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

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The Issues

- Changing payment landscape
- Narrow network litigation
- Accountable Care Organizations ("ACOs")
- Multi-jurisdictional arbitration practice
- Out-of-Network litigation
  - Ingenix litigation (yes – it continues!)
  - Survey of provider and payor actions
- ERISA rights regarding recoupments

The Changing Payment Landscape

The more things change, the more they stay the same

"Medicare's newly announced plans to condition more payments on quality and value is another nail in the coffin of traditional reimbursement, according to experts who say the government's latest demands will … encourag[e] private insurers to follow suit.

…

The announcement on [January 26, 2015] outlined two central goals that Medicare hopes to achieve within four years. One is aimed at linking 90 percent of payments in traditional Medicare to quality and value, and the second is aimed at sending 50 percent of payments to providers in alternative delivery models, such as [ACOs].

…

What is virtually certain is that Medicare's move will spur similar changes in how private insurance plans structure their payments. …. 40 percent of private insurance reimbursements last year were linked to quality, compared with about 10 percent the year prior."

--Law360, January 28, 2015

"Experts largely agree that value-based contracting will not be a panacea . . . . 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."

--Modern Healthcare, January 22, 2015

Narrow Network Litigation

Breaking efforts to bend the cost curve?

Narrow Network Litigation

- "Narrow Network" = network consisting of a smaller number of providers than a traditional Preferred Provider Organization ("PPO")
- Basic concept is to increase patient volume and revenue for provider while lowering costs through reduced rates and/or increased quality
- Issuers of individual plans and Medicare Advantage Organizations ("MAOs") increasingly rely on them
- Great for in-network providers, though patient advocacy groups have raised access concerns

Narrow Network Litigation

- Patients filed at least 5 putative class actions and 1 multi-plaintiff action against payors in California in 2014
- Five of the California actions arise out of ACA market transition from non-grandfathered PPO plans to ACA-compliant individual plans; one of the actions involves a Medicare Advantage ("MA") plan
- Allegations in the actions involving ACA plans are generally:
  - Plaintiffs thought they were buying PPO plans with broad networks and low deductibles, but received Exclusive Provider Organization ("EPO") or PPO plans with narrow networks and high deductibles
  - Issuers listed physicians in provider guide during open enrollment who were subsequently eliminated from network
  - Issuers delayed in sending ID cards, which were mislabeled
  - Narrow networks are inherently inadequate

Narrow Network Litigation

- Plaintiffs in the California actions generally plead:
  - Fraudulent or negligent misrepresentations or omissions
  - Violations of California UCL, FAL, and/or CLRA
  - Breach of contract
  - Declaratory judgment
- Additional, novel claims include:
  - Concealment (Cal. Ins. Code § 332)
- Relief sought typically includes:
  - Injunctive relief
  - Restitution
  - Civil penalties
  - Damages

Narrow Network Litigation

- Jurisdictional considerations
  - CAFA removal
  - Primary administrative jurisdiction
- Class certification considerations
  - Uniformity of misrepresentations, reliance
  - Varying plan designs and alleged network deficiencies
  - Class-wide proof of diminution in value of plan
  - Differences in premium tax credits
- (Additional) merits considerations
  - Providers' contribution to inaccuracies
  - Availability of mandatory injunctive relief
  - Continuing need for injunctive relief

Narrow Network Litigation

- California regulators are now involved in narrow network issues in that state
- The Department of Managed Health Care ("DMHC") has investigated and concluded that Anthem's and Blue Shield's provider manuals were inadequate during open enrollment (which helps plaintiffs)
- The California Department of Insurance ("DOI") has issued new network adequacy standards
- Key question: How much will out-of-network providers benefit?

Narrow Network Litigation

- Both patients and providers have sued MA plans:
  - *Roberts v. United Healthcare Servs., Inc.* (Cal. Super. Ct. L.A. County, filed Mar. 28, 2014) (MA member challenging United's alleged lack of in-network urgent care clinics)
  - *Fairfield Cnty. Med. Ass'n v. United Healthcare of New England*, 985 F. Supp. 2d 262 (D. Conn. 2013) (issuing injunction in favor of physicians who were removed from United's network through contractual amendment, while also granting motions to compel arbitration)
- The Centers for Medicare & Medicaid Services ("CMS") have amended the Medicare Managed Care Manual to permit special enrollment following "substantial" network changes

Accountable Care Organizations

The next litigation frontier?

Accountable Care Organizations

- ACOs are still new – adoption accelerated by the ACA
- Commercial ACOs can vary structurally by ownership, providers, financial incentives, risk sharing
- Administrative and clinical integration, and use of financial incentives to increase quality and lower cost, harkens back to HMO era of 1990s, early 2000s
- No significant, reported ACO litigation yet
- Potential risk areas, informed by HMO era
  - Provider compensation
  - Patient actions for nondisclosure
  - Tort liability

Accountable Care Organizations

- In *Grider v. Keystone Health Plan Central, Inc.*, No. CIV.A.2001-CV-05641, 2003 WL 22182905 (E.D. Pa. Sept. 18, 2003), the district court found that physicians participating in a HMO pleaded fraud by alleging that the HMO:
  - Misrepresented the attainability of its performance measures for physician compensation; and
  - "Shaved" capitation payments by underreporting the patients who were attributable to the physicians.
- *Grider* is instructive for ACOs

Accountable Care Organizations

- Patients have argued that HMOs have fiduciary and tort duties to disclose provider compensation arrangements impacting health care delivery
- ERISA preempted state law claims based on such duties, and the U.S. Court of Appeals for the Third Circuit recognized only a narrow fiduciary duty in *Horvath v. Keystone Health Plan East, Inc.*, 333 F.3d 450, 454 (3d Cir. 2003)
  - No duty under *Horvath* absent a request by the plaintiff, circumstances that put the defendant on notice of the plaintiff's need for the information, or evidence that the plaintiff was harmed.

Accountable Care Organizations

- ACOs that simply contract with payors to provide medical services to health plan members are likely not ERISA fiduciaries that owe duty of disclosure.
- State law governing duty to disclose health care provider's economic interest is mixed. *Compare Moore v. Regents of the Univ. of Cal.*, 987 P.2d 479 (Cal. 1990) *with Neade v. Portes*, 739 N.E.2d 496 (Ill. 2000) *and Jezek v. Carecredit LLC*, No. 10C7360, 2011 WL 2837492 (N.D.Ill. 2011).
- If ACOs have a duty to disclose under state law, they probably lack an ERISA preemption defense

Accountable Care Organizations

- ACOs that engage in population health management may perform administrative and clinical functions, and reward provides who comply with quality measures
- These functions are reminiscent of "cost-containment" performed by HMOs, which prompted lawsuits based on vicarious liability or corporate practice of medicine
- Unlike HMOs, ACOs may not have ERISA preemption as a defense to state tort actions arising from unfortunate outcomes

Ethical Considerations in Multi-Jurisdictional Arbitration Practice

Best practices for navigating UPL rules

Multi-Jurisdictional Practice

- Is representation of a client in an arbitration considered the practice of law? If so, what are an out-of-state lawyer's ethical obligations in connection with arbitration?
- The states take varying approaches, which may be set forth in bar rules, ethics opinions, court rules, case law, and/or statutes
- A majority of states have adopted some form of ABA Model Rule 5.5(c), which permits out-of-state lawyer to temporarily participate in arbitration that is "reasonably related" to lawyer's practice in a jurisdiction in which lawyer is admitted

Multi-Jurisdictional Practice

- New York
  - Arbitration is not the practice of law
  - N.Y. R.P.C. 5.5 does not mention arbitrations
- California
  - Has not adopted Rule 5.5
  - Permits out-of-state attorneys to participate in arbitration if they obtain arbitrator's approval, file certificate with State Bar, serve certificate
  - Failure to timely file and serve certificate is a ground for disapproval and disqualification

Multi-Jurisdictional Practice

- Florida
  - Has adopted Rule 5.5, with modifications
  - Non-Florida lawyer may arbitrate if (i) the appearance is for a client who resides in 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
  - Non-Florida attorneys may not participate in more than 3 arbitrations within a 365-day period

Multi-Jurisdictional Practice

- Key Takeaways:
  - While most states do not limit multi-jurisdictional arbitration practice, some do
  - Depending on the state, the applicable rules may appear in a variety of source materials
  - Best practice is to review secondary authority (e.g., 50-state survey) and source materials before arbitrating in new jurisdiction

Out-of-Network Litigation

Are provider and payor actions on the rise?

Introduction

- Classic dispute involves a non-contracted provider who contests the sufficiency of benefit payments for services rendered
- Since the 2000s, focus has been industry-wide litigation regarding payors' use of the Ingenix databases to determine usual, customary, and reasonable charges ("UCR")
- Anecdotally, migration to value-based payment is not slowing out-of-network litigation. Potential explanations:
  - Providers that do not integrate are solidly out-of-network
  - Payors transitioning from UCR to percentage of Medicare
  - Payors suing over provider waivers of patient cost-sharing
  - Patients more sensitive to costs with growth of HDHPs

Ingenix Litigation

- Beginning in the early 2000s, medical associations and individual providers and patients filed putative class actions against major payors alleging that:
  - Ingenix databases skewed out-of-network payments downward as a result of self-reported data and flawed methodologies
  - Payors concealed flaws and restrained trade
- Large settlements followed:
  - In 2008, Health Net paid $215 million to settle *Wachtel* class action in the District of New Jersey
  - In 2009, United paid $350 million to settle *AMA* class action in the Southern District of New York, plus $50 million to fund FAIR Health database following NY AG investigation

Ingenix Litigation

Actions against other payors continue:

- *In re Aetna UCR Litig.,* No. 2:07-cv-3541 (D.N.J.)
  - Aetna terminated $120 million settlement after large number of opt-outs. Plaintiffs' motion for leave to amend complaint is pending.
- *Franco v. Conn. Gen. Life Ins. Co.*, No. 07-cv-6039 (D.N.J.)
  - Cigna defeated class certification and won at summary judgment. Plaintiffs have appealed to Third Circuit.
- *In re WellPoint, Inc. Out-of-Network "UCR" Rates Litig.*, No. 2:09-ml-02074-PSG-FFM (C.D. Cal.)
  - WellPoint was largely successful at motions to dismiss phase and also defeated class certification. Case nevertheless continues.

Provider Actions

- Payors are increasingly disputing their obligation to pay based on provider plaintiffs' waivers of patient cost-sharing
- *North Cypress Med. Ctr. Operating Co, Ltd. v. Cigna Healthcare*, No. 4:09-cv-02556 (S.D. Tex. Aug. 10, 2012)
  - North Cypress (a general acute care hospital) sued Cigna, alleging ERISA violations and state-law claims for denials, underpayments, and late payments of out-of-network claims
  - Cigna counterclaimed, alleging that charges were "phony" because North Cypress routinely waived co-insurance
  - District court dismissed Cigna's counterclaim but granted summary judgment in Cigna's favor based on North Cypress's billing practices (which relieved Cigna of liability)
  - North Cypress's appeal to the Fifth Circuit remains pending

Provider Actions

- *Biomed Pharms., Inc. v. Oxford Health Plans (NY), Inc.*, 522 Fed. App'x 81 (2d Cir. 2013)
  - Oxford argued that it had no obligation to pay because Biomed regularly waived co-insurance and deductibles without first making an adequate inquiry into the patient's financial hardship
  - District court dismissed and Second Circuit affirmed, reasoning that the "waivers were not based on a good faith inquiry into the family's financial condition" and were given regularly
- *IV Solutions, Inc. v. United Healthcare Servs., Inc.*, No. 12-CV-4887, 2014 WL 6896023 (C.D. Cal. Dec. 5, 2014)
  - United argued that it did not have to pay because IV Solutions regularly waived co-payments and deductibles
  - District court excluded evidence of home infusion association's ethical standards, which stated that providers should not grant waivers routinely

Provider Actions

- *Orthopedic Specialists of S. Cal. v. Cal. Public Emp. Ret. Sys.*, 228 Cal.App. 4th 644 (Cal. Ct. App. 2014):
  - Provider of nonemergency orthopedic services sued CALPERS for failing to pay UCR, consistent with oral representations and DMHC regulation concerning emergency services
  - Appellate court affirmed dismissal because oral representations are nonbinding on CALPERS and services were not emergent
- *Children's Hosp. Cent. Cal. v. Blue Cross of Cal.*, 226 Cal.App.4th 1260 (Cal. Ct. App. 2014):
  - Emergency services provider sued under quantum meruit theory and obtained billed charges at trial
  - Appellate court reversed, finding that trial court should have admitted evidence of hospital's acceptance of amounts less than billed charges, which was relevant to UCR

Payor Actions

- *Conn. Gen. Life. Ins. Co. v. Health Diagnostic Lab. Inc.*, No. 3:14-cv-01519 (D. Conn. Filed Oct. 15, 2014)
  - Cigna seeks $84 million in damages, alleging that HDL waived patient cost-sharing, inflated its charges, and paid referral fees to in-network providers
  - HDL's motion to dismiss based on ERISA preemption and failure to comply with Rule 9(b) remains pending
  - Cigna has sued ambulatory surgery centers ("ASCs") and other providers under similar theories in recent years
- *United Healthcare Servs., Inc. v. Sanctuary Surgical Ctr., Inc.*, 5 F. Supp. 3d 1350, 1353-55, 1365 (S.D. Fla. 2014)
  - United sued ASCs for waiving patient cost-sharing and recently defeated ERISA preemption defense

Payor Actions

- Bay Area Surgical Group ("BASG") Litigation
  - Aetna first sued BASG in California state court in 2012, alleging that BASG waived patient cost-sharing, inflated its bills, and maintained improper referral arrangements with Aetna's in-network providers
  - United and Cigna filed similar lawsuits against BASG. Cigna settled. United's action continues
  - BASG responded by bringing 16 different lawsuits against Aetna and various plan sponsors in California state court, which were consolidated with Aetna's action in May 2013
  - BASG also brought a federal lawsuit against Aetna and 100-plus ERISA plan sponsors. The case has been stayed pending resolution of the consolidated state proceeding

NY Balance Billing Reform

- Enacted in 2014, effective March 31, 2015
- Provider Disclosures
  - Providers must disclose the following to both existing and prospective patients:
    - The health plans in which the provider participates
    - Estimated cost of nonemergency services
    - Contact and plan participation information for other providers who are referred or coordinated by the patient's provider
      - *E.g.*, Anesthesiologists and surgical assistants

NY Balance Billing Reform

- Insurer Disclosures
  - Disclosures are required and must include:
    - Clear description of out-of-network payment methodology
    - Amount that insurer will pay under that methodology as a percentage of UCR
    - Examples of anticipated out-of-pocket costs for frequently billed out-of-network services
  - UCR defined as 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"
    - Determined by a benchmarking database, like FAIR Health

ERISA Rights and Recoupments

Yet another emerging trend?

Recoupments

- In 2014, two district courts determined that providers had ERISA rights in connection with recoupments:
  - *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) (finding that certain providers were ERISA beneficiaries and enjoining payor from unilaterally recouping erroneous payments)
  - *Premier Health Ctr., P.C. v. UnitedHealth Group, Inc.*, No. 11-425, 2014 WL 4271970, (D. N.J. Aug. 28, 2014) (finding that providers with AOBs had standing under ERISA and conditionally certifying class of providers that contested sufficiency of notices)
- Observations:
  - Provider standing under ERISA may turn on facts of each case
  - Standing affords providers notice and "full and fair review" but does not necessarily prevent recoupments

Questions?

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