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HMO LAWSUIT WATCH

December 2002 Edition

Lawsuit Name & Citation	Brief Description
Aetna v. Klay 11th Cir. No. 02-16333-C (petition granted, 11/20/02)	The Eleventh Circuit Court of Appeals will hear the appeal of a group of health plans challenging a Florida District Court's certification of a class of doctors who sued the health plans. The class of doctors alleges that the health plans are violating federal racketeering and state prompt-pay laws.
Alleman v. BlueCross BlueShield of Illinois U.S. Dist. Ct., S.D. Ill. No 2002-CV-4107-JPG (10/3/02) www.ilsd.uscourts.gov/Opinions/02-4107_Alleman_motion_to_remand.pdf	Plaintiff Alleman was the attorney for a non-party who was employed by Wall Mart and covered by an ERISA health benefit plan. The non-party hired Alleman to represent her in a personal injury suit arising out of a car accident. Although a reimbursement provision of the ERISA plan provided that there would be no reduction of the Plan's lien for attorney's fees, Plaintiff sought attorneys fees under the Illinois Common Fund Doctrine, which allows parties who create, preserve or increase the value of a fund in which others have ownership interest, to be reimbursed from that fund for litigation expenses, including attorney's fees. Plaintiff asserted this claim on his own behalf, and on the behalf of an alleged class of attorneys in state court. Defendant removed the case to Federal Court based on diversity and federal question, alleging that this matter arose under § 502 of ERISA. The court, in granting plaintiff's motion to remand the case, held that the Plaintiff was not suing as a fiduciary, but rather on his own behalf according to the Common Fund doctrine and based on his "quasi-contractual" right to payment of fees for services rendered. The court determined that this claim would not and did not affect the relationship of the plan and participant, Plaintiff's client. Further, the court found that Plaintiff's claims had nothing to do with ERISA provisions, nor did his claims require the court to construe terms of the ERISA plan under which the non-party was insured. ERISA would not, therefore, preempt the plaintiff's claims that his client's health benefits plan should pay a share of the attorney's fees incurred during the work he did regarding the auto accident. Additionally, the court found no basis for Federal Court jurisdiction.
Bui v. AT&T, et al. 9th Cir. No 01-35509 (11/15/02) www.ca9.uscourts.gov/ca9/newopinions.nsf/D390EBEB4E56813688256C71007CE22F/$file/0135509.pdf?openelement	The lower court ruling granted summary judgment for the defendant on the basis that ERISA preempted all of plaintiff's claims. The Ninth Circuit decided that ERISA preempted only those claims that were based on administrative decisions, not those based on medical malpractice claims. Plaintiff Bui filed suit as the representative of her deceased husband who died after two unsuccessful operations while he was working overseas. He had contacted SOS, a company contracted by his ERISA-governed health benefits plan, to provide emergency and evacuation services. SOS advised him to stay

	in Saudi Arabia, as did the physician that was contacted by his employer, AT&T. Plaintiff filed this suit in federal court alleging SOS' negligent recommendations wrongfully caused her husband's death. Also, she claimed that AT&T was negligent by failing to respond to her husband's wishes to leave Saudi Arabia and also for choosing SOS to provide services. Finally, she also sued AT&T on breach of contract grounds. The Ninth Circuit found that the summary judgment was correctly granted below only as it applied to the breach of contract claim. The other medical malpractice and negligence claims, related to the medical decisions that were made in the course of treatment were within the field of traditional state court jurisdiction and ERISA would not preempt.
Combe v. La Madeleine, Inc., et al. U. S. Dist. Ct., E.D. La. No. Civ.A.01-1244 (11/6/02)	Plaintiff filed suit after she was denied medical benefits under her ERISA-governed, employee benefit plan, despite the fact that she had received pre-approval for jaw surgery. After submitting claims for nearly $120,000, the plan only paid for $8,000 and informed plaintiff that she had reached the maximum lifetimes benefits for the service. The plan did not give the plaintiff a formal denial letter until after she brought suit. Defendants maintained that the service was related to TMJ and the maximum benefit for that condition was only $1000, so the plaintiff actually received more than she was entitled to under the plan. Defendant argued that plaintiff failed to appeal within 60 days and that she needed to exhaust her administrative remedies before she could file suit to recover her benefits. Defendant also argued that the plan administrator's decision was within the plan's definition for TMJ services and was not an abuse of discretion. The court held that plaintiff did exhaust her administrative remedies in accordance with Fifth Circuit mandates. Also, the denial of benefits was an abuse of discretion by the plan administrator because there was no medical evidence that the plaintiff had TMJ and therefore the lifetime maximum benefits the plan claimed applied, actually should not have.
Connecticut General Life Insurance Co. v. Insurance Commissioner for Maryland Md. Ct. of Appeals No. 98 (11/04/02) www.courts.state.md.us/opinions/coa/2002/98a01.pdf	The Maryland Court of Appeals held that the state's external review law, which allows the state insurance commissioner to review decisions made by HMOs is not preempted by the Employee Retirement Income Security Act (ERISA). The Court relied primarily on the United States Supreme Court decision in *Rush Prudential HMO Inc. v. Moran*, finding that the Maryland state statute regulated insurance and therefore was saved from ERISA preemption. The case involved two subscribers in Connecticut General Life Insurance Co. HMOs who sought review under the state statute of denials of benefits under their employer-sponsored health plans – one involving the refusal to authorize inpatient rehabilitation care after a frontal craniotomy for a brain tumor, and one involving the denial of coverage for a one-day inpatient hospital stay following a hysterectomy.

	As a side, the District Court for the District of Maryland recently refused to hear two challenges to the Maryland external review law by HMOs giving deference to the Maryland Court of Appeals.
Hamilton v. United Healthcare of Louisiana U.S. Dist. Ct., E.D. La. No. 01-31179 (11/01/02)	This appeal, by plaintiff Hamilton, arose out of the dismissal of his Fair Debt Collection Practices Act ("FDCPA") claim against HealthCare Recoveries, Inc. Plaintiff was seriously injured in a car accident, necessitating medical and other treatment. He was insured through his father's employer by Defendant's plan, which paid for some of the services that Plaintiff received. The plaintiff's father also had uninsured motorist coverage that paid for additional benefits. Healthcare Recoveries, Inc. was contracted by the defendant to enforce its subrogation rights against Plaintiff. Plaintiff's own insurer, State Farm, paid proceeds on behalf of this matter as well. Plaintiff brought suit to recover those funds and enjoin other recovery attempts to coordinate benefits or subrogate claims. Plaintiff claimed that Healthcare Recoveries' efforts violated the FDCPA and the Louisiana Unfair Trade Practices Act. The Federal court remanded this case to state court, and dismissed the FDCPA claim because, it found, Healthcare Recoveries was not collecting a "debt." This court disagreed, and held that the funds were a debt within the plain meaning of "debt" and the unambiguous language of the FDCPA. Thus, the case was remanded. The court affirmed, however, the district court's ruling that there was no diversity jurisdiction.
Holy Cross Hospital v. Bankers Life & Casualty Co., and *Healthstar, Inc.* U.S. Dist. Ct., N.D. Ill. No. 1:01-cv-1505 (11/8/02) www.ilnd.uscourts.gov/RACER2/index.html	The Plaintiff Holy Cross Hospital had a contract with Defendant, Healthstar, Inc., to provide services at discounted rates to patients within Healthstar's network of contracts in exchange for a guaranteed flow of patients. Healthstar would then contract with Bankers Life and Casualty, a third party payer that was responsible for paying for the healthcare services and expenses. After its contract expired, Holy Cross learned that Healthstar was still discounting the hospital's charges. Holy Cross brought suit to recover the difference in price between the discounted rates and the current retail rates. The court, denying defendant's motion for summary judgment, found that the evidence submitted by the defendant did not establish that a contract-in-fact was still in existence, nor was there evidence to support that plaintiff had ratified the contract.
New York State United Teachers v. United Healthcare Corp. U.S. Dist. Ct., S.D.N.Y. No. 00-CV-2800 (motion to intervene, 11/19/02)	Two large New York state public employee unions and two other public employee organizations have filed a motion to intervene in an existing case against United Healthcare Corp filed by the American Medical Association and other physician groups, alleging that United Healthcare is using an inappropriate system to determine reasonable and customary charges for out-of-network medical claims. The intervenors allege that United Healthcare, acting as administrator, has

See also *American Medical Association v. United Healthcare Corp*. U.S. Dist. Ct., S.D.N.Y. No. 00-CV-2800 (10/23/02)	failed to pay 80% of the out-of-network medical claims submitted by public employees, and which are required to be paid under the health plan. Intervenors allege that the system used to determine the reasonable and customary charges uses statistically insignificant data and does not accurately reflect the physician's expertise and experience. The suit also makes allegations regarding deceptive business practices, breach of contract and breach of the covenant of good faith with union members.

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(ENTIRE COLLECTION)

Lawsuit Name	Citation	Brief Description
ACLU v. Regence BlueShield	Wash. Super. Ct. (7/11/01)	The American Civil Liberties Union and the Washington National Abortion Rights Action League announced the filing of a class action lawsuit against Regence BlueShield in a Washington state court. Plaintiffs charge that the defendant allegedly discriminates against women by failing to provide coverage of certain prescription contraceptives in health insurance policies offered to plaintiffs and other employers. According to plaintiffs, the defendant either excludes coverage of contraceptives or limits coverage to certain contraceptives.
Advantage Care Inc.	Ky. Cir. Ct. (11/8/00)	The Kentucky Department of Insurance (the "Department") announced that it reached an agreement with MedImpact to require participating pharmacies providing services to members of Advantage Care to honor Advantage Care and MedImpact prescription drug benefit cards. MedImpact is the pharmacy benefit manager that negotiated contracts with pharmacists to provide services to members of Advantage Care. On Nov. 8, 2000, the Department asked a Kentucky court to allow state regulators to supervise daily operations of Advantage Care because of alleged financial difficulties.
Aetna U.S. Healthcare	N.Y. Supreme Ct. (filed 5/26/00)	A coalition of 24 New York hospitals filed a lawsuit against Aetna U.S. Healthcare alleging breach of contract and violations of New York prompt pay, managed care, and deceptive business practices laws. Plaintiffs' lawyers stated that the action arises out of Aetna's alleged failure to pay fully and timely for medically necessary services provided to hospital patients. The complaint seeks $95 million in compensatory and punitive damages in addition to attorneys' fees and interest on unpaid claims.
American Dental Association v. Aetna, Inc.	Ill. Dist. Ct. No. 01C6280 (8/15/01)	The American Dental Association and two dentists filed a class action lawsuit on behalf of themselves and a class of dental providers charging that Aetna Inc. underpaid plaintiffs for dental services. The lawsuit alleges claims of breach of contract, libel and tortious interference with contractual relations. On November 5, 2001, this case was transferred to the United States District Court of the Southern District of Florida and is part of the Multi-District litigation discussed above.
Andrews v. Samaritan Health System	Ariz. Ct. App. No. CA-CV00-0386 (12/11/01) http://www.cofad1.state.az.us/opinionfiles/cv/cv000386.pdf	The Arizona Court of Appeals upheld a lower court's ruling that hospitals can enforce untimely medical liens against patients when patients receive payment for their medical services from a liable third party. This is so even if, prior to payment by the liable party, the hospital received payment from an insurer and the hospital agreed to accept the insurer's discounted payments as payment in full.
Batas v. The Prudential Insurance Company of America	N.Y. Supreme Ct. Appellate Div. (3/20/01)	An intermediate New York appeals court held that a lower court properly denied defendants' motion to dismiss claims of fraud, breach of contract, and violations of New York business law in a class action lawsuit brought by health care plan subscribers

		alleging improper denial of medical coverage. The court also found that the lower court properly dismissed a claim for breach of fiduciary duty and reinstated plaintiffs' claim for tortious interference with contract finding that the allegations were sufficient to state a claim.
Bauhaus USA, Inc. v. Copeland	U.S. Ct. of Appeals, 5th Cir. No. 01-60343 (5/21/02) http://www.ca5.uscourts.gov/opinions/pub/01/01-60343-cv0.htm	The U.S. Court of Appeals for the 5th Circuit, citing *Great West v. Knudson*, ruled that Bauhaus could not recover funds paid to Copeland pursuant to a settlement with a tort feasor. Copeland's daughter was injured in a car accident and obtained $750,000 from the liable third party, of which $78, 161.47 was placed in a State Court's custody to cover all liens against Copeland's proceeds. Bauhaus sought recovery from Copeland of $46,229 Bauhaus paid in medical expenses related to the auto accident. The Court, looking at *Great West v. Knudson,* determined that this case was identical and therefore, the plan could not recover the proceeds because ERISA only permitted a plan to seek equitable relief and the plan was seeking legal relief (i.e., personal liability) from Copeland. The dissenting judge disagreed and stated the plan was seeking equitable relief and was entitled to reimbursement from the funds being held in state court.
Blue Shield of California v. Zingale	Cal. Super. Ct. No. 01AS07540 (12/10/01)	Blue Shield of California filed suit against the California Department of Managed Health Care (DMHC) in California Superior Court relating to the DHMC's ability to mandate coverage of certain prescription drugs. Blue Shield's contracts exclude coverage for outpatient prescription drugs prescribed for weight loss. The DHMC reviewed a Blue Shield denial related to such a drug (Xenical) and determined the drug was medically necessary and as such should be covered. Blue Shield is seeking a determination by the court that absent an express statutory mandate, the DHMC lacks the authority to require health plans to cover specific outpatient prescription drugs. On January 15, 2002, a Sacramento Superior Court judge ruled that the California Department of Managed Health Care cannot compel a health plan to provide coverage for a prescription drug that is not part of the plan's contract with the enrollee.
Cal. Assn. of Health Plans v. Kenefick, et al.	(12/10/01) U.S. Dist. Ct. – Cent. Dist. Cal. No. 00-CV-6803 Superior Court, Oakland, CA	A California judge upheld the authority of the California Department of Managed Health Care (DMHC) to fine Kaiser Permanente $1.1 million based on alleged lapses in patient care. The fines were originally assessed in May of 2000 and were based on the deaths of three Kaiser Permanente members from 1996 through 2000. Kaiser Permanente asked the court to find the Director of the DMHC in contempt of court for assessing fines related to Medicare members. Kaiser asserted that with respect to Medicare members, the members' coverage is subject to federal law, not oversight by the DMHC. In a separate action, Kaiser Permanente is asking an administrative law judge to rule that the DMHC exceeded its authority when it levied fines against Kaiser Permanente related to the appropriateness or adequacy of medical care a member received in a doctor's office or hospital.
Calad v. CIGNA Healthcare of Texas	Tex. Dist. Ct. No. 3:00-CV-2693-H	A federal court in Texas held that a patient's negligence claim under the Texas Health Care Liability Act against her HMO was

	(6/21/01) http://pacer.txnd.uscourts.gov/dc/cgi-bin/javaviewer.pl?&docno=33&caseno=3:2000cv02693&docpages=14&puid=00969649731	preempted by ERISA. The court found that the claim was not about quality of care but rather about the patient's HMO's coverage determination and administration of the patient's benefits. The court also held in the same lawsuit that another patient's negligence claim brought against his HMO was not preempted by ERISA because the patient received his health benefits through a government employer. The court found that ERISA preemption does not apply to a government employee benefit plan.
California Medical Ass'n v. Aetna U.S. Healthcare of California, Inc.	Court of Appeal, Fourth Appellate District, Division One, State of California Super. Ct. No. GIC732614 (12/05/01) http://www.courtinfo.ca.gov/opinions/archive/D036140.PDF	The Court affirmed the judgment of the Superior Court of San Diego County to grant defendant's motion to dismiss (without leave to amend) California Medical Association's second complaint. This suit was brought in July 1999 by CMA to recover from defendants payments allegedly due to physicians for services provided to enrollees in health care service plans operated by defendants. CMA asserted that the services were to have been paid by intermediary organizations with whom Aetna contracted to pay physician claims, but due to financial troubles, the intermediaries failed to reimburse physicians. CMA claimed that under California law, HMOs are ultimately responsible for ensuring that physicians are paid, thus, Aetna should reimburse the physicians for any claims the intermediaries failed to pay. On April 2, 2002, the California Supreme Court denied review of this matter.
California Medical Ass'n v. Dept. of Managed Health Care	(02/28/02) Cal. Super. Ct. No. 01CS 01265	Judge Gail D. Ohanesian ruled that the financial solvency regulations adopted on August 31, 2001 that require medical groups and health plans to submit certain information to the Department of Managed Health Care (DMHC) are arbitrary and capricious. The judge stated that the DMHC failed to show that the collection and release of financial solvency information would not harm the integrity of the contract negotiation process between medical groups and managed care plans.
Carducci v. Aetna U.S. Healthcare	D. N. J. No. 01-4675 (JBS) (05/28/02) http://lawlibrary.rutgers.edu/fed/html/ca01-4675-1.html	The U.S. District Court for the District of New Jersey ruled that the Employee Retirement Income Security Act (ERISA) completely preempts state law unjust enrichment claims brought by ERISA-governed HMO enrollees against various HMOs seeking monies the enrollees paid to the plans in satisfaction of the plans' subrogation provisions. Judge Jerome B. Simandle refused to remand the case to state court, holding that the plan participants were seeking "benefits due" under the plans, and thus their claims to declare the plans' subrogation clauses void were governed by ERISA. The court explained the distinction between quality of care claims, which are generally not ERISA preempted, and quantity of care claims, which generally are preempted by ERISA, and found that while this particular case did not clearly fall into one classification or the other, the claims related to the administration of the plans, and thus were preempted by ERISA.
Catholic Healthcare West v. Blue Cross of California	Cal. Super. Ct. No. BC231342 (settled 2/13/01)	Blue Cross of California and Catholic Healthcare West reportedly settled a lawsuit filed by Catholic Healthcare West based on allegations that Blue Cross engaged in unlawful business practices to avoid making payments for medically necessary services.
Chappel v.	Ninth Cir. Ct. of	The Ninth Circuit held that an arbitration clause in an ERISA-

Laboratory Corp. of America	Appeals No. 98017361 (11/14/00) http://www.ca9.uscourts.gov/ca9/newopinions.nsf/9C9FAEDA7ABAE4458825699700627F86/$file/9817361.pdf?openelement	governed health benefits plan was enforceable. However, the court also held that the lower court should have permitted the plan member to amend his complaint to state a claim against the administrator of the plan for breach of fiduciary duty in failing adequately to notify the member of the existence and terms of the arbitration clause. According to the court, the health plan allegedly denied payment for treatment provided to the member based on the plan's finding that the medical condition was pre-existing. The member sought direct judicial review of the denial despite a plan requirement that members must resolve disputes through arbitration.
Chester County Hospital v. Independence Blue Cross	E.D. Pa. No. 02-CV-2746 (5/8/02)	Chester County Hospital filed a civil action against Independence alleging violations of antitrust laws and breach of contract. The Hospital alleges that Independence and several of its subsidiaries violated Federal antitrust laws through accumulating a large market share and then utilizing that market share to coerce the hospital into accepting rates well below what the hospital required. The Hospital alleged Independence's predatory conduct included most favored nation clauses in provider contracts, all products clauses in provider contracts, and minimum employer group enrollment of 75% of the groups' employees in the IBC plan
Cohen v. Empire Blue Cross and Blue Shield	(06/21/2002 – settlement approved) S.D.N.Y. No. 95-4553	The court approved a settlement whereby Empire Blue Cross Blue Shield will pay $21.6 million in restitution for charging approximately 52,000 subscribers excessive out-of-pocket costs. These excessive costs resulted from Empire's use of faulty actuarial methods in determining physician reimbursements.
Community Health Partners, Inc. v. Kentucky	U.S. Supreme Ct. No. 00-1295 (petition filed 2/12/01) http://supreme.lp.findlaw.com/supreme_court/docket/2002/january.html#00-1471	Community Health Partners, Inc. requested the U.S. Supreme Court to review a Sixth Circuit Court of Appeals decision that found that ERISA did not preempt Kentucky's "any willing provider" laws. The Court granted certiorari in June 2002, and will hear oral arguments in the case, now called *Kentucky Assocation of Health Plans, Inc. v. Miller*, on January 15, 2003.
Connecticut State Medical Society v. United Healthcare Insurance Co.	Conn. Super. Ct. No. CV-01-0453618-S (7/12/01)	The Connecticut State Medical Society filed a lawsuit against United Healthcare on behalf of the Society's 7,000 members. The suit claims that the managed care organization allegedly denied payments for medically necessary care, denied payment for care without proper explanation, arbitrarily downcoded claims, and used computerized programs to automatically reduce or deny claims. The suit follows lawsuits filed earlier this year by the Society against six managed care organizations based on allegations that the defendants breached their contracts with physicians and engaged in unlawful business practices in violation of the Connecticut Unfair Trade Practices Act. (*Connecticut State Medical Society v. Aetna U.S. Healthcare*). This case was transferred to the United States District Court of the Southern District of Florida and is part of the Multi-District litigation discussed above.
Connecticut v. Physicians Health Services of	2nd Circuit No. 00-7986 (03/27/02)	The U.S. Court of Appeals for the Second Circuit upheld a July 2000 ruling by a federal district court holding that the state of Connecticut lacked legal standing to sue in federal court.

Connecticut Inc.	http://www.ca2.uscourts.gov:81/isysnative/RDpcT3BpbnNcT1BOXDAwLTc5ODZfb3BuLnBkZg==/00-7986_opn.pdf	Attorney General Richard Blumenthal had filed suit in 1999 under the Employee Retirement Income Security Act seeking to enjoin the managed care plan from using a prescription drug formulary (list of drugs approved for reimbursement). The court of appeals said that the state is not an injured party and that Congress did not intend to allow states to file suits under ERISA.
Continental Orthopedic Appliances, Inc. v. Health Insurance Plan of Greater New York Inc.	N.Y. Dist. Ct. No. CV-95-4541 (12/4/00)	A federal district court in New York refused to certify a class in an antitrust lawsuit challenging a HMO's exclusive contracts with two suppliers of orthopedic and prosthetic devices. Plaintiffs, who were other suppliers of the devices, reportedly alleged that the HMO entered into an exclusive dealing agreement with the two suppliers. The court found that maintenance of a class action was precluded where injury was predicated on the individual relationships between the HMO and the suppliers.
Corsini v. United Healthcare	Rhode Island Dist. Ct. No. CA96-0608-T (5/17/01) http://www.rid.uscourts.gov/opinions/torres/1997/published/06031997_1-96cv0608t_corsini_v_united_healthcare_p.pdf	A federal court held in a class action lawsuit that an HMO's method to determine copayments violated ERISA and ordered the HMO to repay over $4 million to its subscribers in Massachusetts and Rhode Island. Although the HMO paid providers based on discounted fees, the subscribers' copayments for services allegedly were based on higher, nondiscounted fees. The court also reportedly found that the HMO did not violate its fiduciary duty under ERISA by failing to disclose its discounted fee arrangement with providers.
Coventry Health Care of Kansas Inc. v. Via Christi Health System Inc.	D. Kan. No. 01-1261-JTM (Denial of injunction – 12/19/01)	Citing a failure to show it would suffer "irreparable injury" if an injunction was not granted, or that it was likely to succeed on the merits of its antitrust claims, a federal judge refused Coventry Health Care's request for a preliminary injunction to void a contract the insurer lost to a competitor. Coventry filed suit under the Sherman Act, alleging that Preferred Health System (a Via Christi Health System subsidiary) had employed predatory pricing and taken advantage of its monopoly power to obtain the contract.
CSRA Primary Care Associates v. Blue Cross and Blue Shield of Georgia	Ga. Super. Ct. No. 2000 RCCV 705 (11/21/00)	A Georgia court reportedly ordered Blue Cross and Blue Shield of Georgia to make withheld payments to a network of physicians.
Czarnopys v. Crystal Flash Limited Partnership of Michigan	W.D. Mich. No. 1:02-CV-216 (04/25/02)	In a same day opinion, the U.S. District Court for the Western District of Michigan ruled that a health plan administrator acted arbitrarily and capriciously in denying a plan participant treatment for her cancer, and notifying her of the denial four days before treatment was to begin. Donna Czarnopys was diagnosed in March 2001 with high-grade neuroendocrine carcinoma and received two cycles of chemotherapy. Czarnopys had received approval for her pre-certification request for a bone-marrow transplant operation, but then was notified by the health plan administrator just before the date of treatment that the operation would not be covered because of its' experimental nature.
Dallas County Hospital District v.	(06/19/2002) 5th Circuit	The Fifth Circuit held that as a health plan participant's assignee, a medical provider had derivative standing to bring an

Associates' Health and Welfare Plan	No. 01-10988 http://www.ca5.uscourts.gov/opinions/pub/01/01-10988-cv0.htm	ERISA claim against a plan administrator. The medical provider had standing because, although the plan had an anti-assignment clause, it also permitted providers to receive direct assignments from participants through a "network assignments" provision. The court deferred to the plain language of the plan in rejecting the health plan's argument that the "network assignments" provision only authorized direct payment to network providers, and not assignment of benefits to a provider.
Desert Healthcare District v. PacifiCare FHP Inc.	Cal. Ct. App. No. E026961 (11/30/01)	A California state appeals court has determined that "there is no proper role for the court of equity to play" in the dispute between hospital owner Desert Healthcare District (DHD) and health plan PacifiCare. Suing for payment of unpaid claims due to the bankruptcy of middleman Desert Physicians Association (DPA), DHD alleged that PacifiCare violated Section 1371 of the Knox-Keene Health Care Act, unfair competition law, and acted negligently. DHD asserted that under Section 1371 PacifiCare bore the ultimate responsibility for the payment of claims despite its capitation agreement with DPA, but the court disagreed, saying that Section 1371 imposes procedural requirements and does not create a new and independent basis for liability. The court also rejected DHD's assertions that PacifiCare transferred risk to intermediaries thereby engaging in unfair competition. Lastly, the court found that PacifiCare had not acted negligently because there was no duty to ensure the financial stability of DPA.
Dobner v. Health Care Service Corp.	(06/19/2002) N.D. Ill. No. 01 C 7968 http://www.ilnd.uscourts.gov/RACER2/index.html	The district court decided that ERISA bars Wendy Dobner's claim asserting a violation of Illinois' Consumer Fraud and Deceptive Trade Practices Act based on her health plan administrator's refusal to pay the cost of a wig purchased after receiving chemotherapy. The court held that the plaintiff's claim is preempted by ERISA because her claim "involves interpreting the benefits provided under [her] ERISA plan." Because the consumer fraud act does not specifically regulate the insurance industry, it is preempted by ERISA.
Doe v.Magellan Health Services, Inc.	Mo. Dist. Ct. Nos. 4:00 cv 1715 and 1716 (filed 10/26/00)	Class action lawsuits were filed against Magellan Health Services, Inc. reportedly alleging that Magellan used undisclosed financial incentives and internal controls to limit care provided to Magellan members in violation of RICO and ERISA.
Ehlmann v. Kaiser Foundation Health Plan of Texas	U.S. Supreme Ct. No. 99-1828 (petition for review denied 8/15/00)	The U.S. Supreme Court dismissed a petition for review of a Fifth Circuit decision that held that ERISA did not require HMOs to disclose financial arrangements with their physicians. According to the Fifth Circuit decision, Congress and not the courts should impose any such duty under ERISA and no general duty to disclose could be implied from the general fiduciary duty wording under ERISA. The plaintiff HMO members reportedly decided not to pursue their petition for review by the Supreme Court in light of the Supreme Court's recent decision in *Pegram v. Herdrich*. Although the question was not before the Supreme Court in *Pegram*, the Supreme Court stated that it could be argued that the HMO in *Pegram* is a fiduciary "insofar as it has discretionary authority to administer the plan, and so it is obligated to disclose characteristics of the plan and of those who provide services to the plan, if that

		information affects beneficiaries' material interests."
Empire Healthchoice, Inc. v. TAP Pharmaceutical Products	D. Mass No. 02CV10015 Filed 01/03/02	Empire Healthchoice, a New York state Blue Cross plan, alleges that TAP unlawfully overcharged for the prostate cancer drug, Lupron. The suit alleges violations of the federal Racketeer Influenced and Corrupt Organizations Act and New York state business law. In October of 2001, TAP settled a Federal Government investigation for $875 million, which included criminal and civil charges related to its marketing and sales of Lupron.
Esensten v. Shea	U. S. Supreme Ct. No. 00-12 (petition denied 10/2/00)	The United States Supreme denied a petition seeking review of an Eighth Circuit Court of Appeals decision that held that ERISA did not preempt a state law negligent misrepresentation claim. At issue were allegations that failure of physicians to disclose financial incentives in their contracts with an HMO influenced a patient not to seek treatment from a specialist.
Express Scripts Inc. v. Wenzel	8th Cir. Ct. of Appeals No. 00-2788 (8/22/01) http://www.ca8.uscourts.gov/opndir/02/06/013067P.pdf	The Eighth Circuit held that ERISA did not preempt certain provisions of a Missouri law regulating how HMOs provide prescription drugs through network pharmacies. The law prohibits HMOs from setting a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription unless the limit is applied uniformly to all pharmacy providers in the HMO's network (*e.g.*, retail and mail order pharmacies). Missouri law also requires HMOs to apply the same coinsurance, copayment and deductible factors to all prescriptions filled by a pharmacy provider that participates in the HMO's network. The lawsuit, brought by a mail order pharmacy benefits manager and several business groups, sought an injunction against the acting director of the Missouri Department of Insurance to prohibit the enforcement of the law.
Franciscan Medical Group v. Premera Blue Cross *Tacoma Orthopaedic Surgeons Inc. v. Regence BlueShield*	(03/22/02) Wash. Super. Ct. No. 02-2-05983 (03/22/02) Wash. Super. Ct. No. 02-2-05982	Two similar but separate proposed class actions allege that certain insurers violated state criminal profiteering and consumer protection acts by engaging in illegal billing practices. The complaints contend that the insurers were practicing "downcoding" and "bundling" to reduce payments to providers for health care services under provider agreements between the insurers and providers.
Great-West Life & Annuity Insurance Co. v. Knudsen	534 U.S. 204 (2002) No. 99-1786, on writ of certiorari to the United States Court of Appeals for the Ninth Circuit. (01/08/02) http://supct.law.cornell.edu/supct/html/99-1786.ZS.html	The Supreme Court held, in a 5-4 decision that ERISA did not give an employee benefit plan fiduciary the right to sue a beneficiary for reimbursement of the benefits paid to the beneficiary after she received tort damages from a third party responsible for her injuries. Petitioners attempted unsuccessfully to characterize their claim as one for equitable relief under § 502(a)(3) of ERISA.
Green v. Aetna U.S. Healthcare, Inc.	Cal. Super. Ct. Case No. 412180 (filed 3/6/00)	A class action lawsuit was filed in California state court against a group of California HMOs on behalf of an estimated class of 40,000 Medicare HMO enrollees whose coverage allegedly was wrongfully terminated. The complaint charges that although defendants "knew that they may shortly leave the market," defendants through "carefully crafted advertising . . . induced such persons to leave their former health care programs and enroll in defendants' Medicare HMO plans." Subsequently,

		defendants allegedly terminated the Medicare HMO enrollees. According to the complaint, defendants conspired to restrain trade through "redlining and group boycotting certain locations in California in a discriminatory manner . . . thereby denying customers access to Medicare HMO services." The plaintiff seeks equitable relief and damages under California's unfair competition statute.
Grijalva v. Shalala	Ariz. Dist. Ct. Case No. CIV 93-711 TUC ACM (settled 8/9/00)	Medicare beneficiaries and the Health Care Financing Administration ("HCFA") have settled a class action lawsuit involving the appeal rights of Medicare beneficiaries denied care by HMOs under the Medicare program. The settlement agreement reportedly requires Medicare+Choice ("M+C") organizations to provide four days prior notice to beneficiaries of termination of a course of treatment provided by a nursing home, home health agency, or comprehensive outpatient rehabilitation facility. HCFA also is expected to issue a notice of proposed rulemaking by the end of the year to address procedures and requirements a M+C organization must follow to terminate coverage.
Group Health Plan Inc. v. Philip Morris Inc. *Medica v. Philip Morris Inc.*	D. Minn. No. CV 98-1036 (01/31/02) D. Minn. No. CV 99-1739 (01/31/02)	U.S. District Judge Paul A. Magnuson dismissed the lawsuit filed by Group Health Plan and Medica that sought damages from the tobacco industry over alleged efforts by the industry to mislead the public concerning the effects of smoking. The Court determined that HMOs needed to demonstrate that the industry's conduct had some impact on their members' use of tobacco products, which caused damages. See Group Health Plan Inc. v. Philip Morris Inc., 621 N.W.2d at 14 (Minn. 2001). As to the HMOs' antitrust claims, the court determined that the HMOs were required to show the industry's alleged violations of the state antitrust laws were a "material cause" of the HMOs' injuries.
Hammerich v. Aetna U.S. Healthcare Inc.	(5/29/02) M.D. Fla. No. 8:01-cv-1187-T-30MSS	The district court ruled that the state law action of a participant suing an HMO for not informing him his colon cancer screening test had come back positive is not preempted by ERISA. Claimant and his wife sued Aetna in state court. Aetna removed the case to federal court as preempted by ERISA and claimant moved to remand to state court. The district court granted the remand motion, finding that the participant was not suing Aetna to recover benefits or to enforce his rights under the plan, but was suing for negligence in failing to disclose his test results. Thus, the action was appropriate for state court.
Herman v. Capital Blue Cross	Pa. Ct. of Common Pleas Nos. 2001-SU-03311-01 and 3310-01 (6/29/01)	Chiropractic centers in Pennsylvania filed a class action lawsuit on behalf of policyholders and subscribers of two Pennsylvania Blue Cross plans. The complaint asserts that the health plans allegedly violated state law by accumulating excess surplus funds to finance acquisitions of for-profit affiliates.
Hewitt v. PacifiCare of Texas, Inc.	Tex. Dist. Ct. No. 342-189 541-01 (9/24/01)	An enrollee filed a class action lawsuit against PacifiCare of Texas, Inc. alleging that the health plan negligently changed her cholesterol medication. According to the complaint, the health plan breached its duty to make available safe and effective drugs when it changed its drug formulary.
Hofler v. Aetna US Healthcare of	(07/10/2002) 9th Circuit	The Ninth Circuit held that federal Medicare law does not preempt a state court claim arising from the administration of

California Inc.	No. 00-56401 http://www.ca9.uscourts.gov/ca9/newopinions.nsf/2E073DC3C3B1C8EA88256BF1007DFF23/$file/0056401.pdf?openelement	Medicare benefits. In state court, the plaintiff complained that Aetna, a Medicare+Choice plan, denied her late husband necessary medical attention. Aetna removed the action to federal court, claiming that Medicare preempted the plaintiff's action. However, the court decided that federal preemption was not Congress's intent and remanded the case to state court. The court emphasized that the state law claims did not rely on Medicare for standing or substance, and the state law claims were not "inextricably intertwined" with a claim for benefits. The court also awarded the plaintiff attorney's fees based on Aetna's erroneous removal argument.
Horvath v. Keystone Health Plan East Inc.	E.D. Pa. No. 00-0416 (02/22/02) http://www.paed.uscourts.gov/documents/opinions/02D0141P.HTM	District Judge Ronald L. Buckwalter found that absent a specific request by a subscriber, an HMO had no fiduciary duty to disclose the physician compensation scheme used by the HMO to pay its physicians. Third Circuit precedent set forth that a fiduciary's alleged misinformation or failure to provide information only constitutes an actionable breach of fiduciary duty under Section 404(a) of ERISA when the information is "material." The court followed said precedent in finding for the HMO because the subscriber failed to produce evidence to meet this standard or that lack of such information exposed her to incompetent medical treatment.
Hotz v. Blue Cross and Blue Shield of Massachusetts Inc.	(6/11/02) 1st Circuit No. 01-2313 http://www.ca1.uscourts.gov/cgi-bin/getopn.pl?OPINION=01-2313.01A	The 1st Circuit ruled that a health plan participant is barred by ERISA from seeking remedies, including punitive damages, against a plan administrator under a Massachusetts state law prohibiting unfair claim settlement practices by insurance companies. The court rejected the plaintiff's argument that the law was "saved" from ERISA preemption because state law regulated the insurance agency. Instead, the court found that while a portion of the state law was aimed solely at the insurance agency, it also provided a private right of action that applied to unfair practices in any industry.
Howard v. Coventry Health Care of Iowa Inc.	(6/7/02) 8th Circuit No. 01-3067 http://www.ca8.uscourts.gov/opndir/02/06/013067P.pdf	The 8th Circuit held that the Women's Health and Cancer Rights Act (WHCRA) does not provide a private right of action for an ERISA health plan participant who sued her plan administrator for failing to pay for her post-breast reconstructive surgery. The court explained that the legislative history of WHCRA "does not illustrate an intent to create a private cause of action in addition to those already available under ERISA." The court also agreed with the district court that Howard's other state law claims – breach of contract, violation of public policy, and bad faith – were preempted by ERISA.
In re Managed Care Litigation	Fla. Dist. Ct. No. 00-1334 (8/29/01)	The Florida Medical Association joined the California, Georgia and Texas Medical Associations in their class action lawsuits against health plans pending in a Florida federal district court. In June, the court dismissed RICO claims brought by plaintiff consumers against defendant managed care organizations in consolidated class action lawsuits. The court's order permits plaintiffs to file amended complaints. According to the court, plaintiffs have not alleged properly the predicate acts of mail and wire fraud to support a RICO allegation. However, the court found that plaintiffs in one of the consolidated lawsuits brought against Humana Inc. properly alleged a RICO claim. The court also dismissed without prejudice all of the plaintiffs' ERISA

		claims finding that plaintiffs failed to comply with ERISA's exhaustion of administrative remedies requirements. Earlier this year, the court also dismissed RICO claims brought by physicians against defendants and permitted the physicians to file amended complaints. The lawsuits are part of a group of consolidated class actions, transferred to the Florida court from various courts across the country, brought by consumers and physicians on behalf of millions of potential class members against managed care organizations. The judge subsequently ruled that discovery may proceed in the class action. According to the court, discovery may allow the parties to present further evidence regarding class certification. All the lawsuits "involve common questions of fact concerning whether defendants-either single or as part of a conspiracy-implemented certain policies including . . . utilization review processes, physician financial incentives and/or failure to pay clean claims in a timely manner, which unlawfully deprived health care plan subscribers of the health care for which they contracted and/or unlawfully interfered with health care providers' delivery of that care." According to medical associations involved in the case, the lawsuits affect more than 6700,000 physicians nationwide. <u>February, 2002</u> – Based on the McCarran-Ferguson Act, Judge Federico A. Moreno dismissed with prejudice racketeering charges raised by 10 of the 16 subscriber plaintiffs. In March, Judge Moreno granted a motion by attorneys representing managed care organizations to immediately appeal the February 20, 2002 decision addressing charges brought by subscribers under the Racketeer Influenced and Corrupt Organizations Act. Judge Moreno stated in his order that the immediate review of the RICO issue by the Eleventh Circuit could move forward the termination of the case. The court expects to rule on class certification within two months. <u>March 14, 2002</u> - The U.S. Court of Appeals for the Eleventh Circuit upheld in its entirety the Southern District Court of Florida's December 2000 ruling in *In re Humana Inc. Managed Care Litigation*. The federal appeals court affirmed that claims between plaintiffs and defendants who are both signatories to contracts containing enforceable arbitration clauses must be arbitrated, but that those arbitration clauses that exclude punitive damages are unenforceable in the suit because they preclude the recovery of treble damages under RICO. Consequently, the federal appeals court ruled that HMOs, which are not signatories to particular contracts containing arbitration clauses, may not rely upon an equitable estoppel theory to compel arbitration of plaintiff's RICO claims.
Ingram v. Harris Health Plan Inc	Tex. Dist. Ct. Case No. 598CV179 (3/20/00)	A Texas federal court judge has approved the settlement of a class action lawsuit brought against Harris Health Plan, Inc. for allegedly failing to disclose financial incentive arrangements with physicians to limit medically necessary care. The settlement reportedly provides that the approximately 200,000 class members covered under ERISA plans are entitled to claims of no more than $50, with the four named plaintiffs in the complaint entitled to up to $9,000 over the class settlement

		amount.
Insurance Dept. of Florida v. Stowell	Fla. Cir. Ct. Case No. 00-CA-1057-15-K (filed 5/30/00)	The Florida Insurance Commissioner has requested a Florida judge to order the return of more than $4 million allegedly taken from SunStar Health Plan by its parent company's executives. The lawsuit alleges that the executives misappropriated and wasted the plan's assets primarily by directing the payment of "exorbitant" management fees and other fees to the parent company and that the executives misused premiums to pay management fees. The Insurance Commissioner also seeks court orders holding the officers and managers in contempt of a court order issued last year to protect and preserve the plan's assets during liquidation proceedings and to freeze the plan's accounts until a full accounting of the financial dealings involved is completed. Last December the Insurance Commissioner filed a lawsuit to liquidate SunStar Health Plan after he determined that the plan allegedly was nearly $9.7 million short of what it should have on hand to pay claims and maintain its surplus.
Jones v. Chicago HMO Ltd. of Illinois	Ill. Supreme Ct. Docket No. 86830 (5/18/00) http://www.state.il.us/court/Opinions/SupremeCourt/2000/May/Opinions/HTML/86830.htm	In reversing a lower court's grant of summary judgment in favor of Chicago HMO Ltd. Of Illinois, the Illinois Supreme Court held that a HMO may be held liable for institutional negligence for assigning more enrollees to a primary care physician than he was capable of serving. In holding that the tort of institutional or corporate negligence may be applied to HMOs, the court recognized prior cases that applied the tort against hospitals based on a hospital's duty independent of physicians to assume responsibility for the care of patients. The court found that HMOs, like hospitals, consist of many individuals who play various roles to provide comprehensive health care services to enrollees. Therefore, the court found that it is "reasonably foreseeable that assigning an excessive number of patients to a primary care physician could result in injury, as that care may not be provided."
Kaiser Foundation Health Plan Inc. v. Zingale	(06/27/2002) Cal. Ct. App. No. C039437 http://www.courtinfo.ca.gov/opinions/archive/C039437.PDF	The court held that California's Department of Managed Health Care cannot require health plans to cover all medically necessary prescription drugs. Kaiser sued the department to overturn a department decision that denied Kaiser's request to exclude Viagra from its coverage. The court decided that the state legislature, via the Knox-Keene Health Care Service Plan Act, intended to prevent health plans from steering patients toward cheaper drugs, and did not intend to require plans to cover all medically necessary medication. Kaiser argued that this decision will allow health plans to maintain affordability of drug coverage by excluding "relatively low health benefit items" from their coverage.
Karen L. v. Physicians Health Services, Inc.	Conn. Dist. Ct. No. 3:99 CV 2244 (7/5/01)	A federal court in Connecticut reportedly certified a class action lawsuit against a Medicaid HMO. Plaintiffs claim that the HMO allegedly did not provide proper notice to its members of coverage claims denied by the HMO.
Kennedy v. United Healthcare of Ohio Inc.	(03/14/02) S.D. Ohio No. C-2-98-0128	The U.S. District Court for the Southern District of Ohio certified a class action filed by subscribers of United Healthcare of Ohio Inc. health maintenance organizations. The class challenges United Healthcare's undisclosed practice of obtaining discounts from providers and basing copayments on providers' actual charges, rather than the discounted rates, resulting in

		subscribers' effectively paying more than the 20 percent copayment required under the health plan. Two other federal courts have recently considered this practice and one ruled the practice violated the Employee Retirement Income Security Act, while the other dismissed the action. *See Corsini v. United Healthcare Services Inc. (05/31/01, D. R.I.); Lefler v. United Healthcare of Utah (10/18/01, D. Utah)*.
Kentucky Association of Health Plans Inc. v. Miller	(06/28/2002) U.S. Supreme Court No. 00-1471 http://supreme.lp.findlaw.com/supreme_court/docket/2002/january.html#00-1471	The Supreme Court granted certiorari to decide whether ERISA preempts state "any willing provider" (AWP) laws, or whether they are laws regulating insurance. Specifically, the Sixth Circuit decision that, although AWP laws "relate to" ERISA health benefit plans, they are "saved" from ERISA preemption because they regulate insurance, will be reviewed. The issue of ERISA preemption of AWP laws, which prohibit health benefit plans from excluding providers within designated geographic boundaries who are willing to abide by the plan's terms, has produced division in the courts. The Bush administration supports the Sixth Circuit's decision, but insurers argue that lack of preemption will increase health costs by decreasing their ability to regulate the quality of care provided. Oral arguments are set for January 15, 2003.
Lakeland Anesthesia Inc. v. Aetna U.S. Healthcare	(07/02/2002) La. Dist. Ct. No. 2000-3426	Louisiana Medical Center joined a Louisiana class action suit. This suit charges that health plans in the state intentionally hampered the payment of lawful reimbursements to physicians by employing practices designed to "deny, delay, and/or diminish" reimbursements to physicians.
Landa v. Humana Medical Plan, Inc.; Cutler v. Humana Medical Plan, Inc	Fla. Cir. Ct. Case Nos. 00-000813-09 and 00-000814-11 (Filed 1/18/00)	Lawsuits filed by Florida physicians allege that Humana reduced the amount reimbursed to physicians by "downcoding" physician bills regardless of the level of care and treatment provided in violation of state fraud laws. Since the lawsuit was filed, Humana Inc. and the Florida Medical Association reached an agreement, announced on Feb. 23, 2000, on the downcoding issue following months of discussion. The agreement seeks "to ensure that physicians know how to correctly submit claims and are being reimbursed in a fair and timely manner."
Lautenbach v. Regence BlueShield	(05/30/2002) W.D. Wash. No. CV01 0412	Regence BlueShield has begun notifying its subscribers of a class action settlement that has been preliminarily approved by the court. The class action claim concerns Regence BlueShield's failure to provide timely notice to its subscribers concerning the termination of its contracts with some health care providers, specifically surgeons, orthopedists, and neurosurgeons. The court has also conditionally certified "all persons directly or indirectly affected" by the terminations as a plaintiff class.
Lazorko v. Pennsylvania Hospital	3rd Cir. Ct. of Appeals No. 98-1776 (12/26/00) http://www.ca3.uscourts.gov/opinarch/981776.txt	The Third Circuit reversed a lower court's dismissal of claims against an HMO that alleged that the HMO was directly and vicariously liable for the death of one of the HMO's members. The member's physician allegedly denied the member's request to be hospitalized after she contemplated suicide. The member later committed suicide. The lawsuit alleged that the HMO imposed financial disincentives that discouraged the member's physician from recommending treatment. In vacating the lower court's holding that ERISA preempted the claims against the HMO, the Third Circuit found that the need to hospitalize the

		member appeared to be a mixed eligibility and treatment decision. Therefore, the court held that the case was not subject to complete ERISA preemption and instructed the lower court to remand the case to state court.
Lefler v. United Healthcare of Utah, Inc.	Utah Dist. Ct. 2:95-CV-1109-S (9/27/01)	The U.S. District Court for the District of Utah dismissed a class action lawsuit brought by participants in a Utah HMO. Plaintiffs alleged that the HMO's practice of calculating the participants' copayments without taking into consideration the negotiated fees charged by the HMO's providers violated ERISA. The court held that "defendant's practice of calculating percentage co-payments from a provider's billed charges, and not from the provider's agreed contractual amount, is based upon, at least, a reasonable interpretation of the plan language and is, therefore, not arbitrary and capricious."
LeTourneau Lifelike Orthotics & Prosthetics Inc. v. Wal-Mart Stores Inc.	(07/10/2002) 5th Circuit No. 01-40995 http://www.ca5.uscourts.gov/opinions/pub/01/01-40995-cv0.htm	The Fifth Circuit held that, under ERISA, a healthcare services provider lacks standing, as an assignee of a participant in a health plan, to bring a claim for payment against the health plan when the plan contains a valid anti-assignment clause. Pamela Nichols assigned her right to seek payment from her health plan to her healthcare services provider. However, coverage for Nichols' leg prosthesis was not verified or pre-approved by the health plan, and thus the healthcare services provider assumed the risk that the health plan might deny coverage. But, Nichols' healthcare services provider was left without standing to sue for coverage because of the anti-assignment clause.
Magliulo v. Metropolitan Life Insurance Co.	S.D.N.Y. No. 01 Civ. 8599 (01/30/02)	Metropolitan Life was denied its motion to dismiss a class action when the U.S. District Court for the Southern District of New York held a participant had paid premiums in excess of those required for Medicare beneficiaries and the plaintiff had a contractual right under her plan to a reduced premium. The court held that a lower premium amounted to a "benefit." Such determination by the court then allows the plaintiff to bring an action under Section 502(a) of ERISA to recover "benefits" due the plaintiff. Additionally, the court did not reject class certification, holding that plaintiff had met her burden of showing typicality, commonality, adequate representation, and numerosity.
Maio v. Aetna Inc.	Third Circuit Ct. of Appeals Case No. 99-1854 (8/11/00) http://www.ca3.uscourts.gov/opinarch/991854.txt	The Third Circuit affirmed a lower court's dismissal of a RICO class action lawsuit brought on behalf of present and former Aetna HMO members who allegedly were induced into enrolling in Aetna's HMO by misrepresentations and omissions of material facts contained in advertising, marketing and membership materials. According to the Third Circuit, plaintiffs claimed that "despite Aetna's representations that it compensated its physicians under a system that provides them with incentives based upon the quality of care provided, Aetna's provider contracts actually offer the physicians financial incentives to withhold medical services and reduce the quality of care to HMO members." The lower court found that plaintiffs failed to allege any injury to their "business or property," an essential element of a RICO claim. In affirming the lower court, the Third Circuit held that plaintiffs "failed to allege the facts necessary to support their assertion that they paid too much for the health insurance they received from Aetna" and failed to

		allege that "they suffered medical injuries, received inadequate or inferior care, or sought but were denied necessary care as a consequence of the structure of Aetna's HMO plan . . . ."
Martin v. Partners National Health Plans of North Carolina, Inc.	Va. Dist. Ct. No. 4:01CV00005 (5/18/01)	A federal district court found that ERISA preempted malpractice and bad faith claims brought by a plaintiff against a health plan. The plaintiff alleged that the health plan acted as a medical care provider instead of a plan benefits administrator and breached the standard of care to which providers are held when the health plan denied coverage of surgery. The court viewed the health plan's denial of coverage as a routine coverage determination rather than medical advice and found that the plaintiff's complaint "related to" an employee welfare benefit plan thereby making it subject to ERISA preemption.
Massachusetts v. Chickering Claims Administrators	Mass. Superior Ct. Case No. 00-4207 (9/20/00)	The Massachusetts Attorney General announced that his office filed a lawsuit against four insurers and obtained a court order the same day that requires the insurers to reimburse an undetermined number of students for claims the insurers allegedly denied illegally. The order also requires the insurers to change their policies that resulted in the alleged illegal denial of coverage. The lawsuit alleged that the insurers violated state law "by refusing to give coverage for preexisting conditions to students who had previous health insurance coverage before signing on with these companies." According to the Attorney General, Massachusetts law requires insurance companies to provide coverage for conditions that existed at the time of enrollment if the individual had previous health insurance coverage.
McCarty v. Blais	Ind. Circuit Ct. No. 49C01-0105-MI-001111-A (6/27/01)	The Indiana Insurance Commissioner announced the filing of a lawsuit against the officers and directors of Maxicare Health Plans, the parent company of Maxicare Indiana, an Indiana HMO. Earlier this year, the court placed Maxicare Indiana in receivership. The complaint alleges that plaintiffs failed to provide funding for the statutorily required continuation of benefits following the placement of the HMO in receivership and failed to fulfill other financial and administrative responsibilities to the HMO.
Medical Society of New Jersey v. Aetna, Inc., AmeriHealth HMO, Inc., Cigna Corp., HealthNet, Inc., Oxford Health Plans Inc.	N.J. Super. Ct. Ch. Div., Nos. C63-02, C64-02, C65-02, C66-02 and C67-02 (5/8/02)	The Medical Society of New Jersey filed five separate lawsuits against Aetna, AmeriHealth, Cigna, HealthNet and Oxford Health Plans alleging that the health plans employed illegal policies and practices that deliberately delayed, denied and impeded payment to physicians who have provided care to the plans' enrollees. The alleged illegal policies and practices include: using market power to force physicians to accept the health plans' contract provisions; arbitrarily denying claims as not medically necessary without conducting proper analysis or review; failing to provide a proper explanation for denied claims; arbitrarily downcoding and bundling, or refusing to pay a modifier on claims for services; improperly staffing utilization review departments which results in delays of service to physicians, failing to pay claims timely in accordance with New Jersey law; and utilizing a claims processing system that automatically denies or reduces payment to physicians.
Medical Society of the State of New York	N.Y. Supreme Ct. No. 604081/01	The New York Medical Society announced that it filed lawsuits against six managed care organizations on behalf of its 27,000

v. Empire HealthChoice HMO Inc.	(8/15/01)	member physicians. Plaintiffs allege that defendants arbitrarily denied medically necessary care, reduced reimbursement, downcoded and bundled claims, and used computer programs that deny claims based on arbitrary guidelines.
Meredith v. MAMSI Ins. Resources Inc.	(6/4/02) 4th Circuit No. 01-2188 http://pacer.ca4.uscourts.gov/opinion.pdf/012188.U.pdf	The 4th Circuit affirmed a lower court ruling that a dental endosseous implant procedure was covered under an ERISA insured health group plan that generally excluded coverage for dental care, except for procedures that were "medically necessary in the treatment of a covered medical condition." The 4th Circuit relied on letters from the participant's doctors describing the purpose of the implants as medical and not dental or cosmetic.
Minn. Senior Fedn. v. United States	U.S. Court of Appeals – 8th Circuit No. 00-3139 2001 U.S. App. LEXI 26477 (12/13/01) http://www.ca8.uscourts.gov/opndir/01/12/003139P.pdf	The 8th Circuit affirmed a district court ruling that the Medicare+Choice payment formula does not violate Medicare members' constitutional rights to travel and to equal protection of the law. Under the Medicare+Choice program, payment amounts to managed care plans vary depending, in part, on where the member lives. In some cases, managed care plans that receive higher reimbursement, use the excess funds to provide additional benefits for members or reduce member premiums. Thus, Medicare+Choice program benefits often vary throughout the United States. Because of these geographically based benefits differences, the Minnesota Senior Federation and a Medicare+Choice enrollee challenged the payment formula on the basis that the payment formula restricted Medicare+Choice members' right to travel and equal protection of the law. On June 24, 2002, the U.S. Supreme Court denied the Federation's petition for review of the case.
Minnesota v. Blue Cross Blue Shield of Minnesota	Minn. 4th Judicial Dist. Ct. (filed 10/3/00)	The Minnesota Attorney General filed a lawsuit against Blue Cross Blue Shield of Minnesota alleging that it violated state law by engaging in a "pattern of misconduct in denying medically necessary health care treatment recommended by physicians for Minnesota children and young adults suffering from mental illness, eating disorders and chemical dependency." According to the complaint, Blue Cross Blue Shield of Minnesota shifted costs to taxpayers and/or families by telling subscribers' children to seek help through the juvenile justice system rather than receive health care treatment covered under a Blue Cross Blue Shield policy. The complaint also alleges that defendant denied or limited coverage for medically necessary treatment after mere "paper reviews" and misrepresented and omitted material facts regarding coverage. The lawsuit seeks declaratory and injunctive relief, civil penalties and restitution for injured consumers. Blue Cross and the Attorney General settled this case in August of 2001.
Montemayor v. Corporate Health Ins. Inc.	(6/24/02 – judgment vacated) U.S. Supreme Court No. 00-665	Following its' June 20th decision in *Rush Prudential HMO Inc. v. Moran*, the U.S. Supreme Court on June 24th vacated a ruling by the 5th Circuit that found that ERISA preempted a Texas statute calling for independent review of HMO decisions.
Neade v. Portes	Ill. Supreme Ct. No. 87445 (10/26/00) http://www.state.il.us/court/Opinions/Supr	The Illinois Supreme Court ruled that a patient may not bring a breach of fiduciary duty claim against a physician for the physician's failure to disclose financial incentives offered by an HMO where the patient also brings a lawsuit against the physician for medical negligence. The court held that a breach

	emeCourt/2000/October/Opinions/Html/87445.htm	of fiduciary duty claim was duplicative of a medical negligence claim and any injuries suffered by the patient as a result of care provided by the physician were sufficiently addressed by application of traditional concepts of negligence. The court, however, also held that physician financial incentive could be used as evidence at trial.
New Jersey Association of Health Plans v. Farmer	N.J. Super. Ct. No. C-59-00 (11/14/00)	A New Jersey court reportedly dismissed a lawsuit challenging the constitutionality of a law that allegedly required the state's commercial health maintenance organizations to pay assessments over the next several years to assist in the payment of the debts of two bankrupt HMOs.
New Jersey Psychological Association v. MCC Behavioral Care, Inc.	N.J. Dist. Ct. No. 96-3080 (settlement 10/24/00)	The New Jersey Psychological Association and CIGNA Behavioral Health Inc. (formerly known as MCC Behavioral Care, Inc.) settled a lawsuit that charged that the termination without cause of a group of psychologists by MCC Behavioral Care, Inc. violated New Jersey public policy. The settlement reportedly includes a financial payment to the psychologists and requires CIGNA Behavioral Health Inc. to permit the psychologists to rejoin its network.
Nyack Hospital v. Aetna U.S. Healthcare	N.Y. Supreme Ct. No. 2870/00 (8/14/01)	A group of hospitals reportedly agreed to settle their lawsuit against Aetna U.S. Healthcare that alleged breach of contract and violations of state laws requiring prompt payment of health care claims.
Oklahoma Association of Health Plans v. Oklahoma Dept. of Health	Okla. Dist. Ct. Case No. CIV-00-1160 (filed 7/3/00)	The association representing HMOs in Oklahoma has filed a lawsuit to challenge a new Oklahoma law that permits patients to sue managed care plans for injuries caused by medical treatment decisions of HMOs.
Orrill v. United Healthcare of Louisiana, Inc.	La. Dist. Ct. for Eastern District of Louisiana (New Orleans) Case No. 00-0299 (Filed 1/31/00)	A class action lawsuit was brought against United Healthcare of Louisiana, Inc. on behalf of an estimated 20,000 plan members who receive pediatric care from specialists with privileges at Children's Hospital of New Orleans. The complaint alleges that the termination of Children's Hospital from United's provider network without notice to plaintiffs was not done for the benefit of the plan and wrongfully denied plan members access to contractually promised pediatric care. According to the complaint, the remaining hospitals participating in the plan are not "equipped to provide . . . sufficient pediatric services and care" and plaintiffs' physicians do not have staff privileges at those hospitals. Plaintiffs allege that they will not be able to receive treatment from their physicians and "may be faced with the situation where in-patient hospital or other specialized pediatric services are medically necessary, but the . . . treating physician in unable to admit . . . to any hospital for treatment or care." The complaint charges that United breached its fiduciary duty under ERISA and failed to provide the benefits it contracted to provide. Plaintiffs seek an order to compel United to provide coverage of medically necessary pediatric care. On March 1, 2000, the court granted United's motion to terminate the proceedings based on the plaintiff's failure to exhaust administrative remedies.
PacifiCare of California, Inc. v. McCall	U.S. Supreme Ct. No. 01-199 (petition denied 10/9/01)	The U.S. Supreme Court decided not to review last year's ruling by the California Supreme Court that held that a Medicare enrollee may sue a HMO for damages when the HMO denies medically necessary treatment. The California court held that

		"Medicare regulations provide for administrative review of a limited class of claims . . . not including those pertaining to quality of care, marketing problems and forced disenrollment" such as plaintiffs alleged in their complaint.
Pappas v. Asbel	Pa. Supreme Ct. No. 98 E.D. Appeal Docket 1996 (4/3/01) http://www.courts.state.pa.us/opposting/supreme/out/j-158-2000mo.pdf	The Pennsylvania Supreme Court confirmed its 1998 decision which held that ERISA did not preempt state law medical negligence claims against US Healthcare Systems of Pennsylvania, Inc. Last year, the United States Supreme Court vacated the 1998 decision and remanded the case for further consideration in light of *Pegram v. Herdrich*, a case in which the United States Supreme Court determined whether treatment decisions by HMOs are fiduciary acts under ERISA. On June 24, 2002, the Supreme Court denied the HMO's petition for review.
Payton v. Aetna/U.S. Healthcare	*N.Y. Supreme Ct. No. 100440/99* (3/23/00)	The New York County Supreme Court has allowed negligence claims to proceed against a HMO in a lawsuit brought by the estate of an HMO enrollee based on allegations of unwarranted delay and confusion in processing requests for coverage. The plaintiff alleged that despite assurances by the HMO that the enrollee's coverage included substance abuse in-patient rehabilitation, the HMO would not issue a determination of medical necessity for in-patient treatment despite repeated attempts by the enrollee to obtain a decision prior to his death from an accidental drug overdose. The court also dismissed a medical malpractice claim finding that the HMO was not practicing medicine.
Pegram v. Herdrich	U.S. Supreme Ct. No. 98-1949 (decided 6/12/00) http://supct.law.cornell.edu/supct/html/98-1949.ZO.html	The Supreme Court in a closely watched case held that mixed treatment and eligibility decisions by HMO physicians are not fiduciary decisions under ERISA. The case involved allegations by a HMO enrollee that the HMO's policy to reward its physician owners for limiting medical care constituted a breach of fiduciary duty under ERISA since the policy allegedly created an incentive to make decisions in the physicians' self-interests instead of in the interests of participants in the ERISA plan. In reversing the Seventh Circuit Court of Appeals which held that the HMO was acting as an ERISA fiduciary when its physicians decided not to order certain medical tests for the enrollee, the Supreme Court held that Congress did not intend HMOs to be treated as fiduciaries when making mixed eligibility and treatment decisions. According to the Court, "the Federal Judiciary would be acting contrary to the congressional policy of allowing HMO organizations if it were to entertain an ERISA fiduciary claim portending wholesale attacks on existing HMOs solely because of their structure, untethered to claims of concrete harm." The Court also rejected the Seventh Circuit's attempt to confine fiduciary breach to cases where the sole purpose of delaying or withholding treatment was to increase the physician's financial reward. The Court found that such a breach of fiduciary claim for all practical purposes is no more than a malpractice claim and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians.
Pennsylvania Pharmacists	(03/13/02) 3rd Circuit	In a 6-5 decision, the U.S. Court of Appeals for the Third Circuit upheld a June 2000 grant of summary judgment and ruled that

Association v. Houstoun	No. 00-1898 http://www.ca3.uscourts.gov/opinarch/001898.txt	42 U.S.C. § 1396a(30)(A) was not intended to benefit providers and therefore pharmacists could not assert a claim against the Pennsylvania Department of Public Welfare (PDPW) to challenge pharmacy reimbursement rates under the Pennsylvania Medicaid program. The pharmacists contended that the PDPW violated 42 U.S.C. § 1396a(30)(A) by allowing its managed care program to set unreasonably low outpatient pharmacy benefit rates.
Pennsylvania Psychiatric Society v. Green Spring Health Services Inc.	3d Cir. No. 00-3403 (02/06/02) http://www.ca3.uscourts.gov/opinarch/003403.pdf	A federal appeals court vacated dismissal and remanded a case alleging that certain managed care organizations refused to authorize necessary psychiatric treatment thereby harming patient care provided by its psychiatrists to their patients. The appeals court disagreed with the district court that the patients' mental health problems did not significantly hinder their ability to sue the MCOs themselves. Based on their findings that the patients' fear of stigmatization and potential incapacity to pursue legal remedies, the Court of Appeals determined that the Pennsylvania Psychiatric Society had third-party standing to sue on behalf of their patients.
Peterson v. Connecticut General Life Insurance Co.	E.D. Pa. No. 00-CV-605 (11/14/00) http://www.paed.uscourts.gov/documents/opinions/00D0858P.HTM	A federal court in Pennsylvania dismissed a lawsuit that alleged that a health plan violated its fiduciary duty to plan participants under ERISA by failing to disclose all of its compensation arrangements with its physicians. The court found that the issue of whether ERISA imposes a "universally applicable, automatic duty upon HMOs" to disclose physician compensation arrangements to plan participants has not yet been directly addressed by the Third Circuit Court of Appeals. Rather, the Third Circuit cases that have addressed the fiduciary duty to disclose have only done so where a plan participant made a specific inquiry or where the fiduciary knew of the plaintiff's particular circumstances requiring disclosure. The court found that without a clear endorsement from the Third Circuit, and the potential burden a broad duty to disclose would impose on HMOs, the court would not permit the action to go forward.
Pharmaceutical Research and Manufacturers of America v. Concannon	(06/28/2002) U.S. Supreme Court No. 01-188 http://supreme.lp.findlaw.com/supreme_court/docket/2002/january.html#01-188	The Supreme Court granted certiorari to decide the constitutionality of a Maine statute that authorizes the state to negotiate rebate agreements with drug manufacturers in order to give prescription drug discounts to uninsured state residents who are not eligible for Medicaid. The statute allows for rebates at least equal to those of the Medicaid program, and denies Medicaid recipients access, without state authorization, to drugs manufactured by companies that refuse to provide discounts. The plaintiff, the pharmaceutical industry's trade association, claims that the Maine statute violates the Constitution's supremacy and commerce clauses.
Plocica v. NYLCare of Texas Inc.	Tx. Dist. Ct. Case No. 4-98CV1021-E (settled 7/18/00)	A confidential settlement was reached in a lawsuit brought under a Texas law that permits malpractice actions against HMOs under certain circumstances. Plaintiff's family brought the lawsuit after the plaintiff committed suicide following his discharge from a psychiatric hospital despite objections allegedly made by his physician. The case was set to go to trial this fall.
Potvin v. Metropolitan Life Insurance Co.	Cal. Supreme Ct. Case No.	The Supreme Court of California ruled that a "without cause" termination clause in a contract between a physician and a

	S061945 (5/8/00) http://www.courtinfo.ca.gov/opinions/archive/S061945.PDF	preferred provider organization is unenforceable to the extent it may limit an otherwise existing right to common law fair procedures. The physician filed the action following the denial of his request for a hearing after he was terminated allegedly without cause. The court found that further proceedings were necessary to determine whether Metropolitan Life Insurance Co. ("MetLife") was required to provide a hearing before removing Dr. Potvin from its preferred provider lists. The court held that an insurer's obligation to provide an opportunity to be heard for without cause terminations arises "only when the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest." The court explained that its holding did not prevent an insurer required to provide fair procedure from exercising the insurer's sound business judgment when establishing standards for removal of physicians from its provider lists. According to the court, removal must be both "substantively rational and procedurally fair." A lengthy dissenting opinion charged that the majority opinion declared that the public policy of California is that physicians are entitled to a minimum income and that a physician is entitled to a hearing if removal from an insurer's preferred provider list would reduce the physician's income below such minimum.
Primax Recoveries Inc. v. Sevilla	N.D. Ill. No. 00 C 6869 (01/11/02) http://www.ilnd.uscourts.gov/RACER2/index.html	The U.S. District Court for the Northern District of Illinois, cited *Great-West Life*, in ruling that as an assignee, Primax Recoveries, could not sue a plan participant for reimbursement under ERISA.
Pryzbowski v. U.S. HealthCare, Inc.	3d Cir. Ct. of Appeals No. 99-5920 (3/27/01) http://www.ca3.uscourts.gov/opinarch/995920.txt	The Third Circuit Court of Appeals held that ERISA preempted an HMO enrollee's state law claim that she was injured allegedly as a result of the HMO's negligence in delaying approval of care by out-of-network physicians. The court found that plaintiff's allegations related to the delay in approving benefits constituted an administrative function of the health plan.
Pybus v. Cigna HealthCare	(06/28/2002) Tex. Dist. Ct. No. 01-02980J	The court awarded $13 million in damages to the family of a nursing home patient who died after his HMO allegedly forced him out of the nursing home in order to cut costs. Cigna HMO disregarded the patient's medical condition, as well as the attending physician's recommendations. This case is the first victory for a plaintiff under Texas' patients bill of rights law entitled the Health Care Liability Act.
Riverhills Healthcare, Inc. v. Aetna U.S. Healthcare, Inc.	Ohio Common Pleas Ct. Case No. A0003249 (amended complaint filed 6/5/00)	A physician practice group in Ohio has filed a class action lawsuit against Aetna U.S. Healthcare, Inc., Humana Health Plan of Ohio, Inc. and United HealthCare of Ohio, Inc. The complaint alleges that defendants failed to pay claims promptly and pay interest on late payments and randomly downcoded in breach of their agreements with plaintiff and in violation of Ohio law. According to the complaint, a "survey completed by the Ohio State Medical Association . . . confirms that 54% of claims submitted by physicians statewide are not timely paid by the

		insurance industry within the 24 day time period mandated by state law, and only 61% are paid within 30 days of receipt."
Robarts v. Blue Cross and Blue Shield of Louisiana	La. Ct. App. No. 02-CA-10 (5/15/02) http://www.fifthcircuit.org/OPINIONS/OIP_2002/05_2002/02ca0010.pdf	A Louisiana Court of Appeals determined that a contract clause granting Blue Cross full discretionary authority to determine eligibility for benefits combined with a letter denying preauthorization which indicated that a final determination would be made after the services were rendered made a contract exclusion for breast reduction surgery ambiguous and thus covered under the plan. The court relied on the fact that if breast reduction surgery was unequivocally excluded, Blue Cross had enough information at the time the preauthorization was requested to deny the request for preauthorization. However, the court, looking to a statement in the letter denying preauthorization that a final determination would be made after the services were rendered, concluded that Blue Cross did not deny the preauthorization and this lack of denial along with Blue Cross' full discretionary authority under the contract to determine benefits, created an ambiguity which must be construed against the insurer.
Rogers v. CIGNA Healthcare of Texas, Inc.	Tex. Dist. Ct. No. GN103195 (9/28/01)	Texas physicians reportedly filed a class action lawsuit against CIGNA Healthcare of Texas, Inc. alleging that the company avoided payment of medical services rendered by physicians. The lawsuit follows the initiation of an investigation by the Attorney General of Texas into the payment practices of Texas HMOs.
Rogers v. Tufts Health Plan of New England, Inc.	N.H. Super. Ct. Docket No. 00-C-170 (filed 3/31/00)	The Insurance Commissioner of New Hampshire, in her capacity as liquidator of Tufts Health Plan of New England, Inc. ("TNE"), filed a complaint with 19 counts against TNE and its affiliated organizations and their directors based on allegations of unfair and deceptive practices. According to the complaint, certain affiliates and directors breached their fiduciary duties to TNE and misled creditors and subscribers of TNE. TNE allegedly "set premium rates at levels that caused TNE to incur substantial underwriting and operating losses" and "breached its duty of reasonable care and negligently misrepresented its financial condition, the soundness of its financial position, and its ability to perform the services" under its contracts with employer groups and subscribers. The complaint also alleges that an affiliate charged TNE fees for administrative services that were "well in excess of the reasonable value of any such services rendered." The complaint seeks damages, including treble damages for the breach of fiduciary duty claim against the directors.
Rush Prudential HMO Inc. v. Moran	(6/20/02) U.S. Supreme Court No. 00-1201 http://supct.law.cornell.edu/supct/html/00-1021.ZO.html	In a 5-4 decision, the U.S. Supreme court held that the Illinois HMO Act, which calls for independent medical review in certain circumstances, is not preempted by ERISA. The majority explained that while the Illinois law "clearly" relates to ERISA, the law is saved from ERISA preemption because it regulates the insurance industry. Rush Prudential had argued that HMOs' characteristics take them outside the insurance industry.
Schultze v. Humana Inc.	Tex. County Ct. No. 97-04373-G (11/16/00)	A jury reportedly awarded approximately $19 million in actual and punitive damages to a primary care physician in a lawsuit brought by the physician against a health care plan based on claims that the plan wrongly deselected him from the plan,

		interfered with his relationships with patients, and defamed him.
Sebelius v. Blue Cross and Blue Shield of Kansas Inc.	(6/11/02 – appeal filed) Kansas Ct. App. Docket no. not assigned	Kansas Insurance Commissioner Kathleen Sebelius filed an appeal to a state trial court's decision to permit a proposed takeover by Anthem, Inc. of Blue Cross and Blue Shield of Kansas, Inc. The trial court found that Sebelius did not approve the takeover because she felt that Anthem would both raise premiums on unprofitable lines of insurance and reduce the insurer's surplus – two forms of conduct that would be harmful to policyholders. The trial court concluded, however, that each form of action could not form the basis of a denial of the merger because both would be permitted by Kansas law.
Shea v. Esensten	Minn. Ct. App. No. 949878 (2/6/01) http://www.lawlibrary.state.mn.us/archive/ctappub/0102/c100366.htm	A Minnesota state court ruled that a patient failed to show a plausible link between purported physician financial incentives to discourage specialist referrals and the care provided by physicians. According to the court, the lower court did not abuse its discretion by excluding at trial, as irrelevant and prejudicial, evidence of the managed care contracts between a clinic and health insurer and evidence of a disciplinary action against a physician.
Snow v. Regence BlueShield	Wash. Dist. Ct. No. C98-1078P (3/20/01)	Class action lawsuits involving subscribers of Regence BlueShield were reportedly settled. The lawsuits alleged that subscribers were compelled to make out-of-pocket payments for treatments provided by nontraditional health care providers (including naturopaths, massage therapists, etc.) despite a state law that allegedly required insurers to cover treatment by those providers.
Somerset Orthopedic Associates, P.A. v. Horizon Blue Cross Blue Shield of New Jersey, Inc.	N.J. Superior Ct. Case No. L00051100 (filed 3/24/00)	A class action lawsuit was filed against Horizon Blue Cross Blue Shield of New Jersey, Inc. challenging defendant's alleged payment practices involving assignments of benefits from patients to providers. Plaintiffs' attorney stated "despite valid assignments of benefits, Horizon often remits payments for services provided by 'out-of-network' providers directly to patients" which makes it costly and often impractical for physicians to recover payments owed to them pursuant to valid assignments. The trial court dismissed the plaintiff's complaint and on December 4, 2001, the court held that the anti-assignment clause in Horizon's subscriber contracts is valid and enforceable to prevent assignment by subscribers of policy benefit payments to non-participating medical providers without Horizon's consent. Because such subscriber assignments are void as contrary to public policy, it affirmed the trial court's dismissal of plaintiff's complaint.
State Board of Registration for the Healing Arts v. Fallon	Mo. Supreme Ct. No. SC82841 (4/10/01) http://www.osca.state.mo.us/courts/pubopinions.nsf/ccd96539c3fb13ce8625661f004bc7da/17b93c45937c2af286256a290072fdc7?OpenDocument	The Missouri Supreme Court held that although ERISA may preempt state laws that interfere with coverage decisions, it does not prevent the state from exercising its traditional police powers to review the medical judgments of a licensed physician. According to the court, the medical judgment of the medical director of Prudential Health Care was distinct form the plan's coverage policies and his decisions did not mandate a benefits structure or alternative way for a plan beneficiary to enforce a claim. The lawsuit involved a medical licensing board's investigation of a physician's medical necessity decisions made in the physician's capacity as medical director of Prudential Health Care.

Teamsters Health & Welfare Fund of Philadelphia and Vicinity v. Bristol-Myers Squibb Co.	S.D.N.Y. Civ. No. 01-9968 (Filed 11/09/01)	In a proposed class action filed against drugmaker Bristol-Myers, Teamsters and other organizations and individuals seek to recover alleged overpayments to physicians for six Bristol-Myers cancer drugs. The complaint alleges that the company violated federal racketeering laws by artificially inflating the published average wholesale price for the drugs, while charging physicians substantially less for the same drugs, allowing the physicians to profit from the difference. The allegations are similar to the TAP Pharmaceutical lawsuit and Federal investigation.
Tennessee Medical Association v. Tennessee Coordinated Care Network	Tenn. Cir. Ct. No. 01C-3077 (filed 10/9/01)	The Tennessee Medical Associated filed a lawsuit alleging that a MCO attempted to recoup alleged overpayments made to physicians by making improper deductions from amounts the MCO owed to the physicians.
Texas v. Aetna U.S. Healthcare, Inc.	Tex. Dist. Ct. Case No. 98-13972 Assurance of Voluntary Compliance (filed 4/11/00)	The Texas Attorney General has entered into an agreement with Aetna U.S. Health, Inc. to settle a lawsuit pending in Texas state court. The lawsuit alleged that Aetna and other HMOs illegally compensated providers to limit providing care to members. According to the Attorney General, the agreement "serves as a model for all Texas health plans to follow." The introduction to the agreement states that it is "a set of principles to guide manage care plans to better serve Texas consumers and strengthen the working relationships with physicians and other health care professionals." Among Aetna's obligations under the agreement is a requirement to disclose financial arrangements with providers, provide consumers with a written list of medical services not covered, provide consumers at least 90 days written notice if a prescription drug is being dropped from coverage, and clarify and disclose how Aetna makes coverage decisions. The agreement also creates an "Office of Ombudsman" within Aetna that will act "as an independent advocate on behalf of members" and "report to the Attorney General on Aetna's ability and efforts to comply with the terms" of the agreement.
Texas v. PacifiCare of Texas	Tex. Dist. Ct. No. GV2000718 (02/11/02)	Texas Attorney General John Cornyn has filed suit against PacifiCare of Texas for violating various state laws under the Texas HMO Act and the Deceptive Trade Practices Act. The violations have allegedly resulted in millions of dollars of unpaid claims, disrupted patient care, and unresolved complaints. Cornyn seeks an injunction that would require PacifiCare to comply with the Texas HMO Act, which requires prompt payment and effective complaint procedures. In addition, he seeks actual damages, civil penalties, and full restitution to harmed providers. The suit alleges that PacifiCare has failed to appropriately monitor its "delegated networks" under contract with PacifiCare that are also required to comply with the Texas HMO Act.
The American Medical Association v. Metropolitan Life Insurance Co.	N.Y. Supreme Ct. Index No. 00105266 (filed 3/15/00)	A class action lawsuit was filed against Metropolitan Life Insurance Company and United Healthcare Corporation seeking damages for alleged breach of contract, deceptive practices, and trade libel. The action was brought by the American Medical Association and the Medical Society for the State of New York on behalf of their members who submit claims to

		defendants, a health plan subscriber on behalf of all subscribers of plans insured or administered by defendants, and a physician on behalf of all providers who have furnished services to members of defendants' health plans. The complaint alleges that subscribers of defendants had an option to pay higher premiums to gain access to physicians of their choice rather than only "in-plan" physicians. In return, defendants agreed to pay subscribers 80% of the usual, customary and reasonable charge ("UCR") for out-of-network treatments, defined as the lowest of the provider's actual charge, the provider's usual charge, and the reasonable and customary charge for the service. However, according the complaint, defendants began to use "inappropriate data to understate the UCR and then to conceal the data from subscribers and providers" resulting in lower payments by defendants to out-of-network providers. Plaintiffs claim that the patients had to pay more than they should have for treatment provided by out-of-network providers or the providers had to incur a loss. On July 31, 2001, the Court dismissed most of the claims in the lawsuit and all claims by the physicians and the AMA were dismissed.
Timmis v. Kaiser Permanente	Cal. Super. Ct. No. 833971-7 (complaint filed 12/6/00)	Health plan members and a physician filed a class action lawsuit alleging that a health plan's policy requiring members to split pills violated the California Business and Professions Code and Consumer Legal Remedies Act. The complaint alleges that the health plan forced members "to accept prescribed medication in dosages twice the amount necessary for a single dose and . . . to split the pills in half in order to obtain their prescribed dosages." The lawsuit charges that pill splitting results in "dangerous under- or over-dosages of medication." According to the complaint, the pill splitting policy increases health plan revenues because the lower dosage pills cost almost as much as larger dosage pills.
U.S. Healthcare Systems of Pennsylvania, Inc. v. Pennsylvania Hosp. Ins. Co.	U.S. Supreme Ct. Case No. 98-1836 (judgment vacated 6/19/00)	The U.S. Supreme Court vacated a judgment by the Pennsylvania Supreme Court that held that ERISA did not preempt an enrollee's claim against an HMO involving allegations of treatment delay. The Supreme Court instructed the Pennsylvania Supreme Court to consider the issue of preemption of state-law claims under ERISA in light of *Pegram v. Herdrich*, which is summarized below. In this lawsuit, the enrollee claimed that his physician and a hospital allegedly were negligent in causing a delay in transferring him to a facility equipped to treat his medical condition. The hospital filed a third party complaint against the enrollee's health plan alleging that the plan refused to authorize the transfer of the enrollee to another facility. The Pennsylvania Supreme Court held that negligence claims against an HMO are not preempted since they do not "relate to" an ERISA plan. The court also found that claims that a HMO is negligent in providing medical benefits in a dilatory manner are "intertwined with the provision of safe medical care" and that "it would be highly questionable" for the court to find preemption of the claims when the U.S. Supreme Court has stated that Congress did not intend to preempt state laws concerning the regulation of the provision of safe medical care.

Unicare Life & Health Ins. Co. v. Saiter	(06/10/02) 6th Circuit No. 00-3856	Previously, Unicare filed a lawsuit against plan participant Nichole Saiter, asserting a right to her entire $100,000 settlement under the plan's subrogation and reimbursement provisions. The United States District Court entered default judgment as to the reimbursement claim when Saiter failed to appear in court. The district court later ruled that the common law "make whole" doctrine precluded Unicare from exercising its subrogation rights. Unicare appealed, and the 6th Circuit, citing the U.S. Supreme Court's recent decision in *Great-West v. Knudson*, dismissed the appeal for lack of subject matter jurisdiction, noting that the complaint "sought only monetary payments from Saiter" and thus, because it only sought legal remedies, the claim was not "cognizable" under ERISA section 502(a)(3).
United Healthcare Insurance Co. v. Levy	Tx. Dist. Ct. Case No. 3:00-CV-569M (9/8/00)	A Texas federal court held in a closely watched case that ERISA preempted the Texas Board of Medical Examiners' (the "Board") attempted regulation, supervision and disciplining of a health plan's medical director for his determination that a member's requested services were specifically excluded from coverage under the health plan. The health plan and medical director brought the lawsuit after the Board made a determination that the requested services were covered under the plan and assessed penalties against the medical director. The court found the Board's substitution of its own judgment for the medical director's decision of whether requested services fall within the plan was "at odds with purpose for ERISA." Therefore, the court held that ERISA preempted the Board from taking action against the medical director in his capacity as a utilization review agent making a coverage determination and held that the Board could not provide an alternative enforcement mechanism to that found in ERISA.
United States ex rel. Minnesota Association of Nurse Anesthetists v. Allina Health Systems	(5/23/02) 8th Circuit No. 99-2356 http://www.ca8.uscourts.gov/opndir/02/01/992356P.pdf	The 8th Circuit refused to stay a lawsuit by Minnesota's largest HMO and dozens of anesthesiologists alleging Medicare fraud. The case will now go back to the U.S. District Court for the District of Minnesota. In 1994, nurse anesthetists sued Allina, and a number of its hospitals and anesthesiologists, alleging that they committed fraud thousands of times over a 6-year period and that they billed Medicare for work they did not perform.
United States ex rel. Peter J. Scott v. Connecticut General Life Insurance Co.	Md. Dist. Ct. Civ. Action No. AMD-97-2340 (Settlement Agreement dated 3/7/00)	The U.S. Attorney for the District of Maryland has announced that Connecticut General Life Insurance Co. ("CGLIC"), a wholly-owned subsidiary of CIGNA, has agreed to pay $8,988,500 to settle allegations that it submitted false claims to the Health Care Financing Administration ("HCFA") for costs for which CGLIC was not entitled to be reimbursed under its Medicare contracts with HCFA as a Part B Medicare carrier and durable medical equipment regional carrier. As part of the settlement, CGLIC also has entered into a comprehensive corporate integrity agreement with HCFA which requires safeguards in CGLIC's administration of its contracts with HCFA. CGLIC allegedly overbilled HCFA for paper costs incurred to print explanation of benefits and checks and charged HCFA for costs related to insurance business unrelated to its contracts with HCFA. The agreement resolves allegations

		made by HCFA and by a former CGLIC employee in a whistleblower lawsuit brought pursuant to the qui tam provisions of the False Claims Act.
Vaughters v. Blue Cross Blue Shield of Kansas City	Mo. Cir. Ct. No. 00-CV-227323 (6/4/02)	A jury awarded a $6 million verdict to a group of physicians who claimed that Blue Cross Blue Shield of Kansas City improperly diverted funds from a profit-sharing arrangement with physicians to fund a new venture in which the physicians had no stake. The physicians were participants in Prevention + Plus, an HMO-style Medicaid program in Kansas City. The jury awarded $3.09 million in punitive damages and $3 million in compensatory damages. The lawsuit claimed both that the plan failed to increase payments to doctors to reflect the program's profits and that it improperly diverted money to finance the start-up costs of a for-profit venture intended to compete with Prevention + Plus.
Walgreen Co. v. Hood	(06/24/2002) U.S. Supreme Court No. 01-1427 http://www.ca5.uscourts.gov:8081/ISYSquery/IRL4108.tmp/5/doc	The Supreme Court will not review a federal appeals court decision that Louisiana does not violate the Medicaid Act by reimbursing independent pharmacies for brand name prescription drugs at a different rate than chain pharmacies. Walgreen Co. alleged violation of Section 30(A) of Title XIX of the Social Security Act, which requires that state Medicaid plan payments be consistent with "efficiency, economy, and quality of care." Because Walgreen is not an intended beneficiary of Section 30(A), it cannot file suit under the section.
Wal-Mart Stores, Inc. v. Carpenter	(6/3/02) 4th Circuit No. 00-2348 http://pacer.ca4.uscourts.gov/opinion.pdf/002348.U.pdf	The 4th Circuit affirmed a ruling in which a district court held that defendant employer, the sponsor and administrator of a health benefits plan with a reimbursement provision, had an equitable lien on personal injury settlement proceeds received by plaintiff employee after she filed for bankruptcy. Distinguishing the U.S. Supreme Court's decision in *Great-West v. Knudson* on enforcing ERISA subrogation/reimbursement claims, the 4th Circuit said the participant here still had control of the amounts recovered through the personal injury lawsuit. The court explained: "[*Knudson*] indicated that if the plan administrator had been seeking an equitable lien on particular property in the hand of the plan beneficiaries, such a suit would sound in equity and would be authorized by [ERISA]."
Wilson v. Chestnut Hill HealthCare	Pa. Dist. Ct. Case No. 99-CV-1468 (2/10/00)	A Pennsylvania federal district court dismissed claims of breach of contract, bad faith, medical negligence and tortious interference brought by a Medicare patient against Aetna. The plaintiff alleged that Aetna instructed a hospital to discharge the plaintiff before she was medically ready for release. The court held that the plaintiff must exhaust administrative remedies before bringing the claims to court. The court distinguished the case from situations where an insurer refuses to pay for treatment. Here, the physician was solely responsible for the discharge decision which could not have been attributed to Aetna under any theory.
Wineinger v. United Healthcare Insurance Co.	Neb. Dist. Ct.Case No. 8:99CV141 (2/16/00)	A United States District Court judge has dismissed ERISA and RICO claims brought by a subscriber on behalf of herself and a class of subscribers against a HMO. The plaintiff alleged that the co-payments subscribers paid should have been based on discounted rates for health care services the HMO negotiated with providers. The plaintiff characterized amounts withheld by

		the HMO from providers as a form of discount. The HMO allegedly used this additional discount amount as a reserve to pay providers if certain criteria were met or retained these amounts if the criteria were not met. Plaintiff alleged that the subscribers did not know about these additional discounts and did not benefit from the discounts through lower co-payments. The complaint raised a breach of fiduciary duty claim and claim for benefits under ERISA, sought an accounting under ERISA, and alleged a RICO violation. The court held that the breach of fiduciary duty and accounting claims were barred because plaintiff had an adequate remedy in her claim for benefits. In addition, the court found that the breach of fiduciary duty claim only created a remedy for the plan itself and not individual members. Finally, the court dismissed plaintiff's claim that the HMO engaged in a pattern of racketeering in violation of RICO by using the mail to send plan participants misleading and fraudulent documents. Holding that the McCarran-Ferguson Act precluded application of RICO, the court found that permitting the plaintiff to proceed with her RICO claim would frustrate or supplant state insurance laws.
Z	Tex. County Ct. No. 97-04373-G (11/16/00)	A jury reportedly awarded approximately $19 million in actual and punitive damages to a primary care physician in a lawsuit brought by the physician against a health care plan based on claims that the plan wrongly deselected him from the plan, interfered with his relationships with patients, and defamed him.
Z	N.J. Super. Ct. No. C-59-00 (11/14/00)	A New Jersey court reportedly dismissed a lawsuit challenging the constitutionality of a law that allegedly required the state's commercial health maintenance organizations to pay assessments over the next several years to assist in the payment of the debts of two bankrupt HMOs.
Z	E.D. Pa. No. 00-CV-605 (11/14/00)	A federal court in Pennsylvania dismissed a lawsuit that alleged that a health plan violated its fiduciary duty to plan participants under ERISA by failing to disclose all of its compensation arrangements with its physicians. The court found that the issue of whether ERISA imposes a "universally applicable, automatic duty upon HMOs" to disclose physician compensation arrangements to plan participants has not yet been directly addressed by the Third Circuit Court of Appeals. Rather, the Third Circuit cases that have addressed the fiduciary duty to disclose have only done so where a plan participant made a specific inquiry or where the fiduciary knew of the plaintiff's particular circumstances requiring disclosure. The court found that without a clear endorsement from the Third Circuit, and the potential burden a broad duty to disclose would impose on HMOs, the court would not permit the action to go forward.
Z	Ill. Supreme Ct. No. 87445 (10/26/00)	The Illinois Supreme Court ruled that a patient may not bring a breach of fiduciary duty claim against a physician for the physician's failure to disclose financial incentives offered by an HMO where the patient also brings a lawsuit against the physician for medical negligence. The court held that a breach of fiduciary duty claim was duplicative of a medical negligence claim and any injuries suffered by the patient as a result of care provided by the physician were sufficiently addressed by application of traditional concepts of negligence. The court,

		however, also held that physician financial incentive could be used as evidence at trial.
Zamora-Quezada v. Health Texas Medical Group of San Antonio	Tex. Dist. Ct. No. SA-97-CA-726-FB (11/22/00)	Humana Inc., PacifiCare Health Systems, Inc., and a medical clinic reportedly settled claims alleging that they denied medially appropriate care to treat disabilities in violation of the Americans with Disabilities Act. The settlement was reached while a jury trial was pending.
Zhou v. Guardian Life Insurance Co. of America	(07/01/2002) 7th Circuit No. 02-1074	The Seventh Circuit affirmed a district court's decision to dismiss a chiropractor's claim under ERISA because he failed to exhaust administrative remedies. Arlene Baker assigned her right to receive payment from Guardian Life Insurance Co. of America, the administrator of her ERISA-governed health care plan, to her chiropractor. Guardian denied payment for some of Baker's treatments. Baker's chiropractor appealed and requested information regarding his patient's file. The insurance company refused the request, upheld its decision, and the chiropractor sued Guardian in U.S. district court instead of pursuing further appellate options with Guardian. The Seventh Circuit rejected the chiropractor's argument that any further appeals would be futile.