THOMSON, RHODES & COWIE, P.C. MANAGED CARE LAW UPDATE

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PENNSYLVANIA FEDERAL COURTS

Eastern District Refuses to Dismiss Reimbursement Lawsuit filed against Independence Blue Cross. The U.S. District Court for the Eastern District of Pennsylvania recently ruled that Children's Hospital of Philadelphia (CHOP) is not barred from pursuing its federal court action against Independence Blue Cross (IBC). CHOP seeks to recover full charges for hospital services provided to IBC members following the expiration of the contract between CHOP and IBC in June of 1999. IBC moved to dismiss the lawsuit on the grounds that the contract was not terminated in accordance with state law notice provisions and, accordingly, the rates in the contract were still in effect for services provided to IBC members. The Court rejected IBC's argument and ruled that the requirements for termination of a provider contract under state law do not apply where the contract expires on its own terms. ***Children's Hospital of Philadelphia v. Independence Blue Cross****, E.D. Pa., No. 99-CV5532, 3-22-00.*

Eastern District Rejects ERISA Preemption Argument. An employee health plan participant filed a medical malpractice action in state court against Aetna Health Plans, a physician and a drug manufacturer following an adverse reaction to a drug prescribed by a participating physician. Aetna removed the action to federal court on the basis that the action was governed by the Employee Retirement Income Security Act (ERISA). After reviewing the allegations of the complaint, the federal district court remanded the case back to state court finding that the plaintiff has challenged the quality of medical care and was not seeking to recover benefits. The court held that plaintiff's claim that Aetna's restrictions with regard to referrals to specialists and in the drugs it would pay for implicated to quality of care and hence were not preempted by ERISA. ***Morton v. Mylan Pharmaceuticals****, E.D. Pa., No. 99-4896, 3-22-00.*

OTHER JURISDICTIONS

Texas and Aetna Settle Claims of Improper Financial Incentives. On April 11, 2000, The Texas Attorney General's office announced the settlement of an action filed by the AG's office arising from claims of improper financial incentives to participating physicians. The agreement does not impose any fines and Aetna does not admit to any wrongdoing. The settlement document includes limits on the manner in which Aetna may offer financial incentives to participating physicians, requires the appointment of a consumer ombudsman, access to experimental therapies for life-threatening illnesses, notice prior to the discontinuation of a previously covered drug and waiver of federal preemption challenges to the AG's authority to enforce the settlement. Commentators believe that the settlement may be used as a template for future settlements in actions against health care insurers. The settlement agreement is available online at http://www.oag.state.tx.us/newspubs/releases/2000/20000411aetna.htm

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PENNSYLVANIA AGENCY ACTIONS

DPW Announces Plan to Reprocure Services for HealthChoices-SouthEast. On April 22, DPW published a notice in the *Pennsylvania Bulletin* announcing the pending release of a draft RFP for the reprocurement of physical health managed care plans for the HealthChoices Program in Southeast Pennsylvania. HealthChoices is the State's mandatory managed care program for MA consumers that was first introduced in the Southeastern Zone (Bucks, Chester, Delaware, Montgomery and Philadelphia counties) in late 1996. HealthChoices was implemented in the Southwestern Zone (Allegheny, Lawrence, Beaver, Butler, Armstrong, Indiana, Westmoreland, Fayette, Greene and Washington) in January of 1999. Currently, DPW contracts with four health plans in the Southeastern Zone and three plans in the Southwestern Zone.. Copies of the RFP may be requested from DPW by e-mail addressed to draftRFP@dpw.state.pa.us Written comments may be sent to this address until May 22, 2000.

SURVEYS AND REPORTS

Survey Reveals Physician Manipulation of Data Reported to HMOs. The April 22, 2000 issue of The *Journal of American Medical Association* published the results of a survey by the National Opinion Research Center. In reviewing the responses of 720 physicians, the surveyors found that 39% of the responding physicians admit to at least "sometimes" manipulating or misrepresenting facts during the past 12 months to help patients secure coverage for care. The survey asked physicians whether they ever used one of the following three tactics: 1) exaggerate the severity of the patient's condition; 2) change the patient's billing diagnosis; or 3) report signs or symptoms that were not present. Physicians were more likely to use one or more of the tactics if 1) the physician believed that "gaming the system" was necessary to deliver high quality care, 2) the patient asked the physician to deceive the insurer, 3) the physician felt pressured for time during patient visits, and 4) the physician's patient population is more than 25% MA. The study's authors suggested that the survey results may underrate the percentage of physicians who manipulate reimbursement rules for the benefit of their patients. The full report in JAMA is available online at http://jama.ama-assn.org/issues/v283n14/full/joc91752.html

Comparison Report on HMO Operations in PA, CT, NJ and NY. Through the collaboration of the hospital associations in PA, CT, NJ and NY, the third edition of a comparative study of 73 HMOs located in those states has been made available. The report, based on 1998 data, examines a variety of indicators including: timeliness of payment, managed care penetration in health care market, size of health plans, HMO medical loss ratios, average premiums from government programs and other statistics. The report is available for purchase at $175.00 (free to members) through the Healthcare Association of New York State at http://www.hanys.org