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ACA-Driven Litigation

Cases to Watch (and What's Next)

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Agenda

The Future of the ACA

Litigation Trends

Regulatory Adjustments

Coverage Expansion Here to Stay But Cost Challenges Remain

Medicaid/Marketplace coverage continuum sets new floor:

- Public and private exchanges have bipartisan support
- Tax credits may be adjusted but will not be eliminated
- Medicaid expansions stalled, but no rollbacks (AR, KY)

Insurer competition is key benchmark, still in flux:

- National brands and state-based Blues offer traditional choices
- Opportunities for Medicaid MCOs and provider-based plans
- Medicaid/Marketplace convergence will favor multi-market insurers

Progress but no magic bullets on cost containment:

- Uninsured rate under 10% but medical trend starting to increase again
- Payment models slowly shifting away from fee-for-service
- More change in public programs than employer-based coverage

Regulatory Trends Shaping Market

Conflict over narrow networks and increased cost sharing:

- ACA incents narrow networks in multiple ways including cost control initiatives
  - Question is whether there will be consumer backlash
- ACA promotes silver plans with high cost sharing
  - Cost sharing reductions available for low income consumers
- Employer market may emulate Marketplaces through private exchanges
  - Could erode wall between individual and group coverage (Wyden-Bennett on slow path)

Balance between federal and state regulation in flux:

- Network adequacy rules are key litmus test
- Federal regulation tends to be more expansive, less flexible
- Marketplace future: Medicaid Plus or commercial market?
  - 2016 election results will shape regulatory future

Transparency/consumer choice will be a wildcard in market transformation

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Breaking News ... Perhaps

Zubik v. Burwell (colloquially, the "*Little Sisters of the Poor*" case), 136 S.Ct. 446 (2015)

- **Issue**: Whether the availability of HHS's administrative accommodation for nonprofit religious employers to comply with the ACA's contraceptive mandate eliminates either the substantial burden on religious exercise or the violation of RFRA that this Court recognized in *Burwell v. Hobby Lobby Stores, Inc*.
- **Background**: In 2014, 18 states and numerous other parties brought a Supreme Court challenge against the ACA's contraception-coverage mandate. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751, 189 (2014).
- The Supreme Court granted the challengers a partial victory in holding that the Religious Freedom Restoration Act of 1993 (RFRA) prohibited the federal government from demanding that closely held corporations provide health-insurance coverage for contraception when doing so violates the sincerely held religious beliefs of the companies' owners.
- This led the HHS to craft an administrative accommodation from the ACA's contraception coverage mandate for non-profit religious colleges, hospitals, and charities that raise faith-based objections to birth control.

Zubik v. Burwell (colloquially, the "*Little Sisters of the Poor*" case), 136 S.Ct. 446 (2015)

- **The "accommodation"**: The current "accommodation" in the ACA mandate rules requires the objecting entity to write a simple letter to the government that claims the exemption, which will be accepted at face value.
- The religious institutions are challenging, however, with the argument that anything they do that assists the government in using their own employee benefit plans as a channel for contraceptives to their employees or students is as much a violation of their faith as a mandate to supply contraceptives directly. Here, they claim, identifying the specific plan that claims the exemption, and providing contact information for that plan, is not the "least restrictive means of carrying out the mandate.
- **Status of the case**: Argument before the Supreme Court took place a week ago Wednesday, March 23, 2016.

Zubik v. Burwell (colloquially, the "*Little Sisters of the Poor*" case), 136 S.Ct. 446 (2015)

- **Ramification**: If HHS's administrative accommodation is overturned as being a substantial burden on the exercise of religious beliefs / not being the least restrictive means, it is not clear how HHS will be able to enforce the contraception mandate.

So..... Why "perhaps" breaking news?

Armstrong v. Exceptional Child Centers, Inc., 575 U.S. ___ (March 31, 2015)

- **Background**: The ACA's Medicaid expansion caused Medicaid enrollment to jump from ~56M to ~72M. A 26% increase in Medicaid enrollees (an extra ~16M Medicaid enrollees—this is projected to eventually rise further to 27M expansion enrollees) has had a large impact on the states, plans, and providers that participate in the Medicaid program.
- **Outcome**: Medicaid providers have no private right of action to challenge a state's reimbursement rates.
- **Ramifications**: If Medicaid providers and beneficiaries cannot go to federal court, the only way to enforce the equal access provision will be through HHS's administrative process. This avenue for relief may be much less effective than litigation by providers and beneficiaries.

Medicaid Network Adequacy

- **Background**: In addition to equal access requirements that states must meet with respect to their traditional fee-for-service Medicaid programs, state-contracted Medicaid managed care plans must also guarantee access and an adequate network.
- **Development**: HHS OIG Report (Access to Care: Provider Availability in Medicaid Managed Care (Dec. 2014)). OIG found that over half of the providers in Medicaid managed care products could not offer timely appointments to enrollees because the providers could not be reached at their listed location, were not accepting new Medicaid recipients, or were not participating in the Medicaid managed care product.
- **Outcome**: Regulatory action. May 2015: CMS released new proposed regulations for Medicaid and CHIP managed care carriers. Directories must be updated within 3 business days, and maintained in machine-readable format.
- **Ramifications**: In a word, litigation, primarily by enrollees, using the regulations are a legal standard predicate for civil actions.

Rejection of Providers' Challenges to Low Reimbursement
vs.
Increasingly Heightened Network Adequacy Standards

Hmmm.

Network Adequacy for Exchange Products

- **Background**: health insurance exchange products must comply with HHS guidelines, which require qualified health plans to provide a weblink to their provider directory, to be updated monthly, with the following information for each provider:
  - location
  - contact information
  - specialty
  - medical group
  - institutional affiliations
  - whether the provider is accepting new patients
- Additionally, issuers in even the state-based exchanges are subject to litigation for failing to maintain an adequate network.

- ***Felser et al v. Blue Cross of California*, Los Angeles Superior Court, No. BC 550739** (July 8, 2014). Class action alleged that Anthem Blue Cross misled "millions of enrollees" about whether their doctors and hospitals were participating in its new plans, and failed to disclose that many policies wouldn't cover care outside its approved network. The suit says that Anthem, the state's largest individual health insurer, delayed providing full information to consumers until it was too late for them to change coverage. Anthem also failed to disclose it had stopped offering any plans with out-of-network coverage in four of the state's biggest counties — Los Angeles, Orange, San Francisco and San Diego.
- ***Harrington et al v. Blue Shield of California et al*, San Francisco Superior Court, No. 14-539283.** The lawsuit accuses Blue Shield of advertising "one of the largest networks in the state" - with more than 60,000 physicians and 351 hospitals - and of failing to disclose that the networks for certain plans were substantially smaller.

False Claims Act Litigation Related to "Identified" Overpayments

- **Background**: the ACA provides that any person who has received an overpayment from the government and knowingly fails to report and return it within 60 days after the date on which it was identified has violated the False Claims Act.
- **Issue**: Any provider that takes government money is at risk. An overpayment that is knowing and improperly withheld, rather than reported and returned within 60 days, becomes an "obligation" to the federal government for purposes of the federal False Claims Act. The FCA provides civil penalties and treble damages for any person who knowingly retains an obligation owed to the federal government. Furthermore, failure to return an overpayment within the 60-day deadline can also result in liability under the Civil Monetary Penalties Law and potential exclusion from participation in the Medicare and Medicaid programs.
- **Major open issues**: An uncertain and evolving area of law is when the 60-day rule is triggered. This is because the ACA does not define what it means to "identify" a false claim. In August 2015, in *Kane v. Healthfirst Inc., et al. and United States v. Continuum Health Partners Inc., et al.*, the Southern District of NY became the first court to attempt to do so, and agreed with the government that the 60 day period begins when a "provider is put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained."

False Claims Act Litigation Related to "Identified" Overpayments (cont'd)

- Yet even the *Kane* court recognized that 60 days to investigate and repay "potential" overpayments may not be enough, cautioning that "[t]herefore, prosecutorial discretion would counsel against the institution of enforcement actions aimed at well-intentioned healthcare providers working with reasonable haste to address erroneous overpayments."
- **Ramifications**: Continued uncertainty and evolving law, heavy liability and reputational risks, and a need to respond quickly and very effectively when put on notice of even "potential" overpayments. Whistleblowers remain a concern, and 60-day period, coupled with first-to-file rules, could motivate precipitous FCA filings.

Employer/Employee Challenges

- **Background**: The ACA's employer mandate generally requires large employers to offer affordable and minimum value health coverage to their full-time employees (employees who regularly work an average at least 30 hours per week). Employers are not generally required to offer coverage to employees working less than 30 hours per week on average.
- **Development**: *Marin v. Dave & Busters, Inc.*, U.S.D.C. Southern District of NY, No. 1:15-cv-03608. Filed as a class action on behalf of roughly 10,000 current and former D&B employees, requesting reinstatement to full-time status and restoration of benefit entitlements along with payment of lost wages and benefits, including reimbursement for insurance or out-of-pocket healthcare costs.
- **Result**: The district court adopted the theory that ERISA Section 510, which prohibits employers and plan sponsors from interfering with an employee's attainment of benefits, effectively prohibits employers from reducing work hours for the purpose of avoiding the requirement to offer health coverage under the ACA.

Healthcare Privacy and Data Breaches

- **Background**: 2015 was the worst year ever for healthcare data breaches in the U.S.
- The Office of Civil Rights (OCR) under Health and Human Services to publish data breaches as reported to them and required by HIPAA.
- Per OCR, there were 253 healthcare breaches that affected 500 individuals or more with a combined loss of over 112 million records.
- The top 10 data breaches alone accounted for just over 111 million records that were lost, stolen or inappropriately disclosed.
- The top six breaches affected at least 1 million individuals–and four of the six were Blue Cross Blue Shield organizations.
- 90% of the top ten breaches were reported as a “Hacking/IT Incident.”
- **Result**: Likelihood of increased encryption in 2016 and beyond. Vigilant employee training. Heightened firewall protections at the outer barrier to the health care organization. Increased insurance limits and hence premiums.


HOLLYWOOD PRESBYTERIAN MEDICAL CENTER
EMERGENCY
Parking
Hospital
Doctor's Tower
1300 North Vermont Ave.
LOS ANGELES FIRE DEPARTMENT
27
L.A.F.D. PARAMEDIC
Designated Baby-Friendly Hospital

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CMS is balancing providing flexibility to plans to control costs with helping consumers understand their plan choices

Premiums – scrutiny and some mitigation efforts:

- Increased rate review
- Some risk adjustment modifications, more anticipated for 2018
  - March 31 risk adjustment forum
- Stricter Special Enrollment Period documentation

Network adequacy – flexibility:

- Fewer requirements than originally proposed
- FFM will use same "reasonable access" standard and states given time to adopt NAIC recommendations
- Transition requirements for those currently in treatment
- Plans can still have narrow networks

Regulatory initiatives to improve transparency for consumers

- Voluntary standardization of plan design at federal level
  - Plans retain flexibility but favored status on *Healthcare.gov*
  - Leading states taking on more active purchasing role
- Minor out-of-network rule changes focus on transparency rather than stricter standards at federal level
  - Notice is required if an in-network facility has out-of-network ancillary providers or else in-network cost sharing applies
  - Leading states intervening more with out-of-network providers
- Further improvements to *Healthcare.gov* expected for 2017 Open Enrollment
  - Quality star rating
  - Likely improved provider and formulary search and easier to use plan comparison tools – privacy issues will be key as consumer tools expand


Thank You

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Education

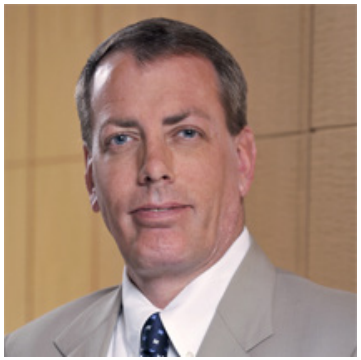
- **Harvard Law School, J.D., cum laude, 1981.**
- **Harvard Divinity School, M.Div., cum laude, 1978.**
- **Saint Olaf College, B.A., American Political Experience, 1975.**

About

Mr. Ario has 30 years of experience helping to shape and implement public policy, including two decades devoted to leading health insurance reform efforts at the state and federal government levels. He provides strategic consulting and policy analysis to assist state governments, health plans, hospitals, foundations, and other stakeholders in understanding and navigating the health reform landscape, with a particular emphasis on the role of public and private exchange-based marketplaces.

Mr. Ario previously served as Director of the Office of Health Insurance Exchanges at the U.S. Department of Health & Human Services (HHS), where he worked closely with states and other stakeholders in leading HHS efforts to develop the regulatory framework for exchanges, including the rights and responsibilities of states and the federal government in expanding coverage, overseeing the insurance marketplace, and safeguarding consumer rights.

Prior to his federal service, Mr. Ario was Pennsylvania Insurance Commissioner from 2007 to 2010 and Oregon Insurance Commissioner from 2000 to 2007. Mr. Ario served on the Executive Committee of the National Association of Insurance Commissioners (NAIC) for a decade and was an NAIC officer from 2003 to 2005.



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- **Western State University College of Law, J.D., summa cum laude, 1998.**

About

Mr. Struve's practice focuses on complex commercial litigation and unfair competition actions, with a particular expertise in healthcare, private equity, insurance and the defense of consumer suits. In the healthcare field, Mr. Struve co-chairs the Firm's Healthcare Litigation practice, and has litigated class and other representative actions, federal and state qui tam litigation, antitrust suits, RICO actions, managed care contracting suits, earnout disputes, partnership actions, bad faith claims and payment disputes, as well as conducted numerous internal investigations and compliance audits. In the managed healthcare and insurance fields, Mr. Struve has litigated numerous class actions and individual unfair business practices suits, bad faith actions, and rescission litigations. Mr. Struve also has represented clients in trials and other litigation of significant matters involving real estate, title insurance, intellectual property, false advertising, employment, misappropriation of trade secrets, product liability, professional liability, partnerships, indemnity, contribution, subrogation, and other areas of the law, and has served as regulatory counsel and governance advisor to healthcare clients.

In addition to leading litigation teams in healthcare disputes in federal and state courts across the United States, Mr. Struve also serves as national governance, regulatory and compliance counsel for a number of companies, and leads teams of firm professionals managing all aspects of clients' multidisciplinary legal functions.

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