

Medicare Enrollees in Managed Care: What Are Their Rights When They Are Wronged?

(Jeffrey Isaac Ehrlich is a certified appellate specialist and heads the appellate practice group of Shernoff Bidart & Darras LLP in Claremont, California.)

The Shernoff firm was counsel for plaintiff in *Ardary v. Aetna*, and represents the plaintiff in *Levy v. Pacificare*.)

Introduction

Millions of Americans eligible for Medicare have enrolled in "Medicare + Choice" managed-care health plans. These plans are paid a fixed monthly fee per enrollee by the federal government to provide enrollees with all their medical care. As enrollment in these plans has increased an important issue has emerged -- what are an enrollee's rights against a managed-care plan if the plan mis-manages the enrollee's care? Can an injured enrollee sue the plan under state law for consequential medical injuries caused by an improper denial of coverage? Or is the enrollee limited to the Medicare grievance and appeals system, which can force a plan to provide a service but contains no mechanism to compensate injured enrollees?

Both the federal and state appellate courts have addressed this issue in California, reaching divergent answers. *Redmond v. Pacificare* (1997) 60 Cal.App.4th 96, decided by the Sixth Appellate District, suggests that the federal statutes governing the resolution of disputes about what Medicare must pay effectively preempt all state common-law remedies against the plan. The Ninth Circuit has taken a contrary view in *Ardary v. Aetna Health Plans of Cal., Inc.* (9th Cir. 1996) 98 F.3d 496, cert. den. 520 U.S. 1251 (1997). In December 1999, the California Supreme Court entered the fray when it agreed to review the decision in *McCall v. PacifiCare of California* (1999) 87 Cal.Rptr.2d 784, a decision by Division Three of the Fourth Appellate District, which had adopted the Ninth Circuit's approach in *Ardary*. On March 15, 2000, the Court also granted review in *Levy v. Pacificare* (1999) 77 Cal.App.4th 9, decided by Division Two of the Fourth District, which had followed *Redmond*.

This dispute has not yet spread to states beyond California. While a host of federal district courts have followed *Ardary*, and none have followed *Redmond*, there are no published opinions weighing in from any state courts outside of California. The Florida Court of Appeal did, however, decline to follow *Redmond* in an action by a teaching hospital seeking reimbursement of medical education expenses against a Medicare HMO in *Shands Teaching Hosp. and Clinics, Inc. v. Humana Medical Plan, Inc.* (Fla. App. 1999) 727 So.2d 341. The Shands court held that the Medicare Act did not preempt the hospital's claims, and distinguished *Redmond* because it involved a claim by an enrollee, not a hospital.

The Split in the Case law

Under Medicare, the Secretary of the Department of Health and Human Services ("HHS") is the final arbiter of any dispute about whether a service is a covered benefit. 42 U.S.C. § 1395ff(a). The Medicare Act borrows the provisions of the Social Security Act, requiring a "final decision" by the Secretary of HHS before judicial review is available, and making limited judicial review available only in federal court. 42 U.S.C. § 405(g) and (h); 42 U.S.C. § 1395ff(b)(1)(C).

The split between the California and federal courts concerns the proper reading of the Supreme Court's 1984

decision in *Heckler v. Ringer*, 466 U.S. 602 (1984) *Ringer* involved a challenge to the Secretary's administrative determination that Medicare would not pay for a particular surgical procedure to alleviate respiratory distress, called "BCBR." The Court held that although plaintiffs sought injunctive and declaratory relief that would have nullified the Secretary's determination, their claims were "at bottom, a claim that they should be paid for their BCBR surgery." 466 U.S. at 614. Their claims therefore "arose under" the Medicare Act because their challenge to the regulations was "inextricably intertwined" with their claims for payment, and the Medicare Act provided both the standing and the substantive basis for the presentation of their claims. *Id.* at 615; 621.

The Supreme Court recently revisited some of the issues presented in *Ringer* in *Shalala v. Illinois Council on Long Term Care, Inc.*, ___ U.S. ___, 120 S.Ct. 1084 (2000). This case involved a challenge by a trade association for Illinois nursing home operators to certain Medicare-related regulations. The lawsuit alleged that the regulations violated various statutes and the Constitution. The issue before the Court was whether the federal courts had jurisdiction over the action under 28 U.S.C. § 1331 (federal question jurisdiction), or whether the suit was cognizable only under the "special review channel" provided in the Medicare Act, 42 U.S.C. §§ 1395ii; 405(g) and (h). The Court held that as in *Ringer*, the challenge to the Medicare regulations arose under the Medicare Act, and was therefore subject to its provisions for administrative and judicial review.

In *Ardary* the Ninth Circuit held that under *Ringer*, a wrongful death action by the heirs of a Medicare beneficiary did not "arise under" the Act, and was not preempted or subject to the Medicare administrative review system. The *Ardary* plaintiffs alleged that the Medicare provider had improperly refused to authorize an airlift for the decedent to a hospital that could have provided her with proper cardiac care, causing her death. 98 F.3d at 497, n. 3. The court explained that the plaintiffs' standing to bring suit was not based on the Medicare Act, since they were proceeding on state-law based tort theories. 98 F.3d at 499, 500. In addition, the court concluded that:

[T]he state law claims are not 'inextricably intertwined' with the denial of benefits. Although the *Ardary*'s concede that their wrongful death complaint is predicated on Arrowest's failure to authorize the airlift transfer, the claims are not "inextricably intertwined" because the *Ardary*s are at bottom not seeking to recover benefits." *Id.* at 500.

After concluding that plaintiffs' claims did not "arise under" the Act, the court also observed that, because the decedent's death could not be remedied by the retroactive payment of Medicare benefits, plaintiffs' wrongful death claims fell within the class of cases where administrative exhaustion was not required. 98 F.3d at 500. *Ardary*'s analysis has been widely followed by federal district courts across the country. See, e.g., *Albright v. Kaiser Permanente Med. Group*, 1999 WL 605828, *2 (N.D.Cal. 1999); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796, *3+ (E.D.La. 1999); *Plocica v. Nylcare of Texas, Inc.*, 43 F.Supp.2d 658, 663 (N.D.Tex. 1999); *Wartenberg v. Aetna U.S. Healthcare* (1998 E.D. Pa.) 2 F.Supp. 273, 279; *Berman v. Abington Radiology Associates, Inc.*, 1997 WL 534804, *3 (E.D.Pa. 1997); *Zamora-Quezada v. HealthTexas Medical Group of San Antonio*, 34 F.Supp.2d 433, 440 (W.D.Tex. 1998); and *Caputo v. U.S. Health Care Systems of Pa.*, 1998 WL 808611, *2 (E.D.Pa., 1998).

Redmond

Ardary has received a chillier reception in the California appellate courts. *Redmond v. Pacificare* (1997) 60 Cal.App.4th 96 affirmed the trial court's dismissal of all claims against a Medicare HMO for lack of jurisdiction. The Court of Appeal construed plaintiff's claims as "arising under" the Medicare Act even though the plaintiff was not actually seeking benefits.

The plaintiff in Redmond did not allege that she had suffered any physical harm as a result of the care provided by the Medicare HMO. Rather, she requested reimbursement for surgery and the HMO first turned her down but later paid the claim. She sued for loss of use of the money, emotional suffering and attorney fees. The Redmond court acknowledged that since plaintiff's claim had already been paid, she was not actually making a claim for benefits. Nevertheless, the court found that her claims were "'inextricably intertwined' with a claim that she was entitled to the reimbursement she received," and hence arose under the Medicare Act.

Likewise, in Levy, the plaintiff did not allege any physical injuries. Rather, he claimed that he was diagnosed with lung cancer and needed an operation to save his life. No surgeon in the medical group providing his care would perform the operation, and the group refused to authorize an out-of-group surgeon to perform the operation. Plaintiff then dis-enrolled in the plan and had the surgery.

The Levy court acknowledged that the Social Security Act did not provide plaintiff with the standing for his claims against the HMO, but held that, "at bottom," his claims were based on the contention that the HMO should have allowed benefits that were denied, and were thus "inextricably intertwined with the payment of benefits under the Act."

While Redmond questioned the Ninth Circuit's analysis in Ardary, it did not hold that it was wrong. Rather, it distinguished it as a "special case" that could not be remediated through the Medicare administrative process.

Redmond conflicts indirectly with an earlier decision of Division 1 of the Second Appellate District, Solorzano v. Superior Court (Family Health Plan, Inc.) (1992) 10 Cal.App.4th 1135. Solorzano held that the Medicare Act did not preempt claims based on improper marketing of health plans and permitted the plaintiffs to proceed against the plans even though the inquiry would require a court to decide whether certain benefits were wrongfully withheld.

The California Supreme Court will ultimately decide if the Redmond court construed the Medicare Act correctly. On December 1, 1999, it granted review in McCall v. Secure Horizons (S082236), and more recently agreed to review Levy v. Pacificare of California (S085550). Factually, McCall falls somewhere between Ardary and Redmond. The plaintiff in McCall alleges that the HMO's failure to provide him with timely care caused his health to deteriorate. The Court of Appeal adopted the Ardary approach, holding that the plaintiff's tort claims did not arise under the Act. The facts in Levy more closely resemble Redmond. The plaintiff in Levy required life-saving surgery, but was unable to obtain it from the HMO. He then dis-enrolled, had the surgery, which Medicare paid for. He then sued the HMO for failing to make the surgery available to him.

HHS's View

None of the cases cited above addresses the amendments to the Medicare Act contained in the Balanced Budget Act of 1997, or the rules and regulations concerning those amendments issued by the Department of Health & Human Services ("HHS"). This body of federal law sheds considerable light on the debate.

In 1997 Congress amended Medicare to include an express preemption clause which provides, inter alia, that "state standards" pertaining to "coverage determinations" for managed-care plans "are superseded by standards adopted by the Secretary. 42 U.S.C. § 1395w-26(b)(3)(B)(iii). The scope of preemption therefore turns on whether state tort actions are "state standards" concerning "coverage determinations." HHS has determined that they are not, and the interpretation of a federal statute by the federal agency charged with enforcing it is entitled to "great deference." Podolsky v. First Healthcare Corp. (1996) 50 Cal.App.4th 632,

644 n. 6 (deferring to HHS interpretation of Medicare Act).

Specifically, the HHS final interim rule adopted to implement the preemption provisions in the 1997 Medicare Amendments states that the Medicare appeals process displaces any alternate state "grievance or appeal process." California offers HMO enrollees this type of process, which allows the Department of Corporations to resolve grievances. Health & Safety Code § 1368. This appears to be the type of state procedure that Congress sought to preempt, since the HHS rule next distinguishes between this type of state procedure and state-law based judicial remedies for tort or breach of contract. The rule explains:

The specific preemption does not preempt State remedies for issues other than coverage under the Medicare contract (i.e. tort claims or contract claims under State law are not preempted). The same claim or circumstance that gave rise to a Medicare appeal may have elements that are subject to State remedies that are not superseded. 63 Fed. Reg. 34968, 35013 (June 26, 1998)

The HHS rule advances a view similar to that of the Ninth Circuit in *Ardary*, which recognized that where the plaintiff was not making a claim for benefits there is no preemption, even if the tort claims asserted might require the fact-finder to determine if benefits were improperly withheld.

It will be interesting to see what the California Supreme Court makes of the issue in *McCall*. If the Court follows the lead of *Redmond* and rejects the Ninth Circuit's approach in *Ardary*, the last word may lie with the U.S. Supreme Court, given the millions of California seniors affected by the decision.