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VISIONARIES

The promise of prompt payment

ERIC D. KATZ
NAGEL RICE DREIFUSS & MAZIE, LLP
COUNSELLORS AT LAW
301 S.LIVINGSTON AVENUE
SUITE 201
LIVINGSTON, NEW JERSEY 07039-3991
[973] 535-3100
FAX: [973] 535-3373
EKATZ@NRDMLAW.COM

The promise of prompt payment

Attorney Eric Katz sets his sights on New Jersey health plans

David Frabotta
CONTRIBUTING EDITOR

IT'S HIGH-PROFILE, even for a lawsuit, but it might have been avoided. In April, a physician filed a class-action lawsuit against New Jersey's biggest managed care organizations: Horizon Blue Cross Blue Shield of New Jersey, CIGNA Healthcare of New Jersey, United Healthcare of New Jersey and Oxford Health Plans and Healthnet New Jersey.

The suit claims the companies failed to make prompt and timely payments and systematically violated the Consumer Fraud Act and contractual agreements.

John I. Sutter, MD, of Clifton, N.J., had been opening lines of credit to finance operations, including a mortgage on his home, to pay a growing staff as well as bank loans to make technology investments.

Dr. Sutter's cash flow slowed to a trickle because "it takes months for some of these cash-flow issues to be resolved."

After a year of certified letters and countless conversations with medical directors, Dr. Sutter sought the help of attorney Eric Katz, soon to be a partner at Nagel Rice Dreifuss & Mazie. But after another two years of attorney-assisted problem resolution, "Issues and concerns had fallen on deaf ears; that's why we've been brought to the point where we are at now," Katz says.

If a judge allows the case to go forward as a class-action, tens of thousands of New Jersey physicians would be eligible to participate.

Katz has some momentum. The country's first class-action designation for breach of contract was obtained October 2001 in Madison County, Ill. Dr. Timothy Kaiser v. CIGNA accuses the health plan of bundling and downcoding CPT codes to circumvent appropriate payment methodologies.

Then last month, U.S. Federal Judge Federico Moreno granted class-action status to a landmark case filed to combat alleged abuses by some of the nation's largest for-profit MCOs. The case marks the largest physician-led class certification in federal court history, known as MDL 1334.

The lawsuit identifies Aetna, United Healthcare, CIGNA, Coventry, Wellpoint, Humana Health Plan Inc., Pacificare Health Systems Inc. and Anthem Blue Cross Blue Shield as co-conspirators who have violated contracts and defrauded doctors in violation of the federal Racketeer Influenced and Corrupt Organization Act (RICO). Specifically, MDL 1334 alleges collusion in setting fee schedules; pretrial began a few weeks ago.

Eric Katz: "It's an extremely positive development for us."

"This certification is an extremely positive development for us," Katz says. "This judge has been dealing with this case for more than a year now and has made an informed decision, and it's well-reasoned if you read the opinion.

"Logic dictates that if those grievances can be filed as a class, then [ours] should be filed as a class. It's nuts and bolts with the same kind of issues; it all stems from the same type of provider agreements between the same parties, so it lends credence to our allegations even though we don't allege the collusion theory."

Q Why did you pursue this kind of healthcare litigation?

A Until a few years ago, my legal expertise had been in product liability and toxic torts.

At the same time, I had a growing number of family members and friends who were physicians. I began to gravitate to the areas that I knew by association and that seemed worthy of going into because there was work to be done and there were areas of opportunity.

Q What were some of your first impressions of the industry?

A My initial impression was that doctors are lousy businessmen. Unlike any other profession, doctors are much more concerned about their customers than they are the bottom line.

Given that they are engaged in a very noble profession, I concluded that they could use some guidance from those who care about them and care about their importance while also recognizing their shortfalls.

Q What did you discover when you began to offer physicians guidance about their businesses?

A The typical rank-and-file doctor is not doing well financially, by any stretch of the imagination, but they still put the quality of care that they give their patients above anything else. I found that they were very appreciative to have someone looking out for them in the same way that they look out for their customers.

Q In what stage is Dr. Sutter's case?

A It was originally filed in New Jersey against five managed care companies on behalf of New Jersey physicians only. Without objection, the case was broken up into five separate actions at the defendants' request. Three of the cases then were moved to federal court in Miami with CIGNA, Healthnet and United Healthcare. Subsequently, they were transferred down to the Florida case, MDL 1334.

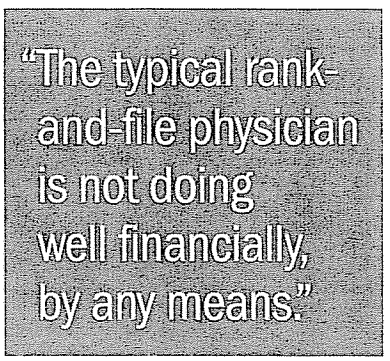
However, I have a motion pending to remand those cases back to state court, and there is no doubt in my mind that the motion will be granted because the cases never should have been removed in the first place; there were no legitimate federal grounds. They were moved, ostensibly, because there was a federal question. But in reality, those three managed care companies sought to bury these cases with the other cases that are going on in Florida.

The two remaining cases in state court are against Oxford and Horizon.

Q What drew you to this particular case?

A The reality is that insurance companies only care about their bottom lines, which directly affects the subscribers who are paying a premium for quality care. They are not getting it, but it's the doctors that are responsible.

If New Jersey people are going to get the care that they need, then doctors must be given the tools to provide that care. In this instance, the tool is proper cash flow.



Q What are the pinnacle issues alleged in the complaint?

A With each of the companies that we sued, the doctors have separate agreements with the plans. Each agreement has specific time frames in which managed care companies agree to pay claims. It will be summary judgmental, when the appropriate time comes, that a substantial number of claims are not getting paid within that time period set for the contract.

For example, Oxford promises to pay claims within 30 days. We can demonstrate that the vast number of claims are not being paid anywhere near 30 days. It's in the contract; it's black and white, so there really is no excuse for it. It's the same with the other companies that we sued. There is an indisputable failure to pay promptly.

There is also a statutory claim that we filed under New Jersey's prompt payment laws. They require the insurance companies to pay non-capitated claims that are submitted electronically within 30 days and to pay paper claims within 40 days, and in those instances where claims are not paid promptly, the insurance companies are responsible to pay 10% interest annually.

So far the state of New Jersey has audited CIGNA and Oxford, and has found hundreds of thousands of violations of prompt payment. In the case of CIGNA, the New Jersey state department of banking and insurance declared that CIGNA fails to pay statutory interest on 96% of the claims that are delinquent.

Q How have plans violated the Consumer Fraud Act as you interpret it?

A We intend to prove that the defendants induced Dr. Sutter and the other providers into accepting their arbitrary fee schedule, which prompts the doctor to be reimbursed at a lower rate to begin with. To top it off, they are not being paid in a timely manner. It's like a spiral out of control.

When plaintiffs agree to these schedules, they at least expect to get paid promptly and appropriately for their services. Contrary to this promise, the defendants are repeatedly engaging in acts of commercial deception and fraud due to misrepresentations about their claims processing and payment practices.

These doctors are the consumers, and

what they have purchased is the access to the patient bases, and the insurance companies are not fulfilling the services that they have agreed to provide.

Q Is it possible that plans intend to comply with their legal and contractual obligations but lack the administrative efficiencies?

A I haven't had the opportunity to sit down with the managed care companies to determine what sort of problems they might be having. There was sufficient notice before these laws went into effect in 1999 in New Jersey. There is nothing new here. If it is an issue of getting your ducks in a row, there was ample time to do so.

Even so, there was no negotiating in these agreements; they are presented to physicians on a take-it-or-leave-it basis. So managed care companies are breaching their own agreements. My assumption is that they would be able to abide by their own contractual terms.

Q What pragmatic changes can be expected from the exposure of this claim?

A Disputes that are adversarial are not the best means to the end you are trying to reach. I've worked closely with Dr. Sutter for two years before filing this suit, trying to address these problems without filing a lawsuit, but nothing ever materialized.

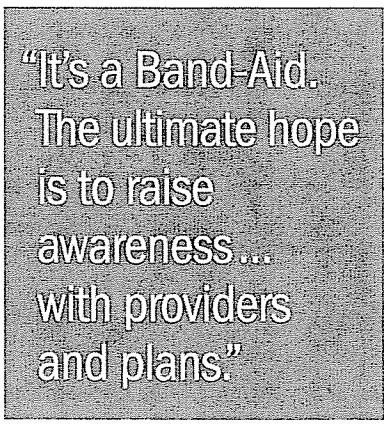
The ways in which the industry needs to work together is by actually sitting down and conferencing together. I'm not sure this proposed litigation will yield anything except a dialogue.

In New Jersey, we have companies like Horizon Blue Cross, which one day notifies its physicians that it is cutting rates 40%. That's just not good business, but many doctors must take it or leave it. There is a lot of animosity and physicians are dropping out of some plans.

If there is going to be any long-term constructive results, then people have to sit down outside of the litigation context to discuss these issues, and I'm not quite sure what that venue might look like.

Q Will the litigation itself yield change?

A No. it's a Band-Aid on a larger problem. The ultimate hope is to raise awareness of these problems with providers and plans, as well as the real and potential impact on patients.



From the patients' standpoint, it's only when physicians refuse treatment that members will see the reality of how their payer works with their provider. Until now, physicians have been incurring losses to maintain the level of care to which patients are accustomed.

Besides providing doctors with a minimally acceptable cash flow going forward, we hope to raise the awareness of the public and managed care community that there are problems to be dealt with.

Q How can plans be successful against these types of allegations?

A They are litigating zealously; they are putting forth a commendable effort.

But as an outsider, one of the things that people say to me when they hear about these cases is that the cases are going nowhere because of all the motions being filed. The reason is because the companies don't want to get to the issues on their merits. The managed care companies battle these things to the death without ever getting to the merits of the case and the root of the problems.

Q When you look at the industry as a whole, what are the most pressing legal issues going forward?

A A lot of progress can be made if plans simply would pay on time. That is the single biggest pet peeve among providers, and it has the most negative impact on their practices.

The other significant issue, which is outside the scope of this litigation, is that there needs to be a revamping of the methodologies and reimbursement on fee schedules because physicians are not being adequately compensated. Physicians have not been able to negotiate as a group because it's considered an antitrust violation. But there are new laws in New Jersey, which went into effect earlier this year, to allow doctors to collectively bargain.

They call it collective bargaining for a reason. This must be a partnership, and right now, it isn't.

Q What is most incriminating for the plans going forward?

A The most incriminating thing is not a directly actionable claim; that is, doctors must spend significant amounts of time and money just to deal with the bureaucracy of the managed care companies about claims or referrals and other administrative tasks. Doctors must designate at least one person—and most of the time several people—to administrate this, and often they are dealing with people on the other end of the phone who don't have the educational background. We have clerks making decisions about how doctors should practice medicine, and this is a huge issue.

Although this problem has nothing to do with our case or any other one out there to my knowledge, it profoundly contributes to the culture of these cases. **MHE**