁴² The plaintiffs pleaded violations of state law, ERISA, the Racketeer Influenced Corrupt Organizations Act (“RICO”) and the Sherman Act.⁴³ United and Ingenix settled in January 2009 for \$350 million.⁴⁴ That settlement came on the heels of Health Net’s resolution of Ingenix litigation in 2008.⁴⁵ The Ingenix litigation against Aetna, CIGNA, and WellPoint remains pending.

1. *In re Aetna UCR Litig.*, MDL No. 2020 (D.N.J.)

Aetna members and out-of-network providers began filing putative class actions in 2007, which were eventually consolidated into federal multi-district litigation

⁴² *The Am. Med. Ass’n v. United Healthcare Corp.*, No. 1:00-CV-02800, Fourth Amended Complaint, at ¶¶ 2, 116-22, 204-11, 334-38, 356-60 (S.D.N.Y. July 11, 2007) ECF No. 294.

⁴³ *Id.* at ¶¶ 258-316 (ERISA), 317-33, 398-411 (NY, FL law), 334-48 (Sherman Act), 349-97 (RICO).

⁴⁴ *The Am. Med. Ass’n v. United Healthcare Corp.*, No. 1:00-CV-02800, 2009 WL 1437819, at *1-2 (S.D.N.Y. May 19, 2009) (discussing \$350 million settlement reached in January 2009).

⁴⁵ *Wachtel v. Health Net, Inc.*, No. 2:01-cv-04183-FSH-PS, Opinion at 5 (D.N.J. Aug. 8, 2008) ECF No. 870 (approving \$215 million settlement).

(“MDL”) in the District of New Jersey. Aetna agreed in December 2012 to a global, \$120 million settlement.⁴⁶ Aetna, however, terminated the settlement in March 2014 after large numbers of class members opted out.⁴⁷

The plaintiffs moved for leave to amend in July 2014. Their proposed amendment would challenge not only Aetna’s use of the Ingenix databases, but also Aetna’s other out-of-network payment methods and alleged failure to disclose those methods.⁴⁸ Aetna has opposed the amendment on the ground that the plaintiffs are also seeking to change their antitrust theory from one based on a “rule of reason” analysis to one based purely on the “per se” rule.⁴⁹ The plaintiffs’ motion is pending.

2. *Franco v. Cigna*, No. 2:07-cv-06039 (D.N.J.)

Cigna members filed a putative class action in the U.S. District Court for New Jersey in 2007. Cigna defeated motions for class certification in January 2013 and April 2014.⁵⁰ Two months later, the district court granted Cigna’s motion for summary judgment on plaintiffs’ ERISA and RICO claims. It reasoned that the members’ policies directed Cigna to use the Ingenix databases and plaintiffs had not produced sufficient evidence that Cigna had breached a fiduciary duty by continuing to use the Ingenix

⁴⁶*In re Aetna UCR Litigation*, MDL No. 2020, No. 2:07-c-03541, Mem. of Law in Supp. of Joint Mot. for Prelim. Certification of Settlement Classes, Prelim. Approval of Settlement, and Approval of Class Notice, at 5, (D.N.J. Dec. 7, 2012), ECF No. 839-1.

⁴⁷ *Id.* Notice of Termination of Settlement at 1-2 (D.N.J. Mar.13, 2014), ECF No. 960. Aetna had discretion to terminate if opt-outs exceeded agreed-upon levels and the aggregate difference between the amounts charged by the provider class members and the allowed amounts under the insurance policies exceeded \$20 million. *Id.* Settlement Agreement at 22 (D.N.J. Dec. 7, 2012), ECF No. 839-2.

⁴⁸ *Id.* Pls’ Br. in Supp. of Mot. for Leave to Am. at 8, 11 (D.N.J. July 11, 2014), ECF No. 979-1.

⁴⁹ *Id.* Aetna Defs’ Mem. of Law in Resp. to Pls’ Mot. for Leave to Am. and in Supp. of Cross-Mot. to Dismiss at 4 (D.N.J. Aug. 29, 2014), ECF No. 995-1.

⁵⁰ *Franco v. Conn. Gen. Life Ins. Co.*, No. 2:07-cv-06039, Opinion at 18-19, 35-36, 37-38 (D.N.J. Jan. 16, 2013), ECF No. 720; *Id.* Opinion at 4, 19 (D.N.J. Apr. 14, 2014), ECF No. 805.

databases.⁵¹ The plaintiffs have appealed.⁵²

3. *In re WellPoint Out-of-Network “UCR” Rates Litig.*, MDL No. 09-2074 (C.D.Cal.)

After WellPoint members and providers sued in 2009, their actions were consolidated into a MDL in the Central District of California. They allege that WellPoint participated in knowingly creating and using flawed data from the Ingenix database.⁵³ After significant motion practice, the Court cut the plaintiffs federal and state antitrust claims but did allow some state-law claims to go forward.⁵⁴ The Court denied class certification in September 2014⁵⁵ and the U.S. Court of Appeals for the Ninth Circuit declined to permit an appeal.⁵⁶ The parties are now conducting discovery.⁵⁷

B. Provider Actions: Payors increasingly play defense by going on offense

1. *North Cypress Med. Ctr. v. Cigna Healthcare*, No. 4:09-cv-02556 (S.D. Tex.)

North Cypress Medical Center, an acute care hospital, sued Cigna in 2009 for

⁵¹ *Id.* Opinion at 2, 3 n3 (D.N.J. June 24, 2014), ECF No. 808.

⁵² *Id.* Am. Notice of Appeal at 2 (D.N.J. Aug. 29, 2014), ECF No. 814.

⁵³ *In re WellPoint, Inc. Out-of-Network “UCR” Rates Litig.*, No. 2:09-ml-02074, First Consol. Am. Compl. at ¶¶ 10-13 (C.D. Cal. Nov. 2, 2009), ECF No. 12.

⁵⁴ *Id.* (In Chambers) Order Granting in Part and Denying in Part Defs’ WellPoint, Inc., United HealthGroup, Inc, and Ingenix, Inc.’s Mots. to Dismiss at 48-49 (C.D. Cal. Aug. 11, 2011), ECF No. 243; *Id.* (In Chambers) Order Granting in Part and Denying in Part Defs’ WellPoint, Inc., United HealthGroup, Inc, and Ingenix, Inc.’s Mots. to Dismiss at 50-52 (C.D. Cal. Sept. 6, 2012), ECF No. 365; *Id.* (In Chambers) Order Granting in Part and Denying in Part Defs’ WellPoint, Inc., United HealthGroup, Inc, and Ingenix, Inc.’s Mots. to Dismiss at 50-51 (C.D. Cal. July 19, 2013), ECF No. 389.

⁵⁵ *Id.* (In Chambers) Order Denying Pls’ Mot. for Class Certification at 30 (C.D. Cal. Sept. 3, 2014), ECF No. 549.

⁵⁶ *Roberts v. United Health*, No. 14-80128, Order at 1 (9th Cir. Nov. 24, 2014).

⁵⁷ *In re WellPoint, Inc. Out-of-Network “UCR” Rates Litig.*, No. 2:09-ml-0207, Order Granting Joint Stip. to Vacate Summ. J. Br. Dates at 2 (C.D. Cal. Jan. 5, 2015), ECF No. 570.

alleged violations of ERISA and the Texas prompt-pay laws.⁵⁸ North Cypress was an out-of-network provider and alleged that Cigna’s use of the Ingenix databases resulted in consistent denials, underpayments, and late payments.⁵⁹ In 2011, Cigna filed its Answer and Counterclaim, asserting that North Cypress billed Cigna for “phony charges” for services. The charges were supposedly inflated because North Cypress never intended to collect and instead waived the co-insurance amounts from the patients. Based on those allegations, Cigna pleaded counterclaims for fraud, negligent misrepresentation, and unjust enrichment.⁶⁰ Those counterclaims were dismissed.⁶¹

The parties then filed cross-motions for summary judgment. The district court held that North Cypress did not have standing to sue Cigna under ERISA because the patients had not yet suffered any injury-in-fact.⁶² It also granted summary judgment to Cigna on North Cypress’s breach of contract claim because Cigna had no obligation to cover charges that patients were not obligated to pay or were not billed for. Since North Cypress either steeply discounted or entirely waived the patients’ co-insurance, Cigna did not breach the agreements.⁶³ North Cypress has appealed.⁶⁴

⁵⁸ *N. Cypress Med. Ctr. Operating Co., Ltd. v. Cigna Healthcare*, No. 4:09-cv-02556, Pls.’ Original Compl. at ¶¶ 38-41 (ERISA), 42-49 (fiduciary duty under ERISA), 50-53 (full and fair review under ERISA), 54-58 (claims procedure under ERISA), 59-60 (request for information), 61-64 (Texas prompt pay) (S.D. Tex. Aug. 11, 2009) ECF No. 1.

⁵⁹ *Id.* at ¶¶ 15-17.

⁶⁰ *Id.* Defs.’ Answer to Pls.’ Second Am. Original Compl., Affirmative Defenses, and Countercls. at ¶¶ 2-5, 48-56 (Fraud), 57-63 (Negligent Misrepresentation), 64-69 (Unjust Enrichment) (S.D. Tex. Nov. 17, 2011) ECF No. 220.

⁶¹ *Id.* Sealed Mem. and Order Granting Mot. to Dismiss Defs.’ Countercls. (S.D. Tex. Apr. 13, 2012) ECF No. 283.

⁶² *Id.* Mem. and Order at 1, 12, 18-19 (S.D. Tex. June 25, 2012) ECF 318; *see also id.* Mem. and Order (S.D. Tex. Aug. 10, 2012) ECF No. 331.

⁶³ *Id.* Mem. and Order at 3-4 (S.D. Tex. Aug. 10, 2012) ECF No. 331.

2. *Biomed Pharms., Inc. v. Oxford Health Plans (NY), Inc.*, 522 F. App'x 81, 82 (2d Cir. 2013)

In 2013, the U.S. Court of Appeals for the Second Circuit affirmed the dismissal of an out-of-network provider's action against Oxford Health Plans based on the provider's financial hardship program for its patients. The provider had waived the co-insurance and deductible for hemophilia medication based on the patient's alleged financial hardship. But the "waivers were not based on a good faith inquiry into the family's financial condition" and the provider granted such waivers on a routine basis. The plan was therefore justified in refusing payment for the medication.⁶⁵

3. *Advanced Ambulatory Surgical Ctr., Inc. v. Cigna Healthcare of Ill.*, No. 13-C-7227, 2014 WL 4914299 (N.D. Ill. Sept. 30, 2014)

Advanced Ambulatory Surgical Center ("AASC") sued Cigna in 2013, seeking payment for preauthorized out-of-network services. Cigna argued that it did not pay because AASC did not require the patients to pay their cost-sharing obligations, which AASC denied. AASC pleaded claims for unjust enrichment, promissory estoppel, fraud, and statutory prompt pay violations under Illinois law. The Court distinguished between the ERISA and non-ERISA claims, finding that ERISA preempted the unjust enrichment and prompt-pay claims but not the promissory estoppel and fraud claims.⁶⁶

4. *IV Solutions, Inc. v. United Healthcare Servs., Inc.*, No. 12-CV-4887, 2014 WL 6896023 (C.D. Cal. Dec. 5, 2014)

In June 2012, IV Solutions ("IVS") sued United for failure to pay for out-of-

⁶⁴ *North Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, No. 12-20695, Cigna's Resp. to Appellees' Supplemental Authorities R28(j) Letter (5th Cir. Nov. 6, 2014).

⁶⁵ 522 F. App'x at 82.

⁶⁶ 2014 WL 4914299, at **1-3.

network home infusion services that were provided at a negotiated discount. United argued that it did not have to pay because IV Solutions routinely waived the patients' deductibles and co-payments. United tried to introduce evidence of an industry group's ethical standards, which state that providers should not routinely waive cost-sharing obligations. The Court, however, refused to admit the evidence and granted IVS's motion in limine because United did not show that the ethical standards were widely used and, moreover, IVS was not a member of the industry group.⁶⁷

5. *Orthopedic Specialists of S. Cal. v. Cal. Pub. Emp. Retirement Sys.*, 228 Cal.App. 4th 644, 175 Cal. Rptr.3d 295 (Cal. Ct. App. 2014)

In *Orthopedic Specialists*, an out-of-network provider of nonemergency services sued California's state health plan, CALPERS, for underpaying claims.⁶⁸ Before treating the plan members, the provider contacted CALPERS and was allegedly led to believe that CALPERS would pay the UCR for the services. The provider argued that it could sue CALPERS and obtain its UCR because emergency services providers can sue health plans directly under California law. The trial court dismissed and the Court of Appeals affirmed. They reasoned that oral promises are not enforceable against government entities. Plus, emergency services providers may sue for direct payment because they are legally obligated to serve all patients. Nonemergency providers have no such right because they may refuse to see patients.⁶⁹

⁶⁷ 2014 WL 6896023, at **1-2, 4-5.

⁶⁸ 228 Cal.App. 4th 644.

⁶⁹ *Id.* at 648.

6. *Children's Hosp. Cent. Cal. v. Blue Cross of Cal.*, 226 Cal. App.4th 1260, 172 Cal. Rptr. 3d 861 (Cal. Ct. App. 2015)

Plaintiff Children's Hospital Central California sued Blue Cross for billed charges for out-of-network emergency services under a quantum meruit theory. The trial judge granted the hospital's motion to exclude evidence of: (i) the rates accepted by or paid to the hospital by other payors; (ii) government program rates; and (iii) the hospital's costs.⁷⁰ The Court of Appeal for the Fifth Appellate District reversed. It held that the jury could find the "reasonable and customary value" of the services by taking into account "the full range of fees that [the] [h]ospital both charged and accepted as payment for similar services." It concluded that the trial judge should have admitted evidence of the amounts paid to the hospital by other commercial payors, Medi-Cal, and fee-for-service Medicare.⁷¹ The California Supreme Court declined to hear the case.

7. *Metcalf v. Blue Cross Blue Shield of Mich.*, No. 3:14-CV-00302, 2014 WL 5776160 (D.Or. Nov. 5, 2014)

In *Metcalf*, a non-participating chiropractor sued Blue Cross to recover payments as an assignee of ERISA benefits. The district court denied Blue Cross' motion to dismiss the claims for lack of standing. It reasoned that ERISA defines a beneficiary as "a person designated by Participant" who may become eligible to receive a benefit and so Plaintiff had standing to bring a cause of action as a beneficiary.⁷²

⁷⁰ 226 Cal. App.4th at 1276-79. The trial judge reasoned that such evidence was irrelevant and inadmissible under the California Department of Managed Health Care's ("DMHC") regulation governing payment for out-of-network medical services. *Id.*

⁷¹ *Id.* at 873, 875-76. The Court of Appeal affirmed the exclusion of evidence concerning the hospital's costs. It reasoned that "[p]arsing the costs for each service would be impractical. As pointed out by [the] [h]ospital, a cost-based system 'would undermine efficiency and reward waste.'" *Id.*

⁷²2014 WL 5776160 at *1, 4.

8. Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Tex., Inc., 16 F. Supp. 3d 767 (S.D. Tex. 2014)

In *Mid-Town Surgical Center*, an out-of-network provider sued Humana for tying the UCR to Medicare rates.⁷³ Humana had supposedly paid only \$6,619.20 on invoices totaling \$1,705,794.00, which was lower than Medicare rates. Before providing services to Humana members, the provider allegedly verified with Humana that the payor would cover the services. Moreover, Humana purportedly stated in its Benefit Plan (which it mailed to the provider) that it would fully reimburse out-of-network providers at a usual and customary or agreed upon rate.⁷⁴ Based on these allegations, the district court found that the provider stated promissory estoppel and negligent misrepresentation claims.⁷⁵ The parties dismissed the case on October 29, 2014.

C. Payor Actions: Forcing providers to defend patient billing practices

1. Cigna has aggressively pursued providers that waive patient cost-sharing

In October 2014, Cigna brought an \$84 million fraud lawsuit against Health Diagnostic Laboratory Inc. (“HDL”) in the District of Connecticut. Cigna alleges that HDL told Cigna members that they would not have to pay co-payments, co-insurance, or deductibles when using HDL’s services. HDL would then overbill Cigna, charging “phantom” rates that were two to three times the Medicare allowable. Additionally, HDL supposedly paid referral fees to in-network providers, who are bound by their network

⁷³ 16 F. Supp. 3d at 771.

⁷⁴ *Id.* at 772.

⁷⁵ *Id.* at 781-83.

contracts to refer patients to in-network providers.⁷⁶

HDL has moved to dismiss, arguing that Cigna lacks standing under ERISA and has not identified any plan terms that HDL supposedly violated. HDL further argues that Cigna's state-law claims are preempted by ERISA and that Cigna has not pleaded its fraud claims with particularity.⁷⁷ The motion remains pending.

Cigna's action against HDL is not unique. Rather, it appears to be the latest volley in reoccurring litigation. Cigna filed similar lawsuits or counterclaims against an intravenous-nutrition provider in California in November 2013,⁷⁸ an ambulatory surgical center ("ASC") in California in May 2013,⁷⁹ and an ASC in New Jersey in September 2012.⁸⁰ In each case, Cigna pleaded similar claims based on allegations of cost-sharing waivers and improper billing practices.

2. The Bay Area Surgical Group ("BASG") litigation continues in California

Aetna first sued BASG, an out-of-network ASC, in state court in Santa Clara County, California in 2012. Aetna alleged that BASG waived patients' cost-sharing, submitted inflated invoices, and induced Aetna's network physicians to refer patients to

⁷⁶ *Conn. Gen. Life Ins. Co. v. Health Diagnostic Lab. Inc.*, No. 3:14-cv-01519, Pls.' Original Compl.at ¶¶ 1, 4, 55, 63-64 (D. Conn. Oct. 15, 2014) ECF No. 1.

⁷⁷ *Id.* Mem. of Law in Supp. of Mot. to Dismiss at 2-3 (Dec. 8, 2014) ECF No. 35.

⁷⁸ *Nutrishare, Inc. v. Conn. Gen. Life Ins. Co.*, No. 2:13-cv-02378, 2014 WL 1028351, at *1 (E.D. Cal. Mar. 14, 2014) (denying Nutrishare's motions to dismiss counterclaims).

⁷⁹ *Conn. Gen. Life Ins. Co. v. La Peer Surgery Ctr. LLC*, No. 2:13-cv-03726, 2014 WL 961806, at *1 (C.D. Cal. Jan. 17, 2014) (granting defendants' motion to dismiss for lack of subject matter jurisdiction on Cigna's ERISA claims, but allowing Cigna to amend to identify ERISA plans).

⁸⁰ *Conn. Gen. Life Ins. Co. v. Roseland Ambulatory Surgery Ctr.*, No. 2:12-cv-05941, 2014 WL 2601972, at *1 (D.N.J. June 11, 2014) (denying in part Cigna's motion to dismiss counterclaims).

BASG in exchange for a share of the profits.⁸¹ United and Cigna then filed similar actions against BASG, claiming \$39 million and \$66 million in damages, respectively.⁸² United's case is ongoing.⁸³ Cigna settled in November 2013.⁸⁴

BASG has now filed 16 separate California state court actions against Aetna and various ERISA plan sponsors, which have been consolidated with Aetna's case.⁸⁵ BASG has also filed a federal ERISA action for benefits due against more than 100 corporate defendants in their capacities as ERISA plan sponsors or administrators.⁸⁶ One of those defendants, First American Financial Corp., sought Rule 11 sanctions against BASG in March 2014.⁸⁷ First American argued that BASG has no standing to bring ERISA claims on behalf of First American's employees and, moreover, has not alleged any conduct that

⁸¹ *Aetna Life Ins. Co. v. Bay Area Surgical Mgmt.*, No. 1-12-CV-217943 (Cal. Super. Ct. filed Feb. 2, 2012); see also *Bay Area Surgical Grp., Inc. v. Aetna Life Ins. Co.*, No. 5:13-cv-05430, Order Granting Def.'s Mot. to Stay; Denying Without Prejudice Defs.' Mots. to Dismiss, to Sever, and for Sanctions (describing the initial action by Aetna) at 3 (N.D. Cal. June 17, 2014) ECF No. 697; Kat Greene, *Benefits Trust Seeks Sanctions in \$26M Aetna ERISA Suit*, Law360 (Mar. 4, 2014), available at <https://www.law360.com/articles/515062/benefits-trust-seeks-sanctions-in-26m-aetna-erisa-suit>.

⁸² Jeff Overley, *United Healthcare Sues Surgery Firm Over \$39M Kickback Plot*, Law360 (June 19, 2012), available at <http://www.law360.com/articles/351878/united-healthcare-sues-surgery-firm-over-39m-kickback-plot> (discussing the case, filed in Santa Clara County Superior Court, case no. 112-cv-226686); see also *Conn. Gen. Life Ins. Co. v. Bay Area Surgical Mgmt, LLC*, No. 5:13-CV-00156, Complaint at ¶¶ 2-7 (N.D. Cal. Jan. 11, 2013) ECF No. 1.

⁸³ See *United Healthcare Servs., Inc. v. Bay Area Surgical Mgmt., LLC*, No. 112-cv-226686 (Cal. Super. Ct. filed June 18, 2012), available at http://www.sccaseinfo.org/pa6.asp?full_case_number=1-12-CV-226686.

⁸⁴ *Conn. Gen. Life Ins. Co. v. Bay Area Surgical Mgmt, LLC*, No. 5:13-CV-00156, Stip. for Dismissal without Prejudice and Order at 2 (N.D. Cal. Nov. 1, 2013) ECF No. 43.

⁸⁵ See Kat Greene, *Benefits Trust Seeks Sanctions in \$26M Aetna ERISA Suit*, Law360 (Mar. 4, 2014), available at <https://www.law360.com/articles/515062/benefits-trust-seeks-sanctions-in-26m-aetna-erisa-suit>; see also Brian Mahoney, *Docs Decry "Bullying" Sanctions Bid in \$26M ERISA Row*, Law360 (Mar. 18, 2014), available at <https://www.law360.com/articles/519688/docs-decry-bullying-sanctions-bid-in-26m-erisa-row>.

⁸⁶ *Bay Area Surgical Grp. Inc. v. Aetna Life Ins. Co.*, No. 5:13-CV-05430, Compl. at 1-11, 79 (N.D. Cal. Nov. 22, 2013) ECF No. 1.

⁸⁷ *Id.* Def. First Am. Fin. Corp.'s Mot. for Sanctions at 1 (N.D. Cal. Mar. 3, 2014) ECF No. 558.

violates ERISA.⁸⁸ The district court denied the motion for sanctions pending resolution of the consolidated California proceeding.⁸⁹

3. United recently defeated the ERISA preemption defense asserted by ASCs

In *United Healthcare Services, Inc. v. Sanctuary Surgical Center, Inc.*, United sued several out-of-network ASCs, alleging that they waived patients' cost-sharing, improperly coded non-covered services as covered services, and paid kickbacks to chiropractors who referred patients for surgery. United pleaded claims for common law fraud, unjust enrichment, violations of Florida's Unfair and Deceptive Trade Practice Act and civil theft. The ASCs moved to dismiss based on ERISA preemption, but the Court denied that motion in its entirety in March 2014.⁹⁰

D. New York legislative reforms concerning balance billing

New York enacted an "Emergency Medical Services and Surprise Bills Law" in 2014 that will have significant implications for providers and insurers alike when it becomes effective on March 31, 2015. The law will impose a variety of requirements concerning disclosure, billing, and payment that are all intended to address patient concerns regarding balance billing by out-of-network providers.

For example, the law will require providers to disclose the health care plans in which they participate as well as the estimated cost of nonemergency services.⁹¹ The

⁸⁸ *Id.* at 2.

⁸⁹ *Id.* Order Granting Def.'s Mot. to Stay; Denying Without Prejudice Defs.' Mots. To Dismiss, to Sever, and for Sanctions at 4, 10 (N.D. Cal. June 17, 2014) ECF No. 697.

⁹⁰ *United Healthcare Servs., Inc. v. Sanctuary Surgical Ctr., Inc.*, 5 F. Supp. 3d 1350, 1353-55, 1365 (S.D. Fla. 2014).

⁹¹ N.Y. Pub. Health Law § 24.

disclosure must include the contact information and network status of other providers (e.g., surgical assistants) who would participate in treating the patient but would bill separately from the treating hospital or physician.⁹² Similarly, insurers must disclose their payment methodology for out-of-network services, plus the amount payable as a percentage of the UCR, and examples of anticipated out-of-pocket costs. The new law defines the UCR as the 80th percentile of “all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database”⁹³

The law will impose rules for “surprise bills” for nonemergency and emergency services alike. If a patient is insured and the physician has accepted an assignment of benefits for nonemergency services, then the physician cannot balance bill the patient, and the payor must pay the physician the billed amount or try to negotiate another amount. If the physician has not accepted an assignment or the patient is uninsured, then the physician may balance bill the patient.⁹⁴

If the patient is insured and the physician has not accepted an assignment of benefits for emergency services, then the payor must pay the physician a reasonable fee and ensure that the patient pays no more than if they were in-network. If the patient is uninsured, then the physician may bill the full amount.⁹⁵ If the parties dispute the amount or obligation to pay, then they may escalate the issue to a new dispute resolution program

⁹² *Id.*

⁹³ N.Y. Ins. Law §§ 3217-a(a)(19)-(20), 3217-a(f)

⁹⁴ N.Y. Fin. Servs. Law at §§ 606, 607(a), 607(b).

⁹⁵ N.Y. Ins. Law § 3241(c); N.Y. Fin. Servs. Law §§ 605(a)-(b).

managed by the Department of Financial Services.⁹⁶

The new law will that require that PPOs and EPOs—like HMOs—offer adequate networks and hold insureds harmless for out-of-network services. HMOs and insurers will be required to offer at least one option for out-of-network coverage at 80 percent of its UCR, as defined in the statute.⁹⁷

V. ERISA Limitations on Payor Recoupments: Another emerging trend?

Payors often conduct retroactive audits of provider claims in order to recoup or offset alleged overpayments. Providers have traditionally had few tools for contesting recoupments and offsets. But two federal district courts recently found that providers were ERISA beneficiaries with notice and appeal rights, which they could exercise to contest recoupments and offsets.

A. *Pennsylvania Chiropractic Ass’n v. Blue Cross Blue Shield Ass’n*, No. 1:09-cv-05619, 2014 WL 1276585 (N.D. Ill. Mar. 28, 2014)

The district court in *Pennsylvania Chiropractic Association* enjoined Independence Blue Cross (“IBC”) from unilaterally recouping erroneous payments to in-network chiropractors after finding that the chiropractors were ERISA beneficiaries. The payments were erroneous because the services were not covered by the patients’ capitated health plans. IBC recouped the erroneous payments by offsetting them against payments owed for non-capitated covered services.

The district court found that certain chiropractors were ERISA beneficiaries because they were entitled to direct payments under their patients’ ERISA plans. The

⁹⁶ *Id.* at §§ 605(a)-(b), 607(a)-(b).

⁹⁷ N.Y. Ins. Law §§ 3241(a), 3241(b)(1)(A).

recoupments by IBC were therefore adverse benefit determinations (“ABDs”) for which the chiropractors had notice and appeal rights. The IBC was obligated give notice of the recoupments by providing: (1) the specific reasons for them, plus references to the supporting plan provisions; and (2) a description of the plan’s review procedures. The district court instructed IBC to establish a procedure whereby a chiropractor would have a reasonable opportunity to appeal an ABD and receive a full and fair review.

B. *Premier Health Ctr., P.C. v. UnitedHealth Group, Inc.*, No. 11-425, 2014 WL 4271970, (D. N.J. Aug. 28, 2014)

In *Premier Health Center*, a putative class of out-of-network physicians holding assignments of benefits (“AOBs”) contested recoupments by United. According to the providers, United processed claims based on the codes billed, and then conducted post-payment audits to identify coding errors and recoup incorrect payments. United’s recoupment notices allegedly violated ERISA by failing to state the reason for the overpayment and explain how to appeal the ABD.

United challenged class certification on commonality grounds, arguing that not all of the physicians had obtained assignments of benefits that conferred standing to pursue ERISA remedies. United argued that ERISA distinguishes between assignments of the right to receive payment and the right to pursue ERISA remedies. The district court rejected United’s standing argument, reasoning that ERISA requires that all notices of ABDs—including offsets or recoupments—be in writing, include the specific ground for the denial, and reference the controlling plan provision. ERISA also requires a “full and fair review” of ABDs. After finding that United’s notices were uniformly noncompliant, the district court conditionally certified the class.