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CLIENT ALERT

Managed Care Lawsuit Watch - November 2015

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This summary of key lawsuits affecting managed care is provided by the Health Care Group of Crowell & Moring. If you have questions or need assistance on managed care law matters, please contact Chris Flynn, Peter Roan, or any member of the Health Care Group.

Cases in this issue:

Mirza v. Ins. Adm'r of Am., Inc.
800 F.3d 129 (3rd Cir. August 26, 2015)

The U.S. Court of Appeals for the Third Circuit overturned a grant of summary judgment denying an ERISA beneficiary the right to seek judicial review because the beneficiary failed to challenge the denial within the plan-imposed deadline for civil actions.

N.G., an employee of The Challenge Printing Company of the Carolinas (Challenge Printing), received treatment for a herniated disc and assigned her benefits under Challenge Printing's ERISA plan to her treating physician, Dr. Neville Mirza. Dr. Mirza filed a claim with Insurance Administrator of America (IAA), the plan administrator. IAA repeatedly denied Dr. Mirza's claim. On August 12, 2010, IAA sent Dr. Mirza a letter stating that he had exhausted the internal review process and that he was allowed to bring a civil action under ERISA § 502(a) if he was not content with its final decision. None of the denials issued by IAA, including the August 12 letter, mentioned that Challenge Printing's plan imposed a one-year limitation for judicial review of final determinations.

Dr. Mirza retained Callagy Law to represent him in his civil action against IAA and Challenge Printing. Callagy Law also represented Spine Orthopedics Sports (Spine) in a suit against IAA and Challenge Printing. Spine retained Callagy Law to challenge a denial of benefits for the provision of anesthesia services to N.G. for the same injury for which she received treatment from Dr. Mirza. IAA claimed that one of its employees informed a member of Callagy Law of the one-year time limit imposed by the terms of Challenge Printing's plan. Callagy Law also obtained a copy of N.G.'s plan in connection with its representation of Spine.

Dr. Mirza waited until March 8, 2012, to file suit against IAA and Challenge Printing. IAA and Challenge Printing filed a motion to dismiss, which the District Court turned into a Motion for Summary Judgment and granted. In finding for the defendants, the District Court noted that the one-year time limit was reasonable, that—absent equitable tolling—the one-year time limit for filing suit had expired. Accordingly, the court determined that Dr. Mirza was not entitled to equitable tolling because he had notice of the one-year deadline; Callagy Law's knowledge of the deadline could be imputed to Dr. Mirza.

On appeal, the Third Circuit overturned the district court's ruling. The Third Circuit noted that while the ERISA statutes do not impose a time limit for bringing a civil action against a plan administrator, because "an ERISA plan is nothing more than a contract," a plan may impose a shorter time limit that what would govern a contract cause of action as long as it is reasonable. The Court found that the one-year limit imposed by Challenge Printing's plan was reasonable. The Court also noted that regulations promulgated by the Department of Labor required a plan administrator to both inform a beneficiary of adverse benefit determinations in writing, and to include in these written notifications a "description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action … following an adverse benefit determination." 29 C.F.R. § 2560.503-1(g)(1)(iv). IAA and Challenge Printing argued that the language of the regulation required an administrator to inform a beneficiary of time limits relating only to review procedures and not civil actions. The Court found this argument unpersuasive, noting that such a reading would write out the word "including" from the regulation and would encourage plan administrators to "hide the ball and obstruct access to the courts." Requiring written notification of time limits for civil actions was in line with the goals of ERISA, one of which "is to provide claimants with adequate information to ensure effective judicial review."

Additionally, the panel held that knowledge of the time limit could not be imputed on Dr. Mirza. The Circuit Court reasoned that plan administrators would have no incentive to inform beneficiaries of time limits if the administrators could simply argue that such time limits could be uncovered by scanning the voluminous plan documents.

The Third Circuit vacated the district court's judgment and remanded for further proceedings consistent with its determination.

For more information, please contact: Avi Rutschman

SE. Pennsylvania Transp. Auth. v. Gilead Sciences, Inc.
No. CIV.A. 14-6978, 2015 WL 1963588 (E.D. Pa. May 4, 2015)

The U.S. District Court for the Eastern District of Pennsylvania dismissed the amended complaint and denied class certification to the Southeastern Pennsylvania Transportation Association (SEPTA) and a putative class of patients who have either purchased or

paid for defendant Gilead Science Inc.'s (Gilead) Hepatitis C drugs at an exorbitant price, or been unable to purchase or obtain the drugs.

Gilead manufactures Sovaldi and Harvoni, two highly effective and profitable treatments for Hepatitis C. Twelve week courses cost $84,000 and $94,500 respectively, and many consumers and government programs have been priced out from purchasing them, according to the complaint. According to plaintiffs, Gilead's pricing scheme for its patented Hepatitis C drugs was unjust because the active ingredient is sold for lower prices abroad, and Gilead enters into certain exclusivity contracts to sell the drugs at discounted prices. The complaint alleged that the pricing scheme constituted a violation of Section 1557 of the Affordable Care Act, a breach of the duty of good faith and fair dealing, and unfair competition under California's Business & Professions Code Section 17200. Plaintiffs also sought class certification of patients who either purchased or paid for Gilead's Hepatitis C drugs at an exorbitant price, or been unable to purchase or obtain the drugs.

Plaintiffs argued that Gilead's pricing scheme violates Section 1557 of the Affordable Care Act, which applies pre-existing laws prohibiting discrimination based on race, color and national origin, sex, disability, and age to health programs receiving federal financial assistance. Plaintiffs claimed the pricing scheme intentionally discriminates against persons with disabilities and has a disparate impact on minorities. The Court found that while Section 1557 creates a private right of action and private remedy for alleged violations, it also imports the various different standards and burdens of proof for each of the cited federal civil rights statutes into a claim. Plaintiffs argued several theories of disability discrimination pertaining to the unfairness of how pharmaceutical companies adjust pricing. The court, however, determined that plaintiffs could not establish a discrimination claim nor support a class action claim. The court also questioned whether plaintiffs' Hepatitis C even constituted a disability, and found that it did not "substantially limit[] one or more major life activities" for the putative class. Under Title IV, the court found that plaintiffs did not make any colorable allegations that Gilead is intentionally pricing out members of any protected class on the basis of their protected status. Because a private right of action under Title VI is only available for allegations of intentional discrimination and not disparate impact, according to the court, and plaintiffs alleged neither discriminatory animus nor sufficient deliberate indifference by Gilead to state a claim, the court dismissed the claim under Section 1557 of the ACA.

Second, plaintiffs' state law claims of unjust enrichment and breach of the duty of good faith and fair dealing all failed because the court found them preempted by federal patent law. The court agreed with Gilead's argument that federal law contemplates the tradeoffs between exclusivity and access with regard to patent rights, and to the extent plaintiffs sought to use state law to challenge Gilead's exercise of its patent rights to make pricing decisions, those claims were preempted and dismissed. Furthermore, the court addressed each claim in turn and found that they were also substantively unavailing.

The district court found that while plaintiffs' policy arguments raised important issues about access and affordability of patented Hepatitis C treatments, the amended complaint did not state a facially plausible claim for relief under federal or state law. Accordingly, the court granted Gilead's Rule 12(b)(6) motion to dismiss on all counts, denied class certification, and denied a motion to intervene as moot.

Litigation on the ACA's anti-discrimination provision appears to have increased. Additionally, just last month, on September 8, 2015, the Department of Health and Human Services Office for Civil Rights (HHS-OCR) issued its proposed anti-discrimination rules applicable to both payors and providers who operate health programs that receive federal financial assistance.

For more information, please contact: Katharine Barach and Harsh P. Parikh

U.S. v. AseraCare, Inc.
No. 2:12-CV-245-KOB (N.D. Ala. Jun. 25, 2015)

The U.S. District Court for the Northern District of Alabama upheld its grant of defendant AseraCare's motion to bifurcate the trial in a False Claims Act (FCA) case into two phases: one to determine the falsity element under the FCA, and the other to resolve all other elements and claims.

The United States seeks over $200 million from AseraCare, alleging that it knowingly submitted false claims to the government for payment under Medicare for hospice care for individuals who were not terminally ill. In bifurcating the trial, the court will allow the jury first to decide whether the claims were indeed false, and then separately to hear evidence of AseraCare's knowledge of the falsity of those claims. Following the court's granting of AseraCare's motion to bifurcate the trial, the United States requested that the court reconsider, arguing that bifurcation is irregular, that it would cause confusion and duplication, and that it is unnecessary.

In upholding its decision, the court acknowledged that its grant of AseraCare's motion represented the first time the elements of an FCA case had been bifurcated at trial but rejected the United States' argument that bifurcation was therefore inappropriate. The court pointed to the uniqueness of the facts of the case, noting that it is not aware of an FCA trial involving a Medicare hospice benefit.

The United States also argued that bifurcation would result in juror confusion and in duplication of evidence, stating that "'a sizable portion' of its evidence is probative in both phases of trial," and contending that the court could not enforce bifurcation without exhaustive review of each piece of evidence. The court dismissed this argument, noting that it had addressed specific evidentiary issues in a status conference, particularly with respect to evidence of AseraCare's general corporate practices in submitting Medicare claims, and that broad evidentiary guidelines would sufficiently address the government's concerns.

Finally, the court reiterated that bifurcation would eliminate undue prejudice against AseraCare. The United States argued that it would use evidence of corporate practices to rebut AseraCare's defense that each patient was eligible for Medicare benefits because a physician had certified him or her as being terminally ill. The court rejected this argument, noting that "evidence of general practices from various locations … is not relevant to the issue of whether a particular claim is false," and added "a claim is either false or not without evidence of corporate practices related to that claim."

Although this case is unique, its impact remains uncertain. By its own terms, the court's decision limits itself to the facts at bar, stating that the unique circumstances of Medicare hospice claims gave rise to the unique bifurcation of the trial. Moreover, the outcome of bifurcation remains unclear, as the trial is ongoing. Attorneys representing defendants in FCA cases have nevertheless been optimistic that the bifurcation of this trial may signal similar outcomes in other cases.

For more information, please contact: Joe Records

Kane ex rel. United States v. Healthfirst, Inc.
No. 11 Civ. 2324(ER), 2015 WL 4619686 (S.D.N.Y. Aug. 3, 2015)

On August 3, 2015, Southern District of New York decided an issue of first impression under the False Claims Act (FCA) requirement to return identified overpayments from Medicare and Medicaid within sixty (60) days. In denying the defendants' motion to dismiss, the court provided some guidance on what it means to "identify" an overpayment and start the sixty-day clock created by the Affordable Care Act (ACA). The court's ruling suggests that, at the very least, a party with an "identified" overpayment increases its risk of incurring FCA liability the longer it takes to quantify and return the overpayment beyond the first sixty days.

The ACA requires that an overpayment must be reported and returned within sixty days of the "date on which the overpayment was identified," and any overpayment retained beyond this period is considered to be an "obligation" with the potential for FCA liability. 42 U.S.C. § 1320a-7k(d).

The alleged overpayments in Kane stemmed from a glitch in defendant Healthfirst's computer system which caused its participating providers in a network operated by Continuum Health Partners, Inc. to seek additional payment from Medicaid based on erroneous remittance advices. In 2010, New York state auditors asked Continuum about the incorrect billing, and Continuum tasked its employee Robert Kane (the relator) with determining which claims had been improperly billed to Medicaid. Four days after Kane submitted a spreadsheet containing claims with alleged erroneous overbillings, Continuum fired him. The complaint alleged that Continuum took no further action to investigate or repay the claims until June 2012 when the government issued a Civil Investigative Demand (CID).

The court focused on the meaning of "identified" in the sixty-day rule. Defendants urged the court to adopt a definition of "identified" that means "classified with certainty," whereas the government urged a definition of "identified" that would be satisfied where a person is "put on notice" that a certain claim may have been overpaid. *See Kane*, Slip Op. at 17. The court noted that both of these views raised difficulties under the statute. The government's view would require the "return" of something before it has been reduced to a specific amount, and the process for determining what is owed could frequently take more than sixty days to complete. On the other hand, the defendants' view would allow them to evade culpability by not investigating to determine what or how much is owed.

By looking at policy, legislative history, and the purpose of the FCA, the court sided with the government. It cautioned, however, that "prosecutorial discretion would counsel against the institution of [FCA] enforcement actions aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments. Such actions would be inconsistent with the spirit of the law and would be unlikely to succeed." *Id*. at 26. In particular, the court noted that FCA liability requires knowledge, and a defendant who is diligently investigating the possibility that it was overpaid is unlikely to be liable even if its investigation takes longer than sixty days. Nonetheless, this aspect of the decision calls into question what the exact purpose of the sixty day requirement was intended to be.

For now, however, perhaps the best reading of the decision is that if someone is put on notice of a potential overpayment and does nothing at all, once sixty days elapses, they are clearly at risk for FCA liability.

CMS has not issued a final rule defining what constitutes "identified"—but, CMS issued its proposed rule on February 16, 2012. The agency has also issued its final rule applicable to Medicare Part C and Part D plan sponsors on the requirement that those

plans report and return "identified" overpayments. The definition of "identified" in these regulations mirrors Judge Edgardo Ramos interpretation of "identified" with respect to 42 U.S.C. §§ 1320a–7k(d) in this case.

For more information, please contact: Diana Huang and Harsh P. Parikh

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Conn. Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP
No. 3:14-CV-1859, 2015 WL 5122269 (D. Conn. Aug. 31, 2015)

The U.S. District Court for the District of Connected granted in part and denied in part defendant surgical centers' motion to dismiss plaintiff Cigna's amended complaint. Cigna brought an action, on its own behalf and in its capacity as a claims administrator and fiduciary for all plans at issue, against seven Texas surgical centers for allegedly misrepresenting out-of-network service charges and for waiving patient responsibility payments. Cigna brought its claims pursuant to the Employee Retirement Income Security Act (ERISA), the Connecticut Unfair Trade Practices Act (CUPTA), and common law tenets of unjust enrichment, fraud, and tortious interference with contract. Cigna alleged that the surgical centers engaged in a "systematic fee-forgiving scheme" that was intended to circumvent the plan's cost-sharing obligations and thereby defraud Cigna. Specifically, Cigna alleged that the surgical centers "lured" members to out-of-network facilities by offering "less expensive" services and waiving cost-sharing obligations, but thereafter billed Cigna for the full cost of treatment at "grossly inflated charges." Cigna alleged that it made approximately $17 million in overpayments as a result of the alleged fraudulent conduct. The surgical centers moved to dismiss on the grounds that Cigna lacked standing, failed to state a cause of action, and failed to plead fraud with sufficient particularity.

First, the surgical centers argued that Cigna lacked both statutory and Article III standing. The surgical centers maintained that Cigna was not a fiduciary of the plans and therefore failed to allege statutory standing under ERISA § 502(a)(3). The court found that Cigna had statutory standing because Cigna sufficiently pled that it is a fiduciary by alleging that Cigna had discretionary authority to (i) interpret and apply terms when reviewing claims, (ii) determine whether a person is entitled to benefits, (iii) review appeals, and (iv) take action to recover improper payments. In addition, the court concluded that Cigna has a "concrete and particularized interest in paying only valid claims to ensure its members' financial interests are protected," and the alleged billing practices "personally affected Cigna." Thus, the court concluded that Cigna also had Article III standing.

Second, the surgical centers argued that Cigna failed to provide fair notice pursuant to Fed. R. Civ. P. Rule 8 by failing to identify in the amended complaint the specific plan terms at issue. The court disagreed, noting that the amended complaint provided the terms of the plans that specifically prohibited the surgical centers' conduct. The court noted that because the amended complaint alleged that all of the plans were subject to these same terms, it was "unnecessary" for Cigna to attach all three hundred and fifteen plans at issue, and that doing so might actually contradict Rule 8. Thus, the court found that the amended complaint provided fair notice of Cigna's claims and the grounds on which such claims rested.

Third, the surgical centers argued that ERISA § 502(a)(3) allows only for equitable relief, and therefore Cigna's claim for money damages was legal in nature and not proper under section 502(a)(3). The surgical centers also argued that the language in Cigna's plan did not create an equitable lien. The court noted that the amended complaint alleged that "Cigna remitted the overpayments to the surgical centers," and that Cigna sought specific funds in a specific amount ($17 million in overpayments). As such, the court concluded that Cigna's claim was equitable in nature. The court also concluded that the basis for the claim

was also equitable, given that Cigna sought to enforce an equitable lien by assignment. Accordingly, the court concluded that Cigna's amended complaint sought "appropriate equitable relief" under ERISA § 502(a)(3).

Fourth, the surgical centers argued that Cigna failed to state a claim under CUTPA because Cigna did not plausibly allege that the surgical centers engaged in any trade or commerce in Connecticut. The court agreed with the surgical centers, finding that allegations relating to "trade" or "commerce" pertained to events that occurred in Texas, not Connecticut.

Fifth, the court examined the surgical centers' argument that Cigna failed to plead fraud with particularity. The court disagreed with the surgical centers, and concluded that Cigna pled the elements of fraud—false representation, reliance, and scienter—with sufficient particularity under Rule 9(b). Specifically, the court concluded that, taken together, the allegations about the surgical centers' practice of waiving cost-share requirements and submitting charges to Cigna for the full amount of treatment sufficiently alleged false representation. The court also found that Cigna sufficiently pled reliance by alleging a process in which Cigna relied on the amount billed by the surgical centers to determine payments. The court concluded that Cigna's allegations that the surgical centers "promised its patients it would waive their cost-sharing obligations" and then billed Cigna for a grossly-inflated amount constituted "strong circumstantial evidence of conscious behavior or recklessness," and thus met the standard for pleading scienter.

Finally, the surgical centers argued that ERISA expressly preempted Cigna's fraud claim and tortious interference with contract claim because the claims "relate to" the ERISA plans and "rely on plan terms to prove the claims." The court held that Cigna's fraud claim was not preempted because it centered on whether the surgical centers intentionally misrepresented the value of services in order to induce Cigna into paying more for reimbursement; thus, the crux of the fraud claim was the surgical centers' alleged misconduct—not the terms of the ERISA plans. The court held that the tortious interference claim was expressed preempted by ERISA because Cigna could not state its claim without referring to the explicit terms of the plan.

For more information, please contact: Shannon Barnard

Cent. United Life, Inc. v. Burwell
No. CV 14-1954(RCL), 2015 WL 5316779 (D.D.C. Sept. 11, 2015)

On September 11, 2015, the federal district court for the District of Columbia granted Central United Life's Motion for Permanent Injunction, thereby preventing the Department of Health and Human Services (DHHS) from enforcing a rule that would have forced fixed indemnity plan issuers to refrain from selling policies to individual consumers who did not certify that they had "minimum essential coverage" in compliance with the Affordable Care Act (ACA). Using the well-known two-step analysis in *Chevron, U.S.A. v. Natural Resources Defense Council, Inc.*, 467 U.S.C. 837, 842 (1984), the District Court agreed that DHHS's rule exceeded the authority granted under the statute.

The Public Health Service Act of 1994 (PHSA), as amended by the Health Insurance Portability and Accountability Act of 1996, establishes "nationwide standards for health insurance plans." But fixed indemnity insurance is not generally viewed as traditional medical insurance—it is most commonly used to supplement an individual's income using fixed amounts (*e.g.*, per day or week) when he or she takes leave from employment due to illness or temporary disability. These plans may also only

cover a limited set of conditions or health care items and services. Thus, the PHSA treats "hospital indemnity or other fixed indemnity insurance" plans as excepted benefits where they are provided as "independent, noncoordinated benefits."

Over four years after the ACA's passage, DHHS issued a rule in May 2014 (the "Rule") that required fixed indemnity companies like Central United Life to obtain individuals' certification that they had minimum essential coverage compliant with the ACA's standards before such individuals could purchase a fixed indemnity insurance plan. If Central United Life decided not to comply with the rule and continue selling fixed indemnity policies without requiring the individual certification to having minimum essential coverage, it would be subject to penalties of up to $100 per day for each person insured in violation of the Rule.

Central United Life filed the Motion for Permanent Injunction to prevent DHHS from enforcing this Rule for three reasons: (1) because it exceeded the scope of DHHS's statutory authority, (2) because it was unconstitutional, and (3) was arbitrary and capricious under the Administative Proceudure Act (APA). DHHS thereafter filed a Motion to Dismiss for Lack of Jurisdiction and/or Motion for Summary Judgment.

Before reaching the merits, the Court ruled on the standing and ripeness arguments raised by both parties. In the end, Central United Life had standing to file the injunctive motion because it demonstrated an "injury in fact" caused by the defendants that the Court could redress with a favorable judgment. *See Lujan v. Defenders of Willife,* 504 U.S. 555, 560-61 (1992). Because of the Rule, Central United Life would suffer concrete harm in being barred from selling fixed indemnity insurance policies to those who did not certify to having minimum essential coverage and because it would have to incur increased costs to comply with the new rule as a whole. The Court ruled in Central United Life's favor on the ripeness issues as well because Central United Life's violation of the rule was ongoing since the certification requirements went into effect and the "prospect of the government enforcing a rule," which is an acceptable presumption for the court to accept. *See Chamber of Commerce v. FEC*, 69 F. 3d 600, 604.

The government argued that the phrase "fixed indemnity insurance" is ambiguous, as "pays a fixed amount under specified conditions" obviously contemplates yet-to-be-stated conditions, and that requiring "minimum essential coverage" simply fills the gap Congress deliberately left open. When the Court evaluated the statute under the two-step *Chevron* analysis, it found that "[t]he governments new reading of the phrase ‘fixed indemnity insurance' … has no basis in the statutory text it purports to interpret and plainly exceeds the scope of the statute." Moreover, the Court determined that minimum essential coverage was not a concept in place when the fixed indemnity insurance plans were removed from the PHSA reach; thus, HHS could not change these plans' exempted status on the basis of this new interpretation of the PHSA's statutory terms.

In granting the Permanent Injunction and denying the Motion to Dismiss, the Court also disagreed with DHHS's arguments that Central United Life was not entitled to relief from the Rule because it took too long to file the present motion and that it had "unclean hands" because it was violating the rules applicable to fixed indemnity issuers before the issuance of the new Rule. Of note, Central United Life argued that the Rule implicated the recent U.S. Supreme Court decision in *National Federation of Independent Business v.* Sebelius, 132 S. Ct. 2566 (2012) (hereafter, "*NFIB*") because it would result in the attachment of "negative legal consequences" of failing to buy insurance beyond the tax penalties authorized by the ACA. The Court disagreed because the negative consequences only would have affected those who chose to buy insurance despite not having minimum essential coverage. The *NFIB* case concerned the rights of people who were essentially being forced to participate in the health insurance marketplaces, while Central United Life's customer base actively and independently decided to participate in the market. Therefore, the Court declined to use it to invalidate the Rule.

For more information, please contact: Stephanie D. Willis

Alaska Legislative Council v. Governor Bill Walker
No. S-16059 (Alaska, Aug. 31, 2015)

On or about July 16, 2015, Alaska's Governor Bill Walker (I) provided a 45-day notice to Alaska's Legislative Budget and Audit Committee that on September 1, 2015, he would unilaterally expand Medicaid under the Affordable Care Act to Alaska residents without seeking legislative approval. After failing to reach a political compromise with the Governor, on August 24, 2015, the Legislative Council initiated a legal action seeking a temporary restraining order, followed by declaratory and injunctive relief against the Governor's proposed expansion.

On August 28, 2015, Judge Pfiffner of the Alaska Superior Court issued an oral decision denying the Council's motion for temporary restraining order and permanent injunction. In reaching his decision, Judge Pfiffner specifically noted that the court would "not be focused on the policy goals of Medicaid expansion; rather, the court will be focused on the means to the end that Governor Walker has chosen."

The court ultimately determined that the Legislative Council failed to show that it was entitled to preliminary relief under either the "balancing of hardship test," or the "probable success on the merits test." Under the first standard, the court held that there was no irreparable injury to the Legislative Council because there is no administrative cost to the state for the proposed expansion—as Judge Pfiffner noted, "federal government is picking up 100 percent of the tab" for the expansion of Medicaid in fiscal year 2016. The court also determined that the Council was unlikely to succeed on the merits. Judge Pfiffner was unconvinced by the Council's argument that the Governor's proposal violated Alaska Medicaid and appropriations statutes, and the State's constitution.

Following its defeat in trial court, the lawmakers appealed Judge Pfinner's order to the Alaska Supreme Court. On August 31, 2015, the high court granted an expedited review of the lower court's decision, but determined that the Council failed to show that the superior court erred in its legal analysis or abused its discretion in denying the Council's motion for preliminary injunction. Alaska's Supreme Court affirmed Judge Pfiffner's order to deny the lawmakers' request to enjoin Governor Walker's plan to expand Medicaid in Alaska.

Following the panel's decision, Governor Walker announced implementation of the Healthy Alaska Plan. The Governor projects that at least 21,000 Alaskans will sign up the first year of Medicaid expansion. Alaska becomes the 31st state, including the District of Columbia, to adopt Medicaid expansion under the Affordable Care Act. The Governor predicts that nearly 42,000 Alaskans will now be eligible for health coverage under the expansion.

For more information, please contact: Harsh P. Parikh

Mueller v. Wellmark, Inc.
861 N.W.2d 563 (Iowa 2015), reh'g denied (Apr. 22, 2015)

The Iowa Supreme Court affirmed a lower court grant of summary judgment finding that agreements between Wellmark and self-insuring employers and between Wellmark and out-of-state BCBS affiliates do not constitute per se violations of Iowa antitrust law. The panel concluded the arrangements are not simple horizontal conspiracies that historically qualify for per se treatment.

A group of chiropractors alleged that Wellmark engaged in per se price-fixing when it entered into agreements with self-insuring Iowa employers to make its network and claims administration available to them. In addition, the plaintiffs alleged that Wellmark engaged in per se price-fixing by participating in the national BlueCard program under which BCBS entities agree to make their in-state networks available to each other when their respective customers need out-of-state services.

Plaintiffs asserted their claims on a per se theory of liability, which is "reserved only for those agreements that are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality." *Texaco Inc. v. Dagher*, 547 U.S. 1, 5 (2006).

The court found Wellmark's arrangements with self-insured employers and out-of-state BCBS affiliates are governed by the rule of reason, not the per se rule. The arrangements are not naked price-fixing but instead akin to joint ventures. The court reasoned that self-insured employers are not entering into bare agreements to refrain from competing on price with Wellmark; they are buying claims-administration services from Wellmark, which includes Wellmark's negotiated pricing.

Focusing on feasibility and efficiency arguments, the court concluded that it would be highly impractical for the vast majority of self-insured employers to engage in the myriad individual transactions necessary if Wellmark's pricing were unavailable. Wellmark's health care provider network provides an important mechanism by which an otherwise unavailable product can be offered. Without such an arrangement "almost all employers would avoid self-insuring."

The court made similar efficiency-related observations about Wellmark's reciprocal arrangements with out-of-state BCBS licensees. Iowans insured by Wellmark occasionally need health care services outside Iowa. Rather than attempt to negotiate its own rates in all fifty states, Wellmark has a reciprocal arrangement with the BCBS affiliates in those states whereby Wellmark can utilize the other licensees' negotiated rates in their respective states, and they can use Wellmark's negotiated rates in Iowa. Wellmark is thus able to offer a fifty-state product that meets the needs of its customers while saving the expense of maintaining a network and rate structure in states where it has relatively few claims.

By stipulation, the plaintiffs limited themselves to a per se claim; thus, the Court did not address the legality of the arrangements under a rule of reason analysis.

For more information, please contact: Roma Sharma

St. Alphonsus Med. Ctr.- Nampa Inc. v. St. Luke's Health Sys., Ltd.
778 F.3d 775 (9th Cir. Feb 10, 2015)

The U.S. Court of Appeals for the Ninth Circuit affirmed a district court's judgment in favor of the Federal Trade Commission (FTC), the State of Idaho, and two local hospitals, which held that the 2012 merger of two health care providers in Nampa, Idaho violated Section 7 of the Clayton Act.

The three largest adult primary care physician (PCP) providers in the Nampa market are Saltzer, St. Luke's, and St. Alphonsus. Under a proposed merger, St. Luke's acquired the assets of Saltzer and entered into a five-year professional services agreement with Saltzer's physicians. In March 2013, the FTC and the State of Idaho filed a complaint in the district court seeking to enjoin the merger under the FTC Act, the Clayton Act, and Idaho law, alleging that the merger would have an anticompetitive effect in the adult PCP market. The district court agreed with the FTC and enjoined the merger. St. Luke's appealed.

As a preliminary issue, the Ninth Circuit noted that to address a Section 7 claim, it must determine the relevant product and geographic markets, which is defined as the "area of effective competition where buyers can turn for alternative sources of supply." The panel determined that the district court correctly found that Nampa, Idaho is the geographic market, reasoning that a hypothetical Nampa PCP monopolist could profitably impose a small but significant non-transitory increase in price on insurers.

Section 7 of the Clayton Act employs a burden-shifting framework. First, the plaintiff must establish a prima facie case that the merger is anticompetitive. The district court found that the FTC established a prima facie case because the post-merger entity's market share, ability to negotiate higher PCP reimbursement rates with insurers, and ability to charge more ancillary services at the higher hospital billing rates. The Ninth Circuit disagreed with the district court's findings regarding ancillary services, but otherwise affirmed and agreed that the Plaintiffs had established a prima facie case.

Because the FTC established its prima facie case, the burden shifted to St. Luke's to rebut the evidence as predictive of anti-competitive effects. St. Luke's rebuttal evidence focused on the procompetitive effects of the merger, particularly on the argument that the merger would allow St. Luke's to improve integrated care and risk-based reimbursement. The Ninth Circuit found that a defendant *can* rebut a prima facie case with evidence that the proposed merger will create a more efficient combined entity and thus increase competition. But the Circuit Court agreed with the district court's finding that that St. Luke's did not demonstrate that efficiencies resulting from the merger would have a positive effect on competition.

Finally, the Ninth Circuit affirmed the district court's remedy of divestiture, noting that divestiture is the most common Section 7 remedy and that it was feasible and could be effectively administered in these circumstances.

For more information, please contact: Christopher Cadena and Harsh P. Parikh

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MCLW editors: Arthur N. Lerner, William A. Helvestine, and Harsh P. Parikh

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For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Joe Records
Counsel – Washington, D.C.
Phone: +1 202.624.2709
Email: jrecords@crowell.com

Christopher Flynn
Partner – Washington, D.C.
Phone: +1 202.624.2864
Email: cflynn@crowell.com

Peter Roan
Partner – Los Angeles
Phone: +1 213.443.5571
Email: proan@crowell.com