

Litigation Issues Under Health Reform

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Topics

- **Essential Health Benefits**
- **Non-Discrimination in Benefits**
- **Mental Health Parity**
- **Provider Non-Discrimination**
- **Medical Loss Ratio**
- **Premium Rate Review**
- **60-Day Medicare Overpayment Rule**
- **Overpayment Recovery Actions (ERISA)**
- **Payor Litigation Over Providers' Patient Discount Practices**

“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

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?**
- **Will the regulations distinguish “coverage” as an insurance policy term versus individual medical / utilization decisions?**

Parity for “Behavioral Health Treatments”

➤ Federal Mental Health Parity:

- “non-quantitative treatment limitations”
- Pre-authorization Requirements
- Utilization Review Protocols & Criteria

➤ California Mental Health Parity Act

- “[Health plans] shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses ... under the same terms and conditions applied to other medical conditions as specified in subdivision (c).”
- Does this mean “parity” as in the Federal Act, or is it a mandate for All Medically Necessary Services?

“All Medically Necessary Behavioral Health Services”

- ***Harlick v Blue Shield*, 9th Cir., Aug. 26, 2011**
 - California’s MHPA does not merely require “parity” between mental and physical treatment
 - It is an expansive mandate to cover ALL medically necessary services for mental conditions
 - Even if the plan does not cover those services for physical conditions
 - The only “parity” that MHPA requires is for the financial limitations like copays and deductibles
 - Blue Shield’s plain, clear and conspicuous exclusion for residential treatment facilities, held invalid

Parity for “Behavioral Health Services”

➤ Residential Treatment Facilities?

- Expressly left open under the PPACA regulations

➤ What about other exclusions?

➤ Unlicensed providers?

- *Harlick*: “Plans must cover medically necessary services by unlicensed providers ‘unless they have licensed providers who will provide the same services.’”

➤ Custodial care?

➤ Non-FDA approved drugs?

➤ Equine therapy? Surf therapy?

➤ Durational limits such as max 100 days in a SNF?

Parity for “Behavioral Health Services”

➤ California DMHC position:

- Knox Keene does not require coverage of non-healthcare licensed services ... until SB 946.
- SB 946 is a “new mandate” requiring Knox-Keene plans to cover behavioral therapy by unlicensed providers (ABA for autism)

DMHC Brief on Appeal, *California Watchdog v. DMHC*

➤ California DOI Position:

- Adopts *Harlick* (must cover all medically necessary behavioral health services).
- Who cares whether they’re licensed?

Parity for “Behavioral Health Services”

➤ Future of MH Parity?

➤ ***Rea v. Blue Shield of California***, CA Superior Court, No. BC468900 (Sept. 2, 2011)

➤ Order Sustaining Defendant’s Demurrer on June 13, 2012

➤ Refused to follow *Harlick*

Autism

- **Applied Behavioral Analysis (ABA)**
 - Educational vs Health Care?
 - Licensed vs Unlicensed Providers?
 - A Basic Health Care Service?
 - Mental Health Parity?
 - Efficacy?

- **ST / PT / OT**

Autism - Recent Case Law

- ***McHenry v. PacificSource Health Plans*, 643 F. Supp. 2d 1236 (D. Or. 2009)**
 - ABA is not “Educational”
- ***D.F. and S.F v. Washington State Health Care Authority et al*, Superior Court of King County Washington, No. 10-2-29400-7 SEA (June 7,2011)**
 - State’s coverage exclusion of ABA violates Mental Health Parity Act
- ***Consumer Watchdog, et al., v. California Department of Managed Health Care et al*, 2009 WL 1939942 (Cal.Superior Ct, LA County)**
 - Health plan coverage may be limited to licensed health providers
- ***California Association of Health Plans v. Lucinda Ehnes, Director, Department of Managed Health Care et al.*, Sacramento Superior Court Case No. 34-2010-00090594, filed October 29, 2010**
 - Are all mental health services (like ABA) “Basic Health Care Services”?
- ***Arce v. Kaiser Found. Health Plan, Inc.*, 181 Cal. App. 4th 471, 481, 104 Cal. Rptr. 3d 545, 555 (Cal. Ct. App. 2010), review denied (Apr. 28, 2010)**
 - Abstention doctrine denied
 - Class Certification allowed to go forward

Autism - Recent Case Law (cont'd.)

- ***Arce v. Kaiser Found. Health Plan, Inc.*, Superior Court , Sept. 19, 2011**
 - Certified a class of all members diagnosed with autism spectrum disorder from 2004 to present, for declaratory relief only, not monetary claims.
- ***Churchill v. Cigna*, E.D. Pa. Aug. 12, 2011**
 - Certified class of all members denied ABA based on medical policy that ABA was experimental or unproven. Denied class of all members “who did not seek ABA in light of” Cigna’s policy.
- ***Harlick v. Blue Shield of California (9th Cir. 2011) pet. for rehearing pending***
 - California’s MHPA does not merely require “parity”, but is an affirmative mandate to cover ALL medically necessary mental health services.
- ***Hummel v. Ohio Dept. of Job & Family Serv.*, 844 N.E.2d 360 (Ohio Ct. App. 2012)**
 - ABA for autism constitutes a “medical service”

Autism under FEHBP

➤ May 2012 Bulletin from OPM

“The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism.

Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program.

The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy.

Accordingly, **plans may propose benefit packages** which include ABA.”

Utilization Review Risks under PPACA

- **Check out the ACO Regulations!**
- **Back to the 1990's**
 - Financial Incentives
 - Evidence-Based Medicine
 - Utilization Review and Denial of Services
 - “Lock in” provider networks
- **Music to plaintiffs’ lawyers ears!**

Goodbye, ERISA Preemption

- **There is no ERISA Preemption for:**
 - Individual Insurance
 - Medicaid / Medicare
 - Other government programs
- **Where do you think are all the previously uninsured are going?**
- **Hello, Personal Injury Damages**
- **Hello, State Court Juries**
- **Hello, Punitive Damages**

Arbitration Re-Invigorated

- ***ATT Mobility v Concepcion*** (U.S. Supreme Court , April 2011)
 - A class action waiver in arbitration clause is enforceable under the Federal Arbitration Act.
 - Overturns *Discover Bank* (Cal. S.Ct.) which had held class waivers unconscionable and therefore unenforceable in consumer contracts.

Arbitration Re-Invigorated

➤ Implications of *ATT Mobility*:

- Waivers of punitive damages?
- Will regulators approve waivers of class actions or punitive damages, or refuse them under “reasonableness” standards?
- **What about state law “prominently display” requirements that have been used repeatedly to deny arbitration?**
 - **FN 4:** Such requirements are acceptable provided they do not “conflict with the FAA or frustrate its purpose to ensure that private arbitration agreements are enforced according to their terms.”

Arbitration Re-Invigorated

- **Kilgore v KeyBank, N.A.** (9th Cir, Mar. 2012)
 - **Ninth Circuit throws out the Broughton/Cruz Rule**
 - **Claims for injunctive relief under 17200 should no longer escape arbitration**

Provider Non-Discrimination

- **PPACA prohibits discrimination against a provider acting within the scope of license**
 - Prohibits discrimination on the basis of participation or coverage
 - Does NOT require plan to contract with “any willing provider”
 - Does NOT prevent the plan from varying reimbursement rates based on quality or performance measures

Provider Non-Discrimination

- By rejecting “any willing provider,” the law recognizes that a Plan may refuse to contract with individual providers. The refusal of an individual contract should not be improper discrimination.
- **What, then, is prohibited discrimination?**
 - The exclusion of or discrimination against classes of providers.
 - Osteopaths
 - Podiatrists
 - Chiropractors
 - Optometrists
 - Acupuncturists
- **What else will be prohibited discrimination?**

Provider Non-Discrimination

- Discrimination against Non-Pars as a class?
- Could this be discrimination based on “participation”?
- Is it “discrimination” to pay non-pars differently from par-providers?

Payments to Non-Par Emergency Providers

- **Nothing is in the statute**
- **But new regulations create rules to “prevent payment of unreasonably low amounts”**
- **Payments must be at least the greatest 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.**

Provider Non-Discrimination – Unknowns?

- **Discrimination based on different negotiated rates?**
 - Resulting from different market power?
 - The “marquee practice” problem
- **Must the same “service” always be paid the same?**
 - Paying optometrist less than ophthalmologist for the same service?
 - Physicians vs Nurses vs Physician Assistants?
 - Is this “varying reimbursement rates based on quality or performance measures”?
- **Having a “closed panel” benefit for optometrists, podiatrists or chiropractors but an “open access” benefit for ophthalmologists and orthopedists?**

Provider Non-Discrimination – Unknowns?

- **Borrowing employment law discrimination theories**
- **“Disparate Impact” Theory**
 - A facially neutral policy that has a discriminatory effect (statistical proof of discrimination)
- **Adopting a new, stricter credentialing standard but grandfathering in the existing network**
- **Uniform credentialing criteria that are more difficult for non-MDs to satisfy than MDs**
- **Uniform “malpractice criteria” that fails to account for different malpractice experience for different specialties**

Provider Non-Discrimination – Unknowns?

➤ Pay-for-Performance Programs

- Will differential payments be challenged as a “subterfuge” for discrimination?
- Is this “varying reimbursement rates based on quality or performance measures”
- Need objective measures and statistical validity

“Horizontal” Provider Non-Discrimination

➤ Federal Mental Health Parity & Equity Act:

- “Non Quantitative Treatment Limitations”
- Standards for Provider Admission into Network
 - “Including provider reimbursement rates”

➤ Psychiatrists versus Other MDs

- CPT Codes and their Reimbursement Rates
- Psychiatrist as Primary Care Physician

Provider Non-Discrimination

- Can “provider nondiscrimination” effectively expand coverage mandates?
 - Acupuncture?
 - Chiropractic?
 - Midwives?
 - Herbal medicines
 - What if Nevada licenses “Laetrile Therapists” or “Chelation Practitioners”?

Provider Non-Discrimination

- **Plan liability for discrimination by delegated entities?**
 - Check IPA & Medical Group Contracts regarding indemnity / insurance for this kind of liability

Provider Non-Discrimination in California

➤ Potential future law – SB 690

- Passed in Senate, now in Assembly
- Current version mimics the Provider Non-Discrimination provisions in PPACA
- Includes provisions stating it is not an “any willing provider provision” and does not prevent a plan or insurer from establishing varying reimbursement rates based on quality or performance measures

Medical Loss Ratio under PPACA

➤ **PPACA MLR Summary:**

- Health insurance issuers offering group or individual health insurance coverage are required to report their MLR each year
- Minimum MLR for large group market – 85%
- Minimum MLR for individual market and small group market – 80%
- States are free to adopt higher minimum MLRs
- HHS Secretary may adjust the minimum MLR for individual market to prevent destabilization
- Health insurance issuers that fail to meet the minimum MLR required to provide rebates to employer (or policyholder)

➤ **California SB 51**

- Passed in October 2011, “to the extent required by federal law,” SB 51 mandates California MLR requirements identical to Federal MLR requirements

MLR Rebate Paid to Whom?

- **Rebates for group policies will generally be to “policyholders” and not directly to “consumers”**
 - **ERISA and State Government Group Health Plans**
 - Rebates paid to **policyholders**, who must use rebate for benefit of subscribers to either
 - Reduce premium for subsequent policy year (reduces taxes)
 - Provide cash refund
 - **Rebates to policyholders of ERISA group health plans may be plan assets**, which must be handled in accordance with **ERISA’s fiduciary responsibility** provisions
 - Policyholder may be the plan or plan sponsor (employer)
 - If the plan or trust is policyholder, entire rebate is plan asset
 - If plan sponsor is policyholder, determining plan’s portion depends on plan provisions, the policy, or manner in which sponsor or participants shared in cost

DOL Technical Release 2011-04 issued Dec. 2, 2011: Guidance on MLR Rebates for Group Health Plans

MLR Rebate Paid to Whom?

- **Non-ERISA and Non-Governmental Group Health Plans**
 - **Rebates paid to the policyholder only if** issuer receives written assurance that rebate will be **used to benefit enrollees**
 - Absent assurance, issuer must distribute in equal amounts to all subscribers without regard to how much each actually paid

Medical Loss Ratio: National Trends

- **HHS Secretary may adjust the minimum 80% MLR for individual market if necessary to prevent destabilization**
- **Waivers Rejected**
 - Ten states and one territory (Wisconsin, Delaware, Florida, Indiana, Kansas, Louisiana, Michigan, North Dakota, Oklahoma, Texas, and Guam) had their requests for waivers rejected on grounds that medical loss ratio would not destabilize states' individual insurance markets.
- **Waivers Granted**
 - Seven states (Georgia, Iowa, Kentucky, Maine, Nevada, New Hampshire, and North Carolina) had waiver requests granted or partially granted.

Monetary Impact of Medical Loss Ratio

- HHS estimates that total rebates in 2012 will be \$1.6 billion.
- According to CAHP
 - Under 4% of the 27.1 million Californians with health coverage are eligible for a rebate.
 - Average rebate for those individuals is \$53.20 -- well below national average of \$126 per person.
- “The retrospective application of the MLR standard is further evidence that the primary source of rising health care premiums in California is the cost of medical treatment and not the administrative overhead of health plans.” –CAHP 6/8/12 CEO Update

Medical Loss Ratio – Potential Issues

➤ Examples of MLR Issues:

- Broker commission practices
- Mid-year Premium holidays to avoid end of year rebates?
- Mid-year provider contract rate adjustments?
- Provider risk sharing measured by MLR stats?
- Selective (discriminatory) premium adjustments driven by perceived market positioning?
- Compensation bonuses for employees that may incentivize achievement of results not requiring MLR rebate payments
- Appropriate identification of Quality Improvement expenses
- Rebate distribution practices
- Accounting for
 - pharmacy benefit expenditures
 - Capitated Providers
 - Vendors

MLR & Rate Regulation - Liability Risks

- “Rebate” requirement creates potentially high dollar damages for class actions by
 - Insurance Regulators
 - Attorneys General
 - Class Action lawyers
 - “Consumer Watchdog” organization

Medical Loss Ratio – Liability Risks

- **Prosecutors focus on “Circumvention Methods”**
 - Having employers pay brokers commissions directly
 - Passing exchange fees on to the consumers?
 - Marketing expenses treated as health education?
 - Aggregating DMHC and DOI products together in California?
- **Plaintiffs will exploit errors and ambiguities in MLR filings to claim fraud**
 - Internally, be wary of “creative” or overly aggressive accounting
 - Look for clear regulatory guidance/direction on MLR calculations
 - Administrative MLR Hearings?
 - Judicial review proceedings of agency MLR decisions?

Medical Loss Ratio

➤ Key Defenses to Private Litigation

➤ Filed Rate Doctrine

- Are the rebates a “rate”?
- “Rebates are essentially a retrospective adjustment or correction to premiums”
- MLR allocations used in initial rate review?
- Is there agency review and approval of rebates?

➤ Abstention

➤ Primary Jurisdiction

➤ No Private Right of Action

MLR Case Study:

U.S. v. Farha, Et al. (M.D. Fla., 2011)

- **March 2011: Five former Wellcare executives indicted.** Trial scheduled for Jan. 2013
- Allegations involve Florida Medicaid's 80% MLR Rebate Requirement for behavioral health care services provided by managed care plans
- **Executives alleged to have fraudulently reduced MLR refund by:**
 - Including fraudulent information in worksheets submitted to Medicaid
 - Improperly including expenditures for certain types of health care services in Behavioral Health Care Worksheet submitted to Medicaid
 - Creating a wholly-owned, capitated provider to conceal costs and increase expenditures reported to Medicaid
 - Issuing approx. \$1 million rebate based on inconsistent and improper methodologies across various reporting periods to avoid scrutiny
 - Failing to respond truthfully to the Medicaid program's request for information regarding MLR
 - Submitting executed policies and procedures that falsely represented that aforementioned worksheets were prepared according to appropriate standards

MLR Case Study:

U.S. v. Farha, Et al. (M.D. Fla., 2011) (cont'd.)

- **Indictments of executives follow:**
 - **2008 plea agreement** by a former WellCare employee and
 - **2009 Deferred Prosecution Agreement** entered into by WellCare with United States Attorney
 - \$40 million in restitution
 - Forfeited an additional \$40 million.
 - Executed Corporate Integrity Agreement with OIG that places compliance obligations for five years.

Premium Rate Review Under PPACA

➤ Summary:

- Health insurance issuers raising rates by 10 percent or more must submit proposed increase to state to determine reasonableness
- Issuer must justify “unreasonable” increases and post explanation on website
- **September 2012:** 10 percent threshold will be replaced by state-specific thresholds, disclosure requirements, and review procedures.
- For States without review procedures or capability, rate increases greater than 10% will be reviewed by HHS
- \$250 million in grants to assist states in developing rate review programs

Premium Rate Review: National Trends

- **States with premium rate approval power?**
 - 27 states and the District of Columbia
- **States with review (but not disapproval) power?**
 - 16 states, including California
 - Virginia has partial review authority

Premium Rate Review: National Trends

- **In the absence of state rate review power, HHS acts**
 - **January 2012** - HHS deemed “unreasonable” a proposed premium rate increase of 13% in small group PPO Plan by Trustmark Life Insurance Company
 - 10,000 residents in Arizona, Alabama, Pennsylvania, Virginia, and Wyoming.
 - Trustmark disagreed with decision and plans to proceed with the rate increase.
 - **March 22, 2012** – HHS declared “unreasonable” proposed rate increases on individual and small group policies of between 12% and 24% on average for John Alden Life Ins. Co and Time Ins. Co.
 - Both underwrote policies for Assurant Health
 - Would effect 42,000 in 9 states.
 - **April 17, 2012** – HHS deemed “unreasonable” proposed rate increase on individual and small group plans of up to 22% by Time Ins. And United Security Life & Health Ins.
 - Would effect 45,000 insureds in 6 states.

Premium Rate Review: Defenses to Possible Litigation

- **Compliance with MLR is key indicator of reasonableness**
- **Defenses to UCL Lawsuits and Class Actions**
 - **No cause of action**
 - Federal statute does not prohibit any rate increase – only requires review
 - **No private right of action**
 - **Abstention**
 - **No State Unfair Competition Law Actions**
 - Rate increases are deemed “unreasonable,” but are **not** illegal or unfair.
 - Also, UCL claim cannot be based on federal right where federal statute denies private right of action

Premium Rate Review in California (SB 1163)

- Proposed Premium rate increases reviewed by DMHC or CDI
- Does not grant authority to approve, reject, or modify proposed rate increase.
- Expressly disclaims right to “establish the rates charged subscribers and enrollees for covered health care services.”
- Power restricted to declaring a rate increase “unreasonable” and requiring “justification” from the plan or insurer

Premium Rate Review in California (SB 1163) (cont'd.)

➤ DMHC guidance February 2, 2012

- Indicates DMHC will consider factors referenced in federal rules, and may consider factors from CDI guidance, in determining whether premium rate increase is unreasonable

➤ CDI guidance April 16, 2012

- Specifies when large group policies (effective on our after 10/1/12) must file
 - Large group policies that cover **250 or fewer certificate holders**
 - Only have to file if proposed increase is greater than 5%
 - Large group policies that cover **more than 250 certificate holders**
 - Only have to file if rate increase in excess of 5% *and* commissioner notifies that filing is required

Premium Rate Review in California (SB 1163) (cont'd.)

➤ Factors for “unreasonableness” under CDI and DMHC Guidance

- Comparison between projected MLR and standard MLR in market segment
- Rate of return of parent company for prior 3 years, and anticipated rate of return for following year
- Annual compensation of 10 most highly paid officers, executives and employees of insurer *and* parent company
- Assumptions underlying increase supported by “substantial evidence”? Choice or combination of assumptions “reasonable”?
- Degree to which increase exceeds rate of medical cost inflation
- Cumulative impact of filed rate combined with previous increases
- Do filed rates result in premium differences between enrollees within similar risk categories that do not reasonably correspond to difference in expected costs?

Premium Rate Review in California: Failed legislative attempt at rate approval

➤ Failed Attempted Legislation – AB 52

- Would have expanded California's rate *review* power into rate *approval* power
- Would have required application to DMHC or DOI for any proposed rate or rate change
- Regulators would have had authority to approve, deny, or modify request for rate increases they found excessive
- Would have allowed enrollees to challenge proposed increase by initiating or intervening in agency hearing or judicial review of agency decisions.
 - Compensation would have been provided for attorneys fees, expert witness fees, and other costs

➤ Defeated in 2011

Premium Rate Review in California: What's Next?

- Insurance Rate Public Justification and Accountability Act Ballot Measure
 - Requires public disclosure and justification of proposed rate changes
 - Commissioner would have authority to reject unjustified rate increases for health insurers and service plans
 - Rate approval program funded through filing fees
 - Prohibits eligibility or premium determinations based on absence of prior insurance coverage or credit history
 - Does not apply to large group health insurance policies
- Currently in signature verification process to qualify for November 2012 ballot.

Premium Rate Review: DMHC Contracts with Consumer Advocacy Group to Review Rate Increases

- In April 2012 DMHC issued \$225,000 contract (funded by PPACA) to Consumers Union to critique premium increases.
- “This partnership will help bolster accountability and transparency in health plan rate setting” -- DMHC Director Brent Barnhart.
- “Consumers Union will not only provide in-depth input on health plan premium rate filings but will also help get more Californians engaged in how plans set those rates.” -- DMHC Director Brent Barnhart.
- “When we look at the proposals, we will see what (actuarial) presumptions are underlying it. If there’s a medical trend assumption that’s out of whack, or if they’re pooling it in an unusual way, we would want to examine it more closely.” – Consumer’s Union Staff Attorney

Premium Rate Review in California: Recent Rate Review Decisions

➤ DMHC

- April 2011 - DMHC declared Anthem Blue Cross's proposed average premium rate increase to individual product of 16 percent "unreasonable"
 - Initially, DMHC did not declare Anthem Blue Cross's rate "unreasonable" but changed course when Anthem lowered proposed rates filed with DOI
 - Anthem proceed with rate increase

➤ DOI

- 2011 – Reviewed about 300 proposed rate increases and convinced insurers to postpone or withdraw rates in 50 cases
- April 6, 2012 – DOI found "unreasonable" 1.8% increase to Aetna's small employer plan.
 - Aetna declined to withdraw increase and noted that it's MLR for the small employer market was 87%.
 - CDI basis: Aetna raised rates by 30% in last 2 years for small employers.

Arguments Opposing Proposed Premium Rate Increases

➤ Unprofitable Product Okay

- **In 2009** Anthem requested 18.5% increase for individual policies with 3% profit margin
 - **Superintendent denied and approved 0% profit margin – reasonable to allow no profit and risk margin on individual product** given Anthem's overall financial health and unique economic situation resulting in financial hardship to subscribers
 - Anthem challenged. Supreme Court dismissed as moot
 - *Anthem Health Plans of Maine v. Superintendent of Insurance, et. al.*, 2011 ME 48 (2011)
- **In 2011** Anthem requested 9.7% increase in premiums for individual policies. Later reduced to 9.2%, including a 3% profit margin
 - Superintendent approved 5.2% increase with built-in risk and profit margin of 1%
 - Maine Supreme Court upheld -- could not find any statutory language requiring Superintendent to take into account insurer's profit while approving rates
 - *Anthem Health Plans of Maine v. Superintendent of Insurance, et. al.*, 2012 ME 21 (2012)
- *See also* California DOI Guidance issued 4/16/12 – one factor to consider is rate of return of the parent company

Arguments Opposing Proposed Premium Rate Increases (cont'd.)

- **In 2010 Massachusetts DOI Rejected Rates for 235 of 274 products Based On:**
 - **Profit Margin Too High:** over 1.9%
 - **Unacceptable Trending:** assumed trend greater than 150% of 2009 CPI for medical care services for New England Region
 - **Utilization Practices:** failure to demonstrate adequately controlling or adjusting utilization practices to maintain claim costs at reasonable levels
 - **Rate Negotiation:** Failure to demonstrate **adequate steps to negotiate rates** of reimbursement to providers
 - **Paying providers differing reimbursement:** for reasons other than (1) differences in providers' quality of care, (1) mix or patients, (3) geographical location, or (4) intensity of services
- Mass. agency decisions rejected each reason DOI had cited for disapprovals.

60-Day Medicare Overpayment Rule

- Providers and suppliers receiving Medicare funds must report and return overpayments within 60 days of date overpayment is identified or on due date of the corresponding cost report, whichever is later
- Enacted as part of PPACA in 2010
- Failure to refund is violation of False Claims Act
- Significant change in False Claims Act environment

60-Day Medicare Overpayment Rule

- Overpayments are “identified” if provider has “actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the overpayment”
- If a provider or supplier receives information concerning potential overpayment, it has obligation to make a “reasonable inquiry” to determine whether overpayment exists
- 60-Day Rule does not begin to run until after provider has opportunity to undertake a “reasonable inquiry”
- 10-Year Look Back Period
- 60-Day Rule also applies to Medicare Advantage (Part C) Plans, but CMS has not yet provided regulatory guidance on the matter

ERISA Class Actions Based on Recoupment Practices

- Provider and provider organizations have brought putative class actions based on alleged recoupment practices
 - Allege that organizations seek to recoup previously paid benefits that post claims audits determine were non-covered, excessive, fraudulent, unsupported by pertinent documentation, or the result of improper billing practices
 - Allege that if benefit not returned organization deducts or offsets the amount from future unrelated claims
- Allege recoupment practices violate RICO and ERISA
 - Decisions allegedly constitute “adverse benefit determination” under ERISA without “full and fair review” (disclosure of plan terms, reason for denial, documentation supporting decision)
 - Alleged breach of fiduciary duties under ERISA

Association of N.J. Chiropractors, et al. v. Aetna Inc., No. 09-3761, D.N.J.

- Chiropractic associations and individual chiropractors filed putative class action against Aetna on July 2010
- Allege that Aetna's SIU would recoup overpayments identified in "Post Payment Audits," in violation of RICO and ERISA, the latter because they allegedly constitute "adverse benefit determinations" made without complying with ERISA
 - Court dismissed RICO claims (June 20, 2011)
 - Court denied motion to dismiss ERISA claims, noting that "Aetna has raised questions as to the viability of Plaintiffs' ERISA claims," but "that a more complete factual picture . . . is necessary to . . . resolve the issue"
- Aetna filed cross-complaint for fraud and misrepresentation – survived Plaintiffs' motion to dismiss
- Case is stayed pending outcome of appeal in *Tri3 Enterprises, LLC v. Aetna, Inc., et al.*, No. 11-3981, D.N.J.

Pennsylvania Chiropractic Ass'n., et al. v. Blue Cross Blue Shield Ass'n., No. 09C5619, N.D. III.

- Plaintiffs chiropractic physician associations and individual chiropractors filed putative class action on Sept. 10, 2009 against various Blue Cross and Blue Shield entities alleging recoupment practices violate RICO and ERISA

- Defendants filed three motions to dismiss, which were granted as to the RICO claims but denied as to the ERISA claims
 - As to RICO claims, the Court held plaintiffs failed to plead predicate acts of racketeering and proximate cause
 - Defendants moved to dismiss ERISA claims on various grounds, including that Blue entities were not proper ERISA defendants, failure to identify plan or participants at issue, and failure to exhaust. Court denied motions to dismiss the ERISA claims

- Motions for judgment on the pleadings and class certification pending

Premier Health Ctr., et al. v. United Health Grp., Inc., No. 11-0425, D.N.J.

- Plaintiffs chiropractors, chiropractic health care facilities, and chiropractic associations filed First Amended Complaint on April 1, 2011 against UnitedHealth entities, OptumHealth, Health Net of Northeast and Health Net of New York
- **Recoupment Practices:** Plaintiffs allege that recoupment practices constitute adverse benefit determinations and allegedly violate ERISA, and that fiduciary duties under ERISA were breached
- **Utilization Review:** Plaintiffs allege OptumHealth's pre-authorization and provider tiering practices violate ERISA as "adverse benefit determinations" without "full and fair review" and because pre-authorizations are allegedly not permitted under plan documents
- UnitedHealth and Health Net filed motions to dismiss. On 3/30/12 the court denied UnitedHealth's motion to dismiss as to all claims, but granted it as to two subsidiaries of UnitedHealth
- Motion for class certification pending

Payor Litigation Over Provider's Discount Practices

- Providers have history of increasing patient volume by waiving patient's coinsurance, deductible or amount exceeding in-plan reimbursement
- Health insurers challenged such practices by contesting billed charges or claiming subsequent overpayments. Litigation was rare
- Aetna recently began pursuing claims against providers concerning the providers' patient discount practices. Suits have been filed in Texas, New York, and California
- On February 2, 2012, Aetna brought suit in Santa Clara County Superior Court against seven California surgery centers
- Alleged practices concern patient discounts for services provided at out-of-network surgery centers: *Aetna Life Insurance Co. v. Bay Area Surgical Management LLC*

Litigation Over Patient Discount Practices:

Aetna Life Insurance Co. v. Bay Area Surgical Management LLC

➤ **Aetna alleges:**

- Surgery centers **illegally induced Aetna's in-network physicians** (who are also investors in out-of network surgery centers) **to refer patients to out-of-network centers** by telling Aetna members they will not be balanced billed and are not responsible for deductibles, coinsurance or other patient responsibility
- Usually for out-of-network services member would be responsible for 20% to 30% of reasonable charges (as coinsurance) plus any charges that exceed Aetna's reimbursement of the reasonable value
- Surgery center **management team cherry-picks for referral** patients with substantial insurance benefits
- Physicians' ownership interest provides **incentive or referral fees** for out-of-network referrals.
 - One received annual bonus of \$980,000.
 - Physicians promised 805% return on investment
- **Physicians fail to adequately disclose to members their ownership/financial interest/incentive to refer**

Litigation Over Patient Discount Practices:

Aetna Life Insurance Co. v. Bay Area Surgical Management LLC

➤ **Aetna alleges (cont'd.):**

- Surgery centers submitted charges that were “artificially inflated because they are much greater than the amount the facility expects to be paid (an amount that would cover their costs plus a reasonable profit)
- Reflected by fact that the facility does not intend to collect those charges from member
- Facilities do not collect or intend to collect any member portion of the charges submitted
- **Example:**
 - Surgery center submits \$66,100 for “correction of bunion” procedure, representing as reasonable charge
 - Surgery center never collects \$10,576 (20% of \$52,880) (total allowed amount) from member as coinsurance or other compensation
 - Surgery center submits claim for \$66,100 with intent that Aetna would remit 80% of \$66,100
 - Aetna pay \$52,880 based on the misrepresentation
 - Aetna should have been charged or paid more than \$42,304 ($\$52,880$ (allowed amount) x Aetna’s 80% responsibility)).
 - Aetna was damaged \$10,576: ($\$52,880$ (amount paid) less $\$42,304$ (most should have paid))

Litigation Over Patient Discount Practices:

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➤ Aetna alleges (cont'd.)

- Payments from 513% to 1135% higher (percentage varied for each center) than Aetna paid its in-network providers in same geographic area for same procedures.
- Scheme resulted in receipt of \$23 million for 1,900 procedures that should have cost \$3 million, a 771% increase

Litigation Over Patient Discount Practices:

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➤ Relief Sought:

➤ Aetna asserts causes of action for:

- UC/17200 based on, *inter alia* (1) offering compensation for referral of patients, (2) referring patients to organization in which physicians have beneficial interest without disclosing interest in writing, (3) submitting false claim, and (4) corporate practice of medicine
- Intentional interference with contractual relations with its members and with its in-network participating providers
- Fraud
- Declaratory judgment
- Unjust enrichment

➤ Aetna seeks

- \$23 million in damages
- Disgorgement of profits
- Attorneys fees
- Injunction, and
- Declaration that "fee-forgiving" practices are illegal

Litigation Over Patient Discount Practices:

Aetna Life Insurance Co. v. Bay Area Surgical Management LLC

➤ Will Aetna's Theories of Liability Prevail?

- Demurrers (by centers and individuals) and motion to strike filed in March 2012. Hearing set for July 20th.

➤ Demurrers assert:

- Legal for physicians to refer patients to surgery centers in which they have ownership interest
- Legal for surgery centers to waive co-payments or otherwise produce discounts
- Aetna lacks standing to bring claims re: corporate practice of medicine
- Alleged practice of selecting patients for surgery at centers, who had out-of-network benefits by Aetna, is not illegal or improper
 - Patients specifically purchased Aetna's PPO and POS policies with high premiums so they could receive out-of-network services

➤ Motion to strike asserts:

- Medicare rule prohibiting waiver of copayments does not apply to case not involving Medicare patients or claims
- Knox-Keene regulations concerning R&C charges for emergency services not applicable
- Aetna's complaints to state and federal entities/agencies are irrelevant
- Aetna lacks standing to bring claims re: corporate practice of medicine

Litigation Over Patient Discount Practices: *Aetna Life Insurance Co. v. Bay Area Surgical Management LLC*

- **Will Aetna's Theories of Liability Prevail? (cont'd.)**
 - **Illegal to waive copays?**
 - Decades ago California Attorney General issued opinion regarding waiving copays. See 64 Ops. Cal. Atty. Gen. 782 (1981)
 - **Fraud?**
 - Fraudulent to submit charges that exceed amount provider expects to collect?
 - Fraudulent to submit charges that do not reflect failure to collect coinsurance?
 - What about providers' practice of submitted full billed charges for out-of-network emergency care?
 - Are the charges "represented" by a provider in a claim relied on by the health insurer in making payment?
 - What if insurers move from UCR to paying set amount based on % of Medicare?
 - **Illegal for surgery centers to offer bonus/fees to physicians for referral of patients?**

Questions?

