

## NO-INJURY CLAIMS UNDER RICO THREATEN MANAGED CARE

by

Daly D.E. Temchine

The Federal Multi-District Litigation Panel assigned to the District Court for the Southern District of Florida (Judge Federico A. Moreno) the responsibility for all of the lead cases which a consortium of plaintiffs' class action lawyers brought against managed care entities (the "*Anti-MCO Cases*"). The plaintiffs in these cases utilize various legal theories to advance their claims, but two federal statutes, Racketeer Influenced and Corrupt Organizations Act (RICO) 18 U.S.C. §§ 1961-1968, and Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* (as amended), are their primary vehicles for accomplishing their goals. ERISA is important because it regulates billions of dollars in employee benefit plan assets, 29 U.S.C. § 1002(3). However, in comparison to RICO, its impact on the economy and business practices is limited as its focus is ERISA benefit plans. RICO, but for some limited exceptions, is applicable to most forms of economic, financial, and transactional conduct by individuals and enterprises. The response of the court to RICO theories advanced in the *Anti-MCO Cases*, thus has broad implications for many business enterprises. That response will have a substantial impact on the expansion of RICO liability theory.

On February 20<sup>th</sup>, 2002, Judge Moreno issued his ruling on a motion by the defendant managed care organizations ("MCO") seeking to dismiss the claims asserted in the "*Subscriber Track*" of the *Anti-MCO Cases*. *In Re Managed Care Litigation*, 185 F. Supp. 2d 1310 (S.D. Fla. 2002). Judge Moreno's ruling to allow certain RICO claims to go forward raises serious concerns.

### *The Finding of a "RICO Injury" Lacks Foundation*

The Subscriber plaintiffs do not allege that they were wrongfully denied coverage of health care benefits, nor do they assert that they received and were injured by health care services that failed to meet the applicable medical standard of care. Plaintiffs' claimed "injury" is that when they selected coverage by an MCO and agreed to pay its premium, they were not aware that the MCO had "secret" internal cost control practices, including the offering of incentives to physicians to limit the cost of care. Had they been aware of those practices and incentives, they would have paid a lower premium, as they would have understood that they would be receiving "less coverage." The remedy sought is the difference in the "value" of the coverage they paid for and thought they would receive, and the "value" of the

---

**Daly D.E. Temchine** is a partner in the Washington, D.C. office of the law firm Epstein, Becker & Green, P.C. ("EB&G"), where he heads up the Health Law Litigation Department. He has been recognized by the *National Law Journal* as a preeminent expert in the field of ERISA preemption. Before he joined EB&G, Mr. Temchine served in the Solicitor of Labor's Office as Deputy Associate Solicitor for Special Litigation and as a Senior Counsel.

“constrained” or “limited” coverage allegedly provided.

This is somewhat analogous to a securities fraud claim — specifically fraud on the market. Here, the coverage products are analogs to the securities. In a fraud on the market claim, if, for example, relevant information is omitted from, or false information included in, a prospectus, an expert’s analysis as to whether investors in the security have suffered a loss is predicated on how the *market* would have valued the security on a fully or accurately disclosed basis.

Typically, a security purchaser’s purposes are as follows: (a) wanting to sell the security promptly for a gain; (b) desiring an income stream; (c) seeking a long-term increase in value; or (d) some combination of the preceding. The expectation of value realization derives from the purchaser having a transferable interest in the security. That value generally is realizable in the investor’s sole discretion whenever they decide to sell the security.

Realization of value with respect to health care coverage, however, is contingent — i.e., the purchaser must need a covered health care service. An insured is entitled to receive — i.e. realize — the value bargained for only in that event. An insured cannot say: “I’m going to realize the value of my policy today, I think I’ll have a triple-bypass and some radiation treatments.” He must have a condition for which these are suitable and covered treatments. Unlike the typical owner of a security, an insured has no right to sell or transfer his coverage — e.g., offer to sell, to an uninsured individual with a heart condition his potential entitlement to coverage for bypass surgery. The right to coverage is not a market commodity.

The “secret” criteria that MCOs supposedly employ are inconsequential to insureds who receive all the coverage they require. For example, an MCO may have a “secret” policy that coverage of autologous bone marrow transplants must be approved by its Medical Director and a panel of oncologists. A participant may not know about this policy, but if her request for such coverage is timely granted, the policy has had no consequence. Until a participant does not receive covered care *solely because* of an MCO’s physician incentives or application of undisclosed guidelines, the participant has no claim, because no injury has arisen from these practices. In sum, under Judge Moreno’s ruling, injury is not required for a RICO claim.

### ***A Contrary Appellate Ruling on the “Value Differential” Claim***

The same “Value Differential” claim was held not to constitute a “RICO Injury” in *Maio v. Aetna, Inc.*, 221 F.3d 472 (3d Cir. 2001) (“*Maio*”), which Judge Moreno declined to follow. In *Maio*, it was alleged that Aetna “engaged in a nationwide fraudulent scheme” to induce individuals to enroll in its plans. Aetna was alleged to have falsely represented that its commitment was to maintaining and improving the quality of health care for its members, when its “real” commitment was to its fiscal and administrative needs. The “evidence” of Aetna’s concealed purpose was its use of the same cost containment practices at issue in the *Anti-MCO Cases*. *Maio*, however, held that RICO claims must be grounded upon actual benefit denials and predicated on concrete circumstances. General apprehensions that benefits *might* be wrongfully denied because of a potential for arguably improper applications of cost management measures were ruled too speculative to sustain a RICO claim. *Maio* also held that the plaintiffs could not establish a “tangible economic harm under RICO unless they allege that health care received under Aetna’s plan *actually* was compromised or diminished as a result of Aetna’s

management decisions challenged in the complaint . . . .” *Id.* at 488. (Emphasis added.)

### ***The “Unconstructed” RICO Enterprise***

An element of a RICO claim is the existence of a criminal enterprise, distinct from the defendant, through which the defendant accomplishes the unlawful acts which have injured the plaintiff. The Subscribers contended that the “enterprise” consisted of the “*network* of physicians, hospitals, pharmacies and health care professionals through which [MCOs] deliver health care to the subscribers.” *In Re Managed Care Litigation*, 185 F. Supp. 2d at 1234. Judge Moreno accepted this contention.

All the entities comprising the “enterprise” have adversarial relationships with the defendant MCOs, beginning with the process of contract negotiations between them, lobbying against each other and, of course, as litigants. Judge Moreno also found that the Subscribers had sufficiently alleged that the MCOs “operate or manage” the “enterprise” by asserting that “they participate, directly or indirectly, in the conduct of such enterprises’ affairs’ . . . .” *Id.* at 1324.

On this reasoning, a manufacturer that established a network of suppliers, and insisted that the goods purchased meet particular specifications as to measurements, material content and mode and time of delivery, could be deemed to “participate in the conduct of an enterprise” consisting of its network of suppliers. The preceding conclusion is predicated upon Judge Moreno’s finding that the complaints “support the inference that the [MCOs] have some part in directing the affairs of each [network].” That broad statement is fairly applicable to *any* purchaser–seller relationship in which the purchaser has particular needs.

For example, assume that competing manufacturers of food containers do not produce them in a five-gallon size with high impact plastic shells colored in “day-glo” orange. A supplier to the Department of Defense (“DOD”) obtains an order for one million containers in that specific color and size, and contracts with a selected network of manufacturers, all of which will have to alter some aspect of their purchasing, manufacturing, and shipping processes to comply with the detailed terms of their contracts with the supplier. Under the “some part in directing the affairs” standard utilized by Judge Moreno, the DOD supplier is at risk of being deemed to: (a) have created an “enterprise” — i.e. the network of manufacturers and, (b) be involved in directing in the “affairs of the enterprise” because of the detailed specificity of its contractual requirements.

### ***RICO Nullifies ERISA’s Remedial Structure***

Judge Moreno acknowledged the conflict inherent between his ruling that an actual injury must be pled with respect to the ERISA claims, and that the RICO claims could proceed without a claim of an actual injury. He seeks to reconcile these contrary results as follows:

Whereas RICO is intended to be read broadly to combat illegal, systematic practices . . . , ERISA strongly favors administrative resolution and the construction of a factual record prior to an action being filed in federal court.

*Id.* at 1332.

The Subscriber plaintiffs' claims involve coverage by ERISA plans specifically regulated by ERISA. The RICO ruling alters the circumstances in which ERISA plan participants may seek judicial remedies for coverage decisions, and the remedies available to them. ERISA thus is made subordinate to RICO. There is no authority for the proposition that Congress intended for RICO to be applied in a manner that nullifies the highly detailed remedial structure of ERISA. *Cf. Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). The RICO ruling thus creates a conflict with ERISA's remedial structure. Critically, the ruling forces the courts to deal with the issue of reforming managed care, which the Supreme Court noted was a legislative policy issue. *Pegram v. Herdrich*, 530 U.S. 211 (2000).

### ***RICO May Criminalize Business Practices Known to and Condoned by Regulators***

Judge Moreno's decision allows MCO cost-containment practices known to and approved by regulators to be treated as criminal conduct for purposes of plaintiffs' RICO claim. In *California Med. Ass'n. v. AETNA U.S. Healthcare of Cal., Inc.*, 114 Cal. Rptr. 2d 109 (Cal. Ct. App. 2001) the plaintiff charged the defendant MCOs with RICO violations. On December 5, 2001, the State Court of Appeals affirmed the dismissal of the Association's lawsuit, and pointed out the absurdity of the claim that managed care cost containment practices known to, and authorized by, regulatory agencies and officials, could serve as the wrongful conduct predicate for RICO claims.

### ***Conclusion***

The February 20<sup>th</sup> decision on the RICO claims in the *Anti-MCO Cases* stretches RICO's expansive reach to new and uncertain limits.

Those rulings were certified by Judge Moreno for interlocutory appellate review by the U.S. Court of Appeals for the Eleventh Circuit on March 25, 2002. The Circuit Court, however, was not obligated to review the rulings on an interlocutory basis, and rejected the application for such a review without explanation. For the immediate future, therefore, these troubling rulings will stand unexamined by a superior court.