Litigation Issues Affecting Health Plans

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Topics

- Essential Health Benefits & Habilitative Care
- The Surgicenter Cases: Referral + Waiver of Copayment
- Privacy & Security Breach Litigation
- Liability for Failed IPAs
- Non-Participating Provider Reimbursement
- Balance Billing
- Erosion of Attorney Client Privilege
“Essential Health Benefits”
“Essential Health Benefits”

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity & Newborn Care
- Mental Health & Substance Abuse including “behavioral health treatment”
- Prescription Drugs
- Rehabilitative & Habilitative Services
- Laboratory Services
- Preventive & Wellness
- Pediatric Services, including oral & vision care
“Essential Health Benefits”
(SB 951 & AB 1453)

- EHB Defined for California
- Includes MHPA and Autism/Behavioral Health Treatment (SB 946)

 Habilitative Services Defined

- Medically necessary ...
- Health care services ...
- That assist in acquiring or improving skills and functioning ...
- Needed for functioning in interaction with an individual’s environment.
“Essential Health Benefits”
(SB 951 & AB 1453)

- California EHB expressly *exclude*:
  - Educational Services
  - Residential Treatment (the *Harlick* decision??)
  - Custodial Care
  - Respite Care
  - Recreational Care
Benefits Non-Discrimination

PHSA § 1302: In defining essential health benefits, the Secretary shall:

- “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life”

- “ensure that health benefits established as essential not be subject to denial . . . on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicated disability, degree of medical dependency, or quality of life”
“Essential Health Benefits”

- Shall not “discriminate on the basis of disability.”
- Shall insure that essential health benefits not be denied based on
  - age
  - expected length of life
  - degree of dependency
  - quality of life
“Essential Health Benefits”

- What about Utilization Review Criteria?
  - Alcoholism as a criteria for liver transplants?
  - Advanced age as a criteria for transplants or major surgery?
  - Expected length of survival or quality of life as criteria for transplants?
  - End of life decisions such as DNR?

- Will the Act alter criteria used in the practice of medicine and in utilization review?
The Surgicenter Cases:
Referrals with Waiver of Copayments
The Surgicenter Cases: Referrals with Waiver of Copayments

- Aetna Life Insurance Co. v. Bay Area Surgical Management LLC, No. 112CV217943, Santa Clara Superior Court (filed Feb. 2, 2012)
  - Defendants are 7 non-par surgicenters and related individuals.
  - Allegations:
    - Defendant surgicenters offer physicians illegal inducements to refer
    - Induce Participating Physicians to refer patients out of network to surgicenters with which they have deals
    - Cherry pick patients for referral based on high insurance coverage
    - Surgicenter seeks non-par reimbursement from insurer at inflated rates that are much higher charges than contracted facility rates
    - Surgicenter waives or reduces copayment so that patient does not pay more than an in-network copayment
    - Surgicenter kicks back profits to the referring physician
    - Physicians do not adequately disclose their financial interest
The Surgicenter Cases: Referrals with Waiver of Copayments

Examples from complaint:

- Physician received an annual bonus of $980,000.
- Physicians promised 805% annualized return on investment.
- Surgicenter charge for “correction of bunion”: $66,100
- Aetna paid $23 million for 1900 procedures that should have cost only $3 million – a 771% increase.

Waiver of Copayment:

- $66,100 charge for “correction of bunion”
- Submits claim for $66,100 (misrepresentation of reasonable charge) with intent that Aetna would remit 80% of $66,100
- Aetna pays $52,880 based on the misrepresentation
- Surgicenter never collects coinsurance of $10,576 (20% of $52,880) (total allowed amount)
The Surgicenter Cases: Referrals with Waiver of Copayments

- September 28th -- Court Overrules Demurrer & Motion to Strike:
  - Aetna adequately pleads a UCL violation based on illegal referrals (B&P Code 650) because alleges that remuneration is based on value or volume of referrals, not proportional to investment or ownership
  - UCL is also supported by alleged fraudulent waiver of copayments (distinguishing a 1981 AG Opinion and the Duz-Mor Case)
  - Failure to disclose waiver of copayment to insurer can be fraudulent
  - Aetna has standing to allege illegal corporate practice of medicine based on surgicenters “cherrypicking” the patients for referral
  - Aetna adequately pleads a cause of action for unjust enrichment
  - Demurrer to claim for “interference with contract” sustained with leave to amend to clarify how member’s or provider’s contracts were affected
CMA & LACMA to the Rescue!

- **LACMA, CMA et al v. Aetna**, Los Angeles Superior Court, filed July 3, 2012
- Alleges Aetna’s PPO Plans are false and misleading – they say they cover out of network benefits but Aetna refuses to cover the non-contracted surgicenters
- Yes! Those same surgicenters in Aetna’s lawsuit.
Another LACMA Initiative: Challenge to “Medical Necessity”

- Alleges the Medical Necessity definition is improper and fails to give proper deference to the treating physician’s opinion
- LACMA is a plaintiff.
- Why not the CMA?
Privacy & Security Breach Litigation
California Customer Records Act (Civil Code §§ 1798.80-1798.84)

- Requires disclosure of “any breach of the security of the system” to any California resident whose “personal information” was acquired by an unauthorized person.

- “Personal information” includes Name AND SSN, Drivers License No., Credit card info, medial information and health insurance information (including ID No.)
Confidentiality of Medical Information Act (CMIA) (Civil Code § 56.36)

- Covers health care providers, health care service plans, and contractors.

- Prohibits “disclosure” of “medical information” regarding a patient without authorization.

- Mandatory and permissive exceptions.

- Requires covered entities that create, maintain, preserve, store, abandon, destroy or dispose of medical records to do so in a manner that preserves confidentiality.
CMIA Remedies

- Individuals may sue for violations
  - Criminal penalties
  - Compensatory and punitive damages

- Negligent release of confidential information or records
  - Nominal damages of $1,000 per person
  - No actual or threatened damages required
  - Administrative fines or civil penalties ranging from $2,500, $25,000 for willful violations and $250,000 and disgorgement if use for financial gain
AB 439 Amendments to CMIA

- Beginning 2013, adds a defense to nominal damage claim if the defendant is a covered entity or business associate, it has complied with notice obligations and taken steps to protect confidential information.
- Actual damages are still awardable.
- Attorneys fees are available even if no damages were sustained.
California Insurance Information and Privacy Protection Act (Cal. Ins. Code §§ 791-791.28)

- Sets standards for use and disclosure of information including, but not limited to, medical records and “personal information” broadly defined.

- Prohibits disclosure without authorization.

- Exceptions to rule requiring authorization exist for agents, fraud detection and law enforcement.

- Insurance Commissioner can bring enforcement action and affected persons can sue.
California Notice of Breach Requirements (Civ. Code § 1798.82).

- Personal notice, letter or electronic, is required when the identities of the affected individuals are known.
- Substitute notice is required in all other instances meaning posting on the business web site, and notice to “major statewide media” meaning print, television and radio and the Office of Privacy Protection.
- Notify CA AG > 500 persons affected.
AG Privacy Enforcement Protection Unit

- July 2012 AG announces creation of new department to focus on protecting consumer and individual privacy through civil prosecution of state and federal laws
- 6 full time prosecutors.
- October 1, 2012 Anthem Blue Cross settlement - $150,000 and over 33,000 letters to Medicare supplement and Part D members.
Privacy & Security Breach Litigation

HHS/OCR Recent HITECH Enforcement Actions:

- **Blue Cross Blue Shield TN**: 1st HITECH Breach Notification case - $1.5 million and CAP – 57 hard drives stolen.

- **UCLA**: $865,500 and CAP - unauthorized viewing of patient medical records.

- **Mass General**: $1 million and CAP - employee took PHI of 192 infectious disease patients off premises and lost it on subway.

- **Cignet Health MD**: $4.3 million, CE refused access to medical records of 41 patients, refused to cooperate with OCR investigation and “made no efforts to resolve the complaints through informal means.”

- **Management Services Org WA**: $35,000 and CAP, HHS investigation found MSO intentionally failed to implement reasonable safeguards to protect privacy of PHI.
Privacy & Security Breach Litigation

- **Strict Liability?**
  - CA law has no specific harm threshold. However, defines breach as:
    - “unauthorized acquisition”
    - “compromises the security, confidentiality, or integrity of personal information”
- Can there be a breach where notification is not required?
- Good faith acquisition for business purposes is a defense
- Meaning of “disclosure” or “release” under CMIA
  - Is inadvertent “loss” of media containing PHI included?
  - Unnecessary disclosure to business associates or other third-party vendors covered by exception?
- Standing to sue – Is actual injury required?
- Class certification issues
- Impact of Arbitration Clauses
- Damages
- Due Process Issues
Privacy & Security Breach Litigation

- **Government Audits**
  - A security breach opens door to full scale audit of HIPAA compliance
  - In addition, HHS has begun random audits of Covered Entities, with Business Associates to follow shortly
Health Plan Liability for Failed IPAs
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- Recent litigation sparked by failures of Capitated/Delegated IPAs

- Particularly La Vida Medical Group, a heavily Medi-Cal group in central Los Angeles

- Issue is whether the health plan is liable for physician or hospital claims left unpaid when the IPA fails
Existing Law:

CMA v Aetna (2001): Health plans not liable to IPA contracted physicians who signed contracts to “look solely to” the IPA for payment

Desert Healthcare v Pacificare (2001): Court abstained from this complex economic issue subject to DMHC regulation.


Ochs v Pacificare (2004): Same, but suggests possibility of a “negligent delegation” theory
Health Plan Liability for Failed IPAs

- **Centinela Freeman ER Physicians v Health Net et al**
  - Plaintiffs are non-contracted ER physicians whose claims were left unpaid by LaVida
  - Plaintiffs argue:
    - 1. By prohibiting the physician’s right to balance bill, *Prospect Medical* changed the law so that the right to sue the health plans should be restored
    - 2. Negligent delegation theory should be allowed as suggested in *Ochs*
  - Demurrer Sustained 2011 by Judge Wiley (L.A. Sup. Ct.)
    - Knox-Keene Act and caselaw allow financial delegation.
    - *Prospect* did not change the law of delegation.
  - Appeal Pending, 2d Dist, Div 3
Non-Par Provider Reimbursement
Legal Basis of Recovery

In the absence of a contract express or implied in fact through the conduct of the parties, the cause of action is generally for *quantum meruit* or the reasonable amount for the services in question. The action is equitable in nature to prevent unjust enrichment.

Little guidance about how the reasonable value determination is to be made.
Other Possible Legal Claims

- Unfair business practices under Cal. Business and Professions Code § 17200. Injunctive relief, restitution and attorney’s fees possibly available.

- The basis of the claim is that the plan acted unlawfully by failing to comply with its payment obligations under the Knox-Keene Act.
Argument: Reasonable Value ≠ Billed Charges

➢ Charges are arbitrarily set and bear no relationship to cost.

➢ Charges are inconsistent across facilities in the same geographic area.

➢ In the non-contracted setting, patients and payers have no control over the amounts charged.

➢ Providers almost never receive full billed charges as payment.
Argument: “Reasonable Charges” Should be the Default Payment Rate

- Silent PPO law requires “active encouragement” to access PPO discounts.
- Aggregate charge information is publically available, so charge comparison is possible.
- Amounts paid are confidential.
- Discounts should only be available for network providers.
Court Decisions on Reasonable Value

  “With respect to a Medicaid plan, “services are worth what people ordinarily pay for them . . . .”

» Kunz v. Patterson Floor, 67 Cal. Comp. Cases 1588 (2002) “[T]he ‘usual fee’ to which we refer is the fee usually accepted, not the fee usually charged, because that is an aspect of the economics of a medical provider's practice in the current market.”

» Howell v. Hamilton Meats, 52 Cal.4th 541 (2011)
  “As we have seen, a medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value.”
Jury Verdict Awarding Hospital Billed Charges

- **Children’s Hospital Central California v. Blue Cross of California**, Case No. MCV 048512 (Madera County Sup. Ct.) (2011).

  - Trial court denied discovery regarding contracted payment information because “the court finds that ‘fees usually charged’ does not mean payments accepted.”
  - Jury verdict of $10.7m finding hospital’s billed charges were the reasonable value for post-stabilization services rendered to plan’s Medi-Cal managed care beneficiaries.
  - Notice of Appeal filed by Blue Cross 8/3/12.
Health & Safety Code § (HS)1317.2a(d) requires payers to pay “reasonable charges” for emergency services.

HS 1395.6 requiring “active encouragement” to make unlawful “silent PPOs” or the improper leasing of discounted rates.

HS 1262.8: Plans are required to pay charges for authorized post-stabilization services.
The “Gould” Standard


  - Provider’s training, qualifications, length of time in practice;
  - nature of services;
  - geographic prevailing provider rates;
  - other relevant aspects of the medical provider’s practice; and
  - any unusual circumstances.
Nothing is in the statute

But new regulations create rules to “prevent payment of unreasonably low amounts”

Payments must be at least the greater of:

- the median “in-network” amount payable by the plan for the service;
- an amount calculated in the manner usually used by the plan to calculate UCR rate; or
- the Medicare rate.

Neither the statute nor regs prohibit balance billing.
Balance Billing
Balance billing of Knox-Keene plan members for services owed by the plan is prohibited.

Indemnity/PPO/Point of Service plan contract defines level of payment and balance billing may be permitted.

Medicare/Medicaid balance billing is prohibited.
Balance Billing


- Provider can bill for amounts owed by the member, but cannot bill for amounts owed by the plan whether contracted or not.
Balance Billing

- Makes it an “unfair billing pattern” for providers to bill plan members for emergency services.
- Does not apply to post-stabilization services.
AB 1203 (eff. 1/1/09).

Prohibits a non-contracting hospital from billing a KKA plan member for post-stabilization services unless:

- The provider contacts the plan upon stabilization and the plan authorizes post-stabilization treatment or fails to transfer patient within 12 hours;
- The patient refuses to be transferred; or
- The hospital is unable to identify the patient’s health care service plan.
Balance Billing

- Disputes over whether the patient is stable for transfer.
- Disputes over patient responsibility for post-stabilization care.
- Provider “Upcoding”.
- DMHC granted preliminary injunction against plan member billing in *People v. Jeannette Martello*, LASC No. GC047718 (Order dated 5/29/12).
No Attorney Client Privilege under ERISA Plan!!
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- *Stephan v Unum, Ninth Circuit, Sept 21, 2012*
  - “Fiduciary Exception” to AC Privilege
  - Insurer is a claims fiduciary under ERISA
  - Attorney’s duty extends to beneficiaries of the ERISA plan
  - Therefore beneficiaries can discover attorney client communications of the plan (insurer)
The AC Privilege applies only after the insurer and beneficiary are sufficiently “adverse”

At the least this means after the completion of all internal appeals

Receipt of a demand letter from the beneficiary’s attorney does NOT make the situation sufficiently adverse to protect the insurer’s AC privilege

No Attorney Client Privilege under ERISA Plan!!
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- A conflict exists between the 3rd and 9th Circuits

- Wachtel v Health Net (3d Cir. 2007)
  - Whatever could be said of traditional trusts and their beneficiaries, an insurance company is sufficiently adverse to its insureds to support the AC privilege
No Attorney Client Privilege under ERISA Plan!!

- Sensitize in-house counsel to lack of privilege
- Does using outside counsel make a difference?
- Is this good “policy” under the law?
  - Will it discourage seeking counsel opinion?
  - Will it have a chilling effect on opinions given by counsel?

No Attorney Client Privilege under ERISA Plan!!
Questions?