AMERICAN BAR ASSOCIATION Health Law Section
Health eSource
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Trends and Developments in Managed Care Litigation

Vol. 12 No. 2

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I. Introduction

In the tripartite relationship among Payors (insurers and self-funded plans), Providers (physicians, hospitals, and other medical service providers), and Patients (members of individual or group health plans), not a day passes without palpable tension among them. Payors strive to adhere to their committed risk set forth in their health benefit plans, Providers demand fair payment for services rendered, and Patients simply want coverage for their medical expenses. This is the world of "Managed Care Litigation."

Put another way, the Payor-Provider-Patient relationship is a tug of war that is "all about the money," frequently having little to do with patient care because when litigation is initiated by an out of network provider, it is usually an attempt to recover the difference between a perceived underpayment and billed charges. By definition, there is not a contract between the parties which would speak to amounts of payment and patient care. Conversely, a member seeking coverage for a procedure invariably contends that the procedure is "medically necessary," indirectly implicating a desire for the best possible care. Then the question is whether the policy language affords coverage for the desired service, or an alternative service.

The first part of this article will discuss some of the empirical data attendant to managed care cases filed since January 2014, namely the first nine months of 2014 compared to the first nine months of 2015. The second half of this article will discuss some recurring subject matter themes appearing in those cases.

II. The numbers behind managed care case filings

In the first nine months of 2014, there were 312[1] managed-care related lawsuits, involving "Blue Cross Blue Shield Plans" (109 cases), "Aetna" (82 cases), "United Healthcare" (47 cases), "Humana" (41 cases), and "CIGNA" (33 cases).[2] Of all of those cases, 104 were filed on behalf of members, 75 were filed on behalf of physicians, 75 were filed on behalf of other service providers, and 36 were filed on behalf of facilities. There were 14 cases on behalf of Plan Sponsors (employers offering a group health plan for the benefit of their employees), six cases involving a plan's subrogation rights, and two cases filed by health insurers seeking repayment from provider(s).

During this period, the greatest concentration of cases was filed in the U.S. Eleventh Circuit (75), followed by the U.S. Ninth Circuit (46), and the U.S. Fifth and Sixth Circuits (42 each).

In the first nine months of 2015, there were 362 managed-care related disputes, filed against Blue Cross Blue Shield Plans (159 cases), Aetna (86 cases), United Healthcare (55 cases), Humana (16 cases), and CIGNA (46 cases). Of all of those cases, 153 were filed on behalf of members, 35 were filed on behalf of physicians, 20 were filed on behalf of other service providers, and 89 were filed on behalf of facilities. There were 50 cases on behalf of Plan Sponsors, seven cases involving a plan's subrogation rights, and eight cases filed by health insurers seeking repayment from provider(s).

During this period, the greatest concentration of cases was filed in the U.S. Sixth Circuit (74), followed by the U.S. Ninth Circuit (64), and the U.S. Tenth Circuit (42).

The number of newly filed cases increased by about 16 percent from the first nine months of 2014 and same time period in 2015. The number of cases filed on behalf of members seeking coverage of a disputed claim has increased by 47 percent. While cases filed on behalf of physicians and other service providers have decreased, cases filed by facilities have more than doubled. Cases filed by health insurers seeking recovery of overpayments have quadrupled. The U.S. Sixth Circuit has replaced the U.S. Eleventh Circuit as the hotbed of newly filed cases, although new case filings in the U.S. Ninth Circuit have remained high in both periods.[3]

The root cause of these trends would appear to be based on issues pertaining to the network relationship between Payors and Providers, particularly the "narrowing" of networks. As physicians and other service providers go in-network, their disputes become governed by contract or an arbitration clause. Facilities which choose to remain out of network may find that their charges are subject to a high patient responsibility, where the patient lacks the ability to pay. Payors' efforts to recover

overpayments are rooted in their efforts to encourage members to obtain treatment from in-network facilities.

III. Emergent case themes

The impetus behind an increasing number of cases from 2014 to 2015 appears to be the Providers revenue compression, frequently as a reduction in out-of-network payments by Payors and increased Patient responsibility. Payors often cite increased costs to treat sick individuals, citing the Patient Protection and Affordable Care Act (PPACA),[4] which likely also prompts a more proactive effort to recover alleged overpayments from Providers. Regardless, the following specific themes have emerged:

Efforts to obtain coverage for mental health benefits represent the largest subject matter of new cases filed in 2015 (29 new cases in 2015 versus 16 cases in 2014). Many of those efforts seek recovery of benefits for treatment received by adolescents at residential treatment centers (19 cases in 2015).[5] Frequently, plaintiffs allege that coverage was denied on the basis that the patient could be treated on an outpatient basis and/or with a less restrictive level of care.[6] There have been 10 filed cases alleging violations of the Federal Mental Health Parity Act and/or its state law equivalent.[7]

The increase in cases seeking coverage for mental health benefits is apparently due to an increased awareness of mental health parity laws. Prior to the passage of such laws, benefits were often limited, if at all available. Yet even though mental health benefits must be "on par" with other plan benefits, many mental health benefit providers remain out of network, leaving members with high patient financial responsibility.

Class action filings have almost doubled in 2015, with 24 new cases filed in 2015 versus 14 in 2014. The subject matter of the 2015 class actions include efforts to obtain coverage of Harvoni®, alleged to be a breakthrough, life saving treatment for Hepatitis C;[8] efforts to obtain coverage for Applied Behavior Analysis therapy for the treatment of autism;[9] coverage for cervical Artificial Disc Replacement;[10] and a challenge to an insurer's requirement that plan enrollees with HIV/AIDS obtain specialty medications from a mail order pharmacy instead of a local pharmacy, which would be out of network and therefore result in pricing discrimination.[11]

In addition, Payors are taking significant, proactive efforts to recover alleged overpayments from providers, typically alleging that the providers are engaging in "fee forgiveness," namely forgiving the out-of-pocket amounts that patients would otherwise have to pay under their health benefit plan to out of network providers.[12] Conversely, Providers frequently allege that Payors are improperly offsetting and/or withholding amounts

properly payable under claim submissions on behalf of other, unrelated patients.[13]

There has been one case directly asserted under PPACA, where an in-network diagnostic laboratory has alleged that the Payor's unilateral 60 percent reduction in reimbursement rates violates Section 2706 of PPACA (no discrimination against a provider acting within the scope of its license, differences in reimbursement rates only based on quality or performance measures).[14]

Additional types of managed care litigation can be expected. For instance, Provider revenue compression will likely drive additional litigation. In-network providers are pursuing litigation under state law prompt pay statutes, alleging that such laws require higher reimbursement than that ordinarily due under the contract.[15] Moreover, certain types of cases will become more common. Citing PPACA, Payors are seeking premium growth[16] and certainly do not appear to be shy about pursuing recovery of overpayments made to Providers.[17] Patients will continue to demand coverage for their claims, especially given the emergence of mental health parity laws.

IV. Conclusion

Managed care case filings are unquestionably up from 2014 through 2015 and show no sign of abating. The class action will likely remain the procedural vehicle of choice for Patients and Providers, which may prove to be a two-edged sword: an action finding coverage across the class unquestionably benefits Patients and Providers, but a successful defense by the Payor may bar all such efforts at coverage. Finally, Payors will continue to mine their claims data looking for outliers and have every incentive to recover overpayments, especially when acting as an ERISA plan fiduciary.

Patients, Providers, and Payors will continue to see new case filings through the remainder of 2015 and beyond, but trending the cases is a healthy (no pun intended) resource, which can augment policy underwriting.

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1 The case statistics discussed in this article are derived **only** from cases filed in the United States District Courts, whether filed as original proceedings or removed from state court. Insofar as the health plans at issue are invariably provided as employer group health benefits, the predicate for removal is usually the Employee Retirement Income Security Act of 1974 (ERISA), which additionally governs the evidentiary burdens of the parties to the litigation. Case pending in state court rest exclusively upon state law theories of recovery (i.e. the Provider's claim that the Payor negligently misrepresented benefits). The cases statistics cited in this article would likely be higher if the state court population of cases were included.

2 The terms "Aetna," "United Healthcare," "Humana," and "CIGNA" are intended to be generic terms which identify with the four major health insurers. The term "Blue Cross Blue Shield Plans" is intended to be a generic term that collectively represents the 36 independently operated Blue Cross and Blue Shield member companies.

3 The Ninth Circuit encompasses California which, given its large population, invariably sees a lot of claims. There does not appear to be any pattern of cases originating within other Circuits.

4 *See e.g.* http://www.wsj.com/articles/insurers-win-big-health-rateincreases-1440628848; http://www.wral.com/blue-crossraises-rate-hike-sought-onaffordable-care-plans/14814644/.

5 *See e.g. Peter B. and Paloma B. v. Anthem Blue Cross Life and Health Insurance Company*, U.S.D.C. D. UT, Doc. No. 2:15-cv-00074-RJS, (filed Feb. 3, 2015); *Bevan R. et al. v. United Healthcare Insurance Company, et al*., U.S.D.C. D. UT, Doc. No. 2:15-cv-00075-DBP, (filed Feb. 3, 2015); *Richard P. et al. v. United Healthcare Insurance Company, et al*.. U.S.D.C. D. UT, Doc. No. 2:15-cv-00402-DBP, (filed June 8, 2015).

6 *Christian S., et al. v. United Healthcare, et al*., U.S.D.C. D. UT, Doc. No. 1:15-cv-00010-EJF, (filed Jan. 13, 2015); *E.B. v. Blue Cross and Blue Shield of Massachusetts, Inc., et al*., U.S.D.C. D. MA, Doc. No. 1:15-cv-10430, (filed Feb. 16, 2015); *Alexis W. v. Blue Cross Blue Shield of Florida, Inc*., U.S.D.C. S.D. FL, Doc. No. 1:15-cv-23271-MGC, (filed Aug. 31, 2015).

7 *See e.g. Raquel F. v. United Healthcare Insurance Company, et al*., U.S.D.C. N.D. CA, Doc. No. 5:15-cv-00879-NC, (filed Feb. 26, 2015); *Jennifer Brazao v. United Healthcare, Inc., et al*., U.S.D.C. C.D. CA, Doc. No. 8:15-cv-00876, (filed June 3, 2015); *Alexandra Carr et al. v. United Healthcare Services, Inc*., U.S.D.C. W.D. WA, Doc. No. 2:15-cv-01105, (filed July 9, 2015).

8 *Janie Kondell, et al. v. Blue Cross and Blue Shield of Florida d/b/a Florida Blue*, U.S.D.C. S.D. FL, Doc. No. 0:15-cv-61118-RLR, (filed May 27, 2015); M*arina Sheynberg, et al. v. Anthem Blue Cross Life and Health Insurance Company*, U.S.D.C. N.D. CA, Doc. No. 5:15-cv-03417-HRL, (filed July 24, 2015); *Beri Murphy, et al. v. United Healthcare Insurance Company*, U.S.D.C. N.D. CA, Doc. No. 5:15-cv-03799-HRL, (filed Aug. 19, 2015).

9 A*.D., et al. v. T-Mobile USA, Inc., et al*., U.S.D.C. W.D. WA, Doc. No. 2:15-cv-00180, (filed Feb. 9, 2015); *W.P., a minor, et al. v. Anthem Insurance Companies, Inc.*, U.S.D.C. S.D. IN, Doc. No. 1:15-cv-00562-TWP-TAB, (filed Apr. 9, 2015); *Anna M. Sanzone-Ortiz v. Aetna Health of California, Inc., et al*., U.S.D.C. N.D. CA, Doc. No. 3:15-cv-03334-WHO, (filed July 20, 2015).

10 *Jeff Bush, et al. v. California Physicians' Service dba Blue Shield of California*, U.S.D.C. C.D. CA, Doc. No. 2:15-cv-07313-DDP-PJW, (filed Sept. 17, 2015).

11 *John Doe on behalf of himself and all others similarly situated v. CIGNA Health and Life Insurance Company, et al*., U.S.D.C. S.D. FL, Doc. No. 0:15-cv-60894-DPG, (filed Apr. 27, 2015).

12 *Aetna Life Insurance Company v. Robert A. Behar, MD and North Cypress Medical Center Operating*

Company, Ltd., et al., U.S.D.C. S.D. TX, Doc. No. 4:15-cv-00491, (filed Feb. 23, 2015); *Connecticut General Life Insurance Company, et al. v. Northwest Regional Surgery Center, LLC, et al*., U.S.D.C. N.D. IN, Doc. No. 2:15-cv-00253-JD-PRC, (filed July 6, 2015); *Connecticut General Life Insurance Company, et al. v. Sky Toxicology, LTD, et al*., U.S.D.C. S.D. FL, Doc. No. 9:15-cv-80994-WJZ, (filed July 17, 2015); *Connecticut General Life Insurance Company, et al. v. Ventura Recovery Center, Inc*., U.S.D.C. C.D. CA, Doc. No. 2:15-cv-07034-MRW, (filed Sept. 4, 2015).

13 *Dr. Jamie Bassel, P.C., et al. v. United Healthcare, et al*., U.S.D.C. E.D. NY, Doc. No. 1:15-cv-02267-CBA-LB, (filed Apr. 21, 2015); *Garden State Pain and Radiology, P.C. and Mann Anesthesia, P.C. v. Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, et al*., U.S.D.C. D. NJ, Doc. No. 2:15-cv-02878-KSH-CLW, (filed Apr. 23, 2015); *Riverview Health Institute, et al. v. United Health Group, Inc., et al*., U.S.D.C. D. MN, Doc. No. 0:15-cv-03064-DSD-JSM, (filed July 15, 2015); *Sanjiv Goel, M.D., Inc. v. Aetna, Inc., et al*., U.S.D.C. C.D. CA, Doc. No. 2:15-cv-07197-ODW-MRW, (filed Sept. 11, 2015); *SurgCenter of Gilbert, LLC v. UnitedHealthcare of Arizona, Inc*., U.S.D.C. D. AZ, Doc. No. 2:15-cv-01933-DJH, (filed Sept. 28, 2015).

14 *Dominion Pathology Laboratories, P.C. v. Anthem Health Plans of Virginia, Inc*., U.S.D.C. E.D. VA, Doc. No. 2:15-cv-00152-RBS-TEM, (filed Apr. 10, 2015).

15 *See e.g. Methodist Hospitals of Dallas v. Aetna Health, Inc*., U.S.D.C. N.D. TX, Doc. No. 3:15-cv-03108-O, (filed Sept. 24, 2015) (contracted provider seeks more than $6 million, representing the cumulative amount of underpayments according to the Compensation Schedule in the parties' Managed Care Agreement, plus recovery under the Texas Prompt Pay Act).

16 *See* n. 4, *supra*.

17 *See* n. 12, *supra*.