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MANAGED CARE LITIGATION AND THE AFFORDABLE CARE ACT

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The managed care industry has begun gearing up for increased litigation resulting from the Patient Protection and Affordable Care Act (ACA).

Overarching litigation issues. The ACA expands the administration of health care in numerous ways, including granting more responsibility to states to administer its requirements. With the administration of state health insurance marketplaces (the "exchanges"), health plans are now more susceptible to liability under the state and federal fraud and abuse laws because of the influx in federal funding to pay or subsidize costs.

ERISA and private actions. Before the ACA, most individuals' health insurance was supplied by employers and thus subject to the Employee Retirement Security Act of 1974 (ERISA), which set forth minimum standards for health benefit plans established by employers. With the increase of individual health insurance policies being purchased at the exchanges, which policies are not subject to ERISA, the door has been opened for additional state and federal law claims, including claims by individuals and providers suing to enforce the ACA rules applicable to these individual policies.

The ACA is silent as to whether it provides the right of a private party to seek judicial relief from injuries caused by another's violation of a legal requirement. In 1975 the U.S. Supreme Court established a four-part test to determine whether Congress intended a private right of action to exist. After passage of the ACA, the Government Accountability Office determined that, under the four-part test, the quality enhancement provisions of the ACA's Section 3512 would not lead to an implied private right of action.

> ADDITIONAL REQUIREMENTS UNDER THE ACA EXPOSE INSURERS TO A GREAT DEAL OF POTENTIAL LITIGATION.

Although the ACA does not explicitly establish a private right of action, it has been held that portions of the ACA are incorporated into ERISA and are enforceable by ERISA plan participants in accordance with the terms of Section 502(a) of ERISA. Section 502(a) permits private plaintiffs to bring actions against plans to recover benefits, enforce their rights, or clarify their rights under ERISA-regulated plans. Therefore, some ACA claims may be raised by "piggybacking" on ERISA's private right of action.

Litigation regarding coverage and payment of benefits. The ACA prohibits non-grandfathered group health plans and health insurance policies in the large group market from imposing annual or lifetime dollar limits on essential health benefits (EHBs). These EHBs must include items or services in ten benefit categories. Although litigation targeting and/or involving health plans has not yet begun, there has been a significant uptick in challenges to the ACA itself, often on constitutional grounds, which discuss the EHB requirements and the contours of EHBs. On the other hand, qualified health plans (QHPs) and insurance policies sold in the individual and small group markets are required to provide EHBs in order to follow established limits on cost sharing and to meet other requirements.

The ACA requires that the EHBs be equal in scope to the benefits offered by a "typical employer plan." As such, EHBs are defined according to a state-specific benchmark plan. All policies required to provide EHBs must offer benefits that substantially equal the benefits of the benchmark plan.

Between now and 2016, states will define EHBs differently with varying degrees of benefits, some requiring more expansive benefits than others based on current state-mandated benefits, among other factors. The differences among states will likely be leveraged by potential litigants to argue what some states should include as EHBs in state-regulated health plans.

The ACA introduces considerable non-discrimination requirements. In addition to the EHB requirements, in the ACA's general provisions at Section 1557, an individual may not be excluded

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from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving federal financial assistance, on the basis of race, color, national origin, sex, age, or disability.

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) oversees and enforces Section 1557. Individuals believing to have been victims of discrimination may file a complaint with the OCR. It is expected that these complaints will be used as a mechanism to ensure and/or enforce the ACA's non-discrimination provisions.

In addition to prohibiting discrimination against individuals, the ACA prohibits discrimination against providers. Litigation against health plans from providers believing to have been victims of discrimination can arise from a number of various provisions enacted under the ACA, ranging from general prohibitions on discrimination against providers, the implementation of the exchanges and payment for out-of-network emergency services, and requirements that QHPs have providers accessible to beneficiaries.

Litigation regarding plan administration and oversight. The ACA provides enrollees both an internal and an external claims appeals process on health plans or policies that were created or purchased after March 23, 2010. Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective internal appeals process for appeals of coverage determinations and claims. Such appeals process must, at a minimum, have an internal claims appeals process; provide notice to enrollees, in a culturally and linguistically appropriate manner, of the available internal and external appeals process; and allow the enrollee to review his/her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

In June 2011 the U.S. Department of Labor, U.S. Department of the Treasury, and HHS promulgated final regulations adding additional requirements for group health plans and group health insurance issuers as well as for individual health insurance issuers. Health insurance issuers offering individual health insurance coverage must provide for only one level of internal appeal and must maintain for six years records of all claims and notices associated with the internal claims and appeals process and must make such records available for examination upon the claimant's or a state or federal oversight agency's request.

These additional requirements expose insurers to a great deal of potential litigation. Specifically, claimants will likely raise issues pertaining to notice and whether notice was properly tendered.

If, after an internal appeal, a plan still decides to deny payment, the ACA gives individuals the right to have an independent review organization decide whether to uphold or overturn the plan's decision. Group health plans and health insurance issuers offering group or individual health insurance coverage must comply with the plan's applicable state external review process, or if a state has not established an external review process, it must implement an effective external review process that meets minimum standards established by the HHS secretary. The regulations set forth 16 minimum standards for state external review processes.

Potential litigation may arise under the external review during the transition period where litigants may argue that they fell through the cracks owing to the numerous and confusing administrative requirements. Plans can also expect litigation to arise owing to the numerous procedural requirements associated with the state, federal, and private external review process. ■

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