MANAGED CARE UPDATE

The following are some recent developments in the law that involve managed care organizations:

I. ERISA PREEMPTION OF NEGLIGENCE CLAIMS


   This case arose as a consolidation of two different lawsuits. In the *Davila* case, Mr. Davila's treating physician prescribed Vioxx, but Aetna refused to pay for this medication. Instead, Mr. Davila was prescribed Naprosyn which caused a severe reaction that required extensive treatment and hospitalization; in the *Calad* case, the patient's treating physician recommended an extended hospital stay following surgery. However, Cigna's discharge nurse denied coverage for the hospital stay and the patient alleged that he experienced postsurgery complications as a result of the denial.

   While the facts varied, the Supreme Court determined that each suit had the following facts in common: (1) each suit was brought in state court under the Texas Health Care Liability Act ("THCLA"); (2) each suit alleged that the plaintiff's respective MCO had violated the THCLA's duty to exercise ordinary care when making health care treatment decisions; (3) each plaintiff alleged that the plaintiff was injured as a proximate cause of the MCO's determination; and (4) each MCO removed the case to federal court, claiming that the plaintiff's cause of action was preempted by ERISA.

   The district court agreed with the MCOs and removed the claims to federal court under ERISA. This would have the effect of leaving the plaintiff with no tort remedy for the alleged acts or omissions of the MCO. The Fifth Circuit Court of Appeals consolidated their cases and several others that raised similar issues and reversed the District Court's
preemption decision in each case citing the Supreme Court's *Pegram* and *Rush Prudential* Opinions.

The Supreme Court of the United States reversed the Fifth Circuit's decision, finding that in each case the plaintiff's claims were the result of a denial of benefits by an MCO and, as such, were completely preempted by ERISA. The Court stressed that ERISA was designed to provide an exclusive federal remedy so that employer benefit plans could be managed uniformly. As such, the Supreme Court held that an MCO could not be subject to liability under state law if the MCO denied coverage for any treatment not covered by the health plan being administered.

Significantly, the Court stated that when an individual brings suit complaining of a denial of coverage, where the individual is entitled to coverage only because of the terms of an ERISA benefit plan, and where there is no other, independent legal duty to provide coverage, the claim falls within the scope of ERISA.

Also, in response to the beneficiaries' argument that their claims were saved from preemption because the THCLA "regulates insurance," the Court held that even statutes that regulate insurance are preempted if those laws provide a separate vehicle for asserting a claim for benefits that is outside of, or in addition to, the exclusive remedies provided by ERISA.

The Court then used this case as an opportunity to discuss how ERISA preemption is to be applied to the mixed eligibility decisions (i.e., decisions that appear to be both eligibility and treatment decisions) that had been discussed in *Pegram*. 
Pegram involved a physician-owned and operated HMO that was sued by a patient/enrollee for malpractice and for a breach of the ERISA fiduciary duty. According to the Court in Pegram, "the plaintiff's treating physician was also the person charged with administering the plaintiff's benefits; it was she who decided whether certain treatments were covered." Based on these facts, the Supreme Court held that "the physician's 'eligibility decision and treatment decision were inextricably mixed.' We concluded that 'Congress did not intend [the defendant HMO] or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions through its physicians.'"

In Davila, the Court differentiated Pegram's unique facts from cases that involve administrators making benefits determinations, by stating:

Since administrators making benefits determinations, even determinations based extensively on medical judgments, are ordinarily acting as plan fiduciaries, it was essential to Pegram's conclusion that the decisions challenged there were truly 'mixed eligibility and treatment decisions,' 530 U.S., at 229, 120 S.Ct. 2143, i.e., medical necessity decisions made by the plaintiff's treating physician qua treating physician and qua benefits administrator. Put another way, the reasoning of Pegram 'only make[s] sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer.' Cicio, 321 F.3d, at 109 (Calabresi, J., dissenting in part). Here, however, petitioners are neither respondents' treating physicians nor the
employers of respondents' treating physicians. Petitioners' coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated.

In a concurring opinion, Justices Ginsburg and Breyer agreed with the majority's decision but recognized the harsh effect of the current law by stating that without Congressional action "virtually all state law remedies are preempted but very few federal remedies are provided." In an attempt to ameliorate this harsh result, the concurring opinion noted that, in the future, an aggrieved party should consider seeking relief under §502(a) of ERISA, "an effective remedy others similarly circumstanced might fruitfully pursue." Justices Ginsburg and Breyer then used their concurring opinion to "join 'the rising judicial chorus urging Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.'" This is something Congress has consistently shown an unwillingness to do.

2. Numerous cases have cited *Davila*, and most have found the beneficiary's claims to be preempted by ERISA. An excellent example of the manner in which *Davila* has changed a circuit court's analysis of the ERISA preemption issue (and ultimate decision on the preemption issue) was *Land v. Cigna Healthcare Corporation of Florida*, 381 F.3d 1274 (11th Cir. 2004).

In *Land*, Mr. Land sought treatment from a hospital emergency department for an injury to his hand that was caused by a bite from his family cat. A Cigna-approved physician ordered that Mr. Land be admitted to the hospital for aggressive antibiotic treatment and constant monitoring. Following his admission to the hospital, a Cigna utilization review nurse approved the use of the antibiotic but determined that Mr. Land did not require
hospitalization, and Mr. Land was discharged that evening. Within a week, Mr. Land's condition worsened. He required multiple operations, none of which proved to be successful, and eventually his finger was amputated.

Mr. Land sued Cigna in state court alleging that Cigna was negligent in the care and treatment of this infection. Mr. Land's case was first removed to federal district court. In a decision that pre-dated the *Davila* decision, the 11th Circuit ruled that, based upon the Supreme Court's analysis in *Pegram*, the case should not be preempted by ERISA.

The 11th Circuit's decision was vacated by the Supreme Court, which instructed the 11th Circuit to now analyze the issue of ERISA Preemption under its *Davila* decision. The 11th Circuit then decided that the Supreme Court had limited the *Pegram* decision stating "*Pegram* is only implicated in circumstances in which the healthcare professionals brought to suit are either the injured party's treating physicians or the employers of the injured party's treating physicians." Since neither of the limited exceptions applied here, the Court reversed its earlier decision and decided that, based on the *Davila* decision, Mr. Land's case was preempted by ERISA. For a similar result, *See Cicio v. Does*, 1-8, 385 F.3d 156 (2nd Cir. 2004).

3. **Pegram v. Herdrich**, 530 US 211 (2000). A patient sued a physician-owned health maintenance organization alleging that the HMO's process to financially reward the physician owners of an HMO constituted a breach of fiduciary duty that the physicians allegedly owed to the HMO enrollees under ERISA. The Seventh Circuit Court of Appeals held that the HMO was acting as an ERISA fiduciary when its physicians made treatment decisions. As such, the physicians owed a fiduciary duty to the enrollees prior to making any treatment decisions. However, the United States Supreme Court reversed
that decision, holding that where eligibility and treatment decisions are inextricably mixed, they are not fiduciary decisions within the meaning of ERISA.

Many cases that had involved ERISA preemption began to be reevaluated in light of the *Pegram* decision. However, the United States Supreme Court's *Davila* decision has significantly limited the applicability of the *Pegram* case to physician-owned MCOs where the MCO is the treating physicians of the MCO enrollee or the employer of the treating physician.

4. **Congressional Inaction.** Over the past few years, the number and variety of cases involving various aspects of ERISA preemption have illustrated the need for congressional action on this issue. Nevertheless, Congress has continued to fail to find a resolution. The 107th Congress came close when, on June 29, 2001, the Senate passed the Patients' Bill of Rights. On August 2, 2001, the House passed its version of this law. However, a conference committee could not reconcile the differences between the House bill and the Senate bill, and the Patients' Bill of Rights died in the conference committee.

On February 5, 2003, Rep. Charlie Norwood (R-GA) introduced two pieces of legislation that Rep. Norwood stated were intended to provide protections to patients enrolled in MCOs. The Patient Protection Act (H.R. 597) is similar to the patients' bill of rights legislation that passed the House in the previous session of Congress, except that H.R. 597 did not include provisions regarding health plan liability, which were a major sticking point in the Conference Committee. In addition to provisions intended to ensure patient access to care, the bill would allow patients to seek an independent review when their physician and insurer disagree over treatment. Since the effect of ERISA on such a process was at issue in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), on
the same day, Rep. Norwood introduced a separate Bill (H.R. 596), entitled "The ERISA Clarification Act." That measure, Rep. Norwood said, clarifies "what appears to be" the U.S. Supreme Court's position regarding ERISA in *Rush Prudential*.

In March 2003, H.R. 596 and H.R. 597 were referred to the House Committee on Education and Workforce's Subcommittee on Employer-Employee Relations. However, since no further action was taken on those bills, they died at the end of the 108th Congress.

5. Until there is a legislative resolution to the issue of ERISA preemption, patients' claims against insurers will be resolved by the courts on an ad hoc basis. While the *Davila* decision provides guidance to the courts, absent legislation, the *Land* case is an excellent example of how difficult it will be for an injured patient to sue an MCO in state court. To give you some historical perspective on how these types of cases were decided prior to the *Davila* case, consider the following:

In *Shifrin v. Group Health Plan, Inc.*, 2001 W.L. 568039 (E.D. Mo. May 23, 2001), one woman must wait to know whether her insurer will pay for her ovarian cancer treatment, while in *Roark v. Humana, Inc.*, 2001 WL 585874 (N.D. Tex. May 25, 2001) another patient's claim that an HMO's delay in authorization for a particular procedure caused her leg to be amputated was dismissed due to ERISA preemption. At that same time, in *Dardinger v. Anthem Blue Cross and Blue Shield*, 2001 WL 575129 (Ohio App. 5 Dist. May 22, 2001), a public employee who is not subject to ERISA was awarded $49 million in punitive damages plus an additional $2.5 million for a bad faith denial. However, this case was remanded for a new trial on the issue of damages.
In trying to resolve liability cases involving ERISA preemption, the federal courts first used a "quantity" versus "quality" approach. Using this approach, if the issue was whether a benefit is covered (i.e., the quantity), then it will be preempted by ERISA, which means that the case will be removed to federal court where the plaintiff's remedy is limited to the cost of the benefit. However, if the question was whether the patient's outcome was affected by the MCO's decision (i.e., the quality), then it is not preempted. The case will then remain in state court and the plaintiff will be permitted to attempt to prove that the MCO is responsible for the patient's pain and suffering.

However, courts had mixed results with this analysis. For example, in *Difelice v. Aetna U.S. Healthcare*, 346 F.3d 442 (3d Cir. 2003), a man sued his HMO alleging that it acted negligently with respect to his treatment for sleep apnea and upper airway obstruction. Specifically, the enrollee alleged that the HMO refused to cover a special tracheotomy tube ordered by his physician because it deemed the tube to be "medically unnecessary" and Aetna's insistence that he be discharged from the hospital before his attending physician deemed it appropriate amounted to negligence under state law.

The enrollee originated the negligence suit in the Philadelphia Court of Common Pleas. The HMO removed the case to federal court, claiming that the suit was completely preempted by ERISA, and then moved to dismiss. The District Court granted the HMO's motion to dismiss, finding the allegations to revolve entirely around the HMO's administration of its plan.

The enrollee appealed the District Court's decisions to the Third Circuit Court of Appeals. The Third Circuit first recognized the difficulty of the quality versus quantity approach by stating that "[D]etermining whether a claim could have been brought under
ERISA has proven to be anything but an exact science." The Third Circuit then found that the HMO's determination not to provide coverage for the special tracheotomy tube was a mixed treatment/eligibility decision. Because the enrollee could have sought coverage for the tube under ERISA's civil enforcement action, the Third Circuit found that claim to be completely preempted by ERISA. Thus, the court upheld the dismissal of that claim.

However, the Third Circuit reversed and remanded the district court's decision with respect to the enrollee's claim that the HMO had insisted on his premature discharge from the hospital. According to the court, the enrollee's claim did not allege that the HMO made an eligibility determination regarding coverage under the enrollee's plan for additional hospitalization. Thus, the claim appears to state that the HMO caused the enrollee's premature discharge for reasons unrelated to coverage, and therefore a state law negligence action was proper, and not preempted by ERISA.

If this case has not been settled or otherwise decided by 2004 and it is re-evaluated under the Davila decision, then, in all likelihood, this aspect of the enrollee's claim will now be pre-empted by ERISA.

II. ERISA PRE-EXEMPTION – OTHER APPLICATION


   **Facts and Procedural History:**
   
   A patient who was a participant in an employee benefit plan requested that Rush Prudential health maintenance organization ("HMO"), allow her to have surgery by an unaffiliated specialist. The HMO denied the claim on the ground that the procedure was not medically necessary. The patient then made a written demand for an independent
medical review of her claim, as guaranteed by §4-10 of the Illinois HMO Act, which further provides that "[i]n the event that the reviewing physician determines the covered service to be medically necessary," the HMO "shall provide" the service. The HMO continued to refuse her demand, and the patient brought a state-court action against the HMO, seeking reimbursement for the surgery and alleging that the HMO failed to comply with the Illinois HMO Act.

The HMO removed the action to federal court, arguing that the complaint stated a claim for ERISA benefits. The U.S. District Court for the Northern District of Illinois treated the patient's claim as a suit under ERISA and denied it, granting summary judgment for the HMO on the ground that ERISA preempted §4-10 of the Illinois HMO Act. The patient appealed. The Seventh Circuit Court of Appeals reversed, finding the reimbursement claim preempted by ERISA so as to place the case in federal court, but it concluded that the state Act was not preempted as a state law that "relates to" an employee benefit plan, because it also "regulates insurance" under ERISA's saving clause. The United States Supreme Court granted cert.

**Issue:**
Is §4-10 of the Illinois HMO Act (as applied to health benefits provided by a health maintenance organization under contract with an employee welfare benefit plan) preempted by ERISA?

**Holding:**
ERISA does not preempt the Illinois HMO Act.
The United States Supreme Court held that: (1) the Illinois statute requiring HMOs to provide independent review of disputes between a primary care physician and an HMO, and to cover services deemed medically necessary by an independent reviewer, regulated insurance within the meaning of the ERISA preemption provision's saving clause; (2) the Illinois statute did not conflict with ERISA by supplementing or supplanting its civil enforcement scheme; (3) the statute did not impose an arbitral adjudication scheme at odds with ERISA's civil enforcement scheme; and (4) the statute did not conflict with ERISA by impermissibly depriving HMOs of a deferential standard of review of benefits determinations.

**Rationale:**

The Court first recognized that the Illinois HMO Act is an insurance regulation under a commonsense view, because it is directed toward the insurance industry. It then analyzed the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act, stating that when insurers are regulated with respect to their insurance practices, the state law survives ERISA. If a state law regulates insurance, it is not preempted.

A law regulating insurance for McCarran-Ferguson purposes targets practices or provisions that: (1) "have the effect of transferring or spreading a policyholder's risk; (2) are an integral part of the policy relationship between the insurer and the insured; and (3) are limited to entities within the insurance industry." The Court held that §4-10 of the Illinois law clearly satisfies factors two and three under McCarran-Ferguson. First, the independent review requirement satisfies the factor that a provision regulate "an integral part of the policy relationship between the insurer and the insured." Second, the factor that the law be aimed at a practice "limited to entities within the insurance
industry" is satisfied for many of the same reasons that the law passes the commonsense test: it regulates application of HMO contracts and provides for review of claim denials. When it is established that HMO contracts are contracts for insurance, it is clear that §4-10 does not apply to entities outside the insurance industry.

The Court similarly rejected the HMO's contention that the state law enlarged the claim beyond the benefits available in an ERISA suit for benefits, finding that the state law did not supplement or supplant ERISA's civil enforcement scheme. Likewise, the Court held that the state law's procedural imposition did not interfere unreasonably with Congress's intention to provide a uniform federal regime of "rights and obligations" under ERISA. Finally, the state Act did not clash with any deferential standard for reviewing benefit denials in judicial proceedings. ERISA itself says nothing about the standard – it simply requires plans to afford a beneficiary some mechanism for internal review of a benefit denial and provides a right to a subsequent judicial forum for a claim to recover benefits.

2. *United Health Care Insurance Company v. Levy* (N.D. Texas, September 8, 2000). The treating physician of a patient who was located in Texas, requested coverage for long-term private duty nursing care following the patient's discharge from a hospital. A physician who was employed by a third-party administrator to make utilization review ("U/R") decisions for the plan determined that the requested services constituted custodial care which were excluded from coverage under the patient's insurance plan.

The patient then filed a complaint with the Texas Board of Medical Examiners against the physician who made the U/R decision to deny coverage. The health insurer then sued the Texas Board of Medical Examiners in federal court seeking to prevent the Board from reviewing the U/R decision that was made by the physician. The Insurer argued that if
the Board of Medical Examiners could take disciplinary action against the physician as a result of the U/R decision, the Board would, in effect, be regulating an ERISA governed plan which the Insurer claimed was preempted under ERISA. However, the Texas Board of Medical Examiners argued that Congress did not intend for ERISA to preempt the state's ability to regulate the practice of medicine by physicians within its borders.

The Federal District Court for the Northern District of Texas found that ERISA preempted the authority of the Texas Board of Medical Examiners to discipline the physician as a result of a U/R decision. The court noted that if it ruled otherwise, the Board could threaten to revoke the license of the medical director of any managed care plan who made a coverage decision with which the Board disagreed. This could result in the Board of Medical Examiners effectively dictating the terms of the health plan.

3. However, this view of ERISA preemption on this issue is not uniformly applied. In State Bd. of Registration for the Healing Arts v. Fallon, No. SC82841 (Mt. Apr. 10, 2001) the Supreme Court of Missouri, en banc, upheld the lower court's order requiring the medical director for Prudential, which administered an employee benefit plan, to appear before the State Board of Registration for the Healing Arts to review a medical decision he made on behalf of the plan. The physician claimed that ERISA preempted the state law allowing the Board to investigate his decisions insomuch as his actions related to an employee benefit plan. The court held that the statute authorizing the Board to review the actions of medical licensees does not relate to an employee benefit plan. The decision made by the physician concerned whether the procedure at issue was medically necessary, not whether it would be covered by the plan. Such decisions, according to the
court, are purely medical, rather than administrative, decisions and therefore are not preempted by ERISA.

4. *Kentucky Ass'n of Health Plans v. Nichols*, 227 F.3d 352 (6th Cir. 2000). Several HMOs and an association of HMOs brought suit against Kentucky's Commissioner of Insurance seeking a determination that the state's Any Willing Provider (AWP) statute was preempted by ERISA. Kentucky's AWP statute requires health plans to admit a provider to its provider panel if the provider provides services within the geographic area covered by the health plan and agrees to meet the terms and conditions for participation as established by the health plan. The United States Court of Appeals for the Sixth Circuit held that, although the AWP statute related to ERISA plans, and thus was potentially subject to ERISA preemption, the law regulates insurance – and thus was saved from preemption. The HMOs have appealed, arguing that, because the AWP law regulates contracts between plans and providers, the law does not affect consumers directly, and thus does not "regulate insurance." The Commissioner of Insurance disagreed, noting that regulating contracts between insurers and providers is a traditional function of state insurance regulation.

The Supreme Court of the United States then affirmed the decision of the Sixth Circuit Court of Appeals in *Kentucky Ass'n of Health Plans v. Miller*, 123 S. Ct. 1471 (2003). The Court established a new test to determine if a state law "regulates insurance" and is thus exempt from ERISA preemption. First, the law must be specifically directed towards entities engaged in insurance. Second, it must substantially affect the risk-pooling arrangement between the insurer and the insured. The Court reasoned that even though the AWP law prohibited providers from entering into exclusive agreements with insurers, it was still directed towards insurers. The Court said that the fact that the law
focused on the relationship between an insurer and a provider rather than on terms of an insurance policy does not mean that the law failed to regulate insurance because, by expanding the pool of providers, the AWP law altered the scope of permissible bargains between insurers and insureds. According to the Court, this would substantially affect the type of risk-pooling arrangements that insurers may offer.

As such, the Kentucky statute, which provides that health insurers, including HMOs, must accept as part of their provider network any health care provider in the geographic area who agrees to the insurance's terms, will not be pre-empted by ERISA.

5. Great-West Life & Annuity Ins. Co. v. Knudson, 122 S.Ct. 708 (2002). When the defendant enrollee in this case was injured in a car accident, her health plan paid for over $400,000 of her medical expenses, most of which was, in turn, paid by the plaintiff insurance company (a stop-loss insurer). The enrollee's contract with her health plan provided that the plan could seek reimbursement of any payment that it makes on behalf of an enrollee for which the enrollee is entitled to recover from a third party. This right to reimbursement was assigned to the plaintiff insurance company. The enrollee eventually settled her case with the manufacturer of the car and others, resulting in a settlement that earmarked less than $14,000 to pay past medical expenses (i.e., to reimburse the plaintiff insurance company). The insurance company brought suit under §502(a)(3) of ERISA, seeking to enforce the health plan's reimbursement provisions by requiring the enrollee to pay the insurance company $400,000 from the proceeds recovered in the settlement. Section 502(a)(3) of ERISA authorizes a civil action to enjoin an act that violates the terms of the plan or to obtain other equitable relief.
The Supreme Court of the United States held that §502(a)(3) does not authorize the action for enforcement of the reimbursement provision since it sought to impose personal liability on the enrollee for a contractual obligation to pay money. According to the court, §502(a)(3) of ERISA is designed to provide traditional, equitable relief. This would be the case, for instance, if the insurance company claimed that the enrollees were holding funds that, in good conscience, belonged to the insurance company. The court distinguished the insurer's claim, noting that the company was claiming some contractual entitlement to funds because of a benefit that it had conferred on the enrollee.

III. ISSUES RELATED TO COLLECTIVE BARGAINING BY PROVIDERS

1. Texas SB 1468 (1999):
   (i) permits competing physicians to meet and jointly negotiate nonprice terms;
   (ii) fee issues may only be the subject of joint negotiations if the MCO has "substantial market power and those terms and conditions have already affected or threatened to adversely affect the quality and availability of patient care." However, these terms are not defined in the Act;
   (iii) physicians must negotiate through a designated third party who must be approved by the Texas AG;
   (iv) the joint negotiation may not cover more than 10% of the physicians in a MCO's defined geographic area unless the approval of a greater or lesser percentage is consistent with the other provisions of the Act;
   (v) statute does not authorize physicians to jointly coordinate a cessation of their services;
   (vi) physicians may not negotiate to exclude nonphysician providers or to condition participation in one product or participation in all products;
(vii) the Act leaves many questions unanswered; and
(viii) it is unclear as to whether Texas AG involvement is sufficient to qualify for the "State Action" exemption from the federal antitrust laws.

2. The states of New Jersey and Washington have similar laws. However, since these laws do not require the MCO to bargain with the physicians, they have been generally ineffective (see the article entitled "NJ Doctors Get Collective Bargaining Right" that is also included in this Appendix).

3. In 2002, the Ohio state legislature was considering a similar bill and requested comments from the Federal Trade Commission ("FTC"). (See Ohio H.B. 325 at www.legislature.state.oh.us/search.cfm and search on H.B. 325.) In responding to this request for comment on Ohio H.B. 325, the FTC Bureau of Competition and the Office of Policy Planning of the FTC submitted a comment which stated that the bill "on its face authorizes collective physicians conduct that would violate per se price fixing under the federal antitrust laws." (For more details, see the FTC's October 21, 2002 press release at www.ftc.gov/opa/2002/10/physicians.htm.) The FTC has also opposed federal legislation that would create an antitrust exemption for physician collective bargaining.

4. The Department of Justice challenge to Aetna's planned acquisition of Prudential - U.S. v. Aetna, Inc., Civ. Action No. 3-99 CV 398-H (N.D. Tex. Filed June 21, 1999). In this action, the Department of Justice filed suit to block Aetna's proposed acquisition of the Health Insurance Unit of Prudential Insurance Company. Even though this action was settled, it is significant because it is the first time that the federal government has challenged the combination of two such entities. Of special interest is the fact that one of the government's reasons for acting was its concern that the merger of Aetna and
Prudential would give the resulting entity excessive market power such that it could impose adverse contract terms on physicians.

5. The Quality Health Care Coalition Act of 1998 ((HR 1304) i.e., the Campbell Bill), grants health care professionals the same treatment under the antitrust laws as available to collective bargaining units under the National Labor Relations Act. Against all odds, this act passed the House in the 106th Congress but was not acted on by the Senate. As such, the Bill has expired. On March 7, 2002, the Healthcare Antitrust Improvement Act was introduced in Congress. This Act would apply the rule of reason to physicians who collectively bargain with an MCO and would limit the award of attorney fees. First, this bill did not pass the House and Senate by the end of the 2002 session of Congress and, as such, had died in committee and must be reintroduced in the 108th Congress which began in January 2003. However, based on the October 21, 2002 FTC press release describing the FTC's opposition to a pending Ohio bill to allow physician collective bargaining (see above), FTC opposition to this bill should be expected. As such, the likelihood of federal action on this issue is not great.

6. The FTC has been actively investigating MCOs that the FTC believes are engaging in anti-competitive conduct. For example:
   (a) On April 5, 2002, the FTC entered into a consent decree with Obstetrics and Gynecology Medical Corporation of Napa Valley and a number of physicians. The FTC alleged that the physicians engaged in anti-competitive conduct by facilitating or implementing agreements to fix fees and other terms of dealing with payors. The FTC found that the physicians did not clinically or financially integrate their practices to create efficiencies to offset their alleged anti-competitive actions.
(b) On May 12, 2002, two Colorado area physician organizations, Physician Integrated Physician Services of Denver, Inc. and Aurora Associated Primary Care Physicians, their physician leaders and a non-physician consultant entered into settlement agreements with the FTC. The FTC alleged that the involved parties did not use a legitimate "Messenger Model" arrangement and, as a result, the FTC alleged that the manner in which the two groups informed their members of MCO contract offers resulted in a group boycott and a price fixing arrangement. (See Appendix E for additional information.)

(c) On August 20, 2002, the FTC announced consent decrees with eight Denver, Colorado OB/GYN groups, representing about 80 physicians, and a consultant under a similar theory. Then on August 21, 2002, the FTC announced a consent decree with System Health Providers and its parent corporation, Genesis Physician's Group, Inc., which is an organization of approximately 1,250 physicians practicing in the Dallas/Fort Worth area. This settlement also arose as a result of the physicians alleged misuse of the "messenger model" rules.

(d) In addition to the foregoing, the FTC also entered into consent decrees with the following individuals and/or entities as a result of the manner in which the Physician Network attempted to negotiate with an MCO:

(e) On February 6, 2003, the FTC issued an advisory opinion concerning the proposal of several Dayton, Ohio physician groups to create a "health care advocacy group" to collect and disseminate information about the Dayton health care market conditions, including information about insurer payments to physicians. The purpose of the advocacy group's activities was to inform the public about the ill effects of depressed reimbursement by third party payors in Dayton. Specifically, the advocacy group wished to reveal that the two health plans covering most of Dayton's insured population were, through their market power,
depressing prices such that recruitment and retention of physicians had become particularly difficult. The FTC noted that public awareness efforts generally do not implicate the FTCA. The FTC specifically discussed the collection and publication of pricing information, but noted several factors that made it unlikely that those activities would lead to anti-competitive effects. Those factors included: that doctors in the Dayton area did not generally practice in concentrated groups, that many physicians in the area already had access to pricing information directly from the payors, that the advocacy group would not collectively negotiate on behalf of its member physicians nor suggest negotiating strategies for its members.

(f) *In re Carlsbad Physician Association, Inc.*, No. C-4081. The FTC described Carlsbad Physician Association (CPA) as a corporation that was created with the primary goal to "negotiate contracts between physicians and employers, insurers, and administrators independent of influence from any health care organization or facility." According to the complaint, CPA charged a $500 annual membership fee, in return for which it allegedly collectively bargained reimbursement contracts on behalf of its physician clients. The FTC alleged that over 75% of all physicians practicing in the Carlsbad area had joined CPA, which the FTC claimed caused reimbursement rates in that area to soar. The parties entered into a Consent Agreement and, on June 13, 2003, the FTC issued an order requiring CPA to stop negotiating payor contracts on behalf of physicians, except as described in the Order.

(g) *In re California Pacific Medical Group, Inc.*, No. 9306. On July 8, 2003, the FTC filed a complaint against California Pacific Medical Group, Inc. d/b/a Brown and Toland Medical Group (B&T), a corporation that negotiated HMO and PPO contracts on behalf of its physician members. The FTC alleged that B&T
recruited physicians for its PPO network and then had them choose from two fee schedules (both significantly higher than the general reimbursement rates in the area) that they were willing to accept. By joining the PPO network, physicians allegedly agreed not to individually bargain with any of the health plans negotiating with B&T, and not to accept less than the amount listed on the B&T fee schedule from any payor. B&T allegedly collectively negotiated with health plans on behalf of the physicians in its PPO network, which the FTC claimed caused an increase in reimbursement fees in the PPO market. The FTC alleged that the PPO created no administrative efficiencies and, therefore, B&T was in violation of Section 5 of the FTC Act.

(h) *In re Spa Health Organization*, No. C-4088. The FTC alleged that Southwest Physician Associates (SPA) collectively negotiated on behalf of approximately 1,000 physicians in the State of Texas. The FTC claimed that while the activities of SPA began as legitimate negotiations of risk-sharing arrangements, they allegedly evolved into illegal non-risk contracting. The Complaint alleged that, although purporting to act as a "messenger," SPA did not convey offers to its participating physicians if it deemed them to be insufficient. The parties entered into a Consent Agreement and, on July 17, 2003, the FTC issued an order requiring SPA to stop negotiating payor contracts on behalf of, and to stop facilitating communication about price and other contract terms to, its member physicians, except as described in the Order.

(i) *In re Washington University Physician Network*, No. C-4093 (Aug. 22, 2003). The FTC claimed that Washington University Physician Network (WUPN) was created to promote the collective interest of its physician members by allegedly increasing their negotiating leverage with payors. Essentially, the FTC alleged that WUPN acted as an agent for its physician members in negotiations with third
party payors. The parties entered into a Consent Agreement and, on August 22, 2003, the FTC entered an order requiring WUPN to stop (1) negotiating payor agreements on behalf of its physician members and (2) facilitating agreements amongst its members with respect to price and other contract terms, except as described in the Order.

(j) In re Maine Health Alliance, No. C-4095 (Aug. 27, 2003). According to the FTC's complaint, 11 hospitals and 325 physicians in northern Maine joined the Maine Health Alliance and allegedly refused to contract individually with employers and health insurers unless those individuals met the Alliance's collective terms. The parties entered into a Consent Agreement and, on August 27, 2003, the FTC entered an order requiring the Maine Health Alliance to stop (1) negotiating payor agreements on behalf of its physician members and (2) facilitating agreements amongst its members with respect to price and other contract terms, except as described in the Order.

(k) In re Physician Network Consulting, LLC, No. C-4094 (Aug. 27, 2003). According to the FTC complaint, several orthopedic groups were presented with a new price schedule from United HealthCare, a third party payor, decreasing future reimbursement rates. Physician Network Consulting (PNC) allegedly coordinated the groups' response. The orthopedic groups terminated their contracts with United and, subsequently, utilized PNC to negotiate new contracts on their behalf which the FTC alleged caused an increase in reimbursement rates. The parties entered into a Consent Agreement and, on August 27, 2003, the FTC entered an order requiring PNC to stop (1) negotiating payor agreements on behalf of the orthopedic groups and (2) facilitating agreements amongst the groups with respect to price and other contract terms, except as described in the Order.
On September 23, 2003, the FTC issued an advisory opinion concerning six medical societies in the San Francisco area that proposed to utilize a "messenger" arrangement to reduce the costs of the parties independently contracting with health plans and other third party payors. Essentially, the parties proposed to form a nonprofit corporation that would transmit payor offers to the corporation's physician members and then communicate back to payors the names of the physician members had decided to accept the offer. The FTC determined that this "messenger" model would not violate the FTCA, noting that the nonprofit corporation would not collectively negotiate prices or suggest an opinion to physician member on the desirability of an offer or contract term. The FTC also noted that membership in the nonprofit corporation would constitute a relatively small share of the relevant market.

In re South Georgia Health Partners, LLC, No. C-4100 (Oct. 31, 2003). The FTC alleged that 15 hospitals and 500 physicians in south Georgia jointly agreed not to deal with payors who were unwilling to meet their collective terms, which the FTC alleged resulted in an increase in health care costs in Georgia. The parties entered into a Consent Agreement and, on October 31, 2003, the FTC entered an order requiring South Georgia Health Partners to cease and desist from joint negotiations, exchanging price information or inducing any person to engage in prohibited actions, except as described in the Order.

In re North Texas Specialty Physicians, No. 9312. On October 31, 2003, the FTC filed a complaint against North Texas Specialty Physicians (NTSP), a corporation allegedly formed for the purpose of facilitating physician contracting with health insurance firms and third party payors. NTSP had approximately 600 physician participants at the time of the FTC's complaint. The FTC alleged that the manner in which NTSP used the "messenger" model restrained competition.
On November 3, 2003, the FTC issued an advisory opinion concerning a proposal by the Medical Group Management Association (MGMA) to publish the results of a survey of physician practices, including information about the amounts that health plans pay for physician services. MGMA proposed to report this payment data on an aggregate basis (i.e., without reference to the identity of any given payor) for Colorado as a whole and for each metropolitan area. The FTC noted the inherent risk in allowing competing physicians to share pricing information, but found that MGMA's safeguards made it unlikely that this proposal would result in anti-competitive activity. Those safeguards included: focusing on payment data that was at least 90 days old, publishing only statistics that combined data from at least 5 respondents, and publishing information in an aggregated fashion that prevented disclosure of the prices paid by individual insurers or the amounts received by individual physician groups. (This letter may be reviewed in its entirety by clicking on the link included in this Appendix T.)

In re Surgical Specialists of Yakima, PLLC, No. C-4101 (Nov. 14, 2003). In its complaint, the FTC alleged that "most" of the physicians specializing in general surgery, in the Yakima, Washington area, formed Surgical Specialists of Yakima (SSY) with the purpose of collectively negotiating contracts with, and fixing prices and other terms charged to, health care plans and other third party payors. The FTC claimed that although SSY’s operating agreement was drafted to give the appearance that SSY was operating as an integrated entity, in reality each of the physicians was acting independently. The parties entered into a Consent Agreement and, on November 14, 2003, the FTC issued an order requiring SSY to cease and desist operating in a manner other than as described in the order.

In re Memorial Hermann Health Network Providers, No. C-4104 (Jan. 8, 2004). According to the FTC, Memorial Hermann Health Network (MHHNP) acted on
behalf of 3,000 participating physicians to negotiate fees and other terms with health plans and third party payors in the Houston area. The FTC alleged that certain MHHNP activities, including surveying its members regarding the minimum prices they were willing to accept and, based on the results, allegedly setting a minimum acceptable fee and then allegedly refusing to transmit payor offers that did not meet the minimum, violated the FTCA. In addition, the FTC alleged that MHHNP specifically rejected payor requests to have offers submitted to physicians for an individual opt-in/op-out. The parties entered into a Consent Agreement and, on January 8, 2004, the FTC issued an order requiring MHHNP to cease and desist operating in a manner other than as described in the order.

In 2004, the FTC was again very active in enforcing the Federal Trade Commission Act against physician-hospital organizations that were alleged to have misused the "Messenger Model" or "Limited Messenger Model" when negotiating fees with an MCO. See In re Southeastern New Mexico Physicians IPA, Inc., No. C-4113 (August 5, 2004); In re California Pacific Medical Group, Inc. d/b/a Brown and Toland Medical Group, No. 9306 (May 10, 2004); In re Evanston Northwestern Healthcare Corp. and ENH Medical Group, Inc. (Feb. 10, 2004); In re Tenant Healthcare Corp. and Frye Regional Medical Center, No. C-4106 (Jan. 29, 2004); In re Piedmont Health Alliance, No. 9314 (Oct. 1, 2004); In re Memorial Hermann Health Network Providers, No. C-4104 (Jan. 8, 2004); In re North Texas Specialty Physicians, Docket No. 9312 (Nov. 15, 2004); and In re White Sands Health Care System, LLC, No. C-4130 (Jan. 11, 2005).

7. Compare these results with the February 21, 2002 FTC opinion to MedSouth, where the FTC permitted MedSouth to jointly negotiate payor contracts due to the significant
clinical integration of the physicians who participated in the MedSouth IPA, and also the September 23, 2003 FTC opinion concerning the Bay Area Preferred Physicians, in which the FTC provides an analysis of the messenger model.

In each consent decree, the FTC would permit the physicians to participate in a "qualified clinically-integrated joint arrangement" or in a "qualified risk-sharing joint arrangement." The FTC has defined each of these terms as follows:

"Qualified clinically-integrated joint arrangement" means an arrangement to provide physician services in which:

1. all physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the physicians who participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and

2. any agreement concerning reimbursement or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

"Qualified risk-sharing joint arrangement" means an arrangement to provide physician services in which:
1. all physicians who participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the physicians who participate to jointly control costs and improve quality by managing the provision of physician services, such as risk-sharing involving:
   a. the provision of the physician services to payors at a capitated rate,
   b. the provision of physician services for a predetermined percentage of premium or revenue from payors,
   c. the use of significant financial incentives (e.g., substantial withholds) for physicians who participate to achieve, as a group, specified cost-containment goals, or
   d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; and

2. any agreement concerning reimbursement or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

In the Consent Agreements, the FTC consistently defined a Messenger Arrangement as:
'Messenger Arrangement' means an arrangement, excluding a Limited Messenger Arrangement, pursuant to which Respondent PHA acts as a messenger, or as an agent for or on behalf of a provider, with payors regarding contracts or terms of dealing involving the providers and payors.

Certain of the Consent Agreements also included the following definition of a "Limited Messenger Arrangement":

'Limited Messenger Arrangement' means an arrangement pursuant to which PHA receives a contract offer from a payor, timely conveys without comment or analysis such offer to some or all of the arrangement's participants as directed by the payor, receives from each participant his or her independent, unilateral decision to accept or reject the payor's contract offer, and timely conveys each such response without comment or analysis to the payor.

IV. PROMPT PAY ACTIVITIES

1. The Department of Justice (DOJ) Civil Division in the Eastern District of Pennsylvania has been investigating the following conduct by certain managed care plans:
   (i) the denial of medically necessary care, regardless of whether there is a financial incentive;
   (ii) a managed care plan's failure to pay providers for emergency services or for other services for which the MCO was contractually obligated to pay;
   (iii) a scheme to avoid payment to providers in a timely manner. This would require evidence of a concerted operation within the MCO to refuse to pay otherwise
clean claims within the period of time required by state law, or evidence of other actions that were taken in a deliberate attempt to avoid payment such as continually moving the MCO’s billing processing center and losing claims in the process;

(iv) issues involving specialized programs for managed care. Examples include kickback arrangements involving prescription drug manufacturers, patterns of denial of psych benefits and concerns with subcontracting specialized care, especially where the managed care program does not credential or otherwise supervise the care that is provided by the subcontracted providers; and

(v) cherry picking by physicians. The DOJ defines this as physicians discouraging high utilizers from joining a group's panel or otherwise discriminating against patients with significant health care problems, especially AIDS.

Interestingly, the DOJ's interest has not been limited to Medicare and Medicaid Managed Care Plans. The DOJ takes the position that as long as state law governing these issues is being violated, HIPAA grants the federal government authority to investigate the violation of state law. To the extent that the DOJ can prove violation of state law, then they can also add a federal mail fraud claim.

2. On March 1, 2001, the California Department of Managed Care settled an administrative complaint against PacifiCare that arose as a result of allegations that the health plan failed to pay provider claims within the 45 days required by the California Knox Keene Act. PacifiCare agreed to pay $3 Million Dollars in penalties and interest, including a $250,000 fine. The Department has also indicated that they are examining other health plans doing business in California and may take similar action with other plans.
3. Similarly, in a bulletin released May 18, 2001, the Texas Insurance Commissioner cited mounting complaints by physicians and providers regarding HMOs and health insurers' "less than prompt" payment practices in his emphasis on the penalties these carriers face if they do not make payments within the 45 days required by state regulations. Sanctions include penalties of up to $1,000 per day per unpaid claim as well as revocation of the carrier's license to conduct business in the state. Then, on March 24, 2003, the Attorney General announced that an agreement had been reached with PacifiCare of Texas, Inc. that puts on hold a state lawsuit against the HMO while it implements the terms of a settlement agreement pursuant to which PacifiCare will pay Texas doctors the millions of dollars in past due fees.

4. Interestingly, the Davila case has not been found to preempt a provider's claims against an MCO that are based on the MCO's failure to pay the provider in accordance with the terms of the provider's agreement with the MCO, for example, in Pascack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan, 388 F.3d 393 (3d Cir. Nov. 1, 2004). In this case, a hospital had agreed to provide services at a discounted rate so long as its claims were paid within 30 days. The hospital then brought suit in state court when the plan failed to pay the discounted rate for claims within the 30 days required by the agreement.

The plan removed the case to federal court on the basis of complete preemption by ERISA. However, the Third Circuit remanded the case to state court, finding that the civil enforcement remedy in ERISA was inapplicable because the record provided no evidence that the beneficiaries had assigned their claims against the plan to the hospital. Also, the court noted that the hospital's claim did not depend on an interpretation of the ERISA plan, and coverage was not in dispute. Rather, the case turned on the terms of the

V. PHANTOM PPO

The case of *HCA Health Services of Georgia v. Employers Health Insurance Co.* 2001 WL 91380 (11th Cir. Ga.) (February 7, 2001) is a confusing but excellent example of a growing phenomena sometimes referred to as "Silent" or "Phantom" PPOs.

A patient underwent covered outpatient surgery at a Medical Center. The patient assigned to the Medical Center the patient's right to receive 80% of the costs of the surgery from the patient's insurer. The Medical Center had no PPO or other contractual arrangement with the patient's insurer so the Medical Center expected the insurer to pay the full 80% of the costs of the surgery. However, the insurer claimed that it was entitled to the same discount that was included in a Hospital Provider Agreement between the Medical Center and a seemingly unrelated PPO. The insurer then discounted the Medical Center's payment in the same manner as if the insurer had been the PPO which had the agreement with the Medical Center.

The Medical Center sued the insurer for the difference between the amount that the Medical Center had billed the insurer and the discounted amount that the insurer had paid to the Medical Center. The insurer defended its actions by claiming that it was entitled to the discount due to the fact that the PPO (that had executed the Hospital Provider Agreement with the Medical Center that included a discount on the Medical Center's fees) had "leased" the PPO's right to the discount to another party who then, unbeknownst
to the Medical Center or the patient, "leased" the right to the discounted fee to the patient's insurance company.

The Medical Center claimed that since it never consented to any of these "lease" arrangements, it was entitled to payment in full from the patient's insurer. The Federal Courts reviewed the language in the PPO-Medical Center Agreement and agreed that the PPO had no right to lease the PPO's discount with the Medical Center to another party. Therefore, the court ruled in the Medical Center's favor.

Providers should be aware of the fact that such assignments and "leases" are becoming common place and should insist that the terms and conditions in a MCO agreement prohibit any such arrangement.

VI. CLASS ACTIONS

Grider v. Keystone Health Plan Central, Inc., No. Civ.A.2001-CV-05641 (E.D. Pa. Apr. 27, 2004). A family practitioner and her group practice brought suit against an HMO alleging that the HMO defrauded her and her group through various methods of delaying and denying payment for services provided. Specifically, the physician alleged that the HMO purposefully under-reported the number of patients enrolled in her group, thus resulting in lower capitation payments. She also alleged that the HMO manipulated CPT codes to decrease the amount of reimbursement. At the pre-trial phase, the practitioner asked the court to preclude the HMO from arguing against the certification of a class, due to the HMO's failure to produce certain documents during discovery. The United States District Court for the Eastern District of Pennsylvania denied that motion.
Gregg v. Independence Blue Cross, No. 03482 Dec. Term 2000, 00005 Dec. Term 2002, 00002 Dec. Term 2002 (Pa. Ct. C.P., Apr. 22, 2004). Several health care providers, not including hospitals, brought suit against Independence Blue Cross, which operates PPOs, POs, and HMOs, alleging that Independence improperly denied reimbursement for care provided to its subscribers and engaged in downcoding (arbitrarily paying for a service at a lower rate assigned to another service) and bundling (paying for only one of two services provided during the same visit). The matter was eventually certified as a class action, with the class including physicians, health care providers, and group practices. The class representatives negotiated a settlement agreement and notified the class members of that settlement. The class members were thereafter contacted by other attorneys and medical societies who had filed class actions in other states, advising them to opt out of the settlement in the Independence case claiming that the Independence settlement was too friendly to Independence and would jeopardize their right to participate in the settlement of the other actions. Several thousand class members opted out, many using the forms provided by the other attorneys. The class representatives in the Independence case asked the court to invalidate those opt-outs alleging that the opt-out notice included misleading communications. The Court of Common Pleas of Pennsylvania held that the communications from those attorneys and medical societies were false, misleading, and confusing. Accordingly, the court ordered that the original opt-outs would be voided, a second notice explaining the Independence settlement would be sent to class members – and they would be given the opportunity to opt out, and communications with class members would be limited during the new opt-out period.

VII. RICO

Healthguard of Lancaster, Inc. v. Gartenberg, No. Civ. A. 02-2611 (E.D. Pa. Mar. 5, 2004). An HMO sued a chiropractor who was a participating provider in its plan,
alleging that the chiropractor and his billing contractor violated RICO (the Racketeer Influence and Corruption Organization Act) by engaging in a fraudulent scheme to bill the HMO for services that were provided improperly, not provided at all, or provided in the absence of medical necessity. The United States District Court held that while there was evidence of billing activities that demonstrated genuine issues of fact as to elements of common law fraud, the facts were insufficient to evidence a pattern of racketeering activity conducted by an enterprise under the control of the chiropractor and billing contractor, as required by RICO. Therefore, the court granted the defendant's motion for summary judgment on the Rico claims. The plaintiff's state law claims were dismissed without prejudice.

VIII. FALSE CLAIMS ACT

United States ex rel. Hunt et al. v. Merck-Medco Managed Care, L.L.C., 336 F. Supp.2d 430 (E.D. Pa. Sept. 23, 2004). The United States intervened in a _qui tam_ case that alleged that a pharmacy benefits manager (Medco) that contracted with the government's health insurer (Blue Cross) to provide pharmaceutical benefits to government employees violated the False Claims Act (FCA) and certain common law claims. The United States also alleged that Medco violated the Public Contracts, Anti-Kickback statute (AKA). Specifically, the government alleged that Medco violated the False Claims Act by billing Blue Cross for services that were not provided or were provided in a manner that did not comply with its contractual obligations. In addition, the government alleged that Medco violated the AKA by paying a health plan to use its services exclusively and by allegedly accepting payments from drug manufacturers to favor their drugs over others. Medco moved for summary judgment, arguing that the government had not plead its claim specifically enough and that the facts, as described by the government, were legally insufficient to give rise to the stated claims. The United States District Court for the
Eastern District of Pennsylvania denied Medco's motion to dismiss the FCA and AKA claims but granted in part and denied in part Medco's motion to dismiss the common law claims.

*United States ex rel. Drescher v. Highmark*, 305 F. Supp.2d 451 (E.D. Pa. Feb. 20, 2004). The United States intervened in a *qui tam* suit against Highmark alleging that Highmark violated the FCA by causing Medicare overpayments pursuant to the Medicare Secondary Payer statute (MSP) and alleging that Highmark was liable for unjust enrichment and breach of contract in Highmark's capacity as a private insurer and as a Fiscal Intermediary and Part B carrier. The relator also alleged that Highmark retaliated against her in violation of 31 U.S.C. §3730(h).

Highmark filed a motion to dismiss all claims. This decision denied that motion to dismiss and was not a finding based on the merits. The bulk of the court's opinion dealt with the allegations that Highmark as a private insurer or administrator improperly paid MSP claims as the secondary payer when it should have paid them as the primary payer.

The United States District Court for the Eastern District of Pennsylvania stated "a thoughtful analysis of the law has persuaded me to abandon my initial inclination to grant defendant's motion to dismiss..." and allowed the MSP claim to move forward. However, the court questioned whether the government would ultimately be able to support its claim by stating that it is not clear that Highmark, simply by denying payment for claims, actually caused providers to submit those claims to Medicare. Nonetheless, the court stated that if the government could show that Highmark directed providers to bill Medicare or if providers had no other choice but to bill Medicare, the government might be able to succeed with its claim.
IX. STATE LAW CASES INVOLVING PHYSICIAN DESELECTION

1. In *Potvin v. Metropolitan Life Insurance Company*, 997 P.2d 1153 (Cal. 2000), a physician executed a Provider agreement with Metropolitan Life ("Met-Life") which specifically stated that Met-Life could terminate the physician without cause. Met-Life exercised its right to terminate the agreement without cause. However, Met-Life then informed the Physician that he was being terminated due to the fact that he did not meet Met-Life's current selection and retention standard for malpractice history. The physician sued Met-Life, claiming that he was denied fair procedure and due process.

The lower courts held that the physician's agreement with Met-Life stated that it could be terminated without cause and did not require that Met-Life provide the physician with any form of due process prior to exercising its right to terminate. However, the California Supreme Court held that the physician should have been granted due process rights prior to Met-Life terminating the physician's Provider agreement.

Whether this case will have any application outside of California is unclear. However, in California it has created a chilling affect amongst IPAs and other provider networks as to whether a physician can be terminated from participation in a provider panel without some form of due process.

2. *Schultze v. Humana, Tex. Nueces County Ct.*, No. 97-04373-G (11/16/00). Following a six-week trial, a Corpus Christi, Texas jury awarded $19 million in actual and punitive damages to a primary care physician who sued Humana Health Care Plan physicians network and related defendants. The award is expected to be automatically reduced due to state imposed liability caps. The case has subsequently been settled, however, the terms of that settlement are confidential.
The issue was whether Humana terminated the physician for quality of care concerns or whether the physician was terminated as a result of his vocal opposition to Humana's Hospital Inpatient Management Service. This program required primary care physicians to turn over the care of hospitalized patients to a contract physician. Apparently, the jury determined that the peer review claims were a pretext and the physician was terminated for his opposition to Humana's Inpatient Management program.

3. *Sinoff v. Ohio Permanente Med. Group*, 767 N.E.2d 1251 (Ohio Ct. App. 2002). An oncologist claimed that his due process rights were violated when his HMO deselected him as a provider based on the determination of a hospital affiliated with that HMO to terminate the doctor's privileges. The oncologist asserted that the HMO's actions were inappropriate since the hospital had failed to follow the procedural requirements of the Health Care Quality Improvement Act.

Specifically, the oncologist argued that none of the notices provided to him complied with the HCQIA and that his termination was arbitrary, capricious, unreasonable and in violation of two state statutes, one which requires hospitals to provide certain due process procedures to physicians and the other requiring "health insurance corporations" to provide certain due process procedures.

The Court of Appeals of Ohio dismissed the HCQIA-based due process claims, holding that the HCQIA does not create a private cause of action in a physician. But, it allowed the oncologist to go forward with a claim based on the state statute that requires health insurance corporations to provide their participating physicians with notice and an opportunity to reform their practices before terminating them. The court held that the hospital "served as a peer review committee of [an] HMO" and, thus, the oncologist
adequately stated a claim pursuant to the state statute requiring health insurance corporations to provide certain due process procedures to physicians.

4. Compare this result with Pennsylvania Act 68 which specifically states that a managed care plan is not required to provide a provider with any due process rights prior to deselection but would prohibit deselection due to a practice that is prohibited by the statute such as violating a MCO gag-clause.

5. *Singh v. Blue Cross & Blue Shield of Massachusetts, Inc.*, 182 F. Supp.2d 164 (D. Mass. 2001). An internist sued a health insurer and its independent consultant after a peer review audit resulted in a recommendation that the internist be removed from the insurer's provider list. Although the review panel ultimately decided that removal from the plan's provider list was not an appropriate remedy, the internist claimed that he was injured by the peer review process. The doctor alleged defamation, breach of contract, tortuous interference with advantageous business relations, and violation of the state consumer protection statutes.

The court found the insurer and consultant to be immune from suit under the HCQIA and the Massachusetts peer review statute for any actions constituting "professional review actions." This conclusion was based, in part, on the fact that they acted in good faith, in furtherance of quality of care. The court also dismissed the doctor's claims for tortuous interference, which were based on general allegations that word of the investigation had spread and resulted in a loss of referrals. The court found that a tortuous interference claim may not be based on speculative future relationships but, rather, only probable future relationships.
X. **RICO CLAIMS**

1. In *Pacifi-Care Health Systems, Inc. v. Book*, 123 S. Ct. 1531 (2003), the United States Supreme Court ruled that the physicians who were suing Pacifi-Care and United Health Group, Inc. must arbitrate their Racketeer Influenced and Corrupt Organizations ("RICO") Act claims against the two MCOs. The decision reversed the 11th Circuit Court of Appeals' decision, which ruled that the physicians' RICO claims were not subject to the arbitration provisions in the agreements between the physicians and the two MCOs.

2. In *Grider v. Keystone Health Plan Central, Inc.*, 2003 WL 22182905 (E.D. Pa. Sept. 18, 2003) a physician and her practice group brought suit against an HMO with which they contracted, alleging several violations of state and federal law. Specifically, the physicians claimed that the HMO under-reported the number of patients enrolled in the physicians' practice group, thereby reducing capitation payments to the group below that which was agreed upon by failing to count a patient as being enrolled in the physician group until the patient sought services from the group. The physicians also claimed that the HMO manipulated CPT codes by, among other things, engaging in automatic bundling and downcoding.

The physicians also asserted a number of RICO claims. First, they alleged that the HMO engaged in extortion by threatening to withhold money due to the physicians if they questioned the HMO's wrongful delay or denial of payments. The physicians also claimed that the HMO engaged in bribery by providing incentives to claims reviewers to deny valid claims. In addition to these federal claims, the physicians claimed two violations of state law: violation of the prompt-payment statute and breach of an implied duty of good faith and fair dealing under the HMO-physician contract.
The HMO filed a motion to dismiss. The United States District Court for the Eastern District of Pennsylvania granted dismissal of a few of the physicians' claims, but allowed many to go forward. Specifically, the court held that the physicians' claim alleging the under-reporting capitation payments was sufficient to properly alleged acts of fraud for purposes of the RICO claims. The court also found that the physicians sufficiently stated claims for fraud, including (1) that the HMO misrepresented that they would pay for medically necessary services according to the CPT codes, and (2) that the HMO concealed the fact that it provided incentives to claim reviewers to delay or deny payments, and that it automatically downcoded and bundled claims. The court also held that the physicians' claims of extortion and bribery, in violation of RICO, were sufficient to go forward.

The district court also considered the manner in which the Pennsylvania Supreme Court would rule if faced with the issue of whether a private right of action exists to enforce a claim that the MCO violated the "prompt pay" requirements of the Pennsylvania Quality Health Care Accountability and Protection Act (Act 68). The district court concluded that it is consistent with the underlying purpose of Act 68 to imply that such a private right of action exists, despite a State Superior Court decision that just the year before reached an opposite result.