AMA Litigation Center Open Meeting

3–5 p.m.
Sunday, Nov. 10

Northern Hemisphere A3/4
Walt Disney World Swan & Dolphin Resort

i24

THE LITIGATION CENTER OF THE AMERICAN MEDICAL ASSOCIATION AND THE STATE MEDICAL SOCIETIES

OPEN MEETING (I-24)

Sunday, November 10, 2024
3:00 – 5:00 PM Eastern Time
Northern Hemisphere A3/4
Dolphin 5th Floor
Lake Buena Vista, FL

1. Welcome and Call to Order (Jessa Barnard)

2. Scope of Meeting (Leonard Nelson)

3. Presentations

    a. *West Virginia Academy of Eye Physicians v. West Virginia Board of Optometry* (Erin Shriver, MD)

        i. Kanawha County Complaint (Exhibit A)

        ii. Presentation Slides (Exhibit B)

    b. *MultiPlan Antitrust MDL* (Leonard Nelson, Michaela Sternstein)

        i. AMA Press Release (Exhibit C)

        ii. AMA Complaint Against MultiPlan (Exhibit D)

    c. *Montana Medical Association v. Knudsen* (Leonard Nelson) (Exhibit E)

4. Interim Report (Leonard Nelson) (Exhibit F)

5. Speaker Biographies (Exhibit G)

6. Questions (Jessa Barnard)

7. Wrap-Up and Adjournment (Jessa Barnard)

IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

WEST VIRGINIA ACADEMY OF EYE PHYSICIANS & SURGEONS, INC. and WEST VIRGINIA STATE MEDICAL ASSOCIATION,

Plaintiffs,

V.

CIVIL ACTION NO. _____
JUDGE: _____

WEST VIRGINIA BOARD OF OPTOMETRY,

Defendant.

VERIFIED COMPLAINT FOR DECLARATORY JUDGMENT AND PRELIMINARY INJUNCTION

The West Virginia Academy of Eye Physicians & Surgeons, Inc. ("WVAEPS") and the West Virginia State Medical Association ("WVSMA") bring this verified complaint against the West Virginia Board of Optometry ("WVBO") pursuant to Rule 57 of the West Virginia Rules of Civil Procedure, the Uniform Declaratory Judgment Act, W.Va. Code §55-13-1 *et seq.*, seeking declaratory relief from this Court with respect to WVBO exceeding its rule-making authority and failing to adhere to statutory procedures for rule-making, thus rendering 14 C.S.R. § 14 void and null *ab initio.* WVAEPS and WVSMA also petition for a preliminary injunction staying the effectiveness and enforcement of 14 C.S.R. § 14 which expands the scope of optometry until the declaratory judgment counts are resolved.

In support of their request for relief, WVAEPS and the Association state:

THE PARTIES

1. Plaintiff West Virginia Academy of Eye Physicians & Surgeons, Inc. is a corporation formed under the laws of the State of West Virginia.

2. WVAEPS is a statewide, non-profit organization comprised of medical doctors with a mission to advocate for the best quality eye care for patients and increase public awareness regarding eye disease, prevention, early detection and treatment of the same.

3. Plaintiff West Virginia State Medical Association is a corporation formed under the laws of the State of West Virginia.

4. WVSMA is a physician-based non-profit organization with a mission to advance health and promote quality and safety in the practice of medicine in West Virginia.

5. Defendant West Virginia Board of Optometry is an agency of the State of West Virginia authorized by West Virginia Code §30-8-4 and/or other state law.

JURISDICTION AND VENUE

6. Jurisdiction is proper pursuant to West Virginia Code §55-13-1 and West Virginia Code §55-13-12.

7. Venue in this Court is proper pursuant to West Virginia Code §14-2-2.

8. WVAEPS and WVSMA provided notice to the WVBO regarding the subject matters of this Petition on July 12, 2024 via certified mail, return receipt requested, in compliance with West Virginia Code §55-17-3(a)(1).

9. A copy of this Petition shall be served on the Attorney General in compliance with West Virginia Code §55-17-3(a)(3).

FACTS

10. On July 28, 2023, WVBO filed in the State Register a proposed rule that would expand the scope of practice of optometry to include certain eyelid procedures and surgeries. *See* State Register Vol. XL, Issue 30 (July 28, 2023).

11. The Legislative Rule Making Committee considered the proposed rule at a hearing held on July 27, 2023, after which a modified proposed rule was approved on November 1, 2023 and published in the State Register on November 15, 2023. *See* State Register Vo. XL, Issue 46 (Nov. 17, 2023).

12. The modified proposed rule was included in the Committee Substitute House Bill 4110 and enacted by the West Virginia Legislature on March 9, 2024. Governor Justice approved that bill on March 27, 2024.

13. The modified proposed rule subject to this Petition was codified at 14 C.S.R. § 14 and became effective upon passage on March 9, 2024.

14. 14 C.S.R. § 14 expands the scope of the practice of optometry to include certain eyelid procedures and surgeries.

15. At no time did WVBO apply to the Joint Standing Committee on Government Organization regarding a legislative rule that would expand the scope of the practice of optometry to include certain eyelid procedures and surgeries.

16. At no time did WVBO provide to the Joint Standing Committee on Government Organization a statement signed by ten residents of West Virginia who are members of the optometry profession supporting a legislative rule that would expand the scope of the practice of optometry to include certain eyelid procedures and surgeries.

17. At no time did WVBO establish or confirm whether eyelid procedures and surgeries permitted by 14 C.S.R. § 14 are taught at 50% of all accredited optometry schools as required by West Virginia Code §30-8-6.

COUNT I (Declaratory Judgment – Exceed Rulemaking Authority)

18. All prior paragraphs are incorporated herein.

19. WVBO is authorized to propose rules for legislative approval concerning "requirements for an expanded scope of practice for those procedures that are taught at 50% of all accredited optometry schools." W.Va. Code §30-8-6.

20. WVBO proposed the rule codified at 14 C.S.R. § 14 in which certain eyelid procedures and surgeries "shall be included in the description of the practice of optometry and shall be included in the definition of an optometrist's scope of practice."

21. 14 C.S.R. § 14 expanded the scope of practice of optometry.

22. 14 C.S.R. §14 makes no findings of facts or otherwise references whether the eyelid procedures and surgeries it adds to the scope of practice are taught at 50% of all accredited optometry schools.

23. Nothing in any of the materials provided or advanced by WVBO in the rule-making process of 14 C.S.R. §14 represents or confirms whether the eyelid procedures and surgeries added to the scope of practice by 14 C.F.R. § 14 are taught at 50% of all accredited optometry schools.

24. WVBO has expanded the scope of optometry to include certain eyelid procedures and surgeries without evidence that those procedures and surgeries are taught at 50% of all accredited optometry schools.

25. In proposing the rule codified at 14 C.S.R. § 14, WVBO has exceed the authority granted to it in West Virginia Code §30-8-6.

26. 14 C.S.R. § 14 is null and void *ab initio*.

COUNT II (Declaratory Judgment – Failure to Apply)

27. All prior paragraphs are incorporated herein.

28. The process by which WVBO may propose rules that expand the scope of the practice of optometry for legislative approval is governed by West Virginia Code §30-1A-1 *et seq.*

29. A professional or occupational group or organization, like WVBO, "**shall** submit an application to the Joint Standing Committee on Government Organization" pursuant to West Virginia Code §30-1A-2 (emphasis added).

30. An application "shall contain" certain information outlined in West Virginia Code §30-1A-2(d)(1)-(8) including, but not limited to, a definition of the problem, description of why expansion of the scope of practice is necessary, explanation of why regulation is chosen over less restrictive alternatives, details of a funding mechanism, and explanation of public benefit. W.Va. Code §30-1A-2(d).

31. Additionally, the Joint Standing Committee on Government Organization can only accept an application if the applying party also submits a statement of support for the proposed legislation signed by at least ten (10) residents of West Virginia who are members of the profession or occupational group or organization for which expansion of the scope of practice is sought. W.Va. Code §30-1A-2(c).

32. A completed application is forwarded to the Performance Evaluation and Research Division of the Office of the Legislative Auditor ("PERD"), who "shall conduct an analysis and evaluation of the application" based upon specific criteria outlined in the code. W.Va. Code §30-1A-3(a)-(k).

33. PERD shall provide a report and recommendation as to whether the scope of the practice should be expanded. This report and recommendation are publicly published by PERD and the Joint Standing Committee on Government Organization. W.Va. Code §30-1A-3(b) & (k); W.Va. Code § 30-1A-4.

34. After receipt of PERD's report and recommendation, the Joint Standing Committee on Government Organization may hold public hearings to gather testimony from the public and any other interested party. W.Va. Code §30-1A-4(a). It may also issue additional findings and recommendations. W.Va. Code §30-1A-4(b).

35. Ultimately, the Joint Standing Committee on Government Organization provides its findings and recommendations, and the PERD report and recommendation, to the next regular session of the Legislature. W.Va. §30-1A-4(c).

36. The recommendations of the Joint Standing Committee on Government Organization are to be given "considerable weight" by the Legislature in determining whether a scope of practice should be expanded. W.Va. Code §30-1A-6(b); *see also* W.Va. Code §30-1A-1(a) (legislative findings).

37. WVBO did not apply to the Joint Standing Committee on Government Organization regarding the expansion of the scope of the practice of optometry found at 14 C.S.R. § 14.

38. WVBO did not apply to the Joint Standing Committee on Government Organization regarding any legislative rule that would expand the scope of the practice of optometry to include eyelid procedures and surgeries.

39. WVBO failed to adhere to West Virginia Code §30-1A-2(b).

40. WVBO did not provide the Joint Standing Committee on Government Organization with a statement signed by ten residents of West Virginia who are members of the optometry profession supporting 14 C.S.R. § 14.

41. WVBO did not provide the Joint Standing Committee on Government Organization with a statement signed by ten residents of West Virginia who are members of the optometry

profession supporting any legislative rule that would expand the scope of the practice of optometry to include eyelid procedures and surgeries.

42. WVBO failed to adhere to West Virginia Code §30-1A-2(c).

43. WVBO did not provide the Joint Standing Committee on Government Organization with the information listed in West Virginia Code §30-1A-2(d)(1)-(8).

44. WVBO failed to adhere to West Virginia Code §30-1A-2(d).

45. In failing to submit a completed application and signed statement to expand the scope of the practice of optometry to include eyelid procedures and surgeries to the Joint Standing Committee on Government Organization, WVBO prevented:

a. PERD from conducting an analysis and review of the application;

b. PERD from issuing a report and recommendation as to whether the scope of the practice should be expanded as proposed;

c. PERD and the Joint Standing Committee on Government Organization from making the former's report and recommendation publicly available;

d. The Joint Standing Committee on Government Organization from holding public hearings at which testimony may be heard;

e. The Joint Standing Committee on Government Organization from making findings of fact and recommendations as to whether the scope of the practice should be expanded as proposed;

f. The Legislature from benefitting from the report and recommendations of PERD and/or the findings of fact and recommendation of the Joint Standing Committee on Government Organization.

46. WVBO did not adhere to the statutorily mandated process outlined in West Virginia Code §30-1A-1 *et seq*. when it promulgated 14 C.F.R. § 14.

47. 14 C.S.R. § 14 therefore is null and void *ab initio*.

COUNT III (Preliminary Injunction)

48. All prior paragraphs are incorporated herein.

49. WVAEPS and WVSM seek a preliminary injunction staying the effectiveness and enforcement of 14 C.S.R. § 14 which expands the scope of optometry until this Court enters an order fully resolving Count I and Count II herein.

50. WVAEPS and WVSM have shown a reasonable probability of success on the merits as (a) the process by which 14 C.S.R § 14 became law is public record, (b) the facts regarding the legislation of 14 C.S.R. § 14 therefore cannot be disputed, (c) the provisions of West Virginia Code §30-8-6 and West Virginia Code §30-1A-1 *et seq.* are clear and unambiguous, and (d) WVBO has completely and totally failed to adhere to West Virginia Code §30-8-6 and West Virginia Code §30-1A-1 *et seq.*

51. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction as 14 C.S.R. § 14 permits individuals practicing optometry in the State of West Virginia to perform eyelid procedures and surgeries without the benefit of any of the analysis, reports, or recommendations required by West Virginia Code §30-1A-1 *et seq.*

52. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction as 14 C.S.R. § 14 permits individuals practicing optometry in the State of West Virginia to perform eyelid procedures and surgeries without the benefit of any of the protections for public health and safety enshrined in West Virginia Code §30-1A-1 *et seq.*

53. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction as the eyelid procedures and surgeries at issue are already properly encompassed in the scope of the practice of medicine and surgery. *See* W.Va. Code §3-3-4 and W.Va. Code §30-3-10.

54. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction as 14 C.S.R. § 14 creates an unnecessary overlap of the scope of the practice of medicine and surgery and the scope of the practice of optometry, which is likely to confuse patients and the public.

55. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction because 14 C.S.R. § 14 permits individuals who are not ophthalmologists, defined in West Virginia Code §30-8-3(j), to perform eyelid procedures that constitute surgery.

56. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction because it disregards and/or renders moot the additional education and licensure ophthalmologists have gained in order to legally perform eye and eyelid surgeries. *See, e.g.*, W.Va. Code §30-3-10.

57. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction as 14 C.S.R. § 14 permits individuals practicing optometry in the State of West Virginia to perform eyelid procedures and surgeries even though the licensing requirements to practice optometry do not adequately ensure training for such procedures and surgeries. *Compare* W.Va. Code §30-3-10 (requirements for medical doctor specifically addressing surgeries) *with* W.Va. Code §30-8-8 (requirement of optometry with no mention of surgery).

58. WVAEPS and WVSM will suffer irreparable injury by denial of the injunction as 14 C.S.R. § 14 permits individuals practicing optometry in the State of West Virginia to perform eyelid procedures and surgeries without any evidence that such procedures and surgeries are taught at a sufficient number of optometry schools to ensure they are conducted safely.

59. WVSMA has a mission to advance health and promote quality and safety in the practice of medicine in West Virginia and WVAEPS has a mission to advocate for the best quality eye care for patients and increase public awareness regarding eye disease, prevention, early detection and treatment of the same. WVSMA and WVAEPS will suffer irreparable injury by denial of the injunction because their missions will be frustrated, if not thwarted, by 14 C.S.R. §14.

60. The balance of equities favors WVAEPS and WVSM because WVBO knowingly exceeded its rule-making authority and circumvented the statutory requirements for rule-making, and continues to enforce 14 C.S.R. § 14 with full knowledge of these issues.

61. Granting preliminary relief is in the public interest because it protects the public from legislation that either (a) exceeds the WVBO's rule-making authority, or (b) does not adhere to WVBO's legislative or rule-making procedures.

62. Granting preliminary relief is in the public interest because it protects the public from receiving eyelid procedures pursuant to 14 C.S.R. § 14 without any of the safeguards for public health and safety contained in West Virginia Code §30-1A-1 *et seq.*

63. Having demonstrated that WVAEPS and WVSM are likely to succeed on the merits, have and will continue to be irreparably harmed, that the balance of equities are in the favor of WVAEPS and WVSM, and that injunctive relief is in the public interest, WVAEPS and WVSM are entitled to the entry of a preliminary injunction enjoining the enforcement of 14 C.S.R. § 14 until this Court enters order(s) fully resolving Count I and Count II herein.

WHEREFORE, the West Virginia Academy of Eye Physicians & Surgeons, Inc. and the West Virginia State Medical Association requests this Court for an Order:

- Declaring that the West Virginia Board of Optometry exceeded its rule making authority in creating 14 C.S.R. § 14 and, thus, 14 C.S.R. §14 is null and void ab initio;

- Declaring that the West Virginia Board of Optometry WVBO failed to adhere to the statutory process for rule making and, thus, 14 C.S.R. § 14 is null and void ab initio;
- Granting a preliminary injunction that prohibits the enforcement of 14 C.S.R. § 14 until this Court enters order(s) fully resolving Count I and Count II herein;
- Awarding WVAEPS and WVSM the costs of bringing such action pursuant to West Virginia Code §55-13-10;
- Awarding WVAEPS and WVSM their attorney's fees; and
- Awarding WVAEPS and WVSM such further relief as this Court deems appropriate.

Respectfully submitted,

WEST VIRGINIA ACADEMY OF EYE PHYSICIANS & SURGEONS, INC. and WEST VIRGINIA STATE MEDICAL ASSOCIATION,

By counsel,

Spilman Thomas & Battle, PLLC

/s/ Chelsea E. Thompson

Alexander Macia (WVSB # 6077)
Chelsea E. Thompson (WVSB #12565)
300 Kanawha Boulevard, East
Charleston, WV 25301
(304) 340-3800 (telephone)
(304) 340-3801 (facsimile)
amacia@spilmanlaw.com
cthompson@spilmanlaw.com

VERIFICATION

The undersigned, having been duly sworn, deposes and states: that they are an officer of the West Virginia Academy of Eye Physicians & Surgeons, Inc., that they have read the foregoing Complaint and knows the contents thereof, and that the same is true of their own knowledge, except as to matters therein stated to be alleged upon information and belief, and as to which those matters they believe them to be true.

Signature

Abraham S. Mitias
Printed Name

President, WV Academy of Eye Physicians and Surgeons
Title

Taken, subscribed and sworn to before me this 19 day of September, 2024.

My commission expires: April 25, 2029.

[Seal]

NOTARY PUBLIC OFFICIAL SEAL
Dawn Lynnette Dettinger
State of West Virginia
My Commission Expires
April 25, 2029
RENITA CONSULTANTS, PLLC
331 LAIDLEY STREET, SUITE 301
CHARLESTON WV 25301

NOTARY PUBLIC

Notary Public

VERIFICATION

The undersigned, having been duly sworn, deposes and states: that they are an officer of the West Virginia State Medical Association, that they have read the foregoing Complaint and knows the contents thereof, and that the same is true of their own knowledge, except as to matters therein stated to be alleged upon information and belief, and as to which those matters they believe them to be true.

John D. Law
Signature

John D. Law
Printed Name

Executive Director
Title

Taken, subscribed and sworn to before me this 20 day of September, 2024.

My commission expires: 7-3-2028.

[Seal]

OFFICIAL SEAL
STATE OF WEST VIRGINIA
NOTARY PUBLIC
Ida Lynn Dorsey
2927 Riders Creek Road Hurricane, WV25526
My Commission Expires July 3, 2028

Ida Lynn Dorsey
NOTARY PUBLIC

Notary Public

“Eyelid Procedures”: Optometric Scope of Practice Legislation

Erin M. Shriver, MD, FACS
Clinical Professor
Jim O’Brien Gross and Donnita Gross Chair
Vice Chair of Faculty Affairs
Departments of Ophthalmology and Visual Sciences and Otolaryngology

Disclosures

Amgen	Advisor/Consultant
Genentech	Advisor/Consultant
Immunovant	Researcher
Viridian	Researcher

No relevant financial disclosures

4 years of
ophthalmology residency

Primary surgeon for
129-161 eyelid and orbital
procedures during
University of Iowa residency

IOWA

Six years of Optometric Scope of Practice Bills in Iowa since 2014
Eyelid surgery bill passed in 2020

to commence a course of therapy. A licensed optometrist may perform minor surgical procedures and use medications for the diagnosis and treatment of diseases, disorders, and conditions of the eye and adnexa. A license to practice optometry under this chapter does not authorize the performance of surgical procedures which require the use of injectable or general anesthesia, moderate sedation, penetration of the globe, or the use of ophthalmic lasers for the purpose of ophthalmic surgery within or upon the globe. The removal of pterygia and Salzmann's nodules, incisional corneal refractive surgery, and strabismus surgery are prohibited.

b. (1) A licensed optometrist may administer only the following injections:

(a) Sub-conjunctival injections for the medical treatment of the eye.

(b) Intra-lesional injections for the treatment of chalazia.

(c) Botulinum toxin to the muscles of facial expression innervated by the facial nerve, including for cosmetic purposes.

(d) Injections to counteract an anaphylactic reaction.

(2) A licensed optometrist shall not administer any injection prior to receiving approval from the board.

(3) The board shall not approve the use of injections other than to counteract an anaphylactic reaction unless the licensed optometrist demonstrates to the board sufficient educational or clinical training from a college or university accredited by a regional or professional accreditation organization which is recognized or approved by the council for higher education accreditation or by the United States department of education, or clinical training equivalent to clinical training offered by such an institution. Training for the administration and side effects of injection treatment for chalazia and of botulinum toxin shall be required before a licensed optometrist may administer such injections. The board shall adopt rules regarding training required pursuant to this subparagraph and approve training providers.

NEW SUBPARAGRAPH DIVISION. (e) Local injectable anesthetics prior to the administration of injections authorized in subparagraph divisions (a) through (d).

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill allows a licensed optometrist to administer a local injectable anesthetic prior to the administration of other injections authorized by law. Current law requires a licensed optometrist to receive approval from the board of optometry prior to administering an injection.

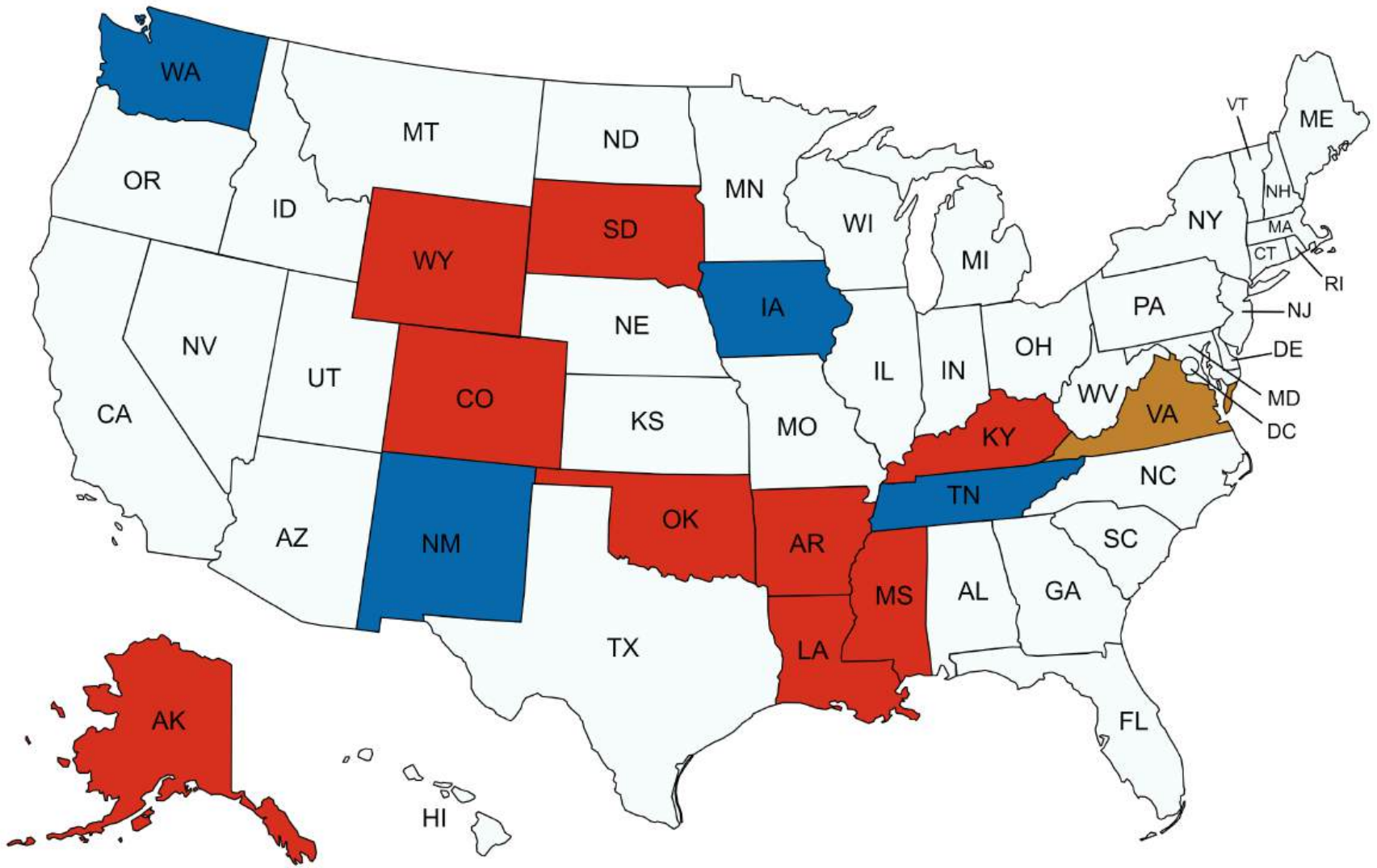






- Optometric Surgical Authority Landscape
- Optometric Surgical Education and Training
- West Virginia Board of Optometry Eyelid Procedures Rule
- Ocular Adnexal and Eyelid Lesions
- Risks of Injections
  - Steroids
  - Anesthetic
- Chalazion Incision & Drainage
- “Non-malignant” vs “Malignant” Eyelid Lesions
- Misdiagnosed Patients
- Questions & Concerns

Optometric Surgical Authority (Nov. 1, 2024)



Laser eye surgery, scalpel eyelid surgery

Laser surgery only

Scalpel eyelid surgery only *(eyelid)*

AMERICAN ACADEMY™ OF OPHTHALMOLOGY

Optometric Education and Training

AMERICAN ACADEMY™ OF OPHTHALMOLOGY

- WV Board of Optometry allowed to add new procedures to scope if “taught” in at least 50% of U.S. optometry schools

NBEO
NATIONAL BOARD OF EXAMINERS IN OPTOMETRY®
200 S. College Street, #2010
Charlotte, NC 28202
Toll Free: 800-969-EXAM

- **3/24 Optometry schools (≈5% of students) in states that allow optometrists to do eyelid procedures:**
  - *Northeastern State Univ. (Oklahoma)*
  - *Southern College of Optometry (Tennessee)*
  - *University of Pikeville (Kentucky)*

- **32-hour ophthalmic procedure course**
  - 16-hours of incisional eyelid procedures & injections
  - <4 hours eyelid injections and lesion excision lab
  - High student:instructor ratio
  - Training and testing primarily on eyelid models

TITLE 14
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF OPTOMETRY

SERIES 14
EYELID PROCEDURES

§14-14-1. General.

1.1. Scope. -- This rule establishes certain eyelid procedures as included within the scope of practice of optometrists.

1.2. Authority. -- W. Va. Code §30-8-1 et. seq., W.Va. Code, 30-8-6, W.Va. Code 30-8-9.

1.3. Filing Date. -- May 9, 2024

1.4. Effective Date. -- May 9, 2024

1.5. Sunset Provision. -- This rule shall terminate and have no further force or effect on August 1, 2029.

§14-14-2. Definitions.

2.1. "Optometrist" means a person who practices optometry as defined in W. Va. Code §30-8-3.

2.2. "Ocular Adnexa" means the eyelids and structures adjacent to the eye.

2.3. "Malignant growth" means abnormal growth of tissue that may invade nearby tissue or spread to other parts of the body.

2.4 "Non-malignant growth" means abnormal growth of tissue that is unlikely to spread to other parts of the body, commonly referred to as benign.

§14-14-3. Scope of Practice.

3.1. The removal, biopsy, and treatment of non-malignant growths of the ocular adnexa that do not extend beyond the dermal layer of skin or mucus membranes shall be included in the description of the practice of optometry and shall be included in the definition of an optometrist's scope of practice.

3.2. An optometrist shall adhere to generally accepted standards of care and follow established clinical guidelines for removal, biopsy, and treatment of abnormal tissue growth from the ocular adnexa. The optometrist shall monitor the patient for any adverse reaction and provide appropriate follow-up care.

3.3. If malignant growth is suspected or confirmed through biopsy, an optometrist shall take appropriate measures to promptly refer the patient to an appropriate specialist in the treatment of malignant growth.

3.4. This rule pertains strictly to the ocular adnexa and does not address procedures involving any other part of the eye or human body.

§14-14-4. Exclusions

4.1. Surgery related to removal of the eye from a living human being;

4.2. Surgery requiring full-thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of the pressure inside the eye;

4.3. Penetrating keratoplasty (corneal transplant), or lamellar keratoplasty;

4.4 Surgery requiring incision of the iris and ciliary body;

4.5. Surgery of the eyelid for eyelid malignancies or mechanical repair of blepharochalasis, ptosis, and tarsorrhaphy;

4.6. Surgery of the bony orbit, including orbital implants;

4.7. Incisional or excisional surgery of the lacrimal system other than lacrimal probing or related procedures;

4.8. Surgery requiring full thickness conjunctivoplasty with graft or flap;

TITLE 14
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF OPTOMETRY

SERIES 14
EYELID PROCEDURES

§14-14-1. General.

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2.2. "Ocular Adnexa" means the eyelids and structures adjacent to the eye.

3.4. This rule pertains strictly to the ocular adnexa and does not address procedures involving any other part of the eye or human body.

Ocular Adnexa

- Eyelids
- Eyebrow
- Conjunctiva (lining of eyelids & eye)
- Orbital contents minus eye & optic nerve
  - Lacrimal gland
  - Lacrimal drainage system
  - Extraocular muscles

https://www.aao.org/image.axd?id=d9d08975-3469-4824-861c-44c0d5d2d4de&t=636560486685430000
https://www.immunopaedia.org.za/wp-content/uploads/2017/07/Lateral-eye-and-orbit-anatomy-1024x669.jpg

14CSR14

TITLE 14
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF OPTOMETRY

SERIES 14
EYELID PROCEDURES

§14-14-3. Scope of Practice.

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3.3. If malignant growth is suspected or confirmed through biopsy, an optometrist shall take appropriate measures to promptly refer the patient to an appropriate specialist in the treatment of malignant growth.

- **"….removal, biopsy, and treatment" – scalpel, steroid injection, intense pulse light treatment?, cryotherapy?, sedation required?, etc.**
- **Size and location of "growths of ocular adnexa"?**
- **Who establishes "standards of care", "established clinical guidelines", and "appropriate follow-up care"? Board of Optometry**

The Exclusions "Strategy"

- The eye is not "ocular adnexa"
  - Corneal procedures?
  - Intraocular procedures?
    Paracentesis

- Surgery of the eyelid for dermatochalasis (excess skin - **blepharoplasty**), ectropion, entropion, laxity, **laceration repair**, **chalazia**,

- Surgery of the orbital soft tissues including fat decompression, extraocular muscle surgery, lacrimal gland surgery?

- "Lacrimal probing or related procedures" – stenting, punctoplasty, **plastic repair canaliculus**

- Conjunctival lesion excision and rearrangement

§14-14-4. Exclusions

4.1. Surgery related to removal of the eye from a living human being;

4.2. Surgery requiring full-thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of the pressure inside the eye;

4.3. Penetrating keratoplasty (corneal transplant), or lamellar keratoplasty;

4.4 Surgery requiring incision of the iris and ciliary body;

4.5. Surgery of the eyelid for eyelid malignancies or mechanical repair of blepharochalasis, ptosis, and tarsorrhaphy;

4.6. Surgery of the bony orbit, including orbital implants;

4.7. Incisional or excisional surgery of the lacrimal system other than lacrimal probing or related procedures;

4.8. Surgery requiring full thickness conjunctivoplasty with graft or flap;

Risks of Injecting Periocular Steroids


THE LANCET

Embolic central retinal artery occlusion after subcutaneous auricular steroid injection

Dr Sai H Chavala, MD • Jennifer F Williamson, MD • Eric A Postel, MD

Published: November 26, 2015 • DOI: https://doi.org/10.1016/S0140-6736(15)60980-0 • Check for updates

- Eye perforation
- Vascular occlusion (stroke) leading to vision loss
- Conjunctival necrosis
- Fat atrophy
- Skin depigmentation
- Glaucoma
- Spread of undiagnosed tumor


MAJOR REVIEW

Vision Loss Secondary to Facial and Periorbital Steroid Injection: A Systematic Review

Sally S. E. Park, B.S., and Anne Barmettler, M.D.†*

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- **Giles CL**. Bulbar perforation during periocular injection of corticosteroids. Am J Ophthalmol 1974;77:438–41.
- **Schlaegel TF**, Wilson FM. Accidental intraocular injection of depot corticosteroids. Trans Am Acad Ophthalmol Otolaryngol 1974; 78: 847–55.
- **Hosal BM**, Zilelioglu G. Ocular complication of intralesional corticosteroid injection of a chalazion. Eur J Ophthalmol 2003; 13: 798–9.
- **Herschler J**. Intractable intraocular hypertension induced by repository triamcinolone acetonide. Am J Ophthalmol1972; 74: 501–4.
- **Akduman L** , Kolker AE, Black DL, *et al.* Treatment of persistent glaucoma secondary to periocular corticosteroids. Am J Ophthalmol1996; 122: 275–7.
- **Fogla R** , Rao SK, Biswas J. Avoiding conjunctival necrosis after periocular depot corticosteroid injection. J Cataract Refractive Surg 2000; 26:163–4.
- **Agrawal S** , Agrawal J, Agrawal TP. Conjunctival ulceration following triamcinolone injection. Am J Ophthalmol 2003; 136: 539–40.
- **Thomas EL**, Laborde RP. Retinal and choroidal vascular occlusion following intralesional corticosteroid injection of a chalazion. Ophthalmology 1986; 93: 405–7.
- **Shorr N**, Seiff SR. Central retinal artery occlusion associated with periocular corticosteroid injection for juvenile hemangioma. Ophthalmic Surg 1986;17:229–31.
- **McLean EB**. Inadvertent injection of corticosteroid into the choroidal vasculature. Am J Ophthalmol 1975;80:835–7.
- **McCleve DE**, Goldstein JC. Blindness secondary to injections in the nose, mouth and face: cause and prevention. Ear, Nose Throat J1995;74:182–8.
- **McGrew RN**, Wilson RS, Havener WH. Sudden blindness secondary to injections of common drugs in the head and neck: clinical experiences. Otolaryngology 1978;86:147–51.
- **Nozik RA**. Orbital rim fat atrophy after repository periocular corticosteroid injection. Am J Ophthalmol 1976;82:928–30.
- **Goyal R ,** Watts P, Lane CM, *et al.* Adrenal suppression and failure to thrive after steroid injections for periocular hemangioma. Ophthalmology 2004;111:389–95.
- **Derendorf H** , Mollmann H, Gruner A, *et al.* Pharmacokinetics and pharmacodynamics of glucocorticoid suspensions after intra-articular administration. Clin Pharmacol Ther1986; 39:313–17.
- **Moshfeghi DM**, Lowder CY, Roth DB, Kaiser PK. Retinal and choroidal vascular occlusion after posterior sub-tenon triamcinolone injection. Am J Ophthalmol 2002;134:132–4.

Risks of Injecting Anesthetic

- Eye perforation
- Spread of undiagnosed tumor
- Allergy to anesthetic
- Reaction to epinephrine
- Oculocardiac reflex


AMERICAN JOURNAL OF OPHTHALMOLOGY

Severe Visual Loss Caused by Ocular Perforation During Chalazion Removal

Kevin M. Shiramizu, MD, Allan E. Kreiger, MD, and Colin A. McCannel, MD


Journal of AAPOS

An asystolic event after eyelid skin bupivicaine injection during chalazion surgery

William R. Katowitz, MD,[a,b] Meghan O'Brien, MD,[a] Eris Kiskis, BA,[a] and Elizabeth M. Elliott, MD[a,b]

14CSR14

TITLE 14
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF OPTOMETRY

SERIES 14
EYELID PROCEDURES

§14-14-3. Scope of Practice.

3.1. The removal, biopsy, and treatment of non-malignant growths of the ocular adnexa that do not extend beyond the dermal layer of skin or mucus membranes shall be included in the description of the practice of optometry and shall be included in the definition of an optometrist's scope of practice.

3.2. An optometrist shall adhere to generally accepted standards of care and follow established clinical guidelines for removal, biopsy, and treatment of abnormal tissue growth from the ocular adnexa. The optometrist shall monitor the patient for any adverse reaction and provide appropriate follow-up care.

3.3. If malignant growth is suspected or confirmed through biopsy, an optometrist shall take appropriate measures to promptly refer the patient to an appropriate specialist in the treatment of malignant growth.

"Non-malignant" growths within optometric scope while "Malignant" growths are not

How to tell between "non-malignant" and "malignant" lesions?

No mention of size, location, and patient age

Eyelid Lesion Procedures: Questions and Concerns

- Many eyelid lesions do not need to be biopsied or excised
- 50+% of chalazia resolve with conservative measures
- Plastic surgery, dermatology, family practice, can perform

- Damage to surrounding tissues (lacrimal, eyelid margin, eye, etc.)
- Interpretation of pathology reports important

- **No evidence eyelid lesions are increasing significantly in WV**
- **No evidence optometry scope expansion improves rural access**
- **Rule goes beyond eyelid lesions?**

TITLE 14
LEGISLATIVE RULE
WEST VIRGINIA BOARD OF OPTOMETRY

SERIES 14
EYELID PROCEDURES

§14-14-1. General.

1.1. Scope. -- This rule establishes certain eyelid procedures as included within the scope of practice of optometrists.

1.2. Authority. -- W. Va. Code §30-8-1 et. seq., W.Va. Code, 30-8-6, W.Va. Code 30-8-9.

1.3. Filing Date. -- May 9, 2024

1.4. Effective Date. -- May 9, 2024

1.5. Sunset Provision. -- This rule shall terminate and have no further force or effect on August 1, 2029.

§14-14-2. Definitions.

2.1. "Optometrist" means a person who practices optometry as defined in W. Va. Code §30-8-3.

2.2. "Ocular Adnexa" means the eyelids and structures adjacent to the eye.

2.3. "Malignant growth" means abnormal growth of tissue that may invade nearby tissue or spread to other parts of the body.

2.4 "Non-malignant growth" means abnormal growth of tissue that is unlikely to spread to other parts of the body, commonly referred to as benign.

§14-14-3. Scope of Practice.

3.1. The removal, biopsy, and treatment of non-malignant growths of the ocular adnexa that do not extend beyond the dermal layer of skin or mucus membranes shall be included in the description of the practice of optometry and shall be included in the definition of an optometrist's scope of practice.

3.2. An optometrist shall adhere to generally accepted standards of care and follow established clinical guidelines for removal, biopsy, and treatment of abnormal tissue growth from the ocular adnexa. The optometrist shall monitor the patient for any adverse reaction and provide appropriate follow-up care.

3.3. If malignant growth is suspected or confirmed through biopsy, an optometrist shall take appropriate measures to promptly refer the patient to an appropriate specialist in the treatment of malignant growth.

14CSR14

3.4. This rule pertains strictly to the ocular adnexa and does not address procedures involving any other part of the eye or human body.

§14-14-4. Exclusions

4.1. Surgery related to removal of the eye from a living human being;

4.2. Surgery requiring full-thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of the pressure inside the eye;

4.3. Penetrating keratoplasty (corneal transplant), or lamellar keratoplasty;

4.4 Surgery requiring incision of the iris and ciliary body;

4.5. Surgery of the eyelid for eyelid malignancies or mechanical repair of blepharochalasis, ptosis, and tarsorrhaphy;

4.6. Surgery of the bony orbit, including orbital implants;

4.7. Incisional or excisional surgery of the lacrimal system other than lacrimal probing or related procedures;

4.8. Surgery requiring full thickness conjunctivoplasty with graft or flap;


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AMA

Thank you
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AMA, ISMS antitrust lawsuit seeks to break MultiPlan price fixing cartel

Oct 24, 2024

CHICAGO — The American Medical Association (AMA) and the Illinois State Medical Society (ISMS) filed a lawsuit (PDF) today against MultiPlan claiming the data analytics agency is at the center of a price-fixing conspiracy with commercial health insurance companies that has undercut fair payment for out-of-network health care services and eliminated market competition resulting in harm to patients and physicians.

The lawsuit filed in the Northern District of Illinois, seeks to hold MultiPlan accountable for its role in an unlawful multilateral price-fixing scheme that has operated roughly since 2015 and has forced physicians to accept increasingly low payment amounts for out-of-network services, which often do not cover their operating costs. This widespread conspiracy has forced many medical practices, particularly smaller ones, to shut their doors, cease offering certain services, or seek other employment arrangements, leaving patients with fewer and fewer medical practice options.

“MultiPlan’s pricing scheme does not generate any savings for patients. The cost of health insurance keeps going up, while the payors, their investors, and their executives profit from money that should have rightfully been paid to doctors providing necessary medical care,” said AMA President Bruce A. Scott, M.D. “Patients today are fed up with a dysfunctional health system – lengthy waits to see physicians, network inadequacy, and rising costs. What this lawsuit makes plain is that while many in our health system are striving for improvement, MultiPlan is profiting from price fixing. This is one more example of insurance companies playing by their own rules without regard to patients or the legitimate costs required to care for them.”

According to an April 2020 study published by the Office of the New York State Comptroller, depending on the service provided, payments based on MultiPlan’s repricing methodology were 1.5 to 49 times lower than payments for the same services based on the traditional method of calculating out-of-network payment rates for physicians.

“The Illinois State Medical Society strongly supports and joins the AMA’s effort to fight this price-fixing collusion by MultiPlan and the major health insurance companies,” said ISMS President Piyush I. Vyas, M.D. “This activity has resulted in below market reimbursement rates paid to physicians for out-of-network healthcare services. The lack of transparency on how these fees are calculated along with the payment structure needs to be fixed. This will ensure patients can afford the healthcare they deserve, and that physicians and other healthcare professionals are compensated appropriately for the important care they provide.”

MultiPlan has a direct economic stake in suppressing out-of-network payment rates below fair levels. For each claim it reprices, MultiPlan receives a fee from the insurer based on a percentage of the difference between the initial claim amount and what the insurer pays. In other words, MultiPlan gets paid more as physicians get paid less. The revenues generated by MultiPlan from its repricing services have increased from $23 million in 2012, to $564 million in 2020 and $709 million in 2021.

“Through our lawsuit, the AMA and ISMS seek injunctive reform for the out-of-network payment systems used by virtually all commercial health insurers by ending their dependence on the MultiPlan scheme,” said Dr. Scott.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

AMERICAN MEDICAL ASSOCIATION, and ILLINOIS STATE MEDICAL SOCIETY, each in an associational capacity on behalf of its members,

Plaintiffs,

v.

MULTIPLAN, INC.

Defendant.

Civil Action No.

COMPLAINT

Table of Contents

1. Plaintiffs American Medical Association ("AMA") and the Illinois State Medical Society ("ISMS"), in their associational capacities on behalf of their members and as representatives of the Litigation Center of the American Medical Association and State Medical Societies ("Litigation Center"), bring this action for declaratory and injunctive relief against MultiPlan, Inc. ("MultiPlan") for its participation in a conspiracy to artificially suppress payments made to physicians and other healthcare providers for out-of-network treatment services, including members of the AMA and ISMS, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

I. Introduction

2. This action seeks to hold MultiPlan accountable for its membership and role in a far-reaching and unlawful cartel ("MultiPlan Cartel") involving the nation's largest health insurers. This conspiracy—a horizontal, multilateral price-fixing scheme orchestrated by MultiPlan—depresses payments for out-of-network care, including for the AMA's and ISMS's members. Through a concerted agreement, the MultiPlan Cartel has effectively eliminated competition in the market for out-of-network treatment services, harming both doctors and patients.

3. Plaintiffs challenge the MultiPlan Cartel under five alternative theories of liability pursuant to Section 1 of the Sherman Act.

4. First, the conspiracy among MultiPlan Cartel members is a naked, horizontal price-fixing conspiracy constituting a per se violation of Section 1 of the Sherman Act. MultiPlan participates in the same market as the insurer members of the MultiPlan Cartel and operates as their agent in orchestrating the conspiracy.

5. Second, the MultiPlan Cartel's conspiracy is a "hub-and-spoke" conspiracy, with MultiPlan acting as the central hub and the various insurer Co-Conspirators serving as the spokes. The MultiPlan Cartel's actions, both collectively and through individual agreements between MultiPlan and the insurers, have effectively stifled competition in the market for out-of-network

treatment services, causing substantial anticompetitive harm to the market and to Plaintiffs.

6. Third, MultiPlan acted as an agent, facilitator, and conduit of the other members of the MultiPlan Cartel and materially aided their anticompetitive goals. The members of the Cartel delegated virtually every aspect of the out-of-network pricing and payment process to MultiPlan, including the authority to set prices, communicate them to providers, and dispose of any attempt by a provider to negotiate, and often even to pay claims and handle any dispute resolution process. In addition, MultiPlan served as a crucial messenger and conduit between the other members of the Cartel, helping them share confidential information with each other that made it easier for them to artificially suppress out-of-network rates.

7. Fourth, MultiPlan's pricing agreements with payors are an unreasonable restraint of trade under Section 1 of the Sherman Act because those agreements have had, and continue to have, anticompetitive effects throughout the market for out-of-network healthcare services. Those vertical agreements have no redeeming procompetitive benefits. They do not generate any savings for patients or subscribers. The cost of health insurance keeps going up, while the payors, their investors, and their executives line their pockets with money that should have been paid to doctors and nurses providing life-saving care.

8. Fifth, MultiPlan and the insurers agreed to exchange extensive, current, confidential, and competitively-sensitive pricing information with one another with the purpose of decreasing payments to providers for out-of-network goods and services. That agreement had no pro-competitive effects. It simply served to cut the amounts paid to providers so that the MultiPlan Cartel could continue to increase their revenues and profits.

9. The difference between "out-of-network" and "in-network" claims (and the rates at which they are reimbursed by insurers) stems from physicians' and other health care providers'

contractual agreements with insurance companies. In-network providers have agreed to accept pre-negotiated, heavily discounted contract rates for their services, which are set by the insurers, in exchange for access to their plan members (often called "patient steerage"). Conversely, out-of-network providers have declined to enter into these agreements (often because the in-network rates offered are unreasonably low) and are free to set prices based on the open market.

10. Patients often prefer (and in some cases require) treatment from out-of-network providers, including in cases of emergency, where an established patient-provider relationship exists, where in-network options are lacking, or where highly specialized care is needed.

11. Given the persistent consumer demand for out-of-network care options, many insurance plans offer out-of-network coverage to plan members (or "subscribers"). In fact, out-of-network benefits are the defining feature of the nation's most popular insurance plan type: the preferred provider organization ("PPO"). PPO plans offer a network of healthcare providers while also providing for the flexibility to seek out-of-network care.

12. Relative to other plan types, like health maintenance organizations ("HMOs"), PPOs command higher premiums in part because they afford their subscribers the freedom to see any provider of their choosing (assuming they are willing to incur increased out-of-pocket costs for out-of-network care). HMOs, in contrast, typically cover services performed only by "in-network" providers.

13. Under normal market conditions, insurers are incentivized to ensure that PPO subscribers (who are paying a premium relative to HMO subscribers to obtain out-of-network benefits) have access to quality out-of-network care options, including by paying providers competitive reimbursement rates. Insurers understand that paying below-market reimbursement rates might result in providers either: (1) refusing to treat their subscribers on an out-of-network

basis, or (2) billing those subscribers for the portions of their claims not covered by insurance (a process known as "balance billing"). When this occurs, subscribers are functionally denied the full value of the out-of-network coverage they have paid for and may look to change plans. To avoid losing these subscribers, insurers have a strong unilateral economic interest in paying competitive out-of-network reimbursement rates, and in competing on that basis to satisfy both subscribers and providers.

14. However, insurers' independent, short-term economic self-interest in competing for out-of-network providers (to avoid subscriber loss) conflicts with their collective, long-term interest in reducing overall out-of-network costs. This presents a collective action problem: To achieve the collective goal of reducing industry-wide out-of-network costs, insurers must work together to set rates. But such coordination is: (1) logistically complex (given the number of claims, services, and insurers involved), (2) difficult to enforce (given each insurer's individual incentive to undercut the competition by offering better out-of-network coverage through the provision of fair, competitive reimbursement rates to providers), and (3) most importantly, a violation of antitrust laws.

15. The MultiPlan Cartel allows insurers to overcome the hurdles of this collective action problem—but in blatant violation of the antitrust laws. Instead of setting their out-of-network reimbursement rates independently, most of the nation's insurers—roughly 700 out of 1,100 total (including all 15 of the largest insurers)—now outsource this rate-setting function to a common entity, MultiPlan. By acting collectively through MultiPlan, insurers (including other members of the MultiPlan Cartel) effectively eliminate competition between themselves for out-of-network provider services. This constitutes naked price-fixing, a per se violation of the Sherman Act, that directly harms providers and patients alike.

16. The MultiPlan Cartel's suppression of out-of-network reimbursement rates directly impacts the ability of many AMA and ISMS members to continue offering critical services and effective treatment in their communities.

17. As part of the MultiPlan Cartel's scheme, insurers are required and agree to provide MultiPlan with proprietary, competitively sensitive information (including claims pricing data and reimbursement strategies). This data enables MultiPlan to coordinate and suppress industry-wide reimbursement rates. As MultiPlan boasts, in order to set rates for the industry, it "leverages reimbursement data from millions of claims" to help insurers reprice out-of-network claims by "remov[ing] the guesswork." This is code for unlawful coordination on prices through the collection of each insurer's otherwise private and competitively sensitive reimbursement data.

18. MultiPlan purports to determine out-of-network reimbursement rates "algorithmically" through proprietary programs, including, for example, Data iSight and Viant. But these programs are little more than a technological smokescreen for traditional price-fixing. As MultiPlan admits, its programs merely calculate "median reimbursement levels." That is, MultiPlan's pricing programs apply basic math functions to particular datasets. However, MultiPlan ensures that its calculations are artificially low by setting arbitrarily low benchmarks relying on invalid data, including data reflecting what insurers pay providers on an in-network basis. As noted above, in-network rates reflect the steep discounts that some providers agree to offer insurers in exchange for the benefits of network participation (most notably, increased patient volume). They do not represent reasonable rates of reimbursement for out-of-network providers, who have entered into no such agreements with insurers and thus do not stand to gain the benefits of network participation.

19. To further suppress and coordinate out-of-network reimbursement levels,

MultiPlan instructs many insurers, including the members of the MultiPlan Cartel, to enter specific algorithmic "overrides" such as "Don't pay more than X% of the Medicare rate." The imposition of such rate caps by even a few of the largest insurers (which, given their market share, are responsible for a huge proportion of all out-of-network claims) results in rapid downward shifts in industry-wide reimbursement levels. Reimbursements paid to providers based on these artificial caps become the very data points MultiPlan then feeds its algorithm to calculate median reimbursement levels in the future. This creates a feedback loop, whereby the cartel increasingly benefits from its anticompetitive conduct over time. Once the market resets based on these new, suppressed levels of reimbursement, MultiPlan can instruct insurers to enter even lower rate caps—all while assuring them that they will remain (in the words of one MultiPlan executive) in the "middle of the pack" compared to competitors, thus avoiding competitive harms.

20. MultiPlan does not stop there. To ensure its fixed reimbursement rates hold, MultiPlan "negotiates" with physicians on behalf of its insurer clients to force those providers to agree to their rates. Those physicians who reject the MultiPlan rates and balance bill their patients are likely to become embroiled in fee disputes with their patients. Such disputes may result in a damaged patient relationship, a loss of the patient, and an ultimately fruitless effort to obtain money from patients who suffer from the economic strain associated with their medical problems. In over 95% of cases, physicians—having no other practical choice—"accept" the initial offer made by MultiPlan, in some circumstances agreeing as a condition of payment not to balance bill patients for the unpaid portions of claims. As a result, in virtually all cases, the MultiPlan rate determination is the final rate of payment, not a mere "recommendation" to the insurer.

21. MultiPlan points to high provider acceptance rates as proof that its payments are reasonable. But what they actually signal is the existence of a cartel (and that cartel's collective

market power). Physicians are forced to accept unprecedentedly low payment rates (and to relinquish their right to balance bill) because virtually all patients are now covered by insurers who coordinate their behavior through MultiPlan. As shown in this Complaint, that physicians have no alternatives confirms that the MultiPlan Cartel has significant market power. The threat of competition is virtually non-existent and thus incapable of disciplining the behavior of cartel members.

22. The MultiPlan Cartel has resulted in the dramatic suppression of out-of-network payment rates. The traditional method of calculating out-of-network payment rates for physicians is based on "usual, customary, and reasonable" provider charges, or "UCR." Under this method, the UCR payment for a particular service is determined by surveying the amounts physicians in a particular geographic market charge for the same or similar medical services and then selecting an allowable charge amount within that distribution of values. Typically, insurers set the UCR payment amount at around the 80th to 85th percentile of what providers in the same market charge for a particular service. (That is, for an 80th percentile, the UCR amount would represent a point in the distribution where approximately 80% of all charges would be below the UCR amount and 20% above.) Today, UCR amounts are calculated from objective data compiled by the independent non-profit organization Fair Health, Inc. ("FAIR"). Unlike MultiPlan, FAIR charges a flat annual fee to insurers and is not compensated based on how low it calculates UCR amounts to be.

23. MultiPlan, however, has changed the rules by replacing the UCR method with its own price-coordination scheme. That strategy has paid off for the MultiPlan Cartel. According to an April 2020 study published by the Office of the New York State Comptroller, depending on the service provided, payments based on MultiPlan's repricing methodology were 1.5 to 49 times lower than payments for the same services based on the traditional method of calculating rates

(i.e., UCR).[1] And whereas prior to 2016, payment rates typically rose over time, since 2016, they have fallen each year because of MultiPlan's price-coordination scheme. Rather than inuring to the benefit of customers and insureds, these "savings" benefit insurance company executives and stockholders.

24. Physicians are forced to accept these increasingly low payment amounts for out-of-network services, which often do not even cover their operating costs.

25. Low out-of-network payment rates can also indirectly suppress in-network rates, as physicians' ability to profitably treat patients on an out-of-network basis is crucial for obtaining better in-network rates. By undermining the economic viability of billing on an out-of-network basis, insurers strip physicians of this leverage, further entrenching lower in-network payment rates. These dynamics have forced many practices, particularly smaller ones, to shut their doors, cease offering certain services, or join massive hospital conglomerates, leaving patients with fewer and fewer healthcare options.

26. MultiPlan knows it can get away with its scheme because virtually every commercial healthcare payer has agreed to use its repricing methodology, leaving physicians and other providers with no practical option but to accept the "repriced" payment amount that MultiPlan imposes.

27. Even in the cases where MultiPlan offers to "negotiate," that negotiation is one-sided. MultiPlan knows that, by bombarding physicians with a constant stream of "repriced" payment demands, it is practically impossible for those physicians to meaningfully negotiate or pursue dispute resolution with respect to individual claims. Accordingly, any "negotiation" with

[1] Office of the N.Y. State Comptroller, An Analysis of Reasonable and Customary Out-of-Network Reimbursement Rates for Medical/Surgical Services in the New York State Health Insurance Program, Report No. 2018-D-2, April 2020, https://perma.cc/T9E3-8LG9.

MultiPlan starts from the position of MultiPlan's collusive offer to radically underpay physicians for their services, and invariably ends with MultiPlan forcing the physician to capitulate to an extreme underpayment.

28. MultiPlan has a direct economic stake in this race to the bottom. For each claim it reprices, MultiPlan receives a fee from the insurer based on a percentage of the difference between the initial claim amount and what the insurer pays.[2] In other words, MultiPlan gets paid more as physicians get paid less. The revenues generated by MultiPlan from its repricing services (not just with physicians) have gone from $23 million in 2012, to $564 million in 2020 and $709 million in 2021. Insurers choose to pay MultiPlan's high fees to facilitate their rate-fixing scheme.

29. The MultiPlan Cartel dates to roughly 2015, but it is not the first scheme by insurers to suppress out-of-network payment rates. From the late 1990s to roughly 2009, insurers fixed these rates through a United subsidiary, Ingenix, Inc. ("Ingenix"), which functionally calculated UCR amounts for the industry. But as investigations, first by the AMA, and, later, by the New York Attorney General ("NYAG") revealed, Ingenix was systematically understating UCR, including by polluting its claims database with discounted in-network payments, as MultiPlan does today.[3] The Ingenix scheme artificially suppressed out-of-network payment rates by 10–28%, leading to massive liability. In 2009, United settled with the AMA and, at approximately the same time, twelve insurers (including the "big four"—Blue Cross/Blue Shield, United, Cigna, and Aetna) settled with NYAG. They agreed to invest tens of millions of dollars in the creation of a new, independent UCR database to replace Ingenix—which would become FAIR—and refrain

[2] In addition, as explained below, the insurers who participate in the MultiPlan Cartel also collect similarly-calculated contingency fees when those insurers act as administrators to self-funded employer plans.

[3] *See* N.Y. State Office of the Att'y Gen., Health Care Report: The Consumer Reimbursement System is Code Blue (Jan. 13, 2009), https://perma.cc/NU82-3TQH.

from developing or using any alternative to FAIR for at least five years. The five-year terms of those settlements ended in 2015 and 2016. When those bans lapsed, insurers shifted away from FAIR and began to fix rates again via MultiPlan.

30. The actions of the MultiPlan Cartel and its price-fixing scheme have recently been the subject of an exhaustive investigation by the New York Times that included interviewing 100 witnesses and evaluating tens of thousands of pages of confidential internal records.[4] That investigation concluded that MultiPlan runs a "lucrative, little-known alliance" of healthcare payors that underpays healthcare providers and undermines the value of commercial insurance.

31. The New York Times investigation has prompted new scrutiny of MultiPlan and its practices. For example, on April 9, 2024, the American Hospital Association called for a federal government investigation into MultiPlan's conduct. In addition, on April 29, 2024, United States Senator Amy Klobuchar sent a letter to Assistant Attorney General Jonathan Kanter and Federal Trade Commission Chair Lina Khan asking them to investigate whether MultiPlan facilitates collusion between commercial health insurance payors. She expressed concern that MultiPlan's "algorithmic tools are processing data gathered across numerous competitors to subvert competition among insurance companies."

32. On May 1, 2024, The New York Times reprised its reporting, publishing an article specifically focused on MultiPlan's price-fixing. Entitled "Collusion in Health Care Pricing? Regulators Are Asked to Investigate," the article noted: "[MultiPlan] has helped big health insurers

[4] *See* Chris Hamby, Insurance Companies Reap Hidden Fees as Patients Get Unexpected Bills, N.Y. Times (Apr. 7, 2024, updated Apr. 9, 2024) ("NYT Report"), https://tinyurl.com/386dhe75; Health Insurers' Lucrative Alliance That Drives Up Patient Bills: 5 Takeaways, N.Y. Times (Apr. 7, 2024), https://tinyurl.com/4f4ttb5f; In Battle Over Health Care Costs, Private Equity Plays Both Sides, N.Y. Times (Apr. 7, 2024), https://tinyurl.com/7hwmjavw.

cut payments to doctors, raising concerns about possible price fixing."[5] The article describes current price-fixing litigation against MultiPlan and quotes Barak Orbach, a law professor at the University of Arizona, as saying: "This should trigger an investigation by the agencies. There seems to be a really strong case."

33. The AMA and ISMS bring this action in their associational capacity on behalf of their members to declare the MultiPlan Cartel and MultiPlan's role in it to be an unlawful, anticompetitive scheme, and to seek injunctive and other appropriate relief to put an end to the Cartel and the injuries it is inflicting on members of the AMA and ISMS and on healthcare throughout the United States.

II. Parties

34. Plaintiff AMA is an Illinois not-for-profit corporation headquartered in Chicago, Illinois. Since its founding in 1847, the AMA has played a crucial role in the development and practice of medicine in this country. It is the voice of organized medicine in the United States. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health, including by supporting patient access to quality health care by assuring that insurance companies pay for that care as the law requires.

35. The AMA has been for many years, and is today, the largest professional association of physicians, residents, and medical students in the United States. All state medical associations and major specialty medical societies are represented in the AMA House of Delegates and thus in the AMA's policy making process. AMA members practice and reside in all states, including Illinois, and practice in all areas of medical specialization. The AMA regularly represents its members to protect the members' rights and their patients' rights before administrative agencies

[5] Chris Hamby, N.Y. Times (May 1, 2024), https://tinyurl.com/447wbbpf.

and legislatures and in litigation.

36. Plaintiff ISMS is a non-profit, membership organization that represents and unifies its physician members in their practice of medicine throughout the State of Illinois. Founded in 1840, the ISMS has grown into the leading advocate for Illinois physicians and patients, representing thousands of physicians in the State across all specialties and practice areas. ISMS represents the interests of its member physicians, medical graduates completing residency and fellowship programs, and medical students, as well as those of patients. The ISMS promotes the doctor-patient relationship, the ethical practice of medicine, and the betterment of public health. ISMS's mission is to educate, advocate for, and support the health and wellbeing of the people of Illinois and the physicians who care for them. As a result of the pervasive, illegal conduct of MultiPlan and the various insurer Co-Conspirators, the members of ISMS have been injured.

37. AMA and ISMS assert claims on behalf of their members and as representatives of the Litigation Center. The Litigation Center is the voice of America's medical profession in legal proceedings across the country. The mission of the Litigation Center is to represent the interests of the medical profession in courts. It brings lawsuits, files amicus briefs, and otherwise provides support or becomes actively involved in litigation of general importance to physicians and patients.

38. AMA and ISMS each have individual standing as they have been injured by MultiPlan's wrongful conduct as alleged herein. AMA and ISMS have expended considerable time and resources helping their members deal with issues concerning the MultiPlan Cartel and its pricing of out-of-network healthcare claims.

39. Moreover, to facilitate its wrongful conduct, MultiPlan uses a system of medical nomenclature known as Current Procedural Terminology ("CPT"), which the AMA owns and has copyrighted and trademarked. This wrongful use of CPT injures the reputation of the AMA

through the incorrect inference by some persons in the healthcare professions that the AMA supports MultiPlan's unlawful conduct.

40. The AMA and ISMS also have associational standing on behalf of their members who have claims against MultiPlan for the violations alleged in this Complaint. Most of the members of the AMA and ISMS are active physicians, many of whom provide out-of-network services that have been subjected to the unlawful conduct of the MultiPlan Cartel with respect to pricing, purported "negotiation," and underpayment for those out-of-network services. The AMA's and ISMS's members would have standing to sue in their own right, the interests the AMA and ISMS seek to protect are germane to the AMA's and ISMS's purposes (e.g., promoting public health, supporting patient access, and assuring insurance companies pay for their members' care as the law requires), and neither the claim the AMA and ISMS assert nor the relief they request requires the participation of the individual members, who are free to pursue their own claims for money damages against MultiPlan and its co-conspirators. The AMA and ISMS seek only declaratory and injunctive relief (e.g., an order enjoining MultiPlan from its unlawful practices) that would benefit themselves and their members.

41. The AMA and ISMS sue not only on their own behalf but also as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition of the AMA and the state medical societies to advance the interests of organized medicine in the courts, pursuant to AMA policies.

42. The AMA and ISMS seek appropriate declaratory and injunctive relief to redress MultiPlan's misconduct, as alleged herein.

43. Defendant MultiPlan, Inc. ("MultiPlan") is a New York corporation. Its principal place of business is located at 115 Fifth Avenue, 7th Floor, New York, New York. MultiPlan is

wholly owned by MultiPlan Holding Corporation. The ultimate parent company of MultiPlan Holding Corporation is MultiPlan Corporation. MultiPlan Corporation is a publicly traded entity. MultiPlan, which purports to be a third-party out-of-network claims repricing service, serves as the conduit by which cartel members share, inter alia, detailed, competitively sensitive, non-public information.

44. MultiPlan has a number of subsidiaries, including Viant, Inc. ("Viant"), a healthcare cost management company incorporated in Nevada and headquartered in Illinois, which MultiPlan acquired in 2010; and healthcare cost management companies National Care Network, LP, incorporated and headquartered in Texas, and its affiliate National Care Network, LLC, incorporated in Delaware and headquartered in Texas, which MultiPlan acquired in 2011.

45. Until October 2020, MultiPlan was a privately held corporation. In October 2020, Churchill Capital Corp. III and its related entities acquired MultiPlan, Inc. and its related entities. Churchill Capital Corp. III is a special-purpose acquisition company created to raise funds to take a private company public. It is incorporated in Delaware and headquartered in New York. After completing the acquisition of MultiPlan, Inc. and its related companies, Churchill Capital Corp. III changed its name to MultiPlan Corporation.

46. In addition to its repricing services, MultiPlan operates multiple nationwide PPO networks. It recruits healthcare providers, negotiates payment rates with them, and sets certain quality and credentialing expectations for the healthcare providers in its network. Then, MultiPlan sells access to its PPO networks as part of a healthcare insurance plan.

III. Co-Conspirators

47. As set forth below, Plaintiffs allege MultiPlan has contracted, combined, conspired, and/or acted as the agent for nearly all major health insurers in the United States—including Aetna, Inc. ("Aetna"), the Cigna Group ("Cigna"), UnitedHealth Group Incorporated ("United"), and

Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") (together, "Other Insurers")—and many of the smaller ones, to form a cartel that unlawfully constrains, fixes, and depresses prices paid to healthcare providers, including the AMA's and ISMS's members, with respect to out-of-network healthcare services provided to patients.

48. MultiPlan has bragged that it contracts with some 700 health insurance companies and payers—including the 15 largest health insurers in the United States—to provide out-of-network claims repricing services.

49. The conspiracy alleged herein includes any person or entity that has entered into an out-of-network claims repricing services agreement with MultiPlan, used MultiPlan's out-of-network claims repricing tools to process claims for out-of-network healthcare services, or otherwise participated in the alleged anticompetitive conspiracy and performed and made statements in furtherance of the conspiracy.

50. MultiPlan is jointly and severally liable for all the acts and omissions of its Insurer co-conspirators.

IV. Jurisdiction and Venue

51. This case arises under Section 1 of the Sherman Act (15 U.S.C. § 1), Section 16 of the Clayton Act (15 U.S.C. § 26), and the Declaratory Judgment Act (28 U.S.C. § 2201). Plaintiffs seek a declaration that MultiPlan has violated and is violating Section 1 of the Sherman Act and to enjoin MultiPlan's anticompetitive conduct, and for such other relief as is afforded under the laws of the United States.

52. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 (federal question) and § 1337(a) (antitrust), and 15 U.S.C. § 15 (antitrust). The Court also has subject matter jurisdiction under 28 U.S.C. § 1332(a) (diversity jurisdiction), because the Plaintiffs and MultiPlan are citizens of different states and the matter in controversy exceeds the sum or value of $75,000,

exclusive of interest and costs.

53. This Court has personal jurisdiction over MultiPlan because it transacts business throughout the United States, including in this district (including repricing claims for out-of-network healthcare services performed in this district by members of the AMA and ISMS) and because MultiPlan is engaged in the alleged antitrust conspiracy, which has a direct, foreseeable, and intended effect of causing injury to the business or property of persons and entities residing in, located in, or doing business throughout the United States, including in this district.

54. Venue is proper in this district pursuant to Section 12 of the Clayton Act, 15 U.S.C. § 22, and under the federal venue statute, 28 U.S.C. § 1391, because certain unlawful acts by MultiPlan and/or the MultiPlan Cartel were performed in this district, and those and other unlawful acts caused harm to interstate commerce in this district. No other forum would be more convenient for the parties or witnesses to litigate this case.

V. Factual Allegations

A. The out-of-network healthcare services industry is dominated by third-party payers and their provider networks.

55. Roughly 90% of U.S. healthcare expenses—including those related to out-of-network care—are paid for not by patients themselves, but by an assortment of public and private third-party payers ("TPPs"), often referred to as "insurers." Third-party payers include government-funded insurance programs (like Medicare and Medicaid), self-insured employers (whose plans are typically administered by commercial insurance companies), and commercial insurance companies themselves (such as United, Anthem, Aetna, Humana, Cigna, and the various Blue Cross/Blue Shield/HCSC companies).

56. Most physicians depend on payments from insurers to stay in business. Typically, physicians collect at most nominal amounts from patients at the point of service (usually in the

form of "copays" or "coinsurance"). They then submit the bill (or "claim") for services rendered to the patient's insurer to obtain payment.

57. All medical claims submitted to insurance use the same set of uniform billing codes. Procedure code sets like CPT ("Current Procedure Terminology") and ICD-10-PCS ("International Classification of Diseases, 10th Revision, Procedure Coding System") tell the payer *which* service the provider performed. Diagnosis code sets like the ICD-10-CM ("International Classification of Diseases, 10th Revision, Clinical Modification") tell the payer *why* the patient received the service. Most claims contain numerous codes, reflecting each diagnosis and treatment administered during a medical visit. Typically, physicians receive payment for each code billed (so long as it is covered by the patient's healthcare plan).

58. Physicians often employ administrative professionals called "billers" and "coders" to extract billing information from patients' medical charts, generate the claims that are submitted to insurance, and ensure that the proper payment amounts are received. Many physicians also employ third-party clearinghouses to pre-screen claims, correct errors, and securely transmit them to insurers (and patients).

59. Insurers seek to predict and, if possible, limit the prices they will pay for medical services. To that end, most insurers maintain "networks" of physicians who have agreed to offer one or more insurers discounted rates for services in exchange for: (1) access to their subscribers (i.e., steerage), and (2) the avoidance of certain administrative burdens associated with negotiating the cost of services with insurers on an ad hoc basis.

60. Network agreements between physicians and insurers typically detail the kinds of services to be covered by the insurer, the amount the provider will be reimbursed for each covered service, and the process by which claims for payment are adjudicated.

61. Physician network agreements incorporate the rates that the insurers pay their in-network physicians.[6] Insurers generally seek to protect the rates and other information in their network agreements from disclosure. They assert that competing insurance companies may use the information to lure physicians to their networks by offering superior terms (which in turn drives up in-network rates for the industry). They also know that physicians may leverage the information to demand more favorable rates during future negotiations. Moreover, public disclosure of negotiated rates can lead to subscriber backlash if negotiated discounts do not result in lower plan premiums. Given these sensitivities, the industry has taken the position that agreed-upon rates under in-network agreements are trade secrets.

62. The in-network rates insurers offer physicians—even for the same services—vary widely. Hospitals, with their extensive service offerings and substantial market presence, typically command higher payment rates from insurance companies, whereas independent physician practices, due to their smaller size and limited bargaining power, typically secure far less favorable in-network rates.

63. In many cases, the in-network rates offered fall below the operational costs incurred by physicians. As one recent study by the American Medical Group Association reports, the median loss for medical groups was $249,000 per physician. A physician in this situation is then faced with a difficult decision: The physician can accept inadequate in-network rates, knowing that doing so may leave the physician in financial extremis. Or the physician can decline to join some or all insurance networks (knowing it will result in the loss of patient volume), which allows

[6] Prior to 2022, in-network rates were virtually always treated as confidential and proprietary. In 2022, federal legislation went into effect requiring insurers to disclose the terms of certain network agreements with hospitals. *See* Transparency in Coverage, 85 Fed. Reg. 72,158 (Nov. 12, 2020) (to be codified at 26 C.F.R pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147; and 45 C.F.R. pt. 158).

the physician to bill patients' insurance plans (assuming those plans have out-of-network benefits) at the prevailing market rate.

1. ***Many physicians operate outside of insurance networks, offering out-of-network care, because of inadequate network rates.***

64. Many physicians refrain from participating in network arrangements for one, some, or all insurers. Some physicians determine that the in-network rates offered by insurers are too low (which is often the case for independent practices), or that the network will not provide them with adequate patient volume to justify the requested discounts. Other physicians refuse to join certain networks because of the administrative burden and expense associated with obtaining in-network payment.

65. Claims submitted to an insurer for healthcare services covered by a network agreement are called "in-network" or "contracted" claims. Claims for services not covered by a network agreement are called "out-of-network," "non-contracted," or "retail" claims.

66. The ability of physicians to submit out-of-network claims in this way, obtain fair payments for them, and profitably practice medicine outside of insurance networks represents a powerful form of leverage on the side of physicians in negotiating in-network rates. It functions, essentially, as a check on insurers' ability to drive in-network rates too low. However, as described herein, the MultiPlan Cartel drastically reduces physicians' leverage in this regard by suppressing out-of-network payment rates far below competitive levels, such that the threat of any physician's going out-of-network becomes increasingly hollow. This, in turn, indirectly suppresses in-network rates as well.

67. The payment process for in-network claims is relatively straightforward. Once the insurer receives a claim from an in-network physician, the claim enters the adjudication process, during which the claim will either be "accepted" (meaning paid), "denied" (not paid), or "rejected"

(returned due to error). If some but not all of the services reflected in the bill are covered by the insurer's plan, the insurer may approve the covered costs while rejecting the non-covered costs.

68. Following adjudication, the insurer submits a report to the physician detailing which codes it is willing to reimburse and at what rate (according to the parties' network agreement). The physician then checks the report for accuracy and may begin an appeals process (the procedure for which is governed by the network agreement) should a dispute arise.

69. In contrast, when a physician is out-of-network, there is no contract between the insurer and the physician to govern the parties' obligations to one another, how claims are adjudicated, or the means for resolving any disputes over such claims. Nor is there an obligation on the part of the physician to render out-of-network services to an insurer's members, with certain limited exceptions (like emergency care). In the absence of such an agreement, the insurer and physician should be free to negotiate what services will be paid for, and in what amount, on the free market.

2. ***Unlike HMOs, PPOs offer out-of-network coverage.***

70. Not all insurance plans cover out-of-network services, and those that do are typically priced at a premium. The two most common forms of health insurance in the United States are HMOs and PPOs. Both employ physician networks to manage costs. However, HMOs require patients to obtain healthcare services only from providers that participate in the plan network and have agreed to offer steeply discounted prices to plan members.[7] PPOs, by contrast, give patients a choice: They can either obtain care from a cost-effective in-network physician (and receive the maximum payment from the insurer under their plan) or they can get care from an out-

[7] An HMO plan may, at times, provide partial reimbursement for services performed by a physician not within network, but only in extraordinary circumstances. Such coverage typically requires prior authorization by the insurer, which will pre-negotiate the terms of reimbursement with the physician.

of-network physician of their choosing (and receive a reduced though still significant payment amount).

71. Under most PPO plans, insurers agree to pay a large, fixed percentage (typically 80–90%) of the expected charge of out-of-network care, which insurers typically refer to as the ‘‘usual, customary, and reasonable” (or “UCR”) amount, less the patient’s cost-share contribution. The UCR amount, as described further below, is supposed to be a fair reflection of the market rate for a given service in a particular geographic area.

72. Because the insurer does not have a contract with the out-of-network physician, the consumer is financially responsible for paying the balance of the bill (i.e., the portion of the bill the insurance company does not pay). And the physician can, with some limited exceptions, pursue the remainder of the physician’s charge from the consumer, regardless of how little or how much the insurer reimburses the consumer.[8]

73. The option to see out-of-network health insurance providers comes at a cost to subscribers. PPO premiums (and deductibles) are significantly higher on average than those for HMOs. For example, for a 30-year-old, the average PPO plan established under the Affordable Care Act costs about $800 more per year than the average HMO plan. Nevertheless, PPOs are the most common plan type in the United States, with nearly half of all insured U.S. employees covered by a PPO, reflecting payers’ and patients’ preference for increased physician choice.

74. There are many reasons consumers may choose to pay higher premiums and deductibles for the option of seeing out-of-network providers. After changing employers, a person

[8] Recent legislation has placed prohibitions on balance billing for emergency care and for certain out-of-network care performed at an in-network facility. *See* Requirements Related to Surprise Billing, 87 Fed. Reg. 52,618 (Aug. 26, 2022) (to be codified at 26 C.F.R pt. 54; 29 C.F.R. pt. 2590; and 45 C.F.R. pt. 149).

may wish to continue working with certain physicians, like a longstanding primary care physician, even if those physicians no longer participate in the insured's new healthcare plan. Other patients know that they have a medical condition that requires specialized treatment that may be available only from out-of-network physicians. Geography is also a factor, as convenient in-network options are often limited for those who travel frequently or who live in rural areas. And many consumers wish to protect themselves financially in the event of a new diagnosis or emergency, when obtaining in-network care may be impossible or inferior to other options.

75. And insurers understand why out-of-network coverage appeals to U.S. consumers. That is why they market PPOs with labels like "freedom" and "choice." Yet, behind the scenes, they do everything possible to under-reimburse the out-of-network physicians who make PPO plans desirable in the first place.

3. ***Competition among PPOs for out-of-network physicians is a crucial element in a functioning market.***

76. In a competitive market, insurers that sell plans with out-of-network benefits are incentivized to ensure that plan subscribers can obtain services from out-of-network physicians. To do so, insurers must, at a minimum, pay out-of-network physicians competitive payment rates.

77. Insurers know that physicians who receive below-market payment amounts for out-of-network care may, in response, refuse to serve their members in the future, or elect to balance bill those patients for the uncovered portions of their out-of-network claims. When this occurs, subscribers are harmed financially and may decide that their plans' out-of-network benefits are overpriced (or even illusory). This may lead them to switch to a competing PPO. The industry often refers to this as member and provider "abrasion."

78. Given the risk of such "abrasion," under normal market conditions (i.e., absent a market restraint), it would be economically irrational for an individual insurer to lowball out-of-

network providers with below-market payments. Insurers would instead compete against each other for out-of-network physician services to keep their current PPO subscribers happy (and obtain new ones), including by offering competitive payment rates on out-of-network claims.

79. But as set forth in further detail below, such competition has been eliminated by the MultiPlan Cartel. Insurers now act collectively, though MultiPlan, to slash out-of-network payment rates. Absent an assurance that their competitors are doing the same thing, individual insurers would not lowball out-of-network physicians in this way for fear of creating subscriber and provider abrasion. The MultiPlan Cartel provides them with that assurance.

B. Historically, insurers have used a variety of methods to price out-of-network physician services.

1. The "usual, customary, and reasonable" method has traditionally been used to calculate out-of-network payment.

80. Historically, normal competitive pressures (along with inflation and other factors) tended to drive up the price of out-of-network care over time. But the insurance industry had a system in place to ensure that they would not be on the hook for excessive physician pricing: UCR.

81. For decades, and until the late 1990s, health insurers based out-of-network payments on statistical benchmarks for medical costs based on prevailing market rates, i.e., the retail prices charged by doctors in particular geographic areas (UCR amounts).

82. Historically, UCR rates were calculated using data from two databases: the Prevailing Healthcare Charges System ("PHCS") and Medical Data Resource ("MDR"). PHCS was created in 1973. Until the late 1990s, it was run by the then-insurance industry trade organization, Health Insurance Association of America ("HIAA").[9] MDR was created in 1987;

[9] HIAA later merged with another industry trade association, the American Association of Health Plans ("AAHP") to form America's Health Insurance Plans ("AHIP"), of which the executives of many members of the MultiPlan Cartel are high-ranking board members.

until the late 1990s, it was run by Medicode.

83. Insurers and physicians have always understood that the UCR amount refers to "the prevailing rate doctors charge when they have not negotiated a lower rate with the insurer on an in-network basis."[10] That is because when doctors (or other professionals) provide services on an out-of-network basis, they do not receive the promise of increased patient volume and other benefits (like prompt and predictable payment) that come with contracting to participate in an insurer's network. In the absence of increased volume or other contractual inducements, physicians would not offer discounts to payers, and payers would not expect to pay substantially less than the retail charge amount. Therefore, pre-negotiated, discounted, in-network rates do not and have never represented reasonable rates of payment for out-of-network claims, and have never been relevant to the proper calculation of UCR amounts.

84. Accordingly, to properly calculate UCR amounts, insurers historically used aggregated, retail medical charge data (not payment data) for like healthcare services performed in the same geographic markets. The calculation of a UCR amount is simply a matter of math applied to appropriate charge data—it is the determination of an amount representing a percentile value within a distribution of charge data.[11]

85. Insurers exercise discretion to determine what percentile amount they use as the applicable UCR amount for their plans. Insurers also decide whether and to what extent their subscribers are responsible for the UCR amount (i.e., whether they are required to pay a coinsurance amount representing a portion of the UCR amount).

[10] Deceptive Health Insurance Industry Practice: Are Consumers Getting What They Paid For? (Part I): S. Hr'g. 111-37 Before S. Comm. on Commerce, Science, & Transportation, 111th Cong. 5 (2009), https://perma.cc/6U25-FDJR.

[11] As an example, a "median" is simply a 50th percentile value.

86. Historically, many insurers employed the 80th or 85th percentile rule to calculate the UCR amounts. This method is based on the distribution of charges for similar medical services within a specific geographic area. In the case of the 80th percentile UCR, this method pegs the UCR amount to the charge amount below which 80% of all submitted charges fall. For example, if, after analysis, the 80th percentile charge for a colonoscopy in a particular geographic area is identified as $1,200, this figure becomes the UCR amount for that service in that market. This approach aims to ensure that UCR amounts reflect prevailing market rates (covering the majority of charges up to the 80th percentile), while eliminating higher outlier charges.

87. Determining UCR amounts in this way does not mean that insurers pay physicians the entire UCR amount. Instead, insurers would typically cap payment at 80–90% of the UCR amount and require that the subscriber pay the remainder as coinsurance. For example, an insurer that promised plan members that it would reimburse out-of-network claims at 80% of the UCR amount would pay the lower of the actual billed charge or 80% of the UCR amount for similar procedures in the same geographic area; the patient would then contribute the remaining 20% of the UCR amount as coinsurance. The obligations of both insurers and patients were thus pegged to the UCR amount.

88. A hypothetical example of how payment would be calculated under this method is as follows: A physician submits a $1,350 bill for a colonoscopy for a patient who has a PPO insurance plan with out-of-network benefits that: (1) follows the 80th percentile rule to set UCR amounts, and (2) pays only 80% of the UCR amount (with the other 20% paid as part of the subscriber's coinsurance). The insurer accesses data from a UCR database for other colonoscopies performed in the same geographic location. The data shows there were 10 other colonoscopies performed in that region, which were billed at $500, $600, $700, $800, $900, $1,000, $1,100,

$1,200, $1,300, and $1,400. These charges are then organized from lowest to highest to determine percentiles:

Procedure	**Percentile**							
	20th	**30th**	**40th**	**50th**	**60th**	**70th**	**80th**	**90th**
Colonoscopy	$600	$700	$800	$900	$1,000	$1,110	$1,200	$1,300

89. At the 50th percentile, half of the charges recorded in the database are lower, and half are higher. At the 70th percentile, 70% of recorded charges are lower, and 30% are higher. In this hypothetical, because the insurer uses the 80th percentile rule to calculate the UCR amount, the UCR amount for colonoscopies in this geographical area is $1,200. As such, the plan would reduce the physician's billed charge from $1,350 to $1,200. Then, the insurer would pay 80% of that amount, or $960. The patient is then obligated to pay the remaining 20% of that $1,200 charge, or $240, as coinsurance.

90. Once a physician receives notice from an insurer of the allowed amount of a claim, that physician can seek additional payment from the patient for the amount of the charged bill above the "allowed amount" (the amount representing the maximum payment a plan will pay for a covered service inclusive of coinsurance and deductibles). This is known as "balance billing." Using the above hypothetical again as an example, the doctor could bill the patient for the $150 difference between its charged claim ($1,350) and the allowed amount ($1,200).

91. The UCR system represented a means of normalizing healthcare costs. As William Marino, former President and CEO of Horizon Blue Cross Blue Shield of New Jersey, explained to the U.S. Senate Committee on Commerce, Science and Technology in 2009, UCR was "designed to permit payment amounts that would be predictable, change with market-based changes in prevailing payments, and keep insurance costs in check by eliminating excessive

charges from the insurance pool."[12]

92. In other words, UCR gave the insurance industry a means of combating what some insurers claimed were excessive charges for medical care, while still adequately compensating physicians. Despite having a means to control costs in a fair and reasonable way, insurers have, at various points, resorted to anticompetitive tactics to further reduce out-of-network costs.

2. ***Prior industry collusion in the form of the Ingenix Cartel (1997–2009) demonstrates the industry's susceptibility to price-fixing schemes.***

93. In many ways, the MultiPlan Cartel is the modern-day incarnation of a prior collusive effort by insurers to suppress out-of-network payment rates: the Ingenix Cartel.

94. Between 1997 and 1998, a United subsidiary called Ingenix purchased the two then-existing claims databases used for the calculation of UCR: MDR and PHCS. It then consolidated those databases in 2001. With United's acquisition of all UCR claims databases, one of the largest insurance companies in the nation became functionally responsible for the way the entire industry would be setting UCR amounts (and, in turn, nationwide payment levels for out-of-network claims).

95. Allowing an insurance company to control the nation's sole UCR database was a massive conflict of interest. Ingenix was incentivized to skew its aggregate claims data downwards in order to reduce apparent UCR amounts—and that is precisely what it did. Every dollar saved on out-of-network payments based on Ingenix's claims data represented increased profits for United, as well as for its rivals in the insurance industry.

96. For more than a decade after United's acquisition of the nation's UCR data infrastructure, the health insurance industry overwhelmingly used Ingenix data to set payment rates

[12] *See* Committee on Commerce, Science, and Transportation, Underpayments to Consumers by the Health Insurance Industry: Staff Report for Chairman Rockefeller, Office of Oversight and Investigations (June 24, 2009), https://perma.cc/TB63-SH6G.

for out-of-network claims. But in the late 2000s, providers and consumers began to complain about uncharacteristically low out-of-network claims payment rates, which resulted in doctors balance billing patients for huge sums. These complaints spurred several investigations and lawsuits over Ingenix's practices, which eventually revealed that Ingenix was systematically manipulating its data with the purpose and effect of reducing apparent UCR amounts.

97. Ingenix achieved this effect in several ways. First, Ingenix commingled charge data on claims submitted under network agreements (which reflected discounted in-network rates) with data reflecting out-of-network retail charges. As noted above, in-network rates do not represent reasonable rates of payment for out-of-network claims because when physicians perform services on an out-of-network basis, they do not receive any of the contractual benefits associated with network participation (i.e., increased patient volume). By improperly including heavily discounted in-network charges in its claims database, Ingenix systematically and artificially depressed the apparent prevailing market rates for services, and, in turn, the calculation of UCR amounts.

98. Second, Ingenix removed higher-end claims from its databases using formulaic edits to identify and purge roughly 5% of all submitted charges without first investigating whether the charge information was incorrect. Insurance companies that contributed data to the Ingenix database did the same. For example, Aetna, which was Ingenix's single largest data contributor, "pre-scrubbed" its data before submitting it, eliminating the highest 20% of valid medical charges before sending claims data to Ingenix.

99. Such data manipulation made the distribution of medical charges in Ingenix's UCR databases appear 10–28% lower than they really were. Any out-of-network claim payment calculations performed using Ingenix's data thus skewed 10–28% lower, resulting in underpayments to physicians and exposing patients to the risk of balance billing.

100. Whenever an insurer or Ingenix received an inquiry from a doctor or patient regarding how UCR amounts were calculated, they responded, "it's proprietary." Meanwhile, Ingenix did not even attempt to maintain that its UCR data was accurate. As an Ingenix employee testified under oath:

> Ingenix has never tested its results to determine if its statistical conclusions bear any relationship to the actual high, low, median or 80th percentile . . . rates charged by health care providers in any given area.[13]

101. As Ingenix and United would later be forced to admit, Ingenix's close ties with the industry—and its status as a United subsidiary—created "inherent" conflicts of interest.

102. Several lawsuits were filed against insurers by physicians who were underpaid and by patients who were balance billed as a result of Ingenix's UCR database manipulation. In the first such lawsuit, brought in a New York State court in 1999, the AMA and several state-specific medical associations filed a class action against United alleging that Ingenix improperly reduced out-of-network payments to physicians in violation of the Racketeer Influenced and Corrupt Organizations Act ("RICO") and the antitrust laws. The suit, subsequently transferred to federal court, settled in 2009, with United agreeing to pay $350 million to class members.

3. ***FAIR Health, Inc. was created in 2009 to replace the Ingenix database and provide a more independent source for UCR calculations.***

103. In February 2008, then-New York Attorney General Andrew Cuomo announced an investigation "into a scheme by health insurers to defraud consumers by manipulating reimbursement rates." Linda Lacewell, the assistant attorney general in charge of that investigation, described Ingenix as "essentially a closed-loop system of the health insurance industry collecting the information among itself, pooling the information together, all relying on

[13] *See*, *supra*, note 12.

the same information, a system that is impenetrable to the consumer." The investigation found, for example, that "[o]ne national insurer filled an entire page with a list of alternative ways in which it purported to calculate out-of-network rates, in language that can best be described as gobbledygook" when, in reality, it simply "pa[id] the same rates for in-network and out-of-network care."

104. The NYAG investigation culminated in the demise of Ingenix. In January 2009, a settlement was announced between NYAG and United; as part of the deal, United agreed to shut down Ingenix and contribute $50 million to the formation of a new, independent non-profit organization, FAIR, to take ownership of the Ingenix UCR database. United further agreed to use FAIR for determining out-of-network payment rates for at least five years, and to refrain from using, owning, operating, or funding any other database for such purpose during that time.

105. Similar settlements quickly followed for the other major insurers. Aetna agreed to pay $20 million for the creation of FAIR, to contribute untainted data to the new database, and to use FAIR for five years. Cigna and WellPoint, Inc. (later known as Anthem, and then Elevance) agreed to pay $10 million and to use FAIR for five years. Other smaller insurers reached settlement agreements that required them to contribute between $200,000 and $1.6 million and to use FAIR for five years.

106. FAIR was incorporated in October 2009 and became available for use in mid-2010. Under the terms of its NYAG settlement, United was required to shut down the Ingenix database within 60 days of the date on which FAIR became available for use. Moreover, United and all other settling insurers were required to begin using FAIR within 60 days of the date on which it became operational, and to use it exclusively for the setting of out-of-network payment rates for a period of at least five years. As FAIR became operational sometime in 2010, the obligation of the

settling insurers (including members of the MultiPlan Cartel) to use FAIR expired sometime in 2015 or early 2016.

107. Once United shut down Ingenix, all insurers that had previously used Ingenix (not just those that had settled with NYAG) had to switch to a different data source. Because United had purchased and consolidated the only two databases available a decade earlier (leaving no privately controlled alternatives in the marketplace), FAIR was the obvious and near-universal choice.

108. FAIR began the gradual process of correcting the skewed UCR database it inherited from United. As FAIR collected more non-manipulated data from insurers (who were required by their settlement agreements to submit accurate, un-scrubbed charge data), the effects of the decades-long scheme to deflate payment rates began to subside. As a result, patients and physicians received more accurate and fair payments from insurers for the medical care they received or provided. But it did not last.

C. Insurers abandoned UCR-based claims pricing in favor of a new scheme orchestrated by MultiPlan.

109. Unsurprisingly, insurers were not happy with the free market dynamics of the UCR system, particularly when they could no longer manipulate UCR downward through Ingenix. Once the NYAG settlement agreements began to expire, insurers sought to eliminate UCR entirely and to replace it with a different methodology that would systematically suppress out-of-network payment rates.

110. Around this time, many insurance executives expressed a desire to use Medicare rates, which are incredibly low, as the new benchmark for setting out-of-network payment levels. However, these executives understood that absent collusion, using barebones Medicare rates as the benchmark would lead to balance billing, create massive member and physician abrasion, and

was therefore untenable. In other words, the major insurers would have to undertake such a shift together to ensure its success. MultiPlan would emerge on the scene at precisely this time to offer a vehicle for collusion.

111. Indeed, the expiration of NYAG settlements opened the door for MultiPlan to become the new "independent" claims repricing service for the insurance industry. And almost immediately after insurers' obligations to use FAIR expired under their agreements with NYAG, the industry abandoned FAIR and instead began using MultiPlan's claims repricing services.

112. A partial timeline of the 2015–2016 shift from FAIR to MultiPlan is below:

> (1) Cigna began using FAIR in 2010. In 2015, it completed its five-year obligation to use FAIR. In 2015, it contracted with MultiPlan to use its claims repricing services.
>
> (2) Aetna began using FAIR in 2010. In 2015, it completed its five-year obligation to use FAIR. On May 1, 2015, Aetna contracted with MultiPlan to use its claims repricing services.
>
> (3) United shut down its Ingenix database and began using FAIR by 2011. In 2016, it completed its five-year obligation to use FAIR. And as United executives have testified, in 2016 United contracted with MultiPlan to use its claims repricing services for parts of its business and further expanded such use in 2017.
>
> (4) Other insurers also began using MultiPlan to reprice their out-of-network claims around the same time.

113. The industry's adoption of MultiPlan's claims repricing methodology was rapid, coinciding with the end of the major insurers' five-year commitments to use FAIR. This represented a complex and historically unprecedented change in insurers' out-of-network claims pricing structure, which had, for decades, been based on appropriate UCR amounts for services. Such rapid and concerted industry-wide change in pricing practices was a telltale sign of collusion and an understanding among major insurers that they all had to undertake the shift together to ensure its success.

D. MultiPlan's business evolved from a traditional PPO network to a dominant force in claims repricing.

1. MultiPlan 1.0 represented the company's initial focus on building and managing a nationwide Preferred Provider Organization (PPO) network.

114. MultiPlan was not always in the claims repricing business. In fact, the company was founded in 1980 as a New York-based hospital network. Over time, MultiPlan expanded its provider and facility footprint. Today, it maintains a nationwide PPO network of over 1.3 million providers, which insurers can "rent" to decrease the number of claims that fall out-of-network. MultiPlan refers to its PPO network business as "MultiPlan 1.0."

115. To build and maintain its massive PPO network, MultiPlan negotiates with physicians and facilities across the country to "establish discounts" for payers "in exchange for patient steerage [to participating physicians] and other physician-friendly terms and conditions."[14] MultiPlan then rents out its network to insurers, who, for a fee, get the benefit of the network discounts MultiPlan has negotiated. Insurers can use the MultiPlan PPO as either their primary provider network, or, in the case of larger insurers, to supplement or geographically extend their own preexisting networks. The terms of MultiPlan's rental arrangements with insurers are set forth in its standard "Network Rental Agreement."

116. The value of MultiPlan's network—and the amount of rent MultiPlan can extract from insurers—is directly tied to the number of providers MultiPlan can convince to participate. The more providers MultiPlan signs up around the country, the more attractive its rental network becomes to potential insurer clients, and, in turn, the more MultiPlan can charge for access. For this reason, MultiPlan touts the participation of 1.3 million plus providers in its network as its major "competitive advantage."

[14] MultiPlan Corporation, Annual Report (Form 10-K), SEC EDGAR (Dec. 31, 2022).

117. To attract physicians to its network, MultiPlan must offer competitive payment rates (and other inducements, like patient steerage). If MultiPlan offers rates (or other terms) that are inferior to what competitor networks offer, it will lose the battle for physicians.

118. In this race for providers, MultiPlan competes against insurers that offer PPO plans and operate their own networks. Many, if not most, of these insurers, including all of the Other Insurer members of the MultiPlan Cartel, also hire MultiPlan to perform out-of-network claims repricing services (as detailed further below). As MultiPlan states in its public filings, MultiPlan "compete[s] with regional PPOs targeting primary network business,"[15] and "with PPO networks owned by [its] large Payor customers."[16] In other words, MultiPlan and the insurers are horizontal competitors when it comes to PPO physician coverage and in the markets for physician services. The same horizontal competitors then collude to fix the manner in which physicians are paid for their services.

119. MultiPlan induces physicians to join its PPO network—and to obligate themselves to provide services to patients insured by MultiPlan's payer clients—with the promise of sky-high payment rates. MultiPlan's standard "Participating Provider Agreement" outlines certain "Contract Rates" which are "equal to eighty (80%) percent" of the physician's "[b]ill charges." The rates specified in most standard network agreements are, by contrast, far lower.

120. But this promise is illusory. Unlike bona fide network agreements, which contractually obligate insurers to pay specific amounts to doctors for performing covered services, MultiPlan's Provider Participation Agreement does not necessarily include a payment obligation. Instead, these agreements often provide that MultiPlan may, "in its sole discretion," rent out its

[15] Churchill Capital Corp III & MultiPlan, Inc., Virtual Analyst Day (Aug. 18, 2020), https://perma.cc/CK4G-24AC.
[16] *See*, *supra*, note 14.

network to insurer clients who may choose not to pay the specified "Contract Rates" and instead opt to reimburse the physician based on the "out-of-Network benefit level" specified in the patient's PPO plan. Specifically, many of these agreements state:

> [MultiPlan] may, in its sole discretion, include Group and each Participating Professional as a Network Provider in any or all Network(s). Group and each Participating Professional acknowledge that certain Programs offered by [payer] Clients accessing the Network (i) may not include a network option; or (ii) **may cover Covered Services under the Participant's Program at . . . out-of-Network benefit level**.

121. MultiPlan knows (but does not disclose to physicians) that many, if not most, of the claims submitted by participating physicians will be reimbursed not at the specified Contract Rates. Instead, these claims will be treated by insurers as out-of-network claims and reimbursed at outrageously low levels that MultiPlan itself sets via its "Data iSight" or Viant out-of-network claims repricing methodologies (which are at the heart of the conspiracy alleged herein).

122. In fact, MultiPlan ensures as much. Its standard Network Rental Agreement with insurers essentially allows payers to pay MultiPlan network physicians however they see fit. It provides that the insurer may "pay claims from [physicians who participate in MultiPlan's PPO network] in accordance with a Member's [i.e., the patient's] plan of benefits (e.g., benefit plans providing benefit levels at Reasonable and Customary, percentage of Medicare, or otherwise) in lieu of" the Contract Rates MultiPlan dangles in front of physicians to induce their participation in the MultiPlan network.

123. Through its network rental business, MultiPlan has aggregated more than 3.5 petabytes of claim and payment data. Such data reflects not only what physicians charge for in-network and non-contracted services, but also what those physicians are willing to accept as payment for those services. MultiPlan refers to this cache of data as the "crown jewels" of its

company.[17]

2. MultiPlan 2.0 marked a shift towards claims repricing and the formation of the MultiPlan Cartel.

124. Just as Ingenix was being investigated for antitrust violations and fraud in the late 2000s, MultiPlan began offering a new service to its insurance company clients: "re-pricing" their out-of-network (or "non-contracted") claims. This is a euphemism for telling insurers how much to pay physicians who perform out-of-network services for their subscribers.

125. In August of 2009, mere months after the rash of NYAG settlements that would shutter Ingenix, MultiPlan announced that it had reached an agreement to acquire the data analytics firm, Viant, Inc.

126. Viant, like MultiPlan, operated a rental PPO network; but it also offered "non-network cost management services" and a post-payment audit service. The acquisition of Viant thus "added analytics-based services" and "re-pricing solutions" to MultiPlan's business portfolio. The Viant acquisition was completed in 2010.

127. In June 2011, MultiPlan acquired another company, National Care Network, LLC ("NCN") for $50 million. Around this time, NCN described itself as a national leader in cost management, boasting powerful data-driven tools and technology solutions. At the time of MultiPlan's acquisition, NCN had a patent application pending for a software program that would become central to the MultiPlan Cartel; that program would eventually be known as "Data iSight."

128. In December 2014, adding to its so-called analytics-based services portfolio, MultiPlan acquired another company called Medical Audit and Review Solutions ("MARS").

129. Through these acquisitions, MultiPlan became the "leader in out-of-network cost

[17] *See*, *supra*, note 14.

containment." In 2022 alone, MultiPlan processed 546 million out-of-network claims[18]. During that same year, its next closest competitor, Zelis (a company that reprices out-of-network claims based on a UCR benchmark), processed only 2 million out-of-network claims.

130. Over time, MultiPlan's analytics-based services have contributed an increasing share of the company's annual revenues, now accounting for roughly 70% of total revenues. MultiPlan reported $561 million in 2019 revenues from its analytics-based services, leaping to $713 million by 2022. Meanwhile, MultiPlan's revenues from network-based services dropped from $314 million in 2019 to $245 million in 2022.

131. For a time, MultiPlan purported to employ several different algorithmic repricing programs, including Viant and Data iSight. However, on information and belief, MultiPlan has consolidated those programs into one. In its 2022 10-K, MultiPlan references Viant only once (in the "corporate history" section) and describes the company's claims re-pricing business as utilizing only one repricing algorithm: the "Data iSight program." Whatever MultiPlan calls its "algorithms" and "solution sets," they all pull data from the same database, operate in the same way, and serve the same function—to facilitate price-fixing in the market for out-of-network physician services.

E. MultiPlan's claims pricing services are designed to fix prices and control payment rates.

132. MultiPlan's out-of-network claims repricing services are two-fold: First, MultiPlan makes re-pricing determinations based on its Data iSight or Viant programs; these determinations involve both an algorithmic component as well as direct input from MultiPlan personnel, who work with insurers to choose pricing strategies and algorithmic overrides—i.e., rate caps—to fix

[18] MultiPlan Corporation, Analyst and Investor Day Presentation, New York City (June 28, 2023), https://perma.cc/J87F-M5XM.

and standardize rates and manipulate the market. Second, MultiPlan negotiates the terms of payment with physicians, ensuring that all payments are conditioned on the promise that the physician will not balance bill the patient. As described below, both of these services are important to the MultiPlan Cartel's ability to fix prices for the industry, while protecting cartel members from competitive harms (like subscriber and physician abrasion).

133. MultiPlan has been open about the effect its anticompetitive price-fixing has on providers. In its investor presentations, MultiPlan openly touts the fact that it helps its competitors systematically underpay healthcare providers. During a fall 2021 investor roadshow presentation, MultiPlan explained to investors that in an illustrative world "Without MultiPlan," a doctor could expect to make $800 on an out-of-network claim, but in an illustrative world with MultiPlan, a doctor would only make $600 on the same out-of-network claim—a 28.6% difference.[19]

134. In another presentation, MultiPlan claimed that its repricing tool was even more effective, writing that it provided insurers "savings of 61%–81% off billed charges."[20]

1. ***The Data iSight methodology relies on a proprietary algorithm, but it is manipulated to generate artificially low payment rates.***

135. The precise method by which MultiPlan sets payment rates is non-public and proprietary. On information and belief, MultiPlan maintains internal white papers that describe in detail the processes that it uses to reprice out-of-network claims. However, public statements by MultiPlan employees, promotional materials, and U.S. Patent No. 8,103,522 (the "'522 patent," submitted by MultiPlan subsidiary NCN) describe MultiPlan's repricing methodology to some

[19] MultiPlan Corporation, Non-Deal Roadshow Presentation Transcript, New York City (Sept. 30 – Oct. 1, 2021), https://perma.cc/KAU3-LBWT.

[20] *See*, *e.g.*, MultiPlan, Tackling Out-of-Network Medical Bills with Data iSight (June 23, 2023) https://perma.cc/K9A8-K2NQ.

extent.[21]

136. MultiPlan purports to calculate out-of-network payments based on "what people are actually paying within the marketplace" or "typical reimbursement rates." It calls this methodology "Data iSight." Insurers who contract with MultiPlan for repricing services automatically send their out-of-network claims to MultiPlan. Then, for each claim, MultiPlan determines a payment amount based on the "amounts generally accepted by providers as payment in full for [like] services."

137. While MultiPlan dresses up its repricing methodology in technological jargon, it has been forced to admit in legal proceedings that once the algorithm establishes a comparator set, in most cases it simply calculates the "median" payment amount for like services.

138. According to the '522 patent, the process of establishing a comparator set depends in part on what kind of claim is being repriced. For an inpatient hospital care claim, Data iSight uses rDRG values ("refined Diagnosis Related Groups") as benchmarks. rDRG is a system created by the Center for Medicare and Medicaid Services ("CMS"); it classifies claims according to type of care, severity, and complexity. When repricing an inpatient claim, Data iSight searches the MultiPlan claims database for other bills for the same rDRG value at other "like" hospitals, then makes a cost adjustment based on the treating hospital's wage index.

139. For outpatient treatment claims, Data iSight uses the Healthcare Common Procedure Coding System (or HCPCS), another CMS-developed system. HCPCS is a collection of standardized codes that represent medical procedures, supplies, products, and services used to facilitate the processing of health insurance claims. Data iSight searches the MultiPlan claims databases for other bills for the same services, on a code-by-code basis, and then makes an

[21] *See* https://perma.cc/6ERS-BYHV.

adjustment based on the wage index where the treatment was rendered.

140. MultiPlan claims that Data iSight is a highly accurate, fair, and transparent way to calculate rates based on certain reasonable benchmarks. But in reality, MultiPlan ensures that Data iSight always generates artificially low payment rates.

a. MultiPlan pollutes its database.

141. MultiPlan (like its predecessor, Ingenix) includes in its dataset payments made pursuant to network agreements. These in-network payments are then fed to Data iSight as comparators, resulting in a "garbage in, garbage out" dynamic. As discussed above, network rates, which are heavily discounted, do not represent reasonable benchmarks for the payment of out-of-network claims because physicians would not offer discounts to payers absent the promise of increased patient volume that comes with network participation. By intentionally corrupting its database with heavily discounted in-network payments, MultiPlan intentionally suppresses apparent "typical" or "median" payment levels for out-of-network care.

b. MultiPlan applies algorithmic overrides.

142. MultiPlan's supposedly sophisticated algorithm merely identifies the median payment (or other percentile value) amount for like services, based on invalid data that MultiPlan feeds its database to suppress those median amounts. However, MultiPlan does not stop there in its efforts to suppress and coordinate industry-wide rates.

143. For many, if not most, of its insurer clients (including all of the Other Insurer members of the MultiPlan Cartel), MultiPlan overrides the algorithm's functioning by instructing payers to enter manual overrides, like caps and floors on payment. These overrides provide MultiPlan an additional means to control and coordinate insurer behavior, thereby reducing member and physician "abrasion" and accelerating the MultiPlan Cartel's goal of suppressing industry-wide out-of-network payment rates.

144. How does MultiPlan implement these overrides? Under MultiPlan's claims repricing services agreements, each insurer client must complete a "Data iSight Client Preferences form." However, the insurer is not free to independently select these preferences. Instead, the insurer and MultiPlan must "mutually agree[] upon" certain "business criteria" by which to set such preferences. In other words, MultiPlan maintains control over these selections.

145. The available "business criteria" are seven "methods" for setting rates, which are devised by MultiPlan. Most of these "methods" cap the amount the insurer is willing to pay for a particular service (regardless of what a reasonable payment would be or what the algorithm would otherwise spit out). For example, one available Data iSight "method" is "[r]eimbursement at which X% of hospitals are profitable." Under this method, insurers and MultiPlan decide to reimburse at a level at which 50% of hospitals lose money for the service provided—fair and reasonable indeed. Another method is "[r]eimbursement at X% of Medicare," meaning MultiPlan and the insurer agree to pay no more than a certain percentage of what Medicare pays for a service. The remaining five methods are: "reimbursement at which the average markup is X%"; "reimbursement at X% of cost"; "reimbursement at X% of charges"; "reimbursement at X percentile of billed charges" (i.e., UCR); and "reimbursement at average of billed charges," as shown below in Table 1 of the '522 patent:

Available Methods	
F1	Reimbursement at which X % of Hospitals are profitable
F2	Reimbursement at which the average mark-up is X %
F3	Reimbursement at X % of Cost
F4	Reimbursement at X % of Medicare Reimbursement
F5	Reimbursement at X % of Charges
F6	Reimbursement at X Percentile of Billed Charges
F7	Reimbursement at Average Billed Charges

146. Data iSight uses these "methods" to formulate an "initial target reimbursement amount" irrespective of the "median" (i.e., percentile value) reimbursement rate. This initial target amount largely determines how physicians who participate in the MultiPlan network will be reimbursed for claims they submit to MultiPlan's insurer clients.[22] When an insurer receives a claim from a physician that is not part of its own PPO network, the insurer sends the claim to MultiPlan. If the physician is a member of MultiPlan's rental network, MultiPlan calculates the expected payment under that agreement's Contract Rates. But instead of just paying the calculated amount, MultiPlan compares that amount to the "target reimbursement amount," which is essentially an upper limit on payment. If the expected Contract Rate amount is greater than the target, MultiPlan will not pay the Contract Rate and will instead shunt the claim back to Data iSight to be "re-priced" like any other out-of-network claim.

147. Next, MultiPlan can instruct payers to apply additional overrides to determine the final reimbursement amount. These overrides include additional "ceilings" and "floors," as shown below in Table 1 of the '522 patent:

[22] As described above, under MultiPlan's nebulous Provider Participation Agreement, doctors are not guaranteed to receive the enticing Contract Rates outlined by MultiPlan. Instead, their claims may be reimbursed in whatever way the insurer and MultiPlan ultimately see fit. In practice, and as contemplated in MultiPlan's network rental agreements with insurers, this means that the purported Contract Rates will be paid only if such rates are below the insurer's "initial target reimbursement amount," which, on information and belief, rarely occurs.

Available Overrides	
O1	Don't Pay Less Than X % of Claim's Cost
O2	Don't Pay Less Than X % of Claim's Charge
O3	Don't Pay Less Than X % of Claim's Reimbursement
O4	Don't Pay More Than X % of Claim's Cost
O5	Don't Pay More Than X % of Claim's Charge
O6	Don't Pay More Than X % of Claim's Reimbursement
O7	Don't Pay More Than Billed Charges

148. While some of MultiPlan's available "methods" and "overrides" appear to be floors on payment (e.g., "Don't pay less than"), in reality, these apparent "floors" are almost always paired with "ceilings" ("Don't pay more than"). By applying both a floor and a ceiling on payment, MultiPlan and the payer functionally decide the exact level at which to set reimbursement rates.

149. These agreed-upon payment levels are usually pegged to "barebones" Medicare rates (which do not even cover physician costs)—the long-held goal of the insurance industry. Even Medicare-pegged rates that may sound reasonable can strain medical practices. For example, paying around 120% of the government-set Medicare rate "sounds fair, maybe even generous," one MultiPlan document states, but this is "inherently misleading" because "the average consumer does not understand just how low Medicare rates are." Data iSight often calculates prices between 160 to 260 percent of Medicare rates, amounts former MultiPlan employees described as "ridiculously low" and "crazy low."[23]

150. For example, during the process of reaching "mutual agreement" as to the business criteria and overrides to be used to set United's out-of-network payments in 2017, MultiPlan explained that with an "override" of 350% of Medicare rates, United would be "leading the pack," alongside one other competitor, in terms of how low it could drive out-of-network payments. But

[23] *See* NYT Report, *supra*, note 4.

an override of 500% of Medicare would put United in line with what the rest of its main competitors were doing. This information about competitor pricing practices was competitively sensitive data that would not have been shared among insurers but for the operation of the MultiPlan Cartel. And, consistent with the MultiPlan Cartel's goal of reducing industry-wide out-of-network payment rates over time, United reduced its payment ceiling from 500% of Medicare rates in 2016, to 350% in 2018, and 250% thereafter.

151. One purpose of the MultiPlan Cartel was to align all the health insurers in terms of the payment ceilings applied to out-of-network claims. The MultiPlan Cartel achieved this purpose: As the Cartel gain more members, it more aggressively reduced payment ceilings. For example, United reduced its payment ceiling from 500% of Medicare rates in 2016, to 350% in 2018, and 250% thereafter.

152. The rate determinations generated by these payment ceiling overrides often do not factor in geographical differences in the cost of key inputs like labor. Numerous providers have observed that MultiPlan reprices claims submitted to United based on a Medicare benchmark, often with no geographical adjustment. For example, Freemont Emergency Services (an emergency room physician group that successfully sued United for suppressing out-of-network payments) documented that between January and May of 2019, it submitted identical claims to United for the same service performed in nine different states. While these bills varied in amount, each was equal to exactly 80% of UCR in the geographical region where the service was performed, as calculated by FAIR at the time. Had these bills been submitted to United during the time in which FAIR was used to set payment rates, each bill would have been paid at exactly the amount charged. But, after having those claims repriced by MultiPlan, United paid these healthcare providers far less. For each of the nine treatments in nine different states stretching from one coast

to another, MultiPlan calculated, and United paid, a payment of exactly $413.39. This resulted in an underpayment to healthcare providers of between $381.61 and $939.61 (or 45% and 70% off of the relevant UCR benchmark).

2. ***MultiPlan's negotiation services are designed to pressure physicians into accepting low payment offers, eliminating the possibility of meaningful negotiation.***

153. After determining a payment amount via the Data iSight methodology, MultiPlan negotiates payment with physicians. This negotiation function is critical to ensuring that all insurers adhere to MultiPlan's payment determinations, and to MultiPlan's ability to orchestrate the conspiracy.

154. MultiPlan makes offers of payment to physicians on a take-it-or-leave-it basis. Typically, MultiPlan gives medical billers less than ten days to respond to its offers and threatens to drop its payments should physicians choose not to accept. In one fax to a healthcare provider, MultiPlan gave the provider eight days to respond to a low-ball offer, warning: "if you do not wish to sign the attached proposal . . . this claim is subject to a payment as low as 110% of Medicare rates based on the guidelines and limits on the plan for this patient."

155. If the medical biller tries to negotiate for a higher rate with MultiPlan, MultiPlan says it is not the insurer and does not have authorization to increase the payment offer. If the biller asks the insurer how MultiPlan reprices its claims, the insurance company explains that it is not responsible for MultiPlan's pricing.

156. But it is not enough to simply force physicians to accept the extremely low payment amounts calculated by Data iSight. To avoid patient backlash and subscriber loss for its insurer clients, MultiPlan also works to ensure that physicians will not hold patients liable for the remainder of the bill. So, MultiPlan conditions all offers of payment on the physician's promise not to "bill the Patient, or financial responsible party, for the difference between the Billed Charges

and the Proposed Amount [i.e., the payment offer]."

157. MultiPlan knows it can force this ultimatum on physicians because virtually every commercial healthcare payer has agreed to use its repricing methodology, leaving physicians with no practical option but to accept the "repriced" payment amount that MultiPlan imposes. Across all claim types, in over 95% of cases, physicians accept the initial payment offer made by MultiPlan, and do so, as required, on the condition that they will refrain from balance billing the patient.

158. MultiPlan "eliminate[s] balance billing" among the miniscule percent of physicians who appeal the initial payment offer by providing "post-payment negotiation" services to payers. As part of this service, MultiPlan again tells physicians that if they do not accept the offer, they may receive no payment at all. The vast majority of these appeals result in physicians accepting the MultiPlan offer, again on the condition they will not balance bill the patient.

159. MultiPlan employees describe an internal culture and incentive structure that discourages them from negotiating reasonable rates with providers. The New York Times reported that employee bonuses are tied to payment reductions. "I knew they were not fair," it quoted former MultiPlan negotiator, Kajuana Young, as saying about the prices generated by MultiPlan.[24]

160. MultiPlan is not merely making recommendations on how competing payors should pay out-of-network claims. Because MultiPlan and its competitors have agreed on the repricing methodology that will be used, the repricing recommendations generated by MultiPlan's repricing tools are accepted by commercial health insurance payors and offered to physicians without alteration. In most cases, the payor authorizes MultiPlan to make the repricing offer and negotiate the out-of-network claim on its behalf—completely abdicating all pricing authority to its

[24] *See* NYT Report, *supra*, note 4.

competitor.

161. MultiPlan's repricing tools are not merely the beginning of a negotiation. On its website, MultiPlan notes that Data iSight repricing is accepted 96% of the time by providers, and 93% of the time by facilities, "making it a defensible methodology for payors."[25] A 2018 MultiPlan study cited even higher numbers: MultiPlan claimed 99.4% of all out-of-network claims for inpatient treatment that are repriced by Data iSight are accepted by healthcare providers. Those acceptance figures were similar for outpatient (98.7%) and professional (94.5%) care.[26] In 2023, MultiPlan's new CEO, Travis Dalton, told the news outlet Axios that 98% of its repriced claims are accepted by providers.[27]

162. Those high acceptance rates are not due to the validity of MultiPlan's repricing methodology, but rather are the result of the agreement between insurance competitors to fix prices, leaving physicians no alternative but to accept the suppressed MultiPlan repricing offers. In the instances where MultiPlan offers to negotiate its repricing offers, the negotiations are one-sided. Because MultiPlan and its competing payors have agreed not to compete with one another, the question in these negotiations is not whether the physician will be harmed by the MultiPlan Cartel, but how much. In any event, whether "co-conspirators retain some pricing discretion" or are able to "deviate" from prices is not determinative. Thus, even if MultiPlan's repricing was the beginning of a negotiation (which it is not), it cannot immunize the MultiPlan Cartel's agreement to fix prices.

163. Indeed, MultiPlan's 30(b)(6) witness testified during a deposition in the *LD, et al.*

[25] MultiPlan, Data iSight Methodology, https://perma.cc/XAD5-HWY5.
[26] *See* MultiPlan Corporation, A Better Reference for Reference-Based Pricing, MultiPlan Data iSight, Health Plan Alliance (Mar. 21, 2018), https://perma.cc/KC8A-3Z8R.
[27] *See* Aaron Weitzman, MultiPlan CEO talks strategy, recent criticism (Apr. 18, 2024) https://tinyurl.com/ryachfb6.

v. United Behavioral Health, et al., 4:20-cv-02254-YGR (N.D. Cal.), case that she was unaware of a time when United ever rejected a claim price for a particular type of claim. *See LD*, ECF No. 396-8 at 222:21–223:10. Moreover, a United witness in the same case testified that they "leave [the] role and responsibility up to Viant and their team to support and defend how they've arrived at those allowed amounts." *See LD*, ECF. 396-11 at 89:16–20.

164. Medical practices interviewed by The New York Times confirmed their inability to negotiate over prices generated by MultiPlan.

165. The New York Times interviewed Tammie Farkas, who handles billing for her husband's small New York-area practice focused on repairing blood vessels in the brain. She said, "It's not a real negotiation" when MultiPlan transmits offers of payment on behalf of insurers.

166. The New York Times further reported that "[i]nsurers can set negotiation parameters for MultiPlan, including not negotiating at all, records and interviews show. . . . Multiple physicians and billing specialists said that in recent years they had increasingly been told their claims weren't eligible for negotiation."[28]

3. ***MultiPlan's contingent fee structure means they profit directly from lower payment rates paid to physicians.***

167. For each physician claim MultiPlan reprices, it collects a fee from the insurer based on the difference between the physician's original claim and the amount the physician eventually accepts. This fee is typically equal to 5–7% of the "savings" obtained by MultiPlan but has been as high as 12% in some cases.[29]

168. MultiPlan is thus highly motivated to calculate the lowest payment rates possible—

[28] *See* NYT Report, *supra*, note 4.

[29] Similarly, in some circumstances, the members of the MultiPlan Cartel also collect contingency "savings" fees usually between 29–35% when acting as third-party administrators (i.e., when administering self-funded employer plans), from which MultiPlan receives its fees.

whether or not "reasonable" or "fair" to the physician. The lower the payment MultiPlan calculates, the higher its contingency fee is. In other words, the less money that is paid to physicians, the more money MultiPlan makes.

169. These contingent fees represent the lion's share of MultiPlan's annual revenues. In 2021 alone, MultiPlan raked in roughly $709 million in fees for repricing out-of-network claims.

VI. MultiPlan's Anticompetitive Scheme

170. A cartel is a group of rivals that conspire to fix prices, allocate markets, or otherwise illegally limit competition. Cartels can be organized by competing sellers of goods or services (who seek to raise prices to increase their revenues) or by buyers (who seek to suppress prices to reduce their costs). Either way, the goal of cartel members is the same: to act (collectively) like a monopolist—or, in the case of a buyers' cartel, such as the cartel alleged herein, like a monopsonist.

171. The MultiPlan Cartel is a buyers' cartel dating back to around 2015 (and perhaps earlier) designed to reduce out-of-network claims payment rates. To achieve this outcome, cartel members agree to: (1) outsource their competitive decisions with respect to out-of-network payment rates to a common decisionmaker, MultiPlan, and abide by its price determinations, and (2) exchange among themselves and MultiPlan competitively sensitive information regarding their payment rates and pricing strategies. This joint delegation and anticompetitive information exchange allows MultiPlan to coordinate insurer behavior and minimize industry-wide payment rates.

A. MultiPlan invites insurers to participate in a collective action to suppress payment rates as part of a horizontal price-fixing conspiracy.

172. As a sophisticated market participant, MultiPlan is aware that its out-of-network claims repricing services are attractive to insurers only if insurers perceive an opportunity to

collectively adopt the same pricing methodology and negotiation strategy.

173. It is well understood that a single insurer, acting alone, will face massive subscriber and physician backlash (or "abrasion") if it reimburses out-of-network claims at below-market, Medicare-style rates. Historically, when insurers refused to pay a reasonable rate of payment on out-of-network claims (and used Medicare rates as the reference point), physicians would balance bill patients or refuse to take the insurers' patients, leading to subscriber complaints, appeals, and departures.

174. Insurers thus understand that to successfully lowball physicians (without risking serious economic harm), they must not only force physicians to accept low payment rates, but also do so on terms that preclude balance billing, something no individual insurer would have sufficient leverage to do on its own. In other words, it would be against the unilateral economic self-interest of any one insurer to join the MultiPlan Cartel, absent awareness that competitors had agreed to do the same.

175. MultiPlan offers a solution to this dilemma, inviting insurers to act collectively with respect to their payment decisions and physician interactions. To that end, it markets its platform as a way for insurers to "outsource the repricing" and negotiation of "out-of-network claims" to a single decision-maker, MultiPlan. According to MultiPlan, by delegating these functions to MultiPlan, "[c]ommercial plans of any size" can obtain significant "discounts on out-of-network charges" while ensuring "low provider abrasion" and "minimizing the balance billing of their members."[30] Such marketing contemplates and invites concerted action among insurers as a means to reduce out-of-network costs. Insurers sacrifice their independent decision-making to a common decisionmaker (MultiPlan) only because they know competitors are doing the same.

[30] *See*, *supra*, note 20.

176. As federal antitrust regulators have explained, "replac[ing] once-independent pricing decisions with a shared algorithm" like the MultiPlan Cartel has done constitutes illegal price-fixing.[31] In other words, when "competitor's jointly delegat[e] key aspects of their decisionmaking to a common algorithm," they "deprive the marketplace of independent centers of decisionmaking" and violate Section 1 of the Sherman Act.[32]

177. The same is true here. The MultiPlan Cartel extinguished this horizontal competition by delegating industry-wide pricing and negotiation authority to MultiPlan. For physicians, this makes independent, individualized payment negotiations impossible. It thereby allows MultiPlan and its Co-Conspirators to dramatically suppress out-of-network payment rates far below what they would have been but-for the MultiPlan Cartel.

178. As part of this scheme, MultiPlan also invites and requires insurers to participate in anticompetitive information sharing. MultiPlan requires each insurer client to submit real-time, non-public pricing information to its database, including:

> (1) claims (both in- and out-of-network) received from physicians,
>
> (2) payments to those physicians, and
>
> (3) proprietary pricing preferences and strategies, which MultiPlan solicits (among other ways) through its mandatory "Data iSight Client Preferences form."

179. This pricing information (including the caps and overrides applied by insurers, via

[31] Hannah Garden-Monheit & Ken Merber, Price fixing by algorithm is still price fixing, FTC Business Blog (March 1, 2024), https://www.ftc.gov/business-guidance/blog/2024/03/price-fixing-algorithm-still-price-fixing.

[32] Statement of Interest of the United States of America at 2-3, *Duffy v. Yardi Systems, Inc.*, et al., No. 2:23-cv-01391 (W.D. Wash. Mar. 1, 2024) (ECF 149); *see also* Statement of Interest of the United States of America at 7, *CornishAdebiyi v. Caesars Entertainment, Inc., et al.*, No. 23-cv-02536 (D.N.J. Mar. 28, 2024) (ECF. 96) (explaining that "[i]t is not necessary for conspirators always to adhere to pricing recommendations for a challenged price-fixing scheme to be per se unlawful.").

mutual agreement with MultiPlan) constitutes competitively sensitive information that would not be shared in a competitive market. An insurer equipped with knowledge of a competitor's pricing data and strategies could gain a competitive advantage and seize market share by reimbursing out-of-network physicians at higher rates than a lowballing competitor. It would be against the economic self-interest of any independent insurer to share that competitively sensitive data with MultiPlan, for use with its competitors (whether directly or indirectly), unless it knew that its competitors were doing the same. Absent such an assurance, an insurer would be undermining its competitive standing vis-à-vis other insurers.

180. MultiPlan is transparent that the value of its services stems from its ability to harvest competitively sensitive payment data from hundreds of insurance companies and to use that data to set rates for the entire industry. MultiPlan touts its "incomparable database"—populated with some 135 million claims a year, or "360,000 claims a day," from "700-plus payer customers"—as the single most "impressive" fact about the company, and the real reason insurers stand to benefit from the decision to "outsource the pricing of [their] out-of-network claims" to MultiPlan.

181. As one former MultiPlan executive, Paul Galant, signaled to the market on a 2020 earnings call, MultiPlan's ability to collect "claims from 700 payers" made the company's repricing tools "very, very different" from those operated by a "single payer" (such as Naviguard, United's in-house repricing tool). According to Galant, MultiPlan's access to industry-wide data, rather than its technology, was the reason "why [insurers] all come to MultiPlan" for claims repricing. And he boasted that MultiPlan's "data advantage" had created a "competitive moat

around [the] company that drives recurring revenues."[33]

182. Galant doubled down on these comments during a Virtual Analyst Day later in 2020. According to Galant, MultiPlan's value proposition had nothing to do with technology, bluntly stating that anyone can "create their own algorithms." The MultiPlan "difference," he explained, was that "we see data across 700 payors," enabling the company to "generate bigger savings" for clients and to obtain better concessions from physicians in negotiations. According to this executive, because MultiPlan can "talk to the entire industry"—rather than just one "specific payer"—it was better equipped to "push for savings" than a payer, acting individually, "who decides to do everything on their own." [34] In other words, MultiPlan could deliver results for insurers because it enabled their collective action.

183. To attract new cartel members (and ensure the ongoing participation of existing members), MultiPlan regularly announces how many insurers are part of its price-fixing scheme. In 2020, Mark Tabak, then-CEO of MultiPlan, stated publicly that the company was "the leader in out-of-network cost containment" and had entered into "multi-year contracts with the leading payers" to provide out-of-network claims repricing service. Likewise, in 2023, MultiPlan executives bragged that "all of the top 15 insurers" in the country had agreed to use MultiPlan's out-of-network claims repricing services.

184. MultiPlan makes the same kinds of representations in private to insurers. For example, MultiPlan's former Chief Revenue Officer, Dale White, induced United to join the MultiPlan Cartel in 2016, stating in an email that seven of the insurer's top ten competitors were already using MultiPlan's repricing services. According to the White, "[i]mplementing these

[33] *See also* MultiPlan Corporation, Non-Deal Roadshow Presentation, New York City (Nov. 19, 2020), https://perma.cc/FW4Z-LDWG.
[34] *See*, *supra*, note 15.

initiatives [would] go a long way to bring United back into alignment with its primary competitor group [Blues, Cigna, Aetna] on managing out-of-network costs." One of the recipients of White's email, United executive Rebecca Paradise, would later testify that a key factor in United's decision to use MultiPlan was that it was "widely used by our competitors." Such statements confirm that concerted action is the point of the MultiPlan Cartel, and that the Other Insurer members of the MultiPlan Cartel join it precisely because their competitors have also agreed to do so.

185. White's email to United was nothing more than an invitation to collude. And it assured United's executives that by joining the collusive scheme, United's out-of-network payments would be "aligned" with those of its competitors, thus enabling the insurer to lowball physicians without suffering competitive harms or "abrasion." This same dynamic has played out with countless other insurers.

B. Insurers have accepted MultiPlan's invitation to collude, demonstrating their commitment to the scheme in several ways.

186. As MultiPlan regularly boasts, over 700 insurers, including all of the nation's top 15 healthcare payers, have accepted MultiPlan's invitation to participate in concerted action with respect to the pricing of out-of-network claims. These insurers show their acceptance of MultiPlan's invitation to collude in at least three ways.

1. Insurers delegate their pricing decisions to MultiPlan through contractual agreements, relinquishing control over key business decisions.

187. First, insurers enter into contracts with MultiPlan through which they delegate to MultiPlan the authority to determine out-of-network payment rates and negotiate those rates with physicians to ensure they accept them. The very act of contracting with a common third party to determine rates and negotiate with physicians signals insurers' conscious commitment to adhere to MultiPlan's price determinations, facilitating their collective action.

188. Under MultiPlan's out-of-network claims repricing services contracts, insurers agree to set payment preferences through "mutual[] agree[ment]" with MultiPlan and abide by MultiPlan's "negotiated rates" so long as they are "consistent with the business criteria mutually agreed upon between [the insurer] and MultiPlan." Through these provisions, insurers delegate to MultiPlan control over key business decisions that directly impact payment rates. The fact that all of MultiPlan's insurer clients cede control to MultiPlan in this way enables MultiPlan to orchestrate uniform behavior by each of its insurer clients to achieve their common, illicit goal of suppressing payment rates across the board—a goal from which MultiPlan profits handsomely.

189. By outsourcing their independent decision-making and negotiation authority to a mutually agreed-upon third party, insurers know that they will not (and cannot) be disciplined by physicians for setting ever-lower payment rates. Physicians are forced to accept unprecedentedly low payment rates, without recourse to balance billing, because virtually all insurers now use MultiPlan's out-of-network claims repricing services. In other words, physicians have nowhere to turn for better terms, and must deal with MultiPlan or receive no payments at all (and rely solely on payments from patients, which is rarely, if ever, a practical alternative).

2. ***Insurers share sensitive data with MultiPlan, granting it access to proprietary information that would not be shared in a competitive market.***

190. Second, insurers provide MultiPlan with copious amounts of competitively sensitive data, including their payment data and payment preferences (including the overrides and caps they enter into Data iSight).

191. Insurers share this data with MultiPlan because they know that MultiPlan will use it to assist them and their co-conspirators (including through the setting of out-of-network payment rates and the effectuation of pricing strategies). They also participate in information sharing so that they can benefit from the proprietary data their competitors are likewise providing to MultiPlan.

192. MultiPlan's relationship with United illustrates how the company leverages insurers' proprietary payment data and pricing strategies to effect its scheme to suppress industry-wide out-of-network prices:

193. In 2016, MultiPlan induced United to join the MultiPlan Cartel by representing that its major competitors had already entered into repricing services agreements with MultiPlan. In 2017, MultiPlan instructed United to pursue a specific, aggressive override strategy, based on what MultiPlan's other insurer clients were doing, that would drive down industry-wide payment rates. In particular, MultiPlan's Dale White instructed that United set out-of-network payments at 350% of Medicare rates, assuring United executives that, by agreeing to use this formula, United would "be in line with [one] competitor" and "leading the pack along with another competitor." MultiPlan was aware of the pricing strategies of United's competitors because, as MultiPlan clients, they had set those benchmarks via "mutual agreement" with MultiPlan. MultiPlan then used that information to make a similar instruction to United. Thus, MultiPlan's role as a clearinghouse for competitively sensitive and otherwise non-public pricing data of each of the members of the MultiPlan Cartel is essential to its ability to orchestrate the MultiPlan Cartel, and to bring each member of the MultiPlan Cartel in alignment with the cartel's overall pricing moves.

194. Against this backdrop, United's pricing became increasingly aggressive over time, backed by MultiPlan's assurances that its out-of-network payments were still consistent with industry norms. Eventually, United agreed with MultiPlan to implement a cap of 250% of Medicare rates in Data iSight. As United executives later explained in a Customer Impact Advisory Brief, it was "utilizing Data iSight, owned by MultiPlan, to administer [an outlier cost management program]" and "90 other payors nationwide use [Data iSight] in a similar manner." United's agreement to MultiPlan's proposed cap thus turned on its understanding that its competitors had

already entered similar agreements with MultiPlan. Absent that assurance, it, like its competitors, would not enter such an agreement because it would be against their independent economic interests.

195. MultiPlan has leveraged its access to insurers' proprietary data and preferences to orchestrate similar agreements with each of the largest health insurance companies in the United States, which would otherwise be competing among themselves for the services of out-of-network physicians by paying market rates.

3. ***Insurers adhere to MultiPlan's pricing determinations, effectively accepting its pricing as the final word for out-of-network claims.***

196. Third, insurers abide by MultiPlan's price determinations. MultiPlan enforces this outcome through its contracts with insurers. Pursuant to MultiPlan's standard out-of-network claims repricing services contract, the insurer cannot set its payment rates as it sees fit. Pricing preferences can only be entered by "mutual agreement" with MultiPlan. Moreover, the insurers' ability to deviate from the Data iSight rate is constrained, as each insurer agrees "not to reduce the . . . provider's rate for claims for which [MultiPlan] has negotiated a rate . . . provided that the negotiated rate is consistent with the business criteria mutually agreed upon between [the insurer] and MultiPlan." The business criteria set by insurers are also informed by MultiPlan's access to and divulging of the competitively sensitive information of other insurers. Because it would be economically irrational for an insurer to pay more than a physician was willing to take, the bar on reducing a provider's rate below what MultiPlan has determined constitutes a tacit agreement by the insurer to pay exactly what MultiPlan instructs it to pay.

197. This tacit agreement is borne out in practice. MultiPlan processes some 370,000 claims per day for its clients. Given this volume, insurers cannot (and do not) independently assess whether MultiPlan's algorithmically adjusted rates are reasonable. Instead, virtually all MultiPlan-

generated rates are sent to providers (usually by MultiPlan itself) with no modification whatsoever on the part of the insurer (or any other form of "human touch").

198. In some 95–99% of cases, providers are stuck with the MultiPlan-generated rates initially offered. As a result, the MultiPlan rate determination is the final payment amount in virtually all cases.

C. The MultiPlan Cartel operates as a "hub-and-spoke" conspiracy, with MultiPlan coordinating an agreement between insurers to fix prices for out-of-network services.

199. The MultiPlan Cartel is also a "hub-and-spoke" conspiracy that is per se illegal under the Sherman Act. Under this mode of analysis, MultiPlan is the "hub" of the conspiracy and the Co-Conspirator insurance companies' agreements with MultiPlan to reprice their claims are the "spokes." The "rim" of the conspiracy is the agreement between the Co-Conspirator insurance companies to use MultiPlan's repricing methodologies to suppress out-of-network payments.

200. Prior to the Co-Conspirators joining the MultiPlan Cartel, commercial health insurance providers made several attempts to underpay healthcare providers through unilateral action. For example, before it joined the MultiPlan Cartel in 2017, in May 2015, United paid $11.5 million to resolve claims that it used down-coding software algorithms, stalling tactics, and other unfair business practices to underpay healthcare providers in Connecticut, New York, North Carolina, and Tennessee. Likewise, in September 2015, United agreed to pay $9.5 million to settle claims that it systematically underpaid out-of-network claims in California. However, these unilateral efforts could be thwarted by healthcare providers, because the providers could elect to provide non-emergency care to patients from other health insurance networks.

201. Commercial health insurance companies realized the need for collective action. Initially, United attempted to solve that collective action problem using its subsidiary, Ingenix. However, when the AMA and the New York State Attorney General shut down the Ingenix

scheme, commercial health insurers needed a new way to agree among themselves to underpay out-of-network claims.

202. MultiPlan solved that problem. It advertised itself to insurance companies as a hub that could be used to collectively reduce out-of-network payments to healthcare providers. As MultiPlan told its investors, using MultiPlan is a "much better mechanism" for payors to collectively slash payments "versus doing it themselves." According to MultiPlan, this is because "if a pay[o]r decides to do everything on their own, their ability to go back to providers and push for savings is fundamentally different than ours. [W]e can talk to the entire industry."[35]

203. For example, as noted above, MultiPlan told United that many of United's competitors were using MultiPlan's repricing services to slash out-of-network payment rates. MultiPlan further advised United on the pricing levels and methodologies adopted by its competitors. MultiPlan eventually reached an agreement to reprice United's claims. Thus, one spoke of the conspiracy was formed—the agreement between MultiPlan and United to suppress out-of-network payments in reference to their competitors' pricing levels and methodologies.

204. MultiPlan persuaded the vast majority of large competing health insurance companies to become "spokes" in the conspiracy through similar inducements. MultiPlan has contracts with the top 15 health insurance payors in the nation and agreements with over 700 insurance payors to reprice their claims. Each of these contracts between a health insurance payor and MultiPlan forms another "spoke" in the MultiPlan Cartel's "hub-and-spoke" conspiracy.

205. MultiPlan uses similar tactics to facilitate collusion along the rim of the alleged hub-and-spoke conspiracy. MultiPlan informs each of the payors that other major payors are using MultiPlan's repricing services to suppress out-of-network claims, that those payors are generating

[35] *See*, *supra*, note 15.

substantial revenues by underpaying out-of-network claims, and that the payor can bring itself into "alignment" with the rest of the industry.

206. Thus, each of the payors knows that its competitors have considered or are considering the same terms offered by MultiPlan—i.e., suppressing out-of-network claims payments and splitting the revenues generated by doing so. Each payor has a strong motive to enter into the conspiracy because they know that without substantially unanimous action, agreeing to unilaterally cut out-of-network payments would be economically self-defeating. And, in the end, each payor agrees to the same course of conduct, which constitutes an important departure from their prior practice of using UCR or FAIR benchmarks to compete against one another on out-of-network payments.

207. Importantly, there is no valid business reason for each of MultiPlan's Co-Conspirators to have entered into agreements with MultiPlan to cut payments to out-of-network physicians. Payors could have created their own in-house repricing tools (and some came close to doing so)—the math behind MultiPlan's methodologies is quite simple. In addition, payors could have used the FAIR benchmark to reprice claims. The only plausible explanation for every healthcare payor of any consequence agreeing to use MultiPlan's out-of-network claims suppression methodology is that MultiPlan provided them with assurances that they could agree to do so with the common understanding that they would not be undermining one another via competition on payment rates.

208. As discussed above, there is extensive circumstantial evidence that health insurance companies have agreed with each other to use MultiPlan's "repricing" methodology to suppress out-of-network payments to physicians, thus forming the "rim" of the conspiracy. This includes evidence that MultiPlan facilitated a parallel transition among insurance companies from a

competitive regime to a coordinated regime, and a variety of "plus factors" that tend to exclude the possibility that this parallel conduct was the result of independent action.

D. There is direct evidence of the MultiPlan Cartel's existence.

1. Contracts between MultiPlan and the Insurers evidence the MultiPlan Cartel conspiracy.

209. MultiPlan has entered agreements with some 700 insurers, comprising nearly every commercial payor in the United States, including the Other Insurer members of the MultiPlan Cartel, which expressly contemplate that MultiPlan and the insurer will collude to set the payment levels for out-of-network claims. These contracts include an agreement to share proprietary data, to use MultiPlan's repricing technologies to lower payments made on claims for payment by out-of-network healthcare providers, and to allow MultiPlan to negotiate rates with providers to eliminate balance billing. Several of these contracts are publicly available.

210. Despite MultiPlan's efforts to keep many of these agreements out of the public eye, many facts concerning those agreements are publicly known. Some versions of MultiPlan's contracts with competing healthcare payors contain an exhibit or amendment entitled "Repricing Services" that allows the competing payor to route its out-of-network claims to MultiPlan for repricing via a direct electronic data interchange or a web-based interface. The contract also specifies the repricing method to be used. Thus, MultiPlan and its competitors have entered into agreements that explicitly discussed the methodology they would use to suppress payments for out-of-network services to physicians.

211. One agreement between MultiPlan and Aetna, for example, provides that the parties must mutually agree upon pricing preferences, and that Aetna will honor rates negotiated by MultiPlan so long as they are "consistent with the business criteria mutually agreed upon between [Aetna] and [MultiPlan]." The parties also agree "[w]here the negotiated amount is less than the

original billed charge," MultiPlan must "obtain the provider's signed agreement to the revised amount or secure proper documentation stating no 'balance bill' to the patient except for deductible, coinsurance and non-covered services based on the providers' adjusted price[.]"

212. In 2014, Cigna and MultiPlan entered into a Master Services Agreement, which has been amended several times to include statements of work and addendums. On April 1, 2015, Cigna and MultiPlan entered into Statement of Work No. 4. This Statement of Work covered repricing of inpatient and outpatient services and repricing using MultiPlan's Data iSight product.

1. **Scope of Work**

1.1 Services

Supplier shall provide the following Services in accordance with the terms and conditions of the Agreement to Company: medical review analysis, including but not limited to, Inpatient Repricing Services (IPR), Outpatient Repricing Services (OPR) and DataiSight (DiS) Repricing Services, (collectively, "Medical Review Analysis" (MRA)) in accordance with all regulatory requirements and guidelines and as defined and described below.

213. The publicly filed version of the Cigna Statement of Work is redacted and does not reflect the percent of savings MultiPlan gets paid on repriced claims.

6. **Fees and Invoicing**

6.1 The fees for the Services shall be as follows: Company will pay Supplier only for successfully priced claims resulting in Savings, in accordance with the following fee schedule.

Fees will not be paid for claims that were not successfully reduced and for which Savings were not achieved. Supplier expenses incurred for unsuccessfully priced claims will be the responsibility of Supplier.

Service	Fee
IPR Services	[redacted] of Savings†
OPR Services	[redacted] of Savings†
Data iSight*	[redacted] of Savings**

214. The Statement of Work No. 4 is dated April 1, 2015, but, on information and belief, was not made public until November of 2023 when it was filed as an exhibit in *TML Recovery*,

LLC et al. v. Cigna Corporation, et al., 8:20-cv-00269-DOC-JDE (C.D. Cal.).

215. Similarly, Asuris Northwest Health, Regence Blue Shield, Bridgespan Health Company, Regence Blue Cross Blue Shield of Oregon, and Regence Blue Cross Blue Shield of Idaho entered into agreements with MultiPlan that address the repricing of out-of-network medical services. Information about the agreements was not made public until it was filed with the Washington State Insurance Commissioner in 2022 and 2023.

216. Other members of the MultiPlan Cartel have entered similar agreements with MultiPlan to access both its rental PPO networks and its out-of-network claims repricing services.

217. MultiPlan has taken steps to keep its agreements with competing health insurance payors a secret. For example, MultiPlan has a Service Agreement with Allied National, Inc. ("Allied") under which Allied utilizes MultiPlan's repricing methodology. The Service Agreement between MultiPlan and Allied states that it is "Confidential Not For Distribution." The Service Agreement also contains a Confidentiality and Proprietary Rights provision, which defines "Confidential Information" to include information relating to MultiPlan's repricing services and methodologies. The Service Agreement prohibits Allied from using that Confidential Information for any reason other than using MultiPlan's repricing services. When Allied filed a third-party complaint in *Butler v. Unified Life Insurance Company, et al.*, CV 17-50 (D. Mont. Nov. 18, 2021) that contained three paragraphs that disclosed information regarding MultiPlan's repricing services, MultiPlan sued Allied for disclosing that information. Ultimately, Allied removed its filing from the docket and redacted those paragraphs in its third-party complaint.

218. Upon information and belief, MultiPlan has entered into additional contracts with many competing commercial health insurance companies that require MultiPlan's competitors to use its out-of-network claims suppression technology.

*2. **Public statements and communications from MultiPlan and the Insurers acknowledge the existence of these agreements and the overall schemes.***

219. Members of the MultiPlan Cartel have admitted to the existence of their agreements to suppress out-of-network payment claims in communications with healthcare providers and the public.

220. MultiPlan is a horizontal competitor of the Other Insurer members of the MultiPlan Cartel, a fact which flows from its position as a nationwide PPO network operator. According to MultiPlan, it operates "the oldest and largest independent Preferred Provider Organization (PPO) network" in the United States. Even as MultiPlan expanded its business from PPO networks into analytic "repricing" tools, as described below, it continued to operate its PPO networks. In 2022, it again claimed to operate "the largest primary PPO in the nation."[36]

221. As described above, to attract physicians to its rental network, MultiPlan must offer them competitive payment rates (and other inducements, such as patient steerage). If MultiPlan offers rates (or other terms) that are inferior to what competitor networks offer, it will lose the battle for physicians.

222. In this contest for physicians, MultiPlan competes against insurers that offer PPO plans, including the Other Insurer members of the MultiPlan Cartel. Thus, as MultiPlan has admitted in public filings, MultiPlan "compete[s] with regional PPOs targeting primary network business," and "with PPO networks owned by [its] large Payor customers."[37] Indeed, MultiPlan's executives have been forced to admit under oath that MultiPlan is a health insurance payor. As Marjorie G. Wilde, Senior Counsel for MultiPlan, explained in a declaration filed in *Jonathan Hott, M.D. v. MultiPlan, Inc.*, 1:21-cv-02421-LLS (S.D.N.Y. Aug. 15, 2022) (ECF 38-2 ¶¶ 3–4):

[36] *See* MultiPlan, MultiPlan's PHCS Network Receives Eleventh Consecutive NCQA Accreditation in Credentialing (July 12, 2022), https://perma.cc/36SD-9QE3.
[37] *See*, *supra*, note 13.

> MultiPlan provides healthcare cost management services and operates a network-only preferred provider organization ("PPO") that does business nationwide by contracting, on the one hand, with healthcare providers, such as hospitals, physicians, physician groups and ancillary providers ("Network Agreements"). These contracted providers agree to give discounts off of medical services rendered to the beneficiaries of clients of MultiPlan. . . . On the other hand, MultiPlan also contracts with its clients, which include health insurance carriers, health maintenance organizations, self-funded health plans, third party [sic] administrators, and other third-party payors that have members and beneficiaries who receive medical services from the provider network assembled by MultiPlan.[38]

223. MultiPlan's public statements concede the existence of its agreements to suppress out-of-network payments with its competitors. On August 18, 2020, MultiPlan's then-CEO Mark Tabak described MultiPlan as "the leader in out-of-network cost containment." As Mr. Tabak explained to investors, MultiPlan has entered into "multi-year contracts with the leading payors," i.e., health insurance companies, to provide this service. He stated that MultiPlan drives down out-of-network payments by "captur[ing] [out-of-network] claims" from competing health insurance networks that contract with MultiPlan for its claims repricing services. MultiPlan then "direct[s]" those claims "to the proper solution set." While these "solution set[s]" may vary in name, they all

[38] In related litigation, MultiPlan has claimed that it is not a payor and does not compete against other payors. *See* Memorandum of Law in Support of Motion to Dismiss at 12, *Adventist Health System Sunbelt Healthcare Corporation v. MultiPlan, Inc.*, 1:23-cv-07031 (S.D.N.Y. Dec. 12, 2023) (ECF 65) (MultiPlan arguing that it does not "pay[] healthcare claims"). That is false. In October 2020, the Centers for Medicare and Medicaid Services ("CMS") finalized a rule known as the Transparency in Coverage Rule. Among other things, the rule requires group health plans and health insurance issuers to make available information on their websites in a machine readable format concerning their negotiated rates with in-network physicians and historical billed charges and allowed amounts. In April 2022, in accordance with the rule, MultiPlan produced network rate files for its PHCS network, Beech Street network, HealthEOS network, HMA network, and MultiPlan network. MultiPlan also produced out-of-network allowed amounts and billed charges to its MultiPlan network, Beech Street Network, and IHP network. MultiPlan made similar machine-readable files available again in December 2023. In other words, MultiPlan admits that it is covered by regulations concerning group health plans and issuers of health insurance and complies with those regulations.

serve the same function: to set out-of-network payment rates at agreed-upon levels or by using an agreed-upon methodology.[39]

224. The Co-Conspirators' plan disclosures also reflect the existence of the agreements between competitors. For instance, Aetna's May 2022 disclosures state that MultiPlan is one of its external pricing vendors and that it will use Data iSight to price out-of-network claims, including using a MultiPlan "advocate" to negotiate with physicians on a member's behalf. United also provides a disclaimer regarding out-of-network providers in which it states that one methodology that may be used to establish the payment amount for out-of-network claims is Viant.

3. Internal communications between MultiPlan and Other Insurer members of the MultiPlan Cartel expose the inner workings of the cartel, revealing how they coordinate pricing and share information.

225. MultiPlan's communications with members of the MultiPlan Cartel shows how the price-fixing conspiracy unfolds in practice. They show that MultiPlan discloses pricing levels among competitors, recommends that they adopt parallel pricing, and then implements that pricing by taking over the Co-Conspirators' price-setting and price-negotiation functions.

226. United is the single largest health insurance company in the United States. Beginning on July 1, 2017, United and MultiPlan entered into an explicit agreement to suppress out-of-network health insurance payment prices.

227. United and MultiPlan implemented this agreement on or around July 1, 2017 by means of an Amendment to the Network Access Agreement (originally entered by United and MultiPlan on January 1, 2010).

228. MultiPlan began recruiting United into the conspiracy several years earlier. On or around October 1, 2015, MultiPlan sent United a presentation entitled, "Data iSight: Maximize

[39] *See*, *supra*, note 15.

Savings Using a Patented Methodology." This presentation argued that United would substantially increase its revenues if it stopped independently pricing out-of-network payments to healthcare providers and used MultiPlan's pricing methodology instead.

229. MultiPlan induced United to join the MultiPlan Cartel by explaining that United's competitors had already entered into similar agreements with MultiPlan and by disclosing the pricing levels adopted by those competitors. In 2016, MultiPlan's former Chief Revenue Officer, Dale White, wrote an email to United executives, explaining that seven of United's top ten competitors were using MultiPlan's repricing services. Mr. White encouraged United to do the same, writing: "Implementation of these initiatives in 2016 will go a long way to bring United back into alignment with its primary competitor group [i.e., Blues, Cigna, Aetna] on managing out-of-network costs."

230. One of the recipients of Mr. White's email, Rebecca Paradise, United's Vice President of Out-Of-Network Payment Strategy, explained that a key factor in United's decision to agree to use MultiPlan's out-of-network payment suppression technology was that the technology "was widely used by our competitors."

231. Mr. White, MultiPlan's Chief Revenue Officer at the time, relayed to another United executive, John Haben, that by agreeing to use the 350% of Medicare rates formula in Data iSight, United would "be in line with another competitor" and "leading the pack along with another competitor."

232. Haben subsequently wrote in an internal United email: "If we implement benchmark pricing as described, with the intent to reduce the threshold to 350 percent CMS, United would be leading the pack along with a major competitor." In that email, Haben referred to "350 percent CMS" as "recommended benchmark pricing."

233. On April 21, 2016, Emma Johnson, the Director of Sales and Account Management for National Accounts at MultiPlan, sent an email to Sarah Peterson (Director of Network Programs, United), Marie Rickmyer (Program Manager for United Out-of-Network Affordability), and Amy Barker (Associate Director of Claims at United) entitled, "Data iSigt HCFA nd [sic] UB ER [GRI and UNET] and other questions." In the email, Ms. Johnson sought agreements from United on the price that MultiPlan's Data iSight pricing methodology would set for certain emergency room claims provided to MultiPlan via United's UNET claims processing system and claims underwritten by United's Golden Rule Insurance Co. ("GRI") affiliate. In the email, Ms. Johnson wrote: "Please confirm your agreement" that pricing for certain emergency room claims "would be 350% of [Medicare] or the [Data iSight] rate whichever is greater" (emphasis added). United subsequently agreed with MultiPlan to set its pricing for those emergency medical services claims at 350% of Medicare rates.

234. In a September 8, 2016 email to Lauren Paidosh (another United employee), John Haben, the United executive, indicated specific knowledge of competitors' pricing formulas adopted through Data iSight. He wrote: "MultiPlan said seven of our top ten competitors use the tool today." He continued: "BCBS [Blue Cross Blue Shield] is even more aggressive and is accessing the option of moving DIS [Data iSight] up even higher to have IPR/OPR (R&C repricing) which is option 3." In this email, Mr. Haben demonstrated specific knowledge of the pricing "option" adopted by United's competitive rival, Blue Cross Blue Shield, in MultiPlan's Data iSight program.

235. Mr. Haben conceded that this knowledge of Blue Cross Blue Shield's pricing formula came from MultiPlan. He was asked under oath: "Did the information that MultiPlan shared with you to be passed along to Ms. Paidosh play any role in your views about whether you

would be comfortable using this product?" He answered: "my goal of informing her, from what I remember, is to inform the organization we are going to move forward with MultiPlan, and just giving them the heads up of our progress."

236. Mr. Haben summarized MultiPlan's recommendation in a 2017 email and presentation he sent to senior management at United entitled "OCM [Outlier Cost Management] MultiPlan Benchmark Pricing Overview." In the email, Mr. Haben wrote, "[t]oday, our major competitors have some sort of outlier cost management; they use Data iSight. United will be implementing July 1, 2017."

237. In the same email, Mr. Haben explained that the agreement between United and MultiPlan could "improve"—i.e., cut—United's out-of-network claim payment "by $900 million" per year.

238. Haben wrote in a 2017 United internal presentation about implementing MultiPlan: "By implementing Outlier Cost Management as currently planned, United catches up to the pack, but not leading."

239. United signed an amendment to its Network Access Agreement with MultiPlan that stated that United would send out-of-network claims to MultiPlan via an electronic data interchange, MultiPlan would use its pricing methodology to "reprice" those submitted claims, MultiPlan would take over the negotiation of those submitted out-of-network claims, and finally United and MultiPlan would split the revenue generated by underpaying providers for their out-of-network claims.

240. Mr. Haben later testified that United initially agreed with MultiPlan to suppress out-of-network claims in a less aggressive manner that put United in "the pack of its peers."

241. Over time, United became more aggressive and agreed with MultiPlan to

implement lower payment formulas in Data iSight, consistent with others in the industry.

242. United wrote in a Customer Impact Advisory Brief that it was "utilizing Data iSight, owned by MultiPlan, to administer [an outlier cost management program]. 90 other payors nationwide use [Data iSight] in a similar manner."

243. United tracked the amount of money that it underpaid healthcare providers using "OCM," its internal term for claims that were routed to Data iSight. United employees prepared a table with a column entitled "No OCM," meaning the additional amount that United would have paid on out-of-network claims had United not agreed with MultiPlan to use MultiPlan's Data iSight product to suppress out-of-network payment. That internal analysis shows that United's agreement with MultiPlan resulted in United paying hundreds of millions of dollars less in out-of-network claims than it would have without its agreement with MultiPlan.

244. MultiPlan and United continued to meet and communicate with one another to fine-tune the details of their agreement on out-of-network pricing and to use MultiPlan's proprietary pricing methodology. On March 13, 2018, MultiPlan officials met with United. During this meeting, MultiPlan provided a presentation entitled, "MultiPlan Update for UnitedHealthcare: 2017 in Review." During this presentation, MultiPlan noted that the agreement between MultiPlan and United had successfully suppressed out-of-network payments to healthcare providers and suggested ways to pay providers even less.

245. After instructing competing commercial payors on how to be in "alignment," MultiPlan pushed the MultiPlan Cartel to cut out-of-network payment rates. For example, in a September 29, 2019 presentation to United entitled "Competitive Landscape for Cost Management," MultiPlan told United that it was up to ten years behind its competitors in terms of cutting out-of-network payments to healthcare providers and urged United to cut its payment rates

further. This meeting was attended by Mr. Haben, who took contemporaneous notes of the meeting, which he sent to Rebecca Paradise, the Vice President of Out-of-Network Strategy for United.

246. During 2019, United agreed to further suppress out-of-network pricing for emergency room claims. Starting in March 2019, MultiPlan and United agreed to cut payments for emergency room services from 350% of Medicare pricing to 250% of Medicare pricing. That price cut was rolled out to providers throughout 2019.

247. Scott Ziemer, Vice President of Customer Solutions–Network at UMR (a United subsidiary), testified under oath that MultiPlan recommended that United use a repricing formula that capped out-of-network payments at 250% of Medicare rates. Mr. Ziemer further admitted that "we [United] don't give . . . instruction" to MultiPlan regarding what prices to set, and instead simply "rely" on MultiPlan's algorithm to determine the payment amount.

248. The fact that MultiPlan and United agreed to use a percentage of Medicare pricing to set out-of-network prices is particularly significant. MultiPlan and United knew that this was a way to make out-of-network pricing seem justified when what they were actually doing was agreeing to a substantial cut relative to the prior FAIR and UCR out-of-network prices that predominated prior to the MultiPlan Cartel. In a secret August 2019 white paper that was disseminated to United and others, MultiPlan confided that Medicare-referenced pricing was "inherently misleading" because most people "do[] not understand how low Medicare rates are." The white paper continued, "[t]he gap between [billed charges] and the barebones Medicare reimbursement can be significant." Thus, not only did MultiPlan and United agree to fix prices, they did so in a way that they knew was intentionally misleading and would generate significant underpayments for providers.

249. MultiPlan routinely shares these white papers with other members of the MultiPlan Cartel. For example, on January 1, 2019, MultiPlan sent a copy of its "Data iSight Professional Methodology" to United. Similarly, in 2016, MultiPlan sent copies of white papers entitled "Data iSight Product and Methodology Inpatient Module," "Data iSight Product and Methodology Outpatient Module," and "Data iSight Product and Methodology Physician Module." Similar white papers also exist for MultiPlan's Viant methodology.

250. Sean Crandell, MultiPlan's Senior Vice President of Healthcare Economics, admitted that MultiPlan's pricing methodology ended out-of-network pricing competition. Under oath, he testified as follows:

> Q. During the same time period, 2017 to 2020, was the out-of-network pricing recommended by Data iSight to United the same or different as that recommended to UnitedHealthcare's competitors?
>
> A. It was the same.

251. In the same testimony, Crandell was asked "if the Data iSight tool is used among various different companies in the industry, do the recommended payment rates generated by Data iSight tool vary depending on which client you're running that calculation for?" Crandell answered: "No."

252. The attorney conducting the examination followed up: "can the tool even factor in who the client is?" Crandell answered: "No, it can't. The system that generates the methodology cannot even factor in the client."

253. The same pattern that transpired with United also occurred with Cigna. In March 2016, officials from MultiPlan and Cigna met to discuss ways that they could work together to reduce out-of-network payments. During this "Non-Par Strategy Summit," Cigna displayed a slide deck that outlined how the company planned to work with MultiPlan to slash its out-of-network payments. Among others, this meeting was attended by Terri Cothron, Cigna's Manager of

National Ancillary & Non-Par Management, who was responsible for overseeing Cigna's contractual relationship with MultiPlan.

254. In advance of that meeting, MultiPlan sent Cigna an email with an attached presentation entitled, "2016 Network Development Meeting: A Client's Perspective on Out-of-Network Costs." The presentation outlined how Cigna could redirect billions of dollars in out-of-network claims from providers to itself and MultiPlan. During the March 2016 "summit," a MultiPlan representative explained how its proprietary pricing methodology (at that time, marketed under the brand names Viant and Data iSight) worked and how it could significantly lower payments to providers for out-of-network claims.

255. After attending MultiPlan's presentation at the March 2016 summit meeting, Ms. Cothron confided to a co-worker that MultiPlan's Data iSight and Viant pricing methodology, "scares me."

256. Nevertheless, Cigna contracted to use MultiPlan's pricing methodology for Cigna's out-of-network claims shortly thereafter. Cigna used internal "Whitebook Reports" to keep track of how much money it earned by underpaying providers using MultiPlan's pricing methodology. Those reports contain line items for each out-of-network claim and the corresponding amount of "savings" generated by using MultiPlan's pricing methodology.

257. Privately, MultiPlan crowed about how successful its agreement with Cigna was in cutting payments to providers for out-of-network claims. In a slide deck entitled, "Cigna & MultiPlan Governance Meeting, June 21, 2021," MultiPlan outlined that it had worked together with Cigna to cut payments to providers for out-of-network claims.

258. MultiPlan has entered into similar agreements with each of the largest health insurance companies in the United States, which would otherwise be competing among

themselves.

259. Recent reporting by The New York Times confirmed that MultiPlan coordinates a price-fixing conspiracy among the major commercial health insurers. Its April 7, 2024 exposé stated: "As MultiPlan became deeply embedded with major insurers, it pitched new tools and techniques that yielded even higher fees, and in some instances told insurers what unnamed competitors were doing, documents and interviews show." The New York Times quoted Lisa McDonnel, a United executive, as writing in an internal email that "Dale did not specifically name competitors but from what he did say we were able to glean who was who," referring to Dale White, the former CEO of MultiPlan.[40]

260. MultiPlan also engages in "road shows" in which it travels to competing insurance companies and provides updates on the claims repricing methodologies adopted by MultiPlan's customers and their competitors.

261. MultiPlan executives Dale White and Susan Mohler are involved in these "road show" presentations, wherein MultiPlan produces detailed descriptions of Data iSight's methodology, reviews the "savings" achieved for MultiPlan's customers, and recommends ways to further suppress out-of-network payments.

262. MultiPlan prepares white papers for its claims repricing clients and Co-Conspirators, which are essentially user's manuals instructing them on how to implement the scheme. These white papers include references to the claims repricing methodologies adopted by horizontal competitors.

[40] *See* NYT Report, *supra*, note 4.

4. ***A U.S. patent filed by a MultiPlan subsidiary explicitly details how the company and its insurer clients agree on a methodology to suppress out-of-network payments.***

263. MultiPlan has obtained a U.S. patent, the '522 patent, that describes its repricing methodology. That patent explains that MultiPlan and competing health insurance networks are explicitly agreeing on the methodology that will be used to calculate and suppress out-of-network payments. Specifically, the patent explains that MultiPlan's customers (i.e., competing healthcare payors) agree with MultiPlan on the methodology or calculation that MultiPlan's repricing tool will use to suppress payments to healthcare providers.

5. ***Government investigations and enforcement actions have also uncovered evidence of MultiPlan's agreements to suppress out-of-network payments to providers.***

264. Government investigations and enforcement actions have also revealed the existence of MultiPlan's agreements to suppress out-of-network payments to providers. According to an enforcement action by the New York Attorney General against AXA Equitable, in May 2009, AXA had a policy of reimbursing 100% of out-of-network claims. Without prior notice to its subscribers, in September 2011 AXA switched to using MultiPlan's Data iSight system to reprice out-of-network claims. As a result of that switch, AXA went from paying 100% of out-of-network claims to paying about 50% of those out-of-network claims.

E. There is indirect evidence of the MultiPlan Cartel's existence.

1. ***Insurers engage in actions which, absent concerted action, would be against their individual economic self-interest.***

265. As part of the MultiPlan Cartel, each member of the MultiPlan Cartel engages in numerous actions that (in the absence of concerted action) would be against their individual economic self-interest, but which, in the context of the scheme, maximize profits for the collective. These "actions against self-interest" are strong circumstantial evidence of a horizontal agreement among insurers to reduce competition for out-of-network physicians and suppress payment rates.

266. First, it would be against the economic self-interest of any individual insurer to lowball out-of-network physicians (the goal and consequence of using MultiPlan, including through agreements to implement aggressive rate caps) because doing so is well known to cause member and physician "abrasion" and, ultimately, economic harm. In the absence of collusion, insurers would pay competitive rates to avoid such economic harm, including subscriber dissatisfaction and loss.

267. Second, it would be against the economic self-interest of any individual insurer to pay for MultiPlan's expensive claims re-pricing services when there are far cheaper, comparable services on the market, including but not limited to those offered by FAIR. Unlike FAIR—which charges insurers a modest, flat annual fee—MultiPlan assesses its clients a fee for each repriced claim, which is based on a percentage of the difference between the billed amount and the sum ultimately paid. For any individual insurer, these contingent fees far exceed the flat annual fee they would have to pay to use FAIR. As such, absent collusion, insurers would not pay MultiPlan's fees and would use FAIR or another cheaper vendor. They do so only because the insurers and MultiPlan, collectively, do much better by essentially dividing their monopsony profits than they would in a fair, functioning, and competitive market not mired by collusion.

268. Third, it would be against the economic self-interest of any individual insurer (all of which are sophisticated, well-resourced companies) to use MultiPlan when they could simply develop their own internal algorithms to price out-of-network claims and avoid paying fees to a third-party vendor altogether. As MultiPlan has itself admitted, anyone can "create their own algorithms."[41] And, in fact, United did develop such an algorithm, known as Naviguard. However, United scrapped Naviguard in 2020 after MultiPlan made United a sweetheart deal—in the form

[41] *See*, *supra*, note 15.

of a massive contingent fee discount—to remain within the MultiPlan Cartel. Absent collusion, it would have been economically irrational for United to scrap Naviguard after investing the resources necessary to develop it.

269. Fourth, it would be against the economic self-interest of each member of the MultiPlan Cartel to share its competitively sensitive and proprietary pricing data and strategies with other insurers through a common third party, unless they knew all other insurers had agreed to do the same. In the absence of concerted action, insurers would not share such information with rivals (through an intermediary or otherwise) because of the risk of competitive harm. After all, competitors could use the information to make superior bids to out-of-network physicians and strengthen their PPO networks and plan offerings relative to the competition.

270. In addition, the MultiPlan Cartel's conduct is parallel. MultiPlan Cartel members have suppressed the amount paid to physicians for out-of-network claims and, in a continuous and parallel fashion, sent repricing notices and depressed payments to physicians pursuant to the MultiPlan Cartel agreement.

271. MultiPlan also facilitated a transition away from a marketplace in which commercial insurers competed to offer out-of-network physicians UCR payments to a coordinated regime in which commercial health insurance networks cut payments to physicians and then split those "savings" with self-funded insurance plans.

272. The insurance market is made up of two types of plans, risk-based (also called "fully insured") and ASO (also called "self-funded"). Under a risk-based model, the insurance company collects premiums and pays claims. If the premiums exceed the claims, the insurance company profits, but if the claims exceed the premiums, the insurance company carries the risk of loss. Under an ASO model, the employer carries the risk instead— the premiums are paid into the

coffers of the employer, and the employer is responsible for paying its employees' claims. The employer pays the insurance company a fixed administrative services fee, per member, per month (a "PMPM" fee) to administer the ASO plan. Under these ASO contracts, the employers take on the risk and associated insurance companies enter into "shared savings agreements" that permit the insurance company to send out-of-network claims for ASO employers to MultiPlan for repricing. Large employers, which make up a substantial or even dominant portion of the market for commercial insurance, are almost all on ASO contracts.

273. In order to profit from the out-of-network payment suppression under the MultiPlan Cartel, the cartel members added new terms to their ASO contracts. In addition to the PMPM fees, those ASO contracts now require self-insured groups to pay a percentage (usually between 29–35%) on the difference between a billed out-of-network charge and the amount paid on that out-of-network claim, known as the "shared savings fee." Under the most egregious instances of claim payment suppression, that shared savings fee could end up being even higher than the amount paid to the physician performing the services.

274. For example, a notification concerning Nokia Corporation's ASO plan notes that Nokia participates in a "shared savings program" administered by United. That notice states: "UnitedHealthcare uses a service called Data iSight to review select out-of-network claims and recommend a reduced payment amount for out-of-network covered services."

275. These shared savings agreements generate tremendous profits for insurance companies and self-funding employers at the expense of physicians. United made approximately $1.3 billion from its shared savings agreements to suppress out-of-network claims in 2020. Moreover, in an internal presentation, United stated that it intended to cut its out-of-network payments by $3 billion by 2023.

276. Therefore, if a subscriber group self-finances its health insurance benefits and enters into an ASO agreement with a commercial health network, the subscriber group, health insurer, and MultiPlan enter into multiple explicit agreements to suppress out-of-network payments to physicians and then split the ill-gotten profits from their conspiracy among MultiPlan, the insurance company, and the subscriber group.

277. As a result of these agreements, UCR payment (at least in any real sense), once the industry standard, has gone by the wayside. As John Haben, the former Vice President of Networks at United, testified under oath, United, like the rest of the commercial insurance industry, moved from paying out-of-network claims at "reasonable and customary" rates, or rates determined by benchmarking databases, to using MultiPlan's out-of-network claim suppression tools. One example of such a benchmarking database is FAIR, an independent database that houses aggregated information designed to provide a reasonable and consistent basis for setting payment rates. Before MultiPlan's repricing scheme, FAIR was widely used throughout the industry in pricing out-of-network payments.

278. Mr. Haben testified that United did not want to continue using "reasonable and customary" payment rates because those costs were "uncontrolled." As a result, "reasonable and customary" payments for out-of-network claims are a "legacy program" that United rarely, if ever, uses.

279. Similarly, Debra Nussbaum, an employee of Optum, which is a subsidiary of United, testified at a deposition in case *In re: Out of Network Substance Use Disorder Claims Against UnitedHealthcare*, 19-cv-02075 (C.D. Cal.), that "when [she] first started with Optum/United Behavioral Health, many plans were utilizing reasonable and customary or UCR. I think that, over time, I've seen a major shift to other out-of-network reimbursement

methodologies."

280. Instead, United, like all of its competitors, has shifted to a "shared savings" model where, instead of paying the prevailing "reasonable" rate for a service, they all use the same tools to reduce payments. And since they all have the same "shared savings" clauses in their ASO contracts, they all profit in the exact same way.

281. This parallel shift to a new paradigm was orchestrated by MultiPlan, whose sales executives have repeatedly touted the ability of their repricing service to create "savings" by underpaying out-of-network claims. For instance, in 2014, MultiPlan told insurance networks that inpatient and practitioner savings for its Data iSight product were between 55% and 65%. They told multiple networks about the "success" their competitors had experienced in implementing Data iSight and other MultiPlan claims repricing services—thereby encouraging those networks to join their competitors in implementing parallel conduct.

282. MultiPlan advertises to competing health insurance networks that Data iSight achieves "optimal reimbursement"—i.e., lower payments to physicians—when "compared to Usual and Customary and Medicare-Based pricing."

283. As a result of this coordination by MultiPlan, nearly all major insurance companies have implemented "shared savings" strategies, and nearly all of them use MultiPlan's tools to implement those services.

284. MultiPlan's repricing services also generate parallel repricing offers. According to a complaint filed against MultiPlan in *Emergency Group of Arizona Professional Corp., et al. v. United Healthcare, Inc., et al.*, CV2019-004510 (Sup. Ct. Ariz., Maricopa Cnty., June 10, 2019), MultiPlan's repricing services result in members of the MultiPlan Cartel offering parallel reimbursement amounts for out-of-network services regardless of the location where the service is

offered. For instance, charges that were submitted for CPT code 99284 (emergency department visit for the evaluation and management of a patient) on different dates in early 2019, and in different states, nonetheless resulted in MultiPlan presenting the same reimbursement price:

Location	Date of Service	Billed Amount	CPT Code	Allowed Amount
Wyoming	1/21/19	$779	99284	$413.39
Arizona	1/25/19	$1,212	99284	$413.39
New Hampshire	1/25/19	$1,047	99284	$413.39
Oklahoma	2/8/19	$990	99284	$413.39
Kansas	2/10/19	$778	99284	$413.39
New Mexico	2/10/19	$895	99284	$413.39
California	3/25/19	$937	99284	$413.39
Pennsylvania	5/20/19	$1,094	99284	$413.39

This makes no sense absent the existence of a conspiracy. Because the cost of care in Manhattan, New York, is higher than in Manhattan, Kansas, all legitimate methods of reimbursing out-of-network claims account for the geographic difference between where care is administered

285. In a competitive market, competing health insurance networks would not agree to use a common tool provided by the same company to suppress out-of-network claims. Among other things, by paying reasonable out-of-network reimbursement rates, health insurance networks could be certain that their insureds would not be refused treatment in contexts where a physician had the ability to refuse treatment (i.e., outside of the emergency department). Moreover, absent a conspiracy, health insurance networks would make independent decisions on how to reimburse out-of-network claims, with the freedom to consider the specific circumstances underlying each submitted claim, rather than automatically underpaying claims through MultiPlan's across-the-board methodology.

286. Even if competing health insurance networks' only natural incentive was to keep out-of-network claims effectively contained, they would not naturally agree to do so using the

same tools from the same physician. Instead, these competitors should want to compete to find the optimal balance between keeping the costs of claims down while also minimizing the costs of claims disputes that arise when reimbursement offers are too low.

287. But if the competing health insurance networks agree to implement the exact same reimbursement suppression strategies, they can collectively maximize their profit while shielding themselves from the costs of disputes. The only market players that lose are the physicians who have no choice but to accept the suppressed reimbursement offers.

2. ***The market for out-of-network physicians is susceptible to the formation, maintenance, and efficacy of a cartel.***

288. As the Ingenix debacle shows, the insurance industry is characterized by numerous features, sometimes called "plus factors," that render the industry susceptible to collusion and bolster the plausibility of the cartel alleged herein.

289. Multiple "plus factors" support the existence of MultiPlan's collusive agreements to suppress out-of-network reimbursements, including: (1) high market concentration in the relevant market; (2) high barriers to entry; (3) ample motive to participate in the MultiPlan Cartel; (4) out-of-network physicians face high exit barriers when seeking reimbursement for services they provide; (5) the claims submitted by out-of-network physicians for reimbursement from insurers are relatively fungible; (6) a history of prior collusion; (7) numerous opportunities to collude, including those directly facilitated by MultiPlan; (8) actions against self-interest that only make sense as part of a common plan; (9) evidence of cartel enforcement mechanisms; (10) pervasive and systematic information exchange between the cartel members and MultiPlan; and (11) customary patterns and courses of dealing that can only be explained by the existence of a cartel agreement. These "plus factors" support the existence of agreements between MultiPlan in a horizontal price-fixing conspiracy.

a. High Concentration

290. First, the market among health insurers is highly concentrated. In 2022, the AMA found that 86 percent of PPO markets are highly concentrated as calculated under the Herfindahl-Hirschman Index ("HHI"), a metric used by federal regulators to measure market health with respect to concentration. The AMA, moreover, found that in 58% of metropolitan areas, a single insurer enjoyed a 50% or greater market share, with a significant number of metropolitan areas witnessing a single insurer controlling market shares of 70% or greater. In addition, according to Forbes, in 2021, the top 15 healthcare insurance companies in the nation controlled almost 60% of the entire commercial health plan enrollment in the United States. MultiPlan itself acknowledges this high level of market concentration. In an August 18, 2020 Analyst Day presentation, MultiPlan wrote that "[t]he health insurance sector has consolidated to four top insurers."[42]

b. High Barriers to Entry

291. Second, there are high barriers to entry that make it difficult for new companies to enter the commercial health insurance market with competing plans. These barriers include state and federal regulatory requirements, costs associated with developing physician and patient networks, and developing enough business volume to spread risk. To even gain a foothold, new entrants need to be able to bear the extreme expenditures of time and money required to develop a network of physicians large enough to compete as a commercial healthcare insurer. Even if a new entrant opted not to develop an insurance network, there would still be significant capital outlays required in order to operate as a commercial healthcare payor. They then face the challenge of contending with the economies of scale enjoyed by the large incumbent insurers. Establishing name recognition in an industry occupied by long-entrenched and well-recognized major players

[42] *See*, *supra*, note 15.

presents an additional hurdle.

c. Ample Motive to Participate in Cartel

292. Third, MultiPlan and the members of the MultiPlan Cartel have a massive financial motive to suppress reimbursement payments for out-of-network services. MultiPlan is paid a percentage of the underpayment to physicians. In other words, it only makes money if the cartel is successful in suppressing out-of-network reimbursement payments. The more the cartel suppresses, the more MultiPlan gets paid.

293. Likewise, the Co-Conspirator insurance companies are incentivized to suppress payments to physicians to increase their own profits. For example, in an internal email, United executives stated that by "driving all OON [out-of-network] claims to a more aggressive pricing," United could generate more profits than if it continued paying out-of-network claims at usual and customary rates. The motives of MultiPlan and its Co-Conspirators are aligned because the less the MultiPlan Cartel pays to physicians, the more revenue and profits they get to keep for themselves and split pursuant to their anticompetitive agreements.

294. As MultiPlan itself stated in a presentation to investors, its payor-customers' "incentives are completely aligned" with its own. Indeed, in MultiPlan's 2023 10-K, MultiPlan said: "In addition, because in most instances the fee for our services is linked to the savings we identify, our revenue model is aligned with the interests of our customers. . . . Approximately 90% of revenues for the year ended December 31, 2023 were based on a [percentage of savings] achieved rate."

295. In addition, some insurance companies may have believed (wrongly) that conspiring with their competitors in this way was more appropriate than developing their own out-of-network pricing policies. For example, in 2015, a Cigna employee sent an internal email regarding out of network outpatient behavioral health charges. In the email, the employee

expressed concern with developing "[M]edicare equivalent" charges internally, referencing the problems with Ingenix (detailed further below). In the email, the Cigna employee stated: "We cannot develop these charges internally (think of when Ingenix was sued for creating out of network reimbursements)[.] We need someone (external to Cigna) to develop acceptable Medicaid or otherwise acceptable charges . . . ."

d. High Exit Barriers

296. Fourth, out-of-network physicians face high exit barriers when seeking reimbursement for services they provide. As noted previously, in the United States, some 90% of all healthcare costs are reimbursed, not by patients, but by third-party payers. Given this reality—along with laws and regulations limiting the ability of physicians to directly bill patients as well as the practical difficulties in collecting on balance bills—out-of-network physicians generally have no substitutes for where to seek reimbursement but from a patient's insurer. The only way for out-of-network physicians to "exit" this third-party payer system is to refuse to treat patients unless they pay cash, something very few patients can afford.

e. Fungibility

297. Fifth, the claims submitted by out-of-network physicians for reimbursement from insurers are relatively fungible. All claims are submitted using uniform billing codes, no matter the insurer or the physician. This allows MultiPlan to reprice claims consistently for like claims submitted by physicians to different insurers and across different health plans, across the entire country, making it feasible for MultiPlan and the other members of the MultiPlan Cartel to execute their anticompetitive scheme.

f. History of Prior Collusion

298. Sixth, MultiPlan Cartel members have a history of prior collusion. It is easier for firms in a market to conspire with one another if they have done so before. Because commercial

health insurance networks cannot collectively control out-of-network reimbursement rates through legally enforceable contracts (which is the way that they have traditionally controlled in-network reimbursement rates), they have attempted to enter into illegal cartel agreements to suppress out-of-network reimbursements on multiple occasions. As noted above, in 2000 the AMA and then in 2008, the New York Attorney General investigated United's subsidiary, Ingenix. The New York Attorney General's investigation showed that competing commercial health insurers were sending detailed information on their out-of-network claims to Ingenix to be included in a database that was used to calculate out-of-network reimbursement rates for commercial health insurers. The Attorney General's investigation showed that Ingenix's database resulted in out-of-network claims being underpaid by 10%–28%. On January 13, 2009, United entered into a settlement with the New York Attorney General under which United agreed to shut down the Ingenix database and contribute $50 million toward the creation of a new, independent database—the FAIR database—that would house more aggregated information. As part of a related civil settlement, United and other MultiPlan Cartel members agreed to use the FAIR database for a period of time. After that time period expired, United and other insurers agreed to join the MultiPlan Cartel. As a result of this prior collusion, the Co-Conspirators knew one another and knew that they could trust each other to collude and not alert the government to the existence of the MultiPlan Cartel.

g. Opportunities to Collude

299. Seventh, members of the MultiPlan Cartel have had ample opportunities to meet and collude, including at events organized and hosted by MultiPlan itself. For instance, MultiPlan maintains a Client Advisory Board ("CAB") that hosts lavish, multi-day retreats that bring together executives from competing health insurers to discuss topics such as MultiPlan's ability to deliver cost savings through its programs. These retreats occurred in 2015, as well as in 2019 and 2021, and possibly at other times. In 2019, MultiPlan hosted a CAB retreat at a luxury spa in Laguna

Beach, California attended by executives from MultiPlan, United, Aetna, Cigna, Humana, several Blue Cross Blue Shield associations, and other insurance companies. It held a similar event in the same city in 2021.

300. At these meetings, MultiPlan has seated insurer invitees next to each other, which gives them an opportunity to discuss and join the MultiPlan Cartel. According to sworn testimony by a United executive, at these events, insurance executives "[t]ypically . . . talk about things they've implemented" using MultiPlan's Data iSight scheme and "other things they're looking at" to reduce out-of-network costs and share with each other "new information" about their efforts in this regard. MultiPlan also makes its own presentations concerning cartel members' cost reduction efforts, facilitating the exchange of sensitive, proprietary payment information between rivals.

301. The Other Insurer members of the MultiPlan Cartel and MultiPlan have had opportunities to collude through other channels as well. Aetna, Cigna, HCSC, and other members of the cartel are members of AHIP (formerly, "America's Health Insurance Plans"), a trade organization of insurers that regularly holds conferences and meetings (both public and private). MultiPlan sponsors and sends representatives to AHIP events. Numerous executives employed by members of the MultiPlan Cartel and their co-conspirators sit on AHIP's Board of Directors, including: Gail K. Bourdreaux, President and CEO of Elevance; Bruce D. Broussard, President and CEO of Humana; David Cordani, Chairman and CEO of Cigna; Sarah London, CEO of Centene; Karen S. Lynch, President and CEO of CVS Health (the parent company of Aetna); and Maurice Smith, President, CEO, and Vice Chair of HCSC.

302. AHIP hosts conferences, committee meetings, and board meetings multiple times a year where its members participate in private, closed-door meetings. In 2023, MultiPlan sponsored AHIP's Annual Conference. Upon information and belief, MultiPlan representatives

attended AHIP's 2023 Annual Conference from June 13–15 in Portland, Oregon.

303. MultiPlan also engages in "road shows," visiting members of the MultiPlan Cartel, to provide updates regarding its claims repricing services. At these road shows, MultiPlan executives (including Dale White and Susan Mohler) have shared with insurers detailed descriptions of Data iSight's repricing methodology, the "savings" achieved by various MultiPlan customers, and recommendations to further reduce out-of-network reimbursements. Upon information and belief, MultiPlan meets with each of its clients each year at such road shows, which allows the MultiPlan Cartel to be regularly updated and renewed.

h. Actions Against Self-Interest

304. Eighth, insurers that joined the MultiPlan Cartel have engaged in actions against self-interest. The very agreements between MultiPlan and the commercial health insurance networks are economically irrational absent coordination. If a single insurance network entered into an agreement with MultiPlan to shift away from the UCR methodology and drastically underpay out-of-network claims, physicians would simply refuse to treat insureds of that network altogether (absent a scenario requiring treatment, such as emergency services). As a result, the health insurance network would face serious harm to the value and breadth of its insurance offering as physicians refuse treatment, ultimately leading to a loss of customers for the insurance network.

305. Such an agreement, standing alone, would also expose a health insurance network to significant time and cost expenditures associated with repricing negotiations. While healthcare providers cannot effectively negotiate with the MultiPlan Cartel due to the volume of MultiPlan repricing offers, a single insurance network acting alone would face significant pushback from providers.

306. The insurance network acting alone would also be less likely to secure deals to bring physicians in-network, further reducing the value and potential earnings of the insurance

network. These obvious impacts would reduce profits significantly more than any savings generated by the out-of-network underpayment agreement with MultiPlan. The only way the agreement with MultiPlan is not economically self-defeating is if all insurance networks agree to join the MultiPlan Cartel.

307. MultiPlan has explicitly told investors that its tools are "a much better mechanism" for repricing claims "versus [payors] doing it themselves." As MultiPlan's President of New Markets, Paul Galant, put it: "[I]f a payer decides to do everything on their own, their ability to go back to providers and push for savings is fundamentally different than ours." MultiPlan acknowledges that, without industry coordination, an independent payor cannot single-handedly slash reimbursements to providers. But, through MultiPlan, which "can talk to the entire industry," all payors can agree to join the MultiPlan Cartel and eliminate the risk of individual conduct.

308. In addition, the insurers that have joined the MultiPlan Cartel have refrained from engaging in self-interested, unilateral conduct that would have destabilized the cartel.

309. For example, MultiPlan's competitor-clients have abandoned efforts to in-source claims repricing activities despite the vast savings that such efforts would generate and—in at least one case—despite spending considerable sums actually developing an alternative claims repricing product. As the nation's single largest commercial health insurance provider, United could easily analyze its own historical claims database to ascertain the most efficient pricing levels for out-of-network reimbursements. It could then reprice claims received from healthcare providers based on that data. This would allow United to eliminate MultiPlan as a middleman, saving as much as 9.75% on each repriced out-of-network claim, an amount equal to hundreds of millions of dollars per year. In 2021, United created a product to do just that. It was known internally as Naviguard. One analyst described Naviguard as "an in-house replacement for MultiPlan."

310. United developed a "roadmap" to terminate its contract with MultiPlan by 2023 in anticipation of Naviguard coming online. That plan was ultimately scrapped. United renewed its contract with MultiPlan in January 2023 instead.

311. United's decision makes no economic sense absent a conspiracy. United, like all commercial payors, has a unilateral economic incentive to compete against other health insurance networks to ensure that its insureds can see any physician out-of-network and must therefore pay competitive reimbursement rates. United developed Naviguard to assess and pay claims unilaterally, consistent with that economic incentive. Instead of following through with bringing Naviguard online, United abandoned the project and effectively recommitted itself to the MultiPlan Cartel by renewing its contract with MultiPlan to use MultiPlan's out-of-network claims suppression technology.

312. United's expenditures on Naviguard and its subsequent decision not to bring claims repricing in-house and instead renew its contract with MultiPlan are actions against self-interest, which only make sense in the context of a horizontal conspiracy wherein MultiPlan is fixing prices among payors for out-of-network reimbursements.

313. Joining the MultiPlan Cartel makes very little sense for large payors, like United and Cigna, that can afford to create their own in-house claim suppression tools. It costs millions of dollars to build out the data links and associated information technology necessary to transmit securely a high volume of real-time claims information to MultiPlan for adjudication and repricing in less than 24 hours. It makes zero economic sense for a payor to spend millions of dollars building a data link so that it can share raw information on submitted claims and repricing adjudications with its competitor. The only rational explanation for taking on that sunk cost is that those payors believe that they can recoup those costs through the windfall profits generated by the MultiPlan

Cartel.

i. Evidence of Cartel Enforcement Mechanisms

314. Ninth, because a cartel agreement is illegal, members of the cartel cannot go to court to enforce their illicit agreement. As a result, they need to create informal structures for detecting attempts to disrupt the cartel agreement and ways of enforcing the cartel agreement by heading-off those attempted disruptions.

315. United's plan to abandon the MultiPlan Cartel and to use its in-house Naviguard system to reprice out-of-network claims was one such attempted disruption to the cartel agreement. Having the largest healthcare payor in the United States defect from the MultiPlan Cartel would inevitably destabilize the agreement and might cause other payors to reevaluate their participation in the cartel.

316. So, MultiPlan bought off United with a sweetheart deal. Upon information and belief, in 2022, MultiPlan and United negotiated a new contract for repricing services that went into effect in 2023. MultiPlan gave United extremely favorable commercial terms, allowing United to capture nearly all of the underpayments generated by MultiPlan's claims suppression methodology.

317. This sweetheart deal was so good for United that it caused a temporary drop in MultiPlan's financial performance, which MultiPlan executives discussed during quarterly earnings calls with investors in the fourth quarter of 2022 and the first quarter of 2023. In MultiPlan's 2022 fourth quarter earnings call, MultiPlan's then-CEO Dale White explained, "we have been anticipating that a multiyear contract renewal with one of our largest customers would mute our 2023 revenue growth" and that the contract renewal would be "a headwind against growth in 2023."

318. As a result of MultiPlan's efforts to keep its largest customers using its repricing

tools and in the cartel, in the first quarter of 2023, MultiPlan experienced a 20.6% drop in revenues versus the first quarter of 2022 and a 30.7% drop in earnings before interest, taxes, depreciation, and amortization versus the first quarter of 2022.

319. However, MultiPlan was willing to sacrifice short-term revenues and profits in order to stabilize the cartel and keep the largest cartel members in the fold. As MultiPlan's then-CEO Dale White explained during MultiPlan's earnings call for the first quarter of 2023, renewing repricing agreements with the largest healthcare payors in the United States made MultiPlan's leadership "increasingly confident that our revenues are stabilizing and poised for growth over the next several years."

320. In an apparent effort to sweeten the deal and keep United in the cartel, on June 27, 2023, MultiPlan announced that John Prince, the former President and Chief Operating Officer of Optum, United's health services subsidiary, would join MultiPlan's board of directors.

321. MultiPlan's efforts to enforce the cartel agreement by buying the loyalty of one of the largest payors in the cartel appear to have worked. In an August 2, 2023 press release, the CEO of MultiPlan hailed the second quarter of 2023 as an "inflection point" in which MultiPlan "deliver[ed] second quarter results at the high end of our expectations," leading MultiPlan to increase its revenue guidance for investors for 2023.

322. MultiPlan's willingness to sacrifice short-term profits does not make economic sense absent its knowledge that perpetuating its conspiracy to underpay physicians would pay off in the long run.

323. The MultiPlan Cartel also has structures for monitoring and enforcing the cartel. Typically, a cartel agreement is more stable if the participants in the cartel have a reliable means of ensuring that each of the members of the cartel is abiding by the collusively set price by

monitoring and enforcing their pricing agreement. One of the most efficient ways for members of a cartel to reach an agreement on collusive pricing and to ensure that pricing sticks is for every member of the cartel to allow one competitor to set prices and negotiate those prices. That is exactly what has happened here. Each of the competing payors, who should have been exercising their own discretion to set prices for out-of-network claims, entered into agreements that gave MultiPlan the right to set prices for each cartel member's out-of-network claims and then made MultiPlan the sole entity responsible for negotiating payment of those collusively set prices.

324. MultiPlan and its Co-Conspirators were brazen enough to write formal contracts that included dispute resolution provisions. For example, MultiPlan's contract with Aetna contains a clause enforcing their out-of-network pricing agreement through "mediation . . . administered by the American Arbitration Association under its Mediation Rules for Commercial Financial Disputes . . . in the city of New York." The contract contemplates the possibility that if that mediation was unsuccessful, MultiPlan could sue Aetna to, among other things, enforce the terms of their out-of-network pricing agreement. This threat of litigation or mediation served as a check that ensured the compliance of MultiPlan's Co-Conspirators.

325. MultiPlan's percent of savings payment model also enables MultiPlan's Co-Conspirators to ensure that MultiPlan is underpaying out-of-network claims. MultiPlan sends regular reports to competing payors about how little a physician is paid for out-of-network claims as a result of MultiPlan's proprietary pricing methodology. From these reports, MultiPlan's competitors can monitor how well MultiPlan is adhering to its agreement to cause physicians to be underpaid for out-of-network claims.

326. In addition, MultiPlan recently increased its ability to exchange real-time pricing data and benchmarking information. In June 2023, it announced a new product in its Data and

Decision Science solution suite: PlanOptix.

327. MultiPlan said it created PlanOptix as a direct response to its payors' demands. The product enables "access" to 400 billion "fully indexed" records. For example, a payor can "search a CPT code and understand the price of that particular service . . . at a provider under a certain network." However, payors told MultiPlan that "[i]t's not enough to simply get to the data and information because the records are vast." They wanted payor pricing information.

328. When MultiPlan first announced PlanOptix, it had already "ingested data on over 70 payers," including "all of the national major carriers as well as many of the regional ones."

329. Per payors' requests, MultiPlan enhanced PlanOptix to show competitor pricing data—"not just at a global level, but even at a service level right, labs and X-rays versus inpatient, inpatient versus outpatient." MultiPlan explained that, using PlanOptix, payors would be able to answer questions such as: "Where do I sit versus my competitor?" and "How do I ensure that I'm negotiating correctly when I measure myself against my competitors?"

330. In other words, PlanOptix enables the members of the MultiPlan Cartel to monitor one another's adherence to their agreement to suppress out-of-network reimbursements by eliminating price competition on out-of-network claims. It does so by allowing health insurance payors to directly compare how much they pay to a particular provider for a particular type of out-of-network service.

331. At the November 28, 2023 Bank of America Leveraged Finance Conference, Mr. White openly stated that the purpose of PlanOptix is to "enable payers to benchmark themselves against their competitors." He explained that, using PlanOptix, a payor will know "whether they're above or below or on par with their competition," including with regard to reimbursements paid to "a specific provider."

332. Finally, MultiPlan also prepares white papers for its claims repricing clients, which include references to the claims repricing strategies adopted by other insurers and instruct them on how to implement the scheme.

j. Pervasive and Systematic Information Exchange

333. Tenth, competitors like the members of the MultiPlan Cartel are unlikely to exchange large volumes of competitively sensitive pricing information in the absence of a cartel agreement.

334. However, MultiPlan and competing commercial health insurance companies have agreed to exchange data regarding claims submitted by healthcare providers, reimbursement offers made by commercial health insurance companies in response to those submitted claims, and the actual amount paid in response to those claims.

335. The data exchanged is voluminous. In December 2021, MultiPlan had access to "over 3 petabytes of structured claims data from across 700 payer customers." By June 2023, MultiPlan touted that it had "10+ petabytes of [claims] data."

336. Indeed, during a deposition in an ERISA litigation, when asked whether there was "any information that MultiPlan would not provide for Cigna if Cigna asked," the Cigna witness responded: "from my experience, if I asked for information, they would provide it to me."

337. A United witness in other related litigation said the same. When asked "do you think there's any question that you could ask about the data supporting Viant OPR that . . . MultiPlan would not answer?" he responded, "I have no reason for MultiPlan not to share or provide answers to any questions that we have asked." In response to the follow-up question "so you think that they would answer any question you ask; right?", he responded, "any question specific to the program, yes."

338. The information exchanged by MultiPlan and the other members of the MultiPlan

Cartel is exactly the type of information exchange that the courts have recognized is likely to have anticompetitive effects. *See, e.g., United States v. U.S. Gypsum Co.*, 438 U.S. 441, n.16 (1978) ("Exchanges of current price information, of course, have the greatest potential for generating anti-competitive effects."); *Todd v. Exxon Corp.*, 275 F.3d 191, 212 (2d Cir. 2001) (Sotomayor, J.) ("Price exchanges that identify particular parties, transactions, and prices are seen as potentially anticompetitive."). First, the data exchanged is real-time pricing data, transmitted to MultiPlan automatically and expeditiously through electronic data links from its health insurance clients. Second, the data exchanged is specific to commercial insurance claims. Third, the data exchanged is not publicly available (with few exceptions). Fourth, the data is granular and unblinded—meaning that MultiPlan knows exactly what its competitors are charging for specific medical services and procedures.

339. Here, MultiPlan uses this data to explicitly share confidential pricing information among members of the MultiPlan Cartel in order to fix prices. As discussed previously, when seeking to establish United's out-of-network reimbursement rates, MultiPlan told United that prices set at 350% of Medicare rates would "be in line with another competitor."

340. MultiPlan also disclosed the specific 'option' used by Blue Cross Blue Shield ("option 3") to United executives when recruiting United into the MultiPlan Cartel. United executive John Haben included this information in a September 8, 2016 email to Lauren Paidosh (another United employee) and later conceded under oath that he received it from MultiPlan.

341. The Co-Conspirators enter the MultiPlan Cartel knowing that MultiPlan will share their commercially sensitive pricing information with other existing and prospective members of the MultiPlan Cartel.

342. While MultiPlan shares reams of information about its proprietary pricing

methodology with competing payors, it keeps the same details hidden from providers. When a provider reached out to MultiPlan to learn more about its pricing methodology in July 2019, MultiPlan's executives decided to withhold key information from the provider. In an email sent on July 10, 2019 at 7:50 a.m., Bruce Singleton, MultiPlan's Senior Vice President for Network Development Strategy, told Mike McEttrick, MultiPlan's Vice President of Healthcare Economics, that he wanted to keep the discussion with that provider at "eye level," meaning that he did not want to share the details of how MultiPlan's pricing methodology actually worked with the provider.

343. Competing companies would not risk sharing individual, real-time, and competitively sensitive pricing information with their rivals. Nor would competing companies pay millions of dollars to MultiPlan while simultaneously sharing their competitively sensitive information with MultiPlan absent an agreement to restrain competition. The information exchange operated by MultiPlan and the other members of the MultiPlan Cartel is more consistent with an agreement to restrain trade than competition on the merits. Therefore, this type of information exchange is circumstantial evidence of a cartel agreement among competitors.

k. Customary Patterns

344. Eleventh, MultiPlan has a long history of facilitating and stabilizing the MultiPlan Cartel.

345. MultiPlan boasts that it is "deeply embedded into [its Co-Conspirators'] claims platforms."

346. MultiPlan emphasizes the long-term nature of its relationships with its analytics and claims repricing clients. In a June 28, 2023 investor presentation, it stated that its "Average Length of Large Customer Relationships" was over 25 years.

347. In the words of Churchill Capital's CEO, Michael Klein, MultiPlan has achieved

"payer lock" due to MultiPlan's deep and long-standing integration into its clients' claims processing operations.

348. In MultiPlan's Q3 2020 earnings call on November 12, 2020, then-CEO Mark Tabak described MultiPlan as having "created a competitive moat around our company that drives high recurring revenues."

349. For over a decade, commercial health insurance providers with collective dominance in the U.S. commercial reimbursement market have been locked into multi-year contracts to use MultiPlan's claims repricing services. MultiPlan's consistent public statements trumpeting this high level of market participation and promoting acceptance rates of its reimbursement offers in the high 90th percentile provide reassurances regarding the stability of the cartel to its members.

350. The MultiPlan Cartel has a long-standing and well-functioning ringleader in MultiPlan. MultiPlan takes the lead in recruiting new members into the cartel, shares information with them about the advantages of collusive pricing, threatens that they will suffer financial disadvantage by not joining or defecting from the cartel, and enforces price discipline by encouraging cartel members to match the "aggressive" repricing settings of their competitors.

351. These customary patterns, formulas, and leadership are evidence of agreements and a conspiracy to suppress reimbursement rates.

VII. Relevant Market and Monopsony Power

A. The relevant market is the U.S. commercial reimbursement market.

352. If a relevant antitrust market needs to be defined, the relevant market is the market for the reimbursement of out-of-network physician services by third-party payers.

353. In this market, physicians like AMA's members are sellers of out-of-network medical care, while third-party payers like MultiPlan and the other members of the MultiPlan

Cartel are buyers of those services.

354. Physicians in this market have no reasonable substitutes for the reimbursements provided by commercial insurers for out-of-network medical services, as balance billing patients is futile or illegal in many instances. Moreover, MultiPlan, which along with its Co-Conspirators collectively dominates the relevant market, forces physicians to forgo any reimbursement from insureds as a condition of receiving any compensation at all for out-of-network claims.

355. While physicians can receive reimbursement payments from governmental sources, such as Medicare, Medicaid, and Tricare, those sources of payment are not viable alternatives for commercial reimbursements and do not compete against commercial health insurance. As federal courts have held, "the reality [is] that 'the substitution between commercial buyers and other payors is low, as reflected in measures such as low cross elasticity of demand.'" *In re Blue Cross Blue Shield Antitrust Litigation*, 2017 WL 2797267 at *5–6, 9 (N.D. Ala. June 28, 2017). These forms of government-paid insurance address populations that are not typically served by commercial health insurance. For example, Medicare and Medicaid have statutory age, income, or disability requirements. Similarly, Tricare is available only to current and former members of the United States military.

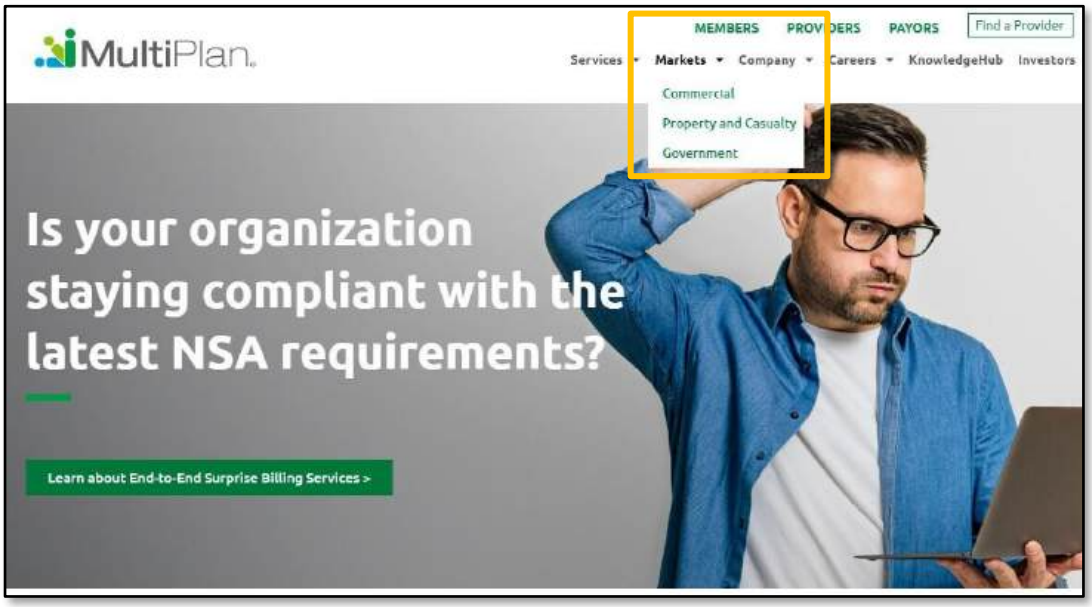
356. The commercial reimbursement market is distinct from the market for reimbursements from non-commercial payors for additional reasons. First, healthcare providers have no ability to negotiate the fees that government insurers pay them. Medicare, Medicaid, and other government programs unilaterally set their reimbursement rates. By contrast, providers negotiate the rates that commercial insurance companies pay, and ordinarily charge commercially insured patients more than they charge Medicare or Medicaid patients. Second, government-paid insurance also does not reimburse in a similar manner as commercial insurance. Medicare

reimbursements are frequently unprofitable.

357. Physicians, including AMA's members, instead look to commercial insurance reimbursements to recoup their costs of rendering healthcare services. Indeed, commercially insured patient cases are essential to the financial sustainability of physicians.

358. Most physicians, including most AMA and ISMS members, rely upon commercially insured patient cases for their financial sustainability.

359. MultiPlan itself recognizes that government payors and commercial payors operate in different markets. On the home page of its website, MultiPlan features a drop down entitled Markets under which it lists Commercial and Government as separate "markets" it serves:



360. In addition, MultiPlan's filings with the SEC make clear that it views government programs as occupying a distinct market segment from the commercial market. In the "Markets We Serve" section of its 2023 10-K, MultiPlan said of Government Programs: "This market segment includes Medicare, Medicaid, TRICARE, Federal Employees Health Benefits, Veterans Administration, and other federal health programs (state and municipal government health plans typically are managed as commercial plans). Commercial insurers and health plans also participate

in this market segment, but there also are Payors that operate government plans exclusively. Most, but not all, of MultiPlan's commercial healthcare services also are of value to Payors of government programs."

361. Furthermore, MultiPlan views in-network and out-of-network claims as occupying separate markets. Indeed, MultiPlan's key product, in its own words, is an out-of-network repricing product. For example, in discussing MultiPlan's recent acquisition of Benefits Science LLC ("Benefit Science Technology" or "BST") during a recent presentation at the 42nd Annual J.P. Morgan Healthcare Conference, then-CEO Dale White explained "MultiPlan's focus over the past 40 years has been on out-of-network claims . . . the products and services that BST has in terms of data, data analytics, advanced healthcare analytics, all enable us, it's the gateway to the in-network claims, it's the gateway into Medicare Advantage, it's the gateway into Medicaid." Implicit in MultiPlan's explanation of its acquisition of BST is that MultiPlan's primary products prior to the acquisition were not yet used in the government or in-network space because they are different markets entirely.

362. A common method to determine the scope of a relevant antitrust market is to assess whether a hypothetical monopolist could impose a small but significant non-transitory increase in price ("SSNIP") in the proposed market, typically 5%. In a case challenging a buyers' cartel, such as this one, the relevant test is whether a hypothetical monopolist could impose a small but significant reduction in purchase price ("SSRIPP"). In this case, a hypothetical monopolist could impose an SSRIPP of 5% or more in out-of-network reimbursements without causing physicians to switch to other forms of reimbursement.

363. Moreover, MultiPlan's imposition of an industry-wide pricing scheme for out-of-network services provides a natural experiment to test the bounds of the relevant market. Despite

MultiPlan and its co-conspirators decreasing reimbursement rates for out-of-network services substantially from the prior FAIR and UCR amounts that existed in the pre-conspiracy period, healthcare providers continued to provide out-of-network services. This suggests that a SSRIPP would not result in a sufficient number of physicians switching to other forms of reimbursement, such as services for government-payors or in-network services.

364. The relevant geographic market, if one is necessary, is the United States. Physicians in the United States cannot practicably turn to payors in other countries, where private medical insurance is uncommon or non-existent and nearly all medical care is administered as a part of a comprehensive government program, for reimbursement of out-of-network medical services. The U.S. healthcare industry, including the market for reimbursement of out-of-network services, is universally recognized by industry participants as distinct from healthcare industries in foreign countries, and is subject to a variety of unique federal and state laws and regulations that apply only in the United States. The MultiPlan Cartel has market power in the relevant market.

365. MultiPlan and its Co-Conspirators, through their conspiratorial agreements, collectively hold dominant power in the relevant market. Nearly every commercial insurer that participates in the relevant market has agreed with MultiPlan to suppress out-of-network reimbursement payments. The members of the MultiPlan Cartel, including MultiPlan, United, Cigna, Humana, Elevance, Aetna, Guidewell, and others, collectively control at least 90% of the relevant market.

366. As MultiPlan has repeatedly stated, each of the "top 15" health insurance companies and over 700 payors subscribe to its claims repricing service. According to Forbes, in 2021, those top 15 healthcare insurance companies alone controlled almost 60% of the entire commercial health plan enrollment in the United States.

367. MultiPlan claims that the entire nationwide market for out-of-network commercial reimbursements is approximately $130 billion annually. Out of that $130 billion, MultiPlan claims that it processed $106 billion in charges in 2019.

368. By claiming to process $106 billion in out-of-network commercial reimbursement charges out of a potential $130 billion, MultiPlan acknowledges that it processes approximately 81.5% of the out-of-network commercial reimbursement claims submitted in the United States.[43]

369. MultiPlan's market power has continued to grow since 2019 as its largest clients have gained market share and additional claims repricing clients have signed up.

370. MultiPlan stands nearly alone in the out-of-network claims repricing business. MultiPlan claims that Data iSight differentiates itself through its patented repricing methodology and its large, proprietary database of historical claims, whereas other claims repricing services base their methodologies on usual and customary rates or Medicare rates. In an Analyst Day presentation, MultiPlan touted that it can process a claim and deliver it back to the payor "within 5 seconds."

371. MultiPlan faces only limited competition, most notably from a company called Zelis. But Zelis and other claims repricing services are mere bit players compared to MultiPlan. In 2022, Zelis processed approximately 2 million claims for repricing. According to a June 28, 2023 presentation, in 2022, MultiPlan processed 546 million claims, accounting for $155 billion in claims. Indeed, MultiPlan touted to investors in 2020 that it is "the largest player in the commercial out-of-network space."

372. The market for reimbursements paid by commercial insurers to healthcare providers for out-of-network medical services is protected by high barriers to entry. Commercial

[43] *See*, *supra*, note 15.

health insurance in the United States has long been a highly concentrated industry, with a small number of large insurers dominating the market. And as noted above, the top 15 insurance companies (which control almost 60% of the entire commercial health plan enrollment in the United States) and hundreds more insurance companies have all agreed with MultiPlan to use its claims repricing services.

373. Indeed, during a trial, Rebecca Paradise, the Vice President of Out-of-Network Strategy at United, testified that MultiPlan said the Data iSight tool was "widely used by our competitors." Moreover, most of MultiPlan's contracts with customers are three years or longer in length, with "high renewal rates." MultiPlan has even touted the "stickiness" of its "long- term customer relationships."

374. This high collective market concentration of the members of the MultiPlan Cartel is probative circumstantial evidence of agreement or agreements to conspire. This dominant collective market power has allowed the MultiPlan Cartel to impose anticompetitive effects on the entire relevant market.

375. In addition to this collectively dominant market power, each insurance company has complete buyer-side market power in the submarket for reimbursements of out-of-network healthcare services provided to its own insureds.

376. When healthcare providers provide out-of-network services to a patient, their only option for seeking reimbursement for those services is to submit a claim to the particular health insurance company that administers the insurance plan in which that patient is enrolled. Thus, when physicians provide out-of-network services to a patient insured by Cigna, for example, they have no choice but to seek reimbursement from Cigna, and no other insurance company or payor is a viable source of reimbursement.

377. As a result, each health insurance company has complete buyer-side power over the reimbursement of out-of-network services provided to its own insureds. When a health insurance company agrees with MultiPlan on the methodology for suppressing reimbursements for such services, it is entering into a price-fixing agreement backed by complete market power in the relevant submarket, leaving physicians like the AMA's and ISMS's members with no practicable option but to accept the artificially suppressed reimbursement that MultiPlan's methodology generates.

B. The MultiPlan Cartel harms competition throughout the relevant market and has no procompetitive effects.

378. Because the MultiPlan Cartel's agreement suppresses reimbursements paid to physicians, MultiPlan and the MultiPlan Cartel made lower reimbursement payments to physicians than the cartel members would have made but for the existence of the cartel agreement. Were it not for the conspiracy, members of the MultiPlan Cartel would have competed against one another to provide adequate compensation to physicians for out-of-network care so that they could guarantee their insureds access to a wide variety of healthcare professionals within or outside of their networks.

379. Commercial insurers want to maintain access to a broad range of out-of-network physicians so they can market the reach of their insurance products.

380. MultiPlan itself recognizes this dynamic. In describing the Payment & Revenue Integrity Services on its website, MultiPlan claims it is "uniquely qualified to help [payors] reduce waste and abuse." MultiPlan explains "[u]nlike other companies that offer healthcare Payment Integrity solutions, MultiPlan operates networks with more than 1.4 million participating providers. We use our Payment Integrity services on our network claims. We value amicable relationships with providers and work to preserve the relationship between payors and

providers."[44]

381. Indeed, in MultiPlan's 2023 10-K, MultiPlan went further to explain the importance of its relationships with providers, saying: "We depend on our providers and our PPO networks to maintain the profitability of our network-based and analytics-based services, as well as the future expansion of our operations. The healthcare providers that constitute our network are integral to our operations. Specifically, a portion of the revenues from our analytics-based services are based on a percentage of the price concessions from these providers that apply to claims of our Payor customers. Further, our ability to contract at competitive rates with our PPO providers will affect the attractiveness and profitability of our network products."

382. Some commercial insurance networks, such as MultiPlan's PHCS Network, are marketed directly to employment groups, individuals, or other payors, while other commercial insurance networks, such as MultiPlan's "wrap" PPO network, are marketed to other commercial insurers. In either case, the number and range of physicians willing to accept patients on an out-of-network basis is a key selling point, and therefore the necessity of competition between commercial insurers to compensate physicians for out-of-network services is unchanged.

383. Physicians cannot avoid the anticompetitive effects of the MultiPlan Cartel. Physicians have no practical ability to reject MultiPlan's take-it-or-leave-it terms and attempt to negotiate a better reimbursement rate. As one healthcare provider explained, "When we reject a [MultiPlan proposal], it takes months to get any payment and we never get paid more than the amount of the [original MultiPlan proposal]."

384. The New York Times's reporting confirmed the providers' inability to negotiate with MultiPlan. It wrote that "Documents and interviews revealed tactics meant to pressure

[44] *See* https://perma.cc/REM9-NUFT.

medical practices to accept low payments. Some offers came with all-caps admonitions and deadlines just hours away. Accept and receive prompt payment; refuse and risk an even lower payout. Practices and billing specialists said this often wasn't an empty threat."

385. MultiPlan also threatens to drop their reimbursements if physicians do not accept their cut-rate offers. In a fax to a healthcare provider, MultiPlan gave the provider eight days to respond to a low-ball offer. But the fax warned, "Please note that if you do not wish to sign the attached proposal . . . this claim is subject to a payment as low as 110% of Medicare rates based on the guidelines and limits on the plan for this patient." In other words, if the provider disagrees with MultiPlan's offer, MultiPlan will lower the reimbursement rate even further.

386. The New York Times reported on April 7, 2024 that: "In some instances, the fees paid to an insurance company and MultiPlan for processing a claim far exceeded the amount paid to providers who treated the patient. Court records show, for example, that Cigna took in nearly $4.47 million from employers for processing claims from eight addiction treatment centers in California, while the centers received $2.56 million. MultiPlan pocketed $1.22 million."

387. While the state and federal laws may establish procedures for certain types of providers to dispute reimbursement amounts through arbitration, the sheer volume of claims that are underpaid by the MultiPlan Cartel makes arbitrating each individual claim practically and financially impossible.

388. MultiPlan also "erect[s] a bureaucratic layer so thick and complicated that few can navigate it."[45] MultiPlan relies on the fact that medical billers overseeing a massive flow of out-of-network claims will not have the time to fight back on individual claims. MultiPlan disputes

[45] Olivia Webb, MultiPlan, the Secret Back-End to Most of the Insurer Industry, is Going Public, Acute Condition (Aug. 5, 2020), https://perma.cc/2WJ7-ZBQ3.

and reprices nearly every out-of-network claim, giving medical billers less than 10 days to respond to those offers. When a medical biller asks the insurer how MultiPlan reprices its claims, the insurance company explains that it is not responsible for MultiPlan's pricing. When the medical biller tries to negotiate with MultiPlan, MultiPlan tells the biller that it is not the insurer and does not have authorization to negotiate with the healthcare provider.

389. According to a 2018 MultiPlan study, 99.4% of all out-of-network claims for inpatient treatment that are repriced by Data iSight are "accepted" by healthcare providers. MultiPlan claims that as little as 2% of Data iSight's prices are appealed for all claim types. MultiPlan has a dominant position as the sole source for out-of-network claim suppression because it has developed a pricing methodology that is often the first, second, and third in a "stack" of pricing methodologies that payors use to slash out-of-network claims. For example, a payor will use MultiPlan's Data iSight product as a "first pass" out-of-network "repricing" method, but it will use MultiPlan's Viant, MARS, or Pricer Pro products as second- or third-pass "repricing" methods. So, if a physician rejects a low-ball offer generated by Data iSight, its next offer will be materially worse because it will be generated by an even more aggressive pricing logic used by another MultiPlan product. In this way, MultiPlan enables its competitors to suppress out-of-network payments by threatening that subsequent offers will be worse for the physician.

390. The MultiPlan Cartel's underpayments have already caused some healthcare providers to fail, thereby limiting the supply of healthcare goods and services available to consumers. For example, in a separate lawsuit filed in San Francisco County Superior Court, VHS Liquidating Trust alleges that Verity Health System went bankrupt as a result of the MultiPlan Cartel. On August 31, 2018, Verity Health System filed for Chapter 11 bankruptcy. As a part of that bankruptcy process, on January 6, 2020, Verity Health System announced the closure of the

St. Vincent Medical Center in Los Angeles, California.

391. Small and independent healthcare providers are especially susceptible to the price-fixing of the MultiPlan Cartel. The New York Times report on MultiPlan included interviews of healthcare providers about MultiPlan's effect on their businesses. Kelsey Toney is a behavioral therapist for children with autism in rural Virginia. She typically charges the rates that Virginia pays for people on Medicaid. As reported by The New York Times, "last year, she said, Meritain Health, an Aetna subsidiary, informed her that fair payment for her services was less than half what Medicaid paid, based on calculations by MultiPlan." She was then faced with the prospect of turning her patients away: "I don't want to say, 'I'm sorry I can no longer accept you,' especially when I'm the only provider within an hour," she said. Toney told The New York Times she "has not billed the parents of her two patients covered by Meritain, but going forward she will not accept patients with similar insurance."

392. On May 1, 2024 The New York Times further reported that "One provider reported slashed payments from UnitedHealthcare, Cigna and an Aetna subsidiary after the insurers routed claims to MultiPlan's most aggressive pricing tool."

393. In its May 1, 2024 report, The New York Times quoted one anonymous rural healthcare provider as saying that MultiPlan "has decimated my life" and caused "the closing of my business," which "left patients having to travel 2.5 hrs for surgery."

394. MultiPlan attempts to justify its behavior as intended to keep prices down for healthcare consumers, but that is not the case. As an August 5, 2020 analysis explained: "Theoretically, MultiPlan's harsh negotiation tactics should be good for rising American health care costs; insurers are supposed to lower costs by negotiating lower prices on behalf of the patient. But instead, MultiPlan acts like a mafia enforcer for insurers, forcing doctors to accept low

payments while insurance premiums for patients . . . somehow continue to rise."[46]

395. In fact, although MultiPlan claims that its out-of-network claims suppression tools help decrease healthcare costs, the data shows otherwise. According to the Centers for Medicare and Medicaid Services, in 2016, a year before several large health insurance companies joined the MultiPlan Cartel, private health insurance expenditures in the United States were $1.03 trillion. By 2021, private health insurance expenditures in the United States were $1.21 trillion, a 17.48% increase. By 2025, private health insurance expenditures in the United States are projected to be $1.53 trillion, a 48% increase over 2016. In short, MultiPlan's "cost containment" justification fails as a factual matter—private health insurance expenditures are ballooning regardless of the MultiPlan Cartel.

396. As the MultiPlan Cartel stiffs healthcare providers billions of dollars, MultiPlan's executives continue to be compensated at astronomical levels. For example, in MultiPlan's 2024 Proxy Statement, MultiPlan's then-CEO was reported to have made $10.7 million in total compensation in 2022 and $7.6 million in 2023. Additional executives also made over $1 million in 2023, such as Jim Head, MultiPlan's CFO, who made over $3 million in total compensation in 2023.

397. Therefore, the MultiPlan Cartel harms competition by systematically underpaying physicians, limiting the amount of revenue that physicians can spend on improving and expanding care, and putting at-risk physicians closer to bankruptcy. MultiPlan cannot justify its conduct. MultiPlan does not contain costs. Its cartel has taken advantage of a rapidly growing healthcare sector to enrich itself at the expense of doctors, nurses, and patients. And the life-saving care provided by physicians is not "exorbitant" as the cartel likes to claim (until they are sworn to tell

[46] *See*, *supra*, note 45.

the truth).

VIII. Fraudulent Concealment, Continuing Violation, and Tolling the Statute of Limitations

398. MultiPlan and the MultiPlan Cartel have affirmatively and fraudulently concealed the conspiracy by various means and methods from its inception.

399. MultiPlan and the MultiPlan Cartel did so in at least two ways. First, they misled the AMA's and ISMS's members and other providers about how reimbursement rates were set. Second, they actively worked to conceal the conspiracy and ensure its secrecy.

400. MultiPlan's explanation of its pricing methodology to providers was false and misleading. Moreover, MultiPlan and the other members of the MultiPlan Cartel intentionally hid from out-of-network providers, including the AMA's and ISMS's members, that reimbursement prices were actually determined by the use of a shared pricing system that used cartel members' real-time, non-public claims data and combined it with their competitors' real-time, non-public claims data to set out-of-network reimbursement rates.

401. MultiPlan also made false and misleading statements to conceal that it colluded with and orchestrated insurers (i.e., its competitors) to work in concert to artificially suppress payments to healthcare providers.

402. MultiPlan and the other members of the MultiPlan Cartel also spent years claiming that reimbursements were derived by algorithm, when in fact they were fixed by the cartel's members.

403. MultiPlan and the other members of the MultiPlan Cartel also publicly misrepresented that they did not engage in anticompetitive conduct. For example, MultiPlan's published Code of Business Conduct and Ethics states that it is "committed to conducting our business with integrity at all times," and that "only legal and ethical means should be used to gather

information about existing and potential competitors."

404. MultiPlan, along with the other members of the MultiPlan Cartel, also took steps to conceal the true nature of their anticompetitive arrangement from the AMA and ISMS.

405. MultiPlan, along with the other members of the MultiPlan Cartel, engaged in a secret and inherently self-concealing conspiracy that did not reveal facts sufficient to put the AMA and ISMS on inquiry notice.

406. The Other Insurer Members of the MultiPlan Cartel privately submitted their own non-public claims data to MultiPlan, and MultiPlan in turn used its proprietary repricing tools, the details of which remain confidential, to propose reimbursement rates. The inner workings and true nature of this process are secrets that are not shared with providers like the AMA's and ISMS's members.

407. MultiPlan and the MultiPlan Cartel members regularly attended invitation-only industry events, including events held and sponsored by MultiPlan, where they discussed behind closed doors how MultiPlan's repricing tools allowed them to reduce costs by suppressing out-of-network reimbursement rates.

408. MultiPlan and the MultiPlan Cartel members had private communications and meetings to discuss out-of-network claim repricing, MultiPlan's repricing tools, and the use of those tools, including by competitors.

409. Neither the AMA, ISMS, nor their affected members therefore had either actual or constructive knowledge of the facts giving rise to their claim for relief. Neither the AMA, ISMS, nor their affected members discovered, nor could they have discovered through the exercise of reasonable diligence, the existence of MultiPlan's conspiracy until shortly before filing this complaint.

410. Through the knowing and active concealment of the MultiPlan Cartel's misconduct by MultiPlan, as well as by the other cartel members, neither the AMA, ISMS, nor their affected members received information that should have put them, or any reasonable person or provider standing in their shoes, on sufficient notice of collusion worthy of further investigation.

411. Neither the AMA, ISMS, nor their affected members could have been on inquiry notice of MultiPlan's scheme and the extent and effect of the MultiPlan Cartel until the New York Times published concerns about MultiPlan's practices, based on recently unsealed confidential documents in other litigation, on April 7, 2024.

412. Even if notice had arisen earlier, an ordinary person acting reasonably diligently would not have had the time, resources, or specialized training to uncover the misconduct that the AMA and ISMS, through counsel, allege herein, earlier than May 2024.

413. The AMA and ISMS exercised reasonable diligence at all times and could not have discovered MultiPlan's alleged misconduct sooner because of MultiPlan's deceptive and secretive actions to conceal its misconduct.

414. The AMA and ISMS filed their claims as soon as they became aware of the anticompetitive conduct alleged herein, in reliance on their own and their counsel's investigation.

415. MultiPlan's fraudulent concealment of its wrongful misconduct has tolled and suspended the running of the statute of limitations concerning the claims and rights of action of the AMA and ISMS and their affected members arising from the conspiracy earlier in time than the four years immediately preceding the date this action was filed.

416. MultiPlan's misconduct also constitutes a continuing violation. Although formed before 2020, the conspiracy has continued thereafter. MultiPlan continues to engage in the anticompetitive conduct alleged herein and has taken no affirmative steps to withdraw from it or

otherwise disavow it.

IX. Anticompetitive Effects And Impact On Interstate Commerce

417. The MultiPlan Cartel directly damages the business and property of the AMA's and ISMS's members and restrains competition in the relevant market. The AMA's and ISMS's members have sustained and continue to sustain economic losses due to MultiPlan's artificial suppression of reimbursement rates for out-of-network healthcare services.

418. But for MultiPlan's conspiracy to fix the price paid for out-of-network healthcare services, the AMA's and ISMS's members would have received higher reimbursement rates for out-of-network healthcare services.

419. While the conspiracy continues, the AMA's and ISMS's members will continue to suffer losses.

420. The antitrust laws aim to prevent injuries such as those alleged here that stem from a conspiracy among buyers to systematically suppress the price paid for a good or service, such as out-of-network healthcare services. Agreements to reduce price competition or fix prices violate the antitrust laws.

421. The outsourcing of both insurers' rate-setting decisions and claims negotiation responsibilities, as well as the MultiPlan Cartel's anticompetitive information exchange, has corrupted the market for out-of-network provider services, replacing independent centers of decision-making with a single effective decisionmaker, MultiPlan, and disrupting the competitive process. Insurers' collective use of MultiPlan's repricing services to set artificially low reimbursement rates subverts the competitive process by depriving the market of "independent centers of decisionmaking" and replacing them with decision-making on prices by one shared pricing "brain."

422. Economic theory and antitrust jurisprudence show that such joint delegation

schemes, particularly when accompanied by information exchange, reduce the intensity of price competition and artificially suppress compensation below competitive levels. In recent guidance to human resources professionals, the Department of Justice Antitrust Division ("DOJ") stated that "[s]haring information with competitors about terms and conditions of employment" can be anticompetitive in that it decreases competition below competitive levels by allowing firms to match each other's compensation rather than compete for services by offering additional compensation.

423. That is precisely what has happened with respect to the prices insurers pay for out-of-network care consumed by their subscribers. As a result of the MultiPlan Cartel, reimbursement rates provided to healthcare providers, including the AMA's and ISMS's members, for out-of-network claims have been suppressed below competitive levels.

424. According to an April 2020 study published by the Office of the New York State Comptroller, depending on the service provided, out-of-network reimbursements paid based on MultiPlan's repricing methodology were 1.5 to 49 times lower than UCR-based reimbursements for the same services. And whereas prior to 2016, reimbursement rates typically rose over time, since 2016 they have fallen year-over-year.

425. The suppression of out-of-network reimbursement rates caused by the MultiPlan Cartel also indirectly suppresses in-network rates by undermining the ability of providers to leave insurance networks if in-network rates fall too low, a key form of leverage providers would have in the negotiation of those in-network rates in the absence of the MultiPlan Cartel. Because of the MultiPlan Cartel, even if providers attempt to leave insurance networks and bill subscribers on an out-of-network basis based on the prevailing market rate, MultiPlan ensures that they will receive reimbursement amounts that are roughly equal to in-network rates and unreasonably low. By

undermining the economic viability of providers performing services on an out-of-network basis, insurers strip providers of a key form of leverage—the ability to decline network participation if in-network rates are too low—thereby suppressing in-network reimbursement rates.

426. Claims that AMA and ISMS members submitted to the MultiPlan Cartel for out-of-network goods and services were underpaid compared to the amount that would have been paid as a reimbursement but for the cartel agreement. When the AMA's and ISMS's members were systematically underpaid for out-of-network claims, they often did not have the practical or legal ability to obtain the balance of those charges from the patient or any other payor.

427. The AMA and ISMS, in their associational capacities on behalf of their members, are efficient enforcers of the antitrust laws with respect to the MultiPlan Cartel. The AMA's and ISMS's members were directly injured when they were underpaid for submitted out-of-network claims due to the cartel agreement. Due to the MultiPlan Cartel's conduct, and as a practical and legal matter, the AMA's and ISMS's members cannot seek payment for these charges from any other source.

428. The AMA's and ISMS's members suffered antitrust injury as a result of the MultiPlan Cartel. For decades, federal courts have recognized that agreements between competitors to underpay providers for goods and services are illegal per se because buyers' cartels are so pernicious that they will almost always harm competition.

429. By reason of the unlawful activities alleged herein, MultiPlan substantially affected interstate trade and commerce throughout the United States and caused antitrust injury to Plaintiffs' members.

X. Cause of Action

Agreement in Restraint of Trade
Section 1 of the Sherman Act, 15 U.S.C. § 1

430. Plaintiffs incorporate each allegation above as if fully set forth herein.

431. Plaintiffs seek declaratory and injunctive relief on their own behalf and in their associational capacity for their members under the Declaratory Judgment Act and Section 16 of the Clayton Antitrust Act for MultiPlan's conduct in violation of Section 1 of the Sherman Act.

432. MultiPlan, directly and through its divisions, subsidiaries, agents, and affiliates, engages in interstate commerce in, among other things, the pricing, purported negotiation, purchase and reimbursement of out-of-network healthcare services for subscribers.

433. Beginning in or around 2015, MultiPlan and the Other Insurer members of the MultiPlan Cartel entered into and engaged in an unlawful contract, combination, or agreement, in restraint of interstate trade and commerce in violation of the Sherman Act, 15 U.S.C. § 1.

434. Specifically, MultiPlan and the Other Insurer members of the MultiPlan Cartel have combined to form a cartel to artificially suppress out-of-network reimbursement rates paid to healthcare providers across the United States and exchanged non-public and competitively sensitive information with one another in order to accomplish that purpose.

435. The conduct of MultiPlan and the Other Insurer members of the MultiPlan Cartel was undertaken with the intent, purpose, and effect of artificially suppressing out-of-network reimbursement rates below the competitive level.

436. MultiPlan and the Other Insurer members of the MultiPlan Cartel perpetrated this scheme with the specific intent of decreasing reimbursement rates for their own benefit.

437. The conduct of MultiPlan and the Other Insurer members of the MultiPlan Cartel in furtherance of the unlawful scheme described herein was authorized, ordered, or executed by

their officers, directors, agents, employees, or representatives while actively engaging in the management of the affairs of MultiPlan and the Other Insurer members of the MultiPlan Cartel.

438. The MultiPlan Cartel has caused the AMA's and ISMS's members to suffer damages in the form of artificially suppressed reimbursement rates for out-of-network services.

439. The contract, combination, or conspiracy alleged herein has taken the form of a horizontal conspiracy between competitors in the market for out-of-network healthcare provider services.

440. In furtherance of this contract, combination, or conspiracy, MultiPlan and the Other Insurer members of the MultiPlan Cartel have at all relevant times committed various acts, all of which are ongoing, including as follows:

- The Other Insurer members of the MultiPlan Cartel provide real-time, private, confidential, and detailed internal claims data to MultiPlan for use in MultiPlan's out-of-network claim repricing tools.
- MultiPlan sells and operates its out-of-network claim repricing tools that reprices the reimbursement rate for out-of-network healthcare services claims.
- MultiPlan and the Other Insurer members of the MultiPlan Cartel knowingly use the same out-of-network claim repricing tools that incorporates the real-time, private, confidential, and detailed internal claims data of the MultiPlan Cartel Members to calculate reimbursement rates for out-of-network healthcare services claims.
- The Other Insurer members of the MultiPlan Cartel pay reimbursements for out-of-network healthcare services claims at the rates calculated by MultiPlan's repricing tools.
- The Other Insurer members of the MultiPlan Cartel outsource out-of-network claims handling to MultiPlan knowing that MultiPlan would set the reimbursement rate of out-of-network healthcare claims at the rates calculated by its repricing tools.

- The members of the MultiPlan Cartel exchange sensitive, real-time, private, confidential, and detailed internal claims data with each other, including by using the MultiPlan out-of-network claims repricing tool.

- The members of the MultiPlan Cartel use many forms and methods of bilateral and multilateral communication across various settings and venues concerning the reimbursement rate for out-of-network healthcare services claims, including their use of MultiPlan's out-of-network claim repricing tools, which had the purpose and effect of maintaining and reinforcing their anticompetitive scheme.

441. There are no procompetitive justifications for the MultiPlan Cartel, and any proffered justifications, to the extent cognizable, could be achieved through less restrictive means.

442. The MultiPlan Cartel is unlawful under a per se mode of analysis. In the alternative, the MultiPlan Cartel is unlawful under either a quick look or rule of reason mode of analysis.

443. As a direct and proximate result of MultiPlan's unlawful scheme, the AMA's and ISMS's members have suffered injuries to their business or property and will continue to suffer economic injury and deprivation of the benefit of free and fair competition unless MultiPlan's conduct is enjoined.

444. Plaintiffs are entitled to a permanent injunction that terminates the unlawful conduct alleged herein, as well as any other equitable relief the Court deems proper.

XI. Petition for Relief

445. Plaintiffs petition for the following relief:

a. A determination and declaration that the conduct set forth herein is unlawful under Section 1 of the Sherman Antitrust Act;

b. An order enjoining MultiPlan from engaging in further unlawful conduct;

c. An award of attorneys' fees and costs;

d. An award of pre- and post-judgment interest on all amounts awarded; and

e. Such other and further relief as the Court deems just and equitable.

Dated: October 24, 2024

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Attorneys for Plaintiffs

Litigation Center of the American Medical Association And the State Medical Societies (I-24)

November 12, 2024
3:00 to 5:00 PM

Montana Medical Association v. Knudsen (9th Cir.)

Presented by Leonard A. Nelson
Litigation Center Director

Americans with Disabilities Act
Definition of Disability

The term “disability” means a physical or mental impairment that substantially limits one or more major life activities.

42 U.S. Code § 12102(1)(a)

A compromised immune system is a disability under the ADA.

Americans with Disabilities Act
Prohibition of Discrimination by Public Accommodations

General Rule. No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the services and facilities of any place of public accommodation.

Participation in Unequal Benefit. It shall be discriminatory to afford an individual, on the basis of disability, with a service or facility that is not equal to that afforded to other individuals.

42 U.S. Code §§ 12182(a) & (b)

Montana Prohibition of Discrimination Based on a Person's Vaccination Status (Montana HB 702)

It is an unlawful discriminatory practice for an employer to take an adverse employment action, including refusal of employment, based on the employee's vaccination status.

Mont. Code Ann. § 49-2-312 (1)

United States Constitution Supremacy Clause

This Constitution and the Laws of the United States which shall be made in Pursuance thereof shall be the supreme Law of the Land, any Laws of any State to the Contrary notwithstanding.

U.S. Const. Article VI

A state law is invalid ("preempted") if it undermines the intended purpose and "natural effect" of the federal law.

Declaratory Judgments Act

In a case of actual controversy, any court of the United States may declare the rights of any interested party seeking such declaration.

The Complaint

On September 22, 2021, the Montana Medical Association, three Montana hospitals and medical clinics, and seven Montana patients with compromised immune systems sued the Montana Attorney General and the Montana Commissioner of Labor and Industry. This was at just about the time that COVID-19 vaccines were becoming available.

The lawsuits asked for a declaratory judgment that Montana health systems, including doctors' offices, should have the right to take appropriate disciplinary actions against their unvaccinated employees, including, if necessary, termination, to protect patients with compromised immune systems. The plaintiffs asserted that the ADA public access requirements should take precedence over Montana's anti-discrimination law.

The District Court Decision

After a full trial, the lower court held that the plaintiffs had proven their case. It found that the plaintiff health care facilities could not be ADA compliant unless they had the right to take remedial action, including termination, against their unvaccinated employees. It further found that any contrary provisions of the Montana Anti-Discrimination Act were preempted by the federal ADA.

The trial court entered a declaratory judgment for the plaintiffs.

Ninth Circuit Appeal

Montana appealed to the United States Court of Appeals for the Ninth Circuit. On appeal, the higher court was bound to accept as true all factual determinations made by the district court, as long as those determinations were backed by *some* evidence. This would include determinations that could be supported by reasonable inferences deduced from the evidence presented.

The Ninth Circuit held that the trial court decision was overly broad in saying that Montana health care facilities would not have to follow the Montana law. There might be some situations in which immunologically compromised patients could safely access health care facilities even if the facilities employed unvaccinated personnel. The issue would have to be resolved on a case-by-case basis, presumably after the patients or the appropriate federal agencies sued the facilities for violation of the ADA. On October 9, 2024, the Ninth Circuit panel reversed.

The plaintiffs have moved for a rehearing or a rehearing *en banc* of the Ninth Circuit panel decision.

Litigation Center Support for the Plaintiffs

The Litigation Center paid for the attorneys' fees and costs of the Montana Medical Association. It also submitted an *amicus* brief in the Ninth Circuit appeal to support the plaintiffs.

Comments?

Physicians' powerful ally in patient care

THE LITIGATION CENTER OF
THE AMERICAN MEDICAL ASSOCIATION
AND THE
STATE MEDICAL SOCIETIES

NOVEMBER 2024
INTERIM REPORT

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About the Litigation Center

The Litigation Center of the AMA and the state medical societies is the voice of America's medical profession in legal proceedings around the country. Established in 1995, the Litigation Center provides physicians with legal assistance and expertise. Since its inception, the Litigation Center has participated in over 1000 cases. Some of these cases have set important legal precedents, some have had broad, practical implications for patients or the medical profession, and some have simply been the right thing to do.

The state medical societies and the Medical Society of the District of Columbia are members of the Litigation Center. Specialty medical societies may and do request assistance from the Litigation Center.

The Litigation Center's docket of cases casts a wide net over the medical-legal landscape, including physician payment issues, medical staff privileges, medical liability issues, peer review, and scope-of-practice matters, among many other topics. Forums range from administrative proceedings to cases before the United States Supreme Court. At any given time, the Litigation Center has approximately 60 active cases.

Organization and Purpose

The Litigation Center is an unincorporated association among the American Medical Association, the state medical societies and the Medical Society of the District of Columbia, organized to coordinate litigation within the Federation of Medicine. Its purpose is to advance American Medical Association policies through the American legal system, including courts, administrative agencies, and alternative dispute bodies.

Executive Committee Members

Officers:
Jessa Barnard, Chair – Executive Director, Vermont Medical Society
Mark Jackson, Vice Chair – Executive Director, Medical Association of the State of Alabama

Members:

Todd Baker – Chief Executive Officer, Ohio State Medical Association
Jean Branscum – Chief Executive Officer, Montana Medical Association
Libby De Bie – Chief Executive Officer, Arizona Medical Association
Lisa Bohman Egbert, MD – Trustee, American Medical Association
Marilyn Heine, MD – Trustee, American Medical Association
Cory W. Meadows – General Counsel, Kentucky Medical Association
Leonard A. Nelson, JD – Senior Division Counsel, American Medical Association
Pratistha Koirala, MD – Trustee, American Medical Association
Jeffrey Scott - General Counsel, Florida Medical Association
Mark Thompson – Executive Director, Medical Society of Delaware

Support for Cases

The Litigation Center generally acts in three types of cases. The first type is a dispute of general interest to the medical community in which a physician or group of physicians with a meritorious legal position confronts an adversary with substantially greater resources. Examples of such adversaries are managed care organizations, hospitals, and governmental bodies. The Litigation Center attempts to mitigate the disadvantage that the physician or group of physicians would otherwise face in the litigation. Litigation Center support can be in the form of a financial grant, in-kind services, or simply public recognition that the AMA endorses the legal argument advanced by the person supported.

The second type of case is a lawsuit brought by a state or specialty medical society that may be of particular interest within that state or for a limited area of medical practice. Examples are lawsuits concerning insurance industry practices, governmental funding or regulation, or scope of practice. Litigation Center support may be in the form of a financial grant or (with the AMA Board of Trustees' approval) joinder as a party to the lawsuit.

The third type of case is a lawsuit, generally at the appellate level, in which an important legal precedent could be established. In such cases, the Litigation Center will file a brief as amicus curiae ("friend of the court") to advise the court of the legal and public policy interests that may be affected by the court's decision and urge the court to decide the case consistently with AMA objectives.

Case Requirements

Litigation Center cases must satisfy both of the following criteria:

- The Litigation Center position must be consistent with AMA policies; and
- The medical society of the state in which a case is to be filed must support Litigation Center involvement.

Additional Selection Criteria

It is impossible to create a definitive list of criteria for determining whether the Litigation Center will accept a case. The parties, merits, and case posture are all relevant. In addition, the following selection factors will be reviewed, as case applicable:

- Whether the legal issues presented extend or clarify the case law on a matter of interest to physicians generally;
- The precedential value of the case (i.e., level of court, jurisdiction, and nature of legal proceeding);
- The scope of applicability of the case determination (i.e., state, regional, national or specialty-specific matter);
- The type and level of assistance being requested of the Litigation Center;

- The likelihood of succeeding on the merits;
- The allocation of Litigation Center resources required by the proposed case;
- The contribution made by others, including the parties and the person who has requested support;
- The comparative value of selecting a particular case as against other pending and likely litigation requests;
- The extent of non-financial costs (e.g., whether litigation makes political and other options less feasible);
- The state medical society and AMA membership status of any individual physicians that the Litigation Center is requested to support (or oppose); and
- Whether options other than litigation are available

Requests for Information

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Financial

Cash on Hand

	09/30/22	09/30/23	09/30/24
Cash on hand	$2,844,746	$2,478,135	$2,468,471

Revenue and Expenses
(as of September 30, 2024)

Revenue:	
Carryover from prior year	$ 2,093,882
State Medical Society dues	$ 174,589
AMA contribution	$ 200,000
Total revenue	$ 2,468,471
Expenses:	
Travel and meetings	$ 17,523
Legal expenses	$ 211,955
Other	$ 1,069
Total expenses:	$ 230,548
Cash Remaining:	$ 2,237,923

November 2024
Summaries of Litigation Center Cases

Active Cases

A. Professional Liability -- Tort Reform

1. Bianco v. Rudnicki (Colo. S. Ct.)

Issue

The issue in this case is whether prefiling, prejudgment interest on past and future economic damages in a medical malpractice action may exceed the Colorado Health-Care Availability Act's ("HCAA") $1 million damages cap.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

On October 5, 2005, Alexander Rudnicki suffered serious injuries during his birth, allegedly as the result of negligence by Dr. Peter Bianco. Dr. Bianco performed an operative vaginal delivery using a vacuum extractor.

Following the delivery, Rudnicki had severe scalp abrasions and bruising on his skull. Medical staff observed him to be floppy, quiet, and unresponsive, with diminished function. Rudnicki was immediately intubated and required extensive medical treatment, which revealed injuries to his scalp and skull caused by the extraction.

As a result of his injuries, Rudnicki has required ongoing physical, occupation, and speech therapy. Rudnicki is unlikely to be able to live independently in the future.

In 2014, Rudnicki's parents filed a complaint in Colorado state court against Dr. Bianco and the hospital where Rudnicki was born, alleging professional negligence. The case was heard by a jury, which found that Dr. Bianco had acted negligently and awarded the Rudnickis more than $4 million in damages.

After the verdict, the defendants moved to reduce the verdict consistent with the state's $1 million damages cap. The case was eventually appealed to the Colorado Supreme Court, which ruled in favor of the defendants and reduced the damages to $391,000.

With the principal legal issues seemingly resolved, the Supreme Court remanded the case to the trial court to calculate the amount of interest that should be awarded to the plaintiff as part of the total judgment. Following additional briefing by the parties, the trial court concluded that the Rudnickis were entitled to more than $1.35 million in interest on the $391,000 award in light of the seventeen years that had elapsed from the time of the injury to the time of the final judgment.

The defendants again appealed, and the Colorado intermediate appellate court affirmed the trial court's award. Both the trial court and appellate court decisions were at odds with prior Colorado precedent without any explanation for why prefiling, prejudgment interest should fall outside of the damages cap.

The Colorado Supreme Court has again granted review.

Litigation Center Involvement

The Litigation Center and the Colorado Medical Society filed an *amicus* brief in support of the defendants.

2. Chatman v. Owens (Mich. Ct. App.)

Issue

The issue in this case is the constitutionality of Michigan's cap on noneconomic damages in medical malpractice actions.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Nurse Kelsey Owens treated Marsha Chatman with a heating pad, which burned her left buttock. The skin healed with the use of ointment and fading cream. When Chatman consulted a plastic surgeon a year later, he found hyperpigmentation in the area but no scarring.

Chatman brought a malpractice suit against Owens. The jury awarded $2.88 million in noneconomic damages: $2 million was for present noneconomic damages and $880,000 for future noneconomic damages extending over 20 years. There were no economic damages. Owens pointed to Michigan's cap on noneconomic damages, and Chatman moved to declare the cap unconstitutional. Adhering to precedent, the trial court denied Chatman's motion.

Plaintiff took an immediate appeal as of right, and now the matter is pending before the court of appeals.

Litigation Center Involvement

The Litigation Center joined the Michigan State Medical Society in an *amicus* brief supporting the defendant.

3. Lewis v. MedCentral Health System (Ohio S. Ct.)

Issue

The issue in this case is whether a trial court properly dismissed a medical malpractice action for failure to comply with Ohio's statute of limitations.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Christine Lewis was a patient in the ER of a hospital operated by MedCentral Health System ("MedCentral"). She was treated by Dr. Anand Patel along with nurses and other health care professionals. While in the ER, she fell out of her hospital bed, fracturing her neck.

On February 14, 2022, Lewis filed a medical malpractice suit against the hospital and "John Doe" defendants, identified as other "physicians, nurses, hospitals, corporations, health care professionals… names unknown." Over a year later, on April 14, 2023, she filed an amended complaint, dropping the "John Doe" defendants, but adding named defendants, including Dr. Patel and MedCentral.

Dr. Patel and MedCentral filed a motion to dismiss, arguing the one-year statute of limitations for medical claims expired on February 14, 2023, and the action against them was barred. Lewis argued that pursuant to Ohio statute R.C. § 2323.451, a plaintiff pursuing a medical claim may join additional defendants within 180 days following the conclusion of the one-year statute of limitations. The trial court granted the motion to dismiss, finding that the purpose of the statute is to allow for amendment of a complaint past the statute of limitations when new claims are discovered through the discovery process, and but not provide for the substitution of parties known but unnamed in the original complaint.

Plaintiff appealed, and the appellate court reversed. The court described R.C. § 2323.451 as remedial in nature, stating that it should be liberally construed in favor of giving the plaintiff an opportunity to litigate the case on the merits. The court reasoned that R.C. § 2323.451 was intended to allow the plaintiff to file the action against the larger entity, such as the hospital and/or any known and identified defendants, within the applicable statute of limitations of one year, and, after identifying through discovery any other specific defendants involved in the plaintiff's care, add those via amendment to the complaint within the 180 day time frame set forth in the statute.

MedCentral and Dr. Patel have now appealed to the Ohio Supreme Court.

Litigation Center Involvement

The Litigation Center joined OSMA and the Ohio Hospital Association in an *amicus* brief supporting the defendants.

4. Rygwall v. ACR Homes (Minn. S. Ct.)

Issue

The issue in this medical malpractice case is whether the plaintiff's expert established causation.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Amy Rygwall was born with a rare medical condition that caused significant physical and mental disabilities. She resided in a group home, owned and operated by ACR Homes. During the day, she attended a community integration program at Rise Services, Inc. While at Rise, Amy had a detailed care plan, which required monitoring at all times for seizures and respiratory distress.

On December 29, 2015, ACR conducted Amy's monthly examination, and the results were "all within normal limits." Amy had a seizure on the evening of December 30 and another in the early morning of December 31, both lasting around 30 seconds. Rise staff reported that Amy was "kind of slumped over a little bit" when she arrived at Rise on December 31 and that she had been more tired than normal over the past week.

At approximately noon on December 31, Amy reportedly had a seizure at the end of her meal. Rise staff verified that Amy no longer had food in her mouth but noted that her breathing was somewhat raspy and indicated that Amy was foaming at the mouth. Rise staff determined that Amy should be taken to an urgent care clinic and contacted ACR, as required in the care plan.

Soon after arriving at urgent care, Amy's face and skin began to turn blue, and she continued to foam at the mouth. Urgent care staff called 911 and placed Amy on oxygen. When emergency personnel arrived, they noted that her lungs sounded "wet," and they transported her to a nearby hospital.

At the hospital, Amy was intubated for respiratory failure and given IV antibiotics "for presumed aspiration pneumonia." The emergency department physician determined that Amy had "respiratory insufficiency and respiratory failure, which requires immediate intervention." A hospital report from later that evening noted that Amy tested positive for methicillin-resistant Staphylococcus aureus (MRSA) and that she had "possible sepsis."

Amy remained hospitalized until January 13, 2016. During that time, her condition further deteriorated. Hospital physicians told Amy's family that her lungs had filled with fluid, her heart muscles had weakened, and her kidneys were shutting down. The physicians further advised that Amy would likely not be able to breathe on her own again, and she would not be able to return to ACR Homes or Rise. Accordingly, Amy's family elected to remove her life support, and she passed away.

On December 27, 2018, Amy's mother and the executor of her estate, Judith Rygwall, sued ACR, asserting claims of medical malpractice and wrongful death arising out of ordinary

negligence, professional liability, and direct corporate negligence. As support for her claims, Rygwall submitted affidavits from two of Amy's treating physicians and two experts, including Dr. Jacob Keeperman. Dr. Keeperman opined that "ACR should have taken immediate steps to ensure that [Amy] was taken for emergency medical care" and that the "delay in obtaining emergency care" and the "failure to provide all relevant medical information" to medical personnel caused or contributed to Amy's deterioration and eventual death.

ACR moved for summary judgment, arguing that Rygwall "failed to produce legally sufficient expert opinions on causation as necessary to bring her claims before a jury." The district court ordered summary judgment for ACR, reasoning that Rygwall failed to establish that ACR's negligence caused Amy's death and that "[u]nder the facts of this case, the jury would be asked to speculate as to the type of appropriate treatment as well as if and when earlier treatment would have prevented Amy's death."

The court of appeals affirmed the trial court's decision, concluding that in Minnesota expert testimony in a medical malpractice case must be more than a simple reiteration of the plaintiff's theory of causation; the expert testimony must demonstrate a reasonable probability that defendant's negligence was the proximate cause of the injury.

Judith Rygwall appealed to the Minnesota Supreme Court.

Litigation Center Involvement

The Litigation Center and the Minnesota Medical Association joined the Minnesota Hospital Association in an *amicus* brief in support of the defendants.

5. Terehoff v. Frenkel (N.Y. Sup. Ct., App. Div.)

Issue

The principal issue in this case is whether, in a medical malpractice suit, an expert witness should be allowed to testify that the physician's error caused the patient's injury if the only basis for the testimony was a statistical correlation between the error and the injury.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Dr. Frenkel, an OB/GYN, failed to diagnose fetal distress in his 25 weeks pregnant patient. Shortly after the misdiagnosis, the mother gave birth, by c-section, to a severely premature baby. Later, the baby developed autism.

The mother sued Dr. Frenkel on behalf of her son, claiming that, had Dr. Frankel diagnosed the mother properly, he could have prescribed medications that would have delayed the birth for two weeks. Had this been done, she claimed, her son would not have developed autism.

The plaintiff called an expert witness to testify that the likelihood of autism in a 27-week birth is

significantly less than the likelihood of autism in a 25-week birth. Dr. Frenkel moved to bar the plaintiff's expert. He argued that the plaintiff was required to prove proximate cause, and a statistical correlation does not by itself prove causation. The testimony about correlation would invite the jury to speculate that the misdiagnosis caused the autism, but the child's autism could well have been caused by a genetic mutation or other factors.

The court denied the motion to bar the expert testimony, and the expert went on to testify about the different likelihood of autism in a baby born after a 25-week pregnancy and a baby born after a 27-week pregnancy. The jury found in favor of the plaintiff and awarded damages of approximately six million dollars.

Dr. Frenkel appealed to the Appellate Division of the Supreme Court – the intermediate level appellate court in New York.

Litigation Center Involvement

The Litigation Center, the Medical Society of the State of New York, and ACOG submitted a brief to support Dr. Frenkel.

B. Professional Liability – COVID-19

1. Land v. Whitley (N.C. S. Ct.)

Issue

The issue in this case is whether North Carolina's Emergency or Disaster Treatment Protection Act ("the Act") immunizes health care providers from all claims of medically negligent care rendered during the COVID-19 pandemic.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

The Act provided immunity for ordinary negligence of health care providers during the COVID-19 pandemic. It did not protect against claims of gross negligence or willful or intentional misconduct.

The care at issue took place on June 29, 2020, shortly after the Act became effective. Doris Land was diagnosed with a high-grade squamous intraepithelial lesion, which was at risk of turning into cervical cancer. Mrs. Land's health care providers ultimately determined that a total vaginal hysterectomy was necessary. During the procedure, the physicians failed to remove a three-inch piece of uterine tissue from Mrs. Land's abdominal cavity, resulting in significant complications, including sepsis, stage 4 kidney failure, and an abdominal infection.

On February 16, 2022, Mrs. Land and her husband filed a complaint against the physicians who performed the hysterectomy and their employers. The plaintiffs alleged both negligence and gross negligence.

On May 2, 2022, the defendants moved to dismiss, arguing that they are immune from the lawsuit under the Act. The trial court denied the motions to dismiss, and the defendants appealed.

On February 6, 2024, the North Carolina Court of Appeals affirmed the lower court order, finding that even for ordinary negligence claims, the Act did not provide complete immunity. Instead, the Act could be advanced as an affirmative defense, which would require the defendants to demonstrate a causal connection between COVID-19 and the alleged harm. The defendants sought review by the North Carolina Supreme Court.

On May 23, 2024, the North Carolina Supreme Court agreed to hear the case. This is a favorable development, consistent with the Litigation Center's brief. Briefing on the merits is ongoing.

Litigation Center Involvement

The Litigation Center and the North Carolina Medical Society filed an *amicus* brief supporting the defendants in the state high court and a supplemental *amicus* brief on the merits.

2. Roebuck v. Mayo Clinic (Ariz. S. Ct.)

Issue

The issue in this medical malpractice case is whether an Arizona law, A.R.S. § 12-516, providing immunity from standard negligence claims arising during the COVID-19 pandemic, violates the Arizona Constitution.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Robin Roebuck had his first heart transplant in 1993 and a second heart transplant and kidney transplant at Mayo Clinic in 2017. On April 20, 2020, Roebuck was hospitalized at Mayo Clinic after presenting with COVID-19 symptoms. Because he had previously received a heart transplant, Roebuck was placed under the care of Mayo Clinic's congestive heart failure team.

On April 23, 2020, a chest x-ray revealed Roebuck had developed pneumonia, and he had to be given supplemental oxygen. That same day, Dr. Hasan Ashraf, a cardiologist, ordered an echocardiogram to assess Roebuck's heart. The echocardiogram confirmed that Roebuck's heart was "doing pretty well" and that he was not having primary cardiac issues or signs of rejection. In light of Roebuck's positive COVID-19 test and the results of the echocardiogram, his doctors "proceeded with regards to the management of COVID" rather than "any cardiac kind of management."

After consulting with Mayo Clinic infectious disease specialists, Dr. Ashraf ordered an arterial blood gas ("ABG") test. The results of the ABG test revealed that Roebuck had very low oxygen content in his blood, warranting treatment with tocilizumab, which he was given shortly thereafter.

Roebuck developed complications from the ABG test, was diagnosed with compartment syndrome, and underwent emergency surgery on his right hand, forearm, and wrist. Roebuck was left with diminished strength and use of his right hand and arm and significant scarring.

In January 2021, Roebuck sued the Mayo Clinic and his physicians, alleging the ABG test had been performed negligently. The defendants moved for summary judgment, arguing that Arizona law provided immunity from standard negligence claims to health professionals acting in good faith during the COVID-19 pandemic. The trial court agreed with the defendants and entered summary judgment. Roebuck appealed.

On September 19, 2023, the court of appeals reversed the trial court, finding that A.R.S. § 12-516 could not bar Roebuck's claims because the law violates the Arizona Constitution's anti-abrogation clause. That clause states that "[t]he right of action to recover damages for injuries shall never be abrogated, and the amount recovered shall not be subject to any statutory limitation." The court remanded the case for further proceedings.

Defendants sought review from the Arizona Supreme Court, and the high court has agreed to hear the case. This is a favorable result, consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined ArMA and several other Arizona health care entities in an *amicus* brief supporting the defendants.

3. Schleider v. GVDB Operations (11th Cir.)

Issue

The issue in this case is whether and to what extent the Public Readiness and Emergency Preparedness Act (the "PREP Act") bars claims of negligence stemming from care provided during the COVID-19 pandemic.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

The estate of a former resident at an assisted living facility brought a wrongful death claim against the facility. The assisted living facility had allegedly failed to take sufficient measures to protect the resident, including a failure to provide necessary personal protective equipment.

The case was filed in a Florida state court, and the defendants then removed it to the federal Southern District of Florida. There, the defendants asserted that the PREP Act barred the plaintiff's claims. The district court in Florida rejected the defendants' arguments and remanded the case to state court for further proceedings.

The defendants appealed to the Eleventh Circuit Court of Appeals.

Litigation Center Involvement

The Litigation Center and Florida Medical Association joined an *amicus* brief supporting the defendants' appeal.

C. Professional Liability – Other Issues

1. Community Health Network, Inc. v. McKenzie (Ind. S. Ct.)

Issue

The issue in this case is whether a medical clinic can be held liable for its employee's unauthorized accessing of medical records.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Katrina Gray was a "medical records coordinator" at the Indiana Orthopedic Center ("IOC"), a subsidiary of Community Health Network ("CHN"). Her duties included the distribution of patient medical records, but only within IOC. She was prohibited from accessing patient records for any but business reasons. As a condition of her employment, Katrina attended orientation and training on patient confidentiality and on HIPAA. After she had successfully completed her orientation and training, Katrina was provided access to Epic, an electronic medical records system.

Notwithstanding her employer's rules and the HIPAA restrictions, Katrina accessed the medical chart of another employee, Heather McKenzie, for non-business reasons. Heather sued CHN, asserting that CHN should be liable, *inter alia*, under *respondeat superior*.

CHN moved for summary judgment, asserting that Katrina's access of Heather's medical records was outside the scope of her employment. Thus, *respondeat superior* should not apply. The trial court denied the motion but certified the issue as an important, unresolved question, deserving of interlocutory review by the Indiana Court of Appeals.

The Court of Appeals observed that Katrina had accessed the health records through employer-conferred authority. This meant that, at least potentially, she had acted within the scope of her employment. Accordingly, the trial court had properly denied summary judgment on the *respondeat superior* claim, and this part of the lower court order was affirmed.

CHN appealed to the Indiana Supreme Court.

Litigation Center Involvement

The Litigation Center and the Indiana State Medical Association filed an *amicus* brief to support CHN.

2. Hagans v. The Hospital of the Univ. of Penn. (Pa. S. Ct.)

Issue

The issue in this medical malpractice case is whether the trial court erred in submitting a jury verdict slip that was inconsistent with the jury instructions and unfairly lowered the plaintiff's burden of proof.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

A pregnant Dejah Hagans arrived at The Hospital of the University of Pennsylvania via ambulance after her water broke. During her delivery, she experienced multiple complications. Her baby was delivered via a delayed cesarian section. The child had brain injuries and a multitude of disorders, including cerebral palsy. He will be dependent on caregivers to feed, toilet, and clean him for life. He will also have to undergo future surgeries and medical interventions.

Hagans sued the hospital and individual providers, alleging medical malpractice. After a three-week jury trial, the jury found in favor of the plaintiff and against the defendants. It awarded what may have been the largest medical malpractice verdict in Pennsylvania history, almost $183 million.

Defendants made a number of post-trial motions, including an argument that the court erred and/or abused its discretion in submitting a jury verdict slip that allowed the jury to find causation if it concluded that the hospital's negligence was the factual cause and/or increased the risk of harm to plaintiff. The court denied all of these motions.

The defendants appealed to the Pennsylvania Superior Court.

Litigation Center Involvement

The Litigation Center and Pennsylvania Medical Society filed an *amicus* brief in support of the defendants.

3. Matos v. Geisinger Medical Ctr. (Pa. S. Ct.)

Issue

The issue in this medical malpractice case is whether a person who voluntarily submitted himself for inpatient mental health treatment but was denied such treatment due to gross negligence or

willful misconduct has a cause of action under Pennsylvania's Mental Health Procedures Act ("MPHA") against the parties who denied the treatment.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Westley Wise, who had a record of acute psychiatric issues, submitted himself for voluntary inpatient examination and treatment by first presenting himself at Geisinger Medical Center ("Geisinger"), and a few days later at Alley Medical Center ("Alley"). Medical personnel at both facilities examined Wise but denied his requests for treatment. Wise murdered his girlfriend, Jessica Frederick, the same day that Alley refused treatment.

Steven Matos, the administrator of Frederick's estate, sued Geisinger and Alley (as well as the mental health professionals that examined Wise at each medical center), alleging liability under the MPHA for gross negligence and/or willful misconduct in failing to diagnose Wise's condition and failing to initiate inpatient treatment. Defendants submitted multiple motions for summary judgment, urging the court to find them not liable. The trial court denied the defendants' motions but allowed an immediate interlocutory appeal to the Pennsylvania Superior Court.

The appellate court affirmed the trial court's denial of the defendants' motions for summary judgment. The court explained that the prerequisites to trigger MPHA liability are different for involuntary examination and treatment versus voluntary inpatient examination and treatment. It reasoned, "While the MHPA requires a written application to begin the involuntary examination process, it does not require a written application to begin voluntary inpatient examination and treatment. Thus, facilities such as Geisinger and Alley may be held liable for refusal to provide voluntary inpatient examination and treatment to a person who submits himself for examination and treatment when the refusal constitutes willful misconduct or gross negligence."

Defendants appealed to the Pennsylvania Supreme Court.

Litigation Center Involvement

The Litigation Center and PAMED filed an *amicus* brief in support of the defendants in the Pennsylvania Supreme Court.

4. Preferred Orthopedics of The Palm Beaches v. Awadallah (Fl. Ct. App.)

Issue

The issue in this case is whether a physician may be held liable for defamation for reporting threats made by their patients.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Dr. Michael Zeide was asked to examine a patient by the patient's workers compensation carrier. During the examination, the patient allegedly made threats against the case adjuster. Dr. Zeide was concerned, and he believed he had a moral duty to report the threat. Dr. Zeide contacted the adjuster and shared the information.

After learning that Dr. Zeide contacted the adjuster, the patient sued Dr. Zeide and his employer for defamation. The case went to trial in Florida state court, and initially, the jury returned a verdict in favor of the physician. The judge, however, concluded the jury instructions were incorrect and ordered the jury to consider the matter with new instructions. The jury then found in favor of the patient and awarded $775,000 in damages.

The defendants have appealed to the Florida Court of Appeals, arguing that the statements to the adjuster were protected under Florida state law privileges and they are entitled to judgment as a matter of law.

Litigation Center Involvement

The Litigation Center and the Florida Medical Association filed an *amicus* brief supporting the defendants in the Florida Court of Appeals.

5. Reibenstein v. Barax (Pa. S. Ct.)

Issue

This medical malpractice case involves two issues: 1) the meaning of the term "cause of death" in the statute of limitations provision in Pennsylvania's Medical Care Availability and Reduction of Error Act ("MCARE"); and 2) whether the MCARE statute of limitations is tolled if a person other than the defendant affirmatively misrepresented or fraudulently concealed the patient's cause of death.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

At the request of her primary care physician, Dr. Conaboy, Mary Ann Whitman underwent a CT scan, which Dr. Barax reviewed. After reviewing the scan, Dr. Barax drafted a radiology report that stated that Mrs. Whitman had an abdominal aortic aneurysm that was "poorly visualized" on the study. His report did not document an aneurysm rupture, or any concern of a possible rupture. The report stated that Dr. Conaboy was contacted with the findings. Five days later, Whitman died from a ruptured abdominal aortic aneurysm. A year later, Plaintiff Linda Reibenstein, the administratrix of Mrs. Whitman's estate, sued Dr. Barax.

In his deposition, Dr. Barax testified that he spoke with Dr. Conaboy and explained to him that the CT scan showed a previously undocumented abdominal aortic aneurysm, but because he could not fully visualize the aneurysm, he could not ascertain whether it was rupturing.

Ms. Reibenstein initiated a separate action against Dr. Conaboy almost six years after Mrs. Whitman's death. Dr. Conaboy moved for summary judgment, citing the MCARE two-year statute of limitations. The trial court granted summary judgment because it found "no evidence of affirmative misrepresentation or fraudulent concealment of the cause of death." Thus, the statute of limitations could not be tolled because decedent's medical cause of death was correctly identified on decedent's death certificate and thus known to the plaintiff.

Plaintiff argued to the Superior Court that Dr. Barax had concealed his communications with Dr. Conaboy concerning Mrs. Whitman's aneurysm, and this concealment was directly related to the cause of Mrs. Whitman's death. Therefore, based on Section 1303.513(d), the two-year statute of limitations should have been tolled.

The Superior Court agreed and vacated the summary judgment, stating: "It is in furtherance of the stated purpose of fair compensation that we interpret 'affirmative misrepresentation or fraudulent concealment of the cause of death' to encompass those acts which caused the patient to die. Where a medical practitioner hides an action that was directly related to the cause of the patient's death, the Commonwealth's interest in redress outweighs the interest in control of medical malpractice insurance costs." The court did not opine on Plaintiff's claim that there was a fraudulent concealment or affirmative misrepresentation by Dr. Conaboy related to Whitman's death.

Dr. Conaboy appealed the Superior Court ruling to the Pennsylvania Supreme Court.

Litigation Center Involvement

The Litigation Center and the Pennsylvania Medical Society joined an *amicus* brief supporting Dr. Conaboy's appeal to the Pennsylvania Supreme Court.

6. Stiefel v. Shiflett (Idaho S. Ct.)

Issue

The issue in this case is whether a physician engages in reckless conduct, thus subjecting the physician to punitive damages, if the physician does not exhaust all possible causes of a patient's symptoms.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

On March 29, 2016, Carl Stiefel woke to go to the bathroom. While on his way back to bed, he collapsed to the ground with the sudden onset of dizziness, nausea, vomiting, headache, ringing in his ear, and the inability to stand or walk. Mr. Stiefel called for his wife who then called 911 for assistance.

Stiefel was transported to St. Luke's Hospital, where he was seen by Dr. Bryan Shiflett, a board-certified emergency physician. Dr. Shiflett observed that Mr. Stiefel was not in acute distress and was cooperative and pleasant. Dr. Shiflett performed a physical and neurological exam. Dr. Shiflet considered the possibility that Stiefel had suffered a stroke and ordered several additional tests, including a CT scan, an EKG, a chest x-ray, and bloodwork.

Following the tests, Stiefel's symptoms improved slightly, but not enough that Dr. Shiflett felt comfortable in sending Stiefel home. Because Dr. Shiflett could not admit patients to the hospital directly, he called a hospitalist who was working at that time and explained the situation. Stiefel was admitted to the hospital, and from that point Dr. Shiflett was no longer involved in his care.

Several hours after Stiefel was admitted to the hospital, his condition began to deteriorate, and he was given an MRI. He was then diagnosed with a posterior circulation stroke. The resulting brain injury caused motor and cognitive dysfunction requiring long-term care and rehabilitation.

On March 21, 2018, Stiefel and his wife filed a complaint in Idaho state court. The complaint named several physicians, including Dr. Shiflett, and the hospital as defendants. The complaint also named Dr. Shiflett's employer, Emergency Medicine of Idaho ("EMI"), under a vicarious liability theory. Prior to trial, all the defendants except Dr. Shiflett and EMI were either voluntarily dismissed or reached settlement agreements.

The trial began on January 18, 2023. During the trial, the plaintiffs argued that Dr. Shiflett breached the standard of care and engaged in reckless conduct by failing to exhaust every possible alternative for Stiefel's symptoms upon his presentation at the emergency room. The

defense contended that Dr. Shiflett acted appropriately, working through a differential diagnosis, before ultimately recommending that Stiefel be admitted to the hospital and evaluated further.

Following the trial, the defense objected to the jury instructions and the use of a special verdict form that allowed the jury to find that Dr. Shiflett was reckless. Under Idaho law, a finding of recklessness would circumvent the state damages cap for civil actions. The trial court denied the defense request and stated that Dr. Shiflett was playing "Russian roulette" by making a conscious choice not to exhaust all potential avenues of diagnosis when Stiefel was first evaluated.

On February 2, 2023, the jury found that Dr. Shiflett breached the standard of care and that this breach proximately caused the plaintiffs' injuries. The jury further found that Dr. Shiflett's actions were reckless.

The jury awarded Mr. Stiefel $1,274,419.15 in past medical expenses, $3,500,000 in economic damages other than past medical expenses, and $8 million in noneconomic damages. The jury also awarded Ms. Moulton $750,000 in noneconomic damages. On July 19, 2023, the court entered judgment in the amount of $12,623,494.82.

Defendants have appealed to the Idaho Supreme Court, where briefing is ongoing.

Litigation Center Involvement

The Litigation Center joined the Idaho Medical Association and other groups in an *amicus* brief supporting the defendants on appeal.

7. Stone v. Witt (Or. S. Ct.)

Issue

The issue in this case is whether physicians may be liable for injuries caused by their patients when the patients are under the influence of prescribed medications.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

In 2017, Marika Stone, a dentist, was struck and killed while riding her bicycle. The driver of the car, Shantel Witt, was found to have 11 prescribed and nonprescribed substances in her blood at the time of the crash. Witt was convicted of first-degree manslaughter, and she was sentenced to 12 years in prison.

In April 2018, Stone's estate filed a wrongful death claim in Oregon circuit court. The complaint not only named Witt as a defendant, but also included claims against her physicians, their employers, and the pharmacy where she filled her prescriptions, Walgreen Co. The theory of plaintiff's claim is that the defendants knew or should have known that Witt was abusing prescription medications, and as a result, it was foreseeable that Witt might cause harm to a third

party.

The non-Witt defendants moved to dismiss the plaintiff's claims, arguing that Witt's negligence did not extend to their conduct. The trial court agreed with the non-Witt defendants and dismissed them from the suit.

The plaintiff appealed, and in April 2024, the Oregon Court of Appeals reversed. The intermediate appellate court held that the plaintiff had sufficiently alleged that the physicians and other provider defendants had a duty of care in treating Witt under Oregon law. The court went on to hold that the plaintiff's complaint sufficiently alleged that the providers had breached that duty and that injuries to a third party, like Stone, were reasonably foreseeable. The court concluded that whether the physicians and other providers were ultimately liable would be a question for the jury.

The defendants sought review by the Oregon Supreme Court, which has agreed to hear the case.

Litigation Center Involvement

The Litigation Center joined the Oregon Medical Association in an *amicus* brief supporting the defendants.

8. Wunderly v. St. Luke's Hospital (Pa. S. Ct.)

Issue

The issue in this medical malpractice case is whether Pennsylvania's Mental Health Procedures Act (MHPA) immunized a hospital against liability for negligence in a patient's physical care that was incidental to his mental health care.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Kenneth Wunderly was admitted to St. Luke's Hospital of Bethlehem, Pennsylvania ("St. Luke's") for involuntary mental health treatment. When admitted, he had pressure ulcers on his buttocks. While in the hospital, his ulcers worsened. He was subsequently moved to an assisted living facility, where he died.

Wunderly's estate sued St. Luke's, alleging medical malpractice. He claimed that the hospital's failure to tend to Wunderly's ulcers and wounds caused and/or contributed to his death. St. Luke's claimed immunity pursuant to Section 114 of the MHPA, which provides immunity from civil or criminal liability for treatment associated with mental health care, unless the defendant's actions constituted willful misconduct or gross negligence.

The trial court determined that treatment for Wunderly's physical wounds was incidental to the mental health treatment, and thus the MHPA immunity applied to the ulcer treatment. It dismissed the case.

Plaintiff appealed to the Superior Court. The Superior Court affirmed the trial court decision, finding that "the primary reason for the hospitalization was to stabilize [Wunderly's] mental health, and the treatment of his pressure ulcers was 'coincident to that mental health treatment.'"

Plaintiff has now appealed to the Pennsylvania Supreme Court.

Litigation Center Involvement

The AMA and Pennsylvania Medical Association joined an *amicus* brief in support of the defendant.

D. Scope of Practice

1. Palmer v. Bonta (C.D. Cal.)

Issue

The issue in this case is whether Cal. Bus. & Prof. Code § 2054(a), which prohibits nonphysicians from publicly representing that they are "doctors," infringes on the free speech rights of nurse practitioners with doctorates in nursing practice.

AMA Interest

The AMA is to work jointly with state attorneys general to identify and prosecute allied health professionals who misrepresent themselves as physicians to their patients. Further, the AMA is to work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified with regard to their professional licensure in order that patients are aware of the professional background of those persons. Scope of practice concerns are a high priority for the AMA.

Case Summary

Cal. Bus. & Prof. Code § 2054(a) provides, in relevant part: "Any person who uses in any sign, business card, or letterhead, or in an advertisement, the words 'doctor' or 'physician,' the letters or prefix 'Dr.,' the initials 'M.D.' or any other terms or letters indicating or implying that he or she is a physician and surgeon … without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon … is guilty of a misdemeanor."

The complaint was filed on June 6, 2023, in the United States District Court for the Central District of California (Los Angeles). The plaintiffs are three nurses, who had received Doctorates in Nursing Practice. The defendants are the California Attorney General, the President of the Medical Board of California, and the Executive Director of the California Board of Registered Nursing. The complaint alleged that Palmer's clinician's jacket identified her as "Dr. J. Palmer, FNP-C." Heather Lewis, another plaintiff, referred to herself in social media as "Dr. Heather Lewis, FNP-C, DNP."

The complaint asserts that the California law violates the plaintiffs' First Amendment right to Freedom of Speech. The plaintiffs seek a declaratory judgment and an injunction to prevent the law's enforcement. They also seek costs and attorneys' fees.

On September 15, 2023, pursuant to the defendants' motion, the district court dismissed the complaint in part, finding that two of the three plaintiffs failed to allege sufficient facts to demonstrate justiciability. The court allowed the two dismissed plaintiffs to amend their complaint to cure the defects. The amended complaint was filed on September 25, 2023, and the defendants answered on October 13, 2023.

Litigation Center Involvement

The Litigation Center joined CMA in a trial court *amicus* brief to support the defendants' motion to dismiss the original complaint.

2. West Virginia Academy of Eye Physicians & Surgeons v. West Virginia Board of Optometry (W.V. Cir. Ct.)

Issue

The issue in this case is whether the West Virginia Board of Optometry properly adopted a regulation that allows optometrists to perform eyelid surgery.

AMA Interest

The AMA is to work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified with regard to their professional licensure in order that patients are aware of the professional background of those persons. Scope of practice concerns are a high priority for the AMA.

Case Summary

On November 15, 2023, the West Virginia Board of Optometry adopted a regulation that allows optometrists to perform eyelid surgery. The West Virginia State Medical Association, in conjunction with the West Virginia Academy of Eye Physicians & Surgeons (WVAEPS, which is the West Virginia chapter of the American Academy of Ophthalmology), sued the Board of Optometry to have the regulation declared invalid.

The challenge is based on both procedural and substantive deficiencies.

Litigation Center Involvement

The Litigation Center made a monetary contribution to the West Virginia State Medical Association to help fund the litigation.

E. Affordable Care Act Protections

1. Braidwood Management v. Becerra (N.D. Tex.; 5th Cir.; S. Ct.)

Issue

The issue in this case was whether the Affordable Care Act ("ACA") requirement that private insurance plans cover certain preventive care services without cost sharing violates the United States Constitution and the Religious Freedom Restoration Act.

AMA Interest

The AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces, and the community.

Case Summary

The ACA requires most private health insurance to cover certain "preventive care" services, without cost sharing from the patient. Preventive care includes a range of services, such as screening tests, immunizations, behavioral counseling, and medications that can prevent the development or worsening of diseases and health conditions. The ACA empowers three agencies affiliated with the Department of Health and Human Services to determine what services fall within this requirement. As new recommendations are issued or updated, coverage must begin in the next plan year that begins on or after one year from the recommendation's issue date.

Plaintiffs, six individuals and two businesses, challenged the legality of the ACA's preventive care service requirements and structure, based on religious, economic, and constitutional reasons. The plaintiffs focused on requirements related to contraception and preventing transmission of HIV, as they desire to purchase insurance policies on the open market that meet their specific needs and are free from the requirements of the ACA.

In September 2022, the federal district court in the Northern District of Texas, on cross-motions for summary judgment, found in favor of the plaintiffs on two of their claims. As part of its ruling, it determined that the members of the United States Preventive Services Task Force (PSTF), an agency the ACA had empowered to make certain of the recommendations at issue, should be deemed Officers of the United States under Article II, §2 of the Constitution. Thus, the PSTF members could only serve if they had been appointed under Article II, §2 protocols, but in fact they had not.

On March 30, 2023, after supplemental briefing from the parties and amici, the federal district court issued its opinion and order addressing the remedies and final judgment. Most notably, the court ordered that all actions taken by HHS to implement or enforce the PSTF recommendations were to be vacated and enjoined. The court also ordered that the named plaintiffs need not comply with the PrEP mandate, as that mandate violated their rights under the Religious Freedom Restoration Act. This result was inconsistent with the Litigation Center's brief.

On March 31, the federal government appealed to the Fifth Circuit. It then sought a partial stay of the trial court decision. Pending resolution of the full appeal, the requested stay would limit

the trial court ruling to insurance policies purchased by the plaintiffs but not to insurance policies purchased by the general public.

On June 21, 2024, the Fifth Circuit issued a decision affirming in part and reversing in part the lower court decision. The appellate court agreed that the Preventive Services Task Force was unconstitutionally appointed but disagreed with the broad nationwide relief ordered by the lower court. The court of appeals also identified several items that needed further review by the district court and remanded the matter for further proceedings. This was a slightly unfavorable decision, though the result is fairly neutral as it leaves the status quo in place.

The federal government has asked the United Stated Supreme Court to hear the case.

Litigation Center Involvement

The Litigation Center joined other Federation members in five *amicus* briefs, one in the district court, one in the court of appeals in support of the stay, two on the merits of the case in the court of appeals, and one in the United States Supreme Court in support of the petition for *certiorari*.

2. New York v. United States Department of Labor (D.C. Cir.)

Issue

The issue in this case is whether a Department of Labor (DOL) regulation, which allows small businesses and consumers to form Association Health Plans (AHPs), falls within the government's administrative discretion, notwithstanding that the regulation undercuts the "risk sharing" and other provisions of the Affordable Care Act (ACA).

AMA Interest

The AMA supports access to medical care for all people. The AMA supports the expansion of adequate health insurance to the presently uninsured through formation of insurance risk pools in each state.

Case Summary

On June 21, 2018, DOL passed a regulation, which would allow the formation of AHPs. President Trump characterized this regulation as a "truly historic step in our efforts to rescue America from ObamaCare and the ObamaCare nightmare," and he said it would "escape some of ObamaCare's most burdensome mandates."

The AHP regulation loosens the rules for employers to join together and be characterized as a single "employer" group under the ACA. These employer groups, if they aggregate more than fifty employees, can sponsor AHPs. The AHPs need to conform only to the ACA large employer health plan requirements and do not have to provide all the essential health benefits applicable to small employer and individual plans.

The net effect will be that insureds covered under AHPs may not have the essential health benefits specified under the ACA. Moreover, insureds covered outside the AHPs but covered under small employer and individual plans will tend to be less healthy than those covered under large employer plans. This means that small employer and individual health insurance health

insurance plans will become less and less affordable for those with preexisting conditions. The social benefits of the ACA will thereby be eroded or even eliminated, and the incidence of underinsurance or complete lack of insurance will increase.

Eleven states plus the District of Columbia sued DOL to have the new AHP regulation declared invalid. The State of New York is the lead plaintiff. The lawsuit argues that the AHP regulation violates at least the spirit, if not the letter, of the ACA. The plaintiffs moved for a preliminary injunction.

The district court found that the AHP regulation was invalid under the Administrative Procedure Act. It vacated the regulation and remanded to the DOL for further consideration.

The DOL appealed to the United States Court of Appeals for the District of Columbia Circuit. The appeal was stayed to allow the Biden administration to review the matter.

Litigation Center Involvement

The Litigation Center, along with the Medical Society of the State of New York, filed briefs in the trial court and in the Court of Appeals to support the plaintiffs. The briefs emphasized the adverse effects on public health of the AHP regulation.

F. Peer Review Confidentiality

1. Sanders v. Children's Hospital of Philadelphia (Pa. Sup. Ct.)

Issue

The issue in these consolidated wrongful death cases is whether a trial judge properly ordered the disclosure of documents related to an infectious disease outbreak at a hospital, despite defendant's claim of privilege under Pennsylvania's Peer Review Protection Act ("PRPA") and Medical Care Availability and Reduction of Error Act ("MCARE").

AMA Interest

The AMA believes that. for peer review to be effective, peer review data should be kept confidential. Also, the AMA is to work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

This is a consolidated action made up of three wrongful death suits filed by families of three premature and critically ill infants who passed away at the Children's Hospital of Philadelphia ("CHOP") in 2016. While in CHOP's neonatal intensive care unit, the three infants received eye examinations, ventilator support, and treatment for a variety of conditions. The infants tested positive for adenovirus; however, CHOP denied that adenovirus was the cause of their deaths.

After CHOP's Infection Prevention and Control Department learned that there was an adenovirus outbreak, CHOP performed an investigation under Pennsylvania's PRPA and MCARE, led by an infectious disease physician. Her efforts included: meetings with staff to review information relating to patient safety measures; patient safety committee presentations; formal root cause

analyses; morbidity and mortality conferences; presentation to an ophthalmologist; presentation at an educational conference; and a published article in a medical journal.

During discovery, plaintiffs requested the production of the hospital documents and power point presentations that were created following the adenovirus outbreak. CHOP claimed that these documents were privileged under the PRPA and MCARE.

The court found that the documents were not created for the purpose of peer review but instead were the result of incident reports and hospital committee meetings held to address and stop the outbreak of the adenovirus. It further found that they had been sent to the peer review organization in an effort to assert privilege. It also held that some of the documents were shared with third parties, breaking any privilege claims. Because the requested materials were not created and maintained solely for the purpose of peer review, the court ruled that they were not privileged. It ordered their production.

CHOP appealed to the Pennsylvania Superior Court, arguing that the trial court erred in ordering disclosure of the documents. In November 2022, the Pennsylvania Superior Court held that some documents (such as the root cause analyses and power point presentations) were privileged, while other documents (such as emails prepared as part of the investigation or safety review) were not privileged.

In December 2022, plaintiffs applied for an *en banc* rehearing, and that application was granted.

Litigation Center Involvement

The Litigation Center, along with the Pennsylvania Medical Society ("PaMed") and other medical societies, filed two *amicus* briefs in the Pennsylvania Superior Court, first in the original appeal and then during *en banc* review.

2. Stull v. Summa Health System (Ohio S. Ct.)

Issue

The issue in this medical malpractice case is whether a resident physician's file is protected from discovery by the peer review privilege under Ohio law.

AMA Interest

The AMA believes that. for peer review to be effective, peer review data should be kept confidential. Also, the AMA is to work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Kalvyn Stull received treatment from Summa Health System (Summa) after being injured in an automobile crash. According to Mr. Stull, the treatment made the injuries he suffered to his brain more severe. He sued Summa and his treating physicians for medical negligence.

As part of discovery requests, Mr. Stull requested production of the file of Dr. Elashi, a Summa resident physician. Summa refused to provide the file, arguing that it was protected from

discovery by the peer review privilege under Ohio Rev. Code Ann. § 2305.252. Mr. Stull moved to compel the production of the resident file, and the court granted the motion.

Summa appealed, and the Ohio Court of Appeals affirmed. The court reviewed the affidavit submitted by Summa as evidence that Dr. Elashi's file was kept as part of the peer review process. The court found that the affidavit did not establish that Dr. Elashi's residency file is a "record within the scope of" a peer review committee as required by Section 2305.252.

Defendants have now appealed the appellate court decision, and the Ohio Supreme Court accepted the case for review on May 23, 2023.

Litigation Center Involvement

The Litigation Center joined the Ohio State Medical Association in an *amicus* brief in support of the defendants' appeal to the Ohio Supreme Court.

G. Medical Staff Privileges

1. Najibi v. Providence St. Joseph Hospital (Cal. Ct. App. 2d Dist.)

Issue

The issue in this case is whether Providence St. Joseph Hospital properly suspended the medical staff privileges of Sasan Najibi, MD, a member of the Hospital's Medical Executive Committee (MEC) and, at the time of the suspension, the Chief of Staff elect.

AMA Interest

Although final authority for termination of hospital staff privileges is vested in the governing board of the hospital, it is expected that the judgment of the organized medical staff will be relied upon in the evaluation of the professional competence, experience, and qualifications of all physicians. Moreover, the medical staff is to develop a process whereby a physician accused of disruptive behavior shall be provided an opportunity to respond within the confines of the organized medical staff.

Case Summary

On June 1, 2022, the Hospital met with the MEC and requested that the MEC summarily suspend Dr. Najibi's medical staff privileges. The Hospital contended that Dr. Najibi created a hostile environment for patients and other staff. The MEC refused to suspend Dr. Najibi at that time.

Following the refusal, on that same day, June 1, 2022, the Hospital summarily suspended Dr. Najibi's medical staff privileges and served him with a notice of suspension. The notice reiterated the points made supra as justifications for the suspension. It also stated that, prior to the vote to impose the summary suspension, "the [Hospital] determined that the Medical Staff had failed to initiate disciplinary action in response to the direction of the Board." It further stated that Dr. Najibi could meet with a Hospital representative, but "Legal counsel shall not be present for either the Board or you."

On September 22, 2022, the Hospital instituted a peer review action against Dr. Najibi. Rather than utilizing physicians from the Hospital medical staff for this purpose, the Hospital convened a panel of physicians from other hospitals.

On April 18, 2023, Dr. Najibi sued the Hospital in Los Angeles County Superior Court. He sought reinstatement to the medical staff and an order prohibiting the Hospital from continuing with the peer review process. The principal cause of action was that California law requires a hospital to undertake reasonable consultations with the MEC before terminating a physician's medical staff privileges, and the Hospital had acted without such consultations. Furthermore, the Hospital was required to give "great weight" to the decision of the MEC, but the Hospital had failed to do so.

The Hospital moved to dismiss Dr. Najibi's complaint.4 On February 5, 2024, the Superior Court granted the motion and dismissed the complaint (without an evidentiary hearing). It found that, while California law imposes various limitations on a hospital's summary termination of medical staff privileges, the suspension in question fell within the Hospital's discretion. Dr. Najibi had failed to show that the Hospital abused that discretion.

Dr. Najibi has appealed to the California Court of Appeal, Second District.

Litigation Center Involvement

The Litigation Center, along with CMA, will support Dr. Najibi's appeal, as the legal issues involved in his suspension are of significant importance to California physicians. Because Dr. Najibi's resources are limited, as he is tasked with both the litigation and peer review process, all while his income is limited. Without support from CMA and the Litigation Center, Dr. Najibi would not pursue the appeal, thus allowing the negative lower court decision to remain.

H. Managed Care Abuses

1. In re Multiplan (N.D. Ill.)

Issue

This issue in this case is case whether MultiPlan, a company that helps health insurance companies calculate payments to physicians and other health care providers, is violating federal antitrust laws through a "hub-and-spoke" price-fixing conspiracy.

AMA Interest

The AMA is to use every available means to maintain a level of payment from health insurance companies that is sustainable and reflects the full cost of practice and the value of the care provided. Out-of-network payments are not to be based on a contrived percentage of the Medicare rate or rates determined by the insurance company. Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing the service and the value of their professional judgment. The AMA is to engage with health plans to facilitate price transparency.

Case Summary

Many of the major health insurance companies in the United States have agreed on common rates they will pay to out-of-network health care providers, including physicians. The agreement is based on a rate structure developed by MultiPlan, Inc., a company that is separate from but works collusively with the insurance companies. The MultiPlan rates are substantially below fair market value and below the payment levels set by the FAIR Health database. In some instances, the fees are fixed according to an arbitrary percentage of Medicare payment rates. The price fixing scheme is maintained under a veil of secrecy, so that neither physicians, nor law enforcement, nor the general public can determine how the fees are being calculated.

The insurance companies who are in on the scheme have agreed to pay according to the MultiPlan prices. The insurance company payments are generally forced upon physicians on a "take it or leave it" basis. If physicians reject the proffered payments, they must then balance bill their patients for a sum that might exceed the patients' ability to pay. The price fixing scheme results in underpayments to physicians of billions of dollars per year.

Lawsuits have been filed in the Northern District of California, the Northern District of Illinois, and the Southern District of New York, and other venues to challenge the purported anti-trust conspiracy. The cases were filed in late 2023 and in 2024.

The cases were referred to the Judicial Panel on Multidistrict Litigation (JPML) for transfer to a single district and consolidation under the Multidistrict Litigation Statute, 28 U.S.C. § 1407. On August 1, 2024, the JPML transferred the cases to Judge Matthew F. Kennelly of the Northern District of Illinois.

Litigation Center Involvement

The Litigation Center and Illinois State Medical Society filed a complaint against MultiPlan and are plaintiffs in the case.

2. Nitta v. Hawaii Medical Service Assn. (Haw. Ct. App.)

Issue

The issue in this case is whether the provider agreements between Hawaii physicians and the state's largest insurer, the Hawaii Medical Service Association ("HMSA"), are unconscionable and thus unenforceable, due to HMSA's dominant market power.

AMA Interest

The AMA is to undertake a formal, legal review of ongoing grievous behaviors of the health insurance industry, including a search for potential litigation partners across the medical federation. The AMA will collaborate with its members to litigate egregious behaviors of the health insurance industry.

Case Summary

Dr. Frederick Nitta is a physician in Hawaii. Although his specialization is obstetrics and gynecology, he has been referred to as "Hilo's welfare doctor," as he has also served as a general practitioner when patients might otherwise be unable to find care. The Litigation Center previously filed an amicus brief on Dr. Nitta's behalf, which the Hawaii Supreme Court relied

upon extensively in a favorable ruling. See Nitta v. Department of Health Services, 152 Hawai'i 43 (2022).

HMSA is an independent licensee of the Blue Cross and Blue Shield Association. It is the largest insurer in Hawaii, serving more than 700,000 people.

Under the terms of the participating physician agreements between HMSA and physicians such as Dr. Nitta, HMSA reserves the exclusive authority to determine which services will be covered by the HMSA policies. In addition, the HMSA agreements purport to invalidate any and all agreements between the physician and the patient, including those in which the patient has agreed to pay for any difference between the cost of the service provided and what HMSA would pay the physician. HMSA also reserves the exclusive right to terminate the participating physician agreements, and physicians are not permitted to negotiate or change any of the terms.

In August 2022, Dr. Nitta, the Hawaii County Medical Society, and a class of patients filed a lawsuit against HMSA in Hawaii state court. The complaint alleged that HMSA repeatedly refused to authorize medically necessary care, which ultimately harmed more than thirty patients under Dr. Nitta's care. The complaint included causes of action for tortious inference with contract, breach of the covenant of good faith and fair dealing, breach of contract, unfair competition, violation of the federal Racketeer Influenced and Corrupt Organizations ("RICO") Act, and infliction of emotion distress. The defendants included HMSA and unnamed HMSA employees.

HMSA moved to dismiss the case and compel arbitration, pursuant to the terms of the provider agreements. In February 2024, the state trial court rejected the motion to compel arbitration and ruled that the participating provider agreements between HMSA and Hawaii physicians were unenforceable. The court held that HMSA unconscionably refused to allow physicians to negotiate the terms of the standard HMSA provider contract. Further, HMSA's contract allowed it to interfere with the physician-patient relationship. Such interference had severe effects, including premature labor resulting in birth defects and a failure to diagnose prostate cancer in time to prevent death, among other harm. It denied the motion to dismiss.

HMSA is appealing to the Hawaii Intermediate Court of Appeals.

Litigation Center Involvement

The Litigation Center and the Hawaii Medical Association filed an *amicus* brief in support of Dr. Nitta.

I. LGBTQ Rights

1. Brandt v. Rutledge (E.D. Ark.; 8th Cir.)

Issue

The issue in this case is whether an Arkansas law, Act 626, banning gender-affirming health care for young people, is constitutional.

AMA Interest

The AMA believes that nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances physicians' ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other ("LGBTQ") patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ.

Case Summary

Act 626 was passed by the Arkansas General Assembly, overcoming a Governor's veto less than 24 hours prior. Act 626 states that "a physician or other health care professional shall not provide gender transition procedures to any individual under eighteen (18) years of age," nor refer any individual to another health care professional for the same. The legislature's proffered justification for this Act is that "the risks of gender transition procedures far outweigh the benefits at this stage of clinical study on these procedures."

For purposes of Act 626, "gender transition procedures" include any medical or surgical services that seek to: (i) alter or remove physical or anatomical characteristics or features that are typical for the individual's biological sex; or (ii) instill or create physiological or anatomical characteristics that resemble a sex different from the individual's biological sex. Act 626 defines "biological sex" as: the biological indication of male and female in the context of reproductive potential or capacity, such as sex chromosomes, naturally occurring sex hormones, gonads, and non-ambiguous internal and external genitalia present at birth, without regard to an individual's psychological, chosen, or subjective experience of gender.

Under Act 626, any health care professional who provides gender-affirming care to a minor, or makes a referral for such care, is subject to discipline by a licensing entity or disciplinary review board. Further, the health care professional faces legal liability in a judicial or administrative proceeding for any "actual or threatened violation" of the Act.

On May 25, 2021, the plaintiffs, including transgender young people and their families, as well as two physicians, sued several Arkansas state officials. The complaint alleges that Act 626 violates the Equal Protection Clause of the Fourteenth Amendment, the Due Process Clause of the Fourteenth Amendment, and the First Amendment. It seeks declaratory and injunctive relief.

The plaintiffs moved for preliminary injunction, which the district court granted. The court cited the Litigation Center's *amicus* brief favorably. The defendants appealed the injunction, and at that time, the court of appeals ruled for the plaintiffs, allowing the injunction to stand.

The case then returned to the trial court, which held a bench trial featuring both fact and expert witnesses. On June 20, 2023, the court again ruled in favor of the plaintiffs and permanently enjoined the defendants from enforcing Act 626. The defendants appealed to the Eighth Circuit.

Litigation Center Involvement

The Litigation Center joined a range of organizations in supporting the plaintiffs' motion for a preliminary injunction, including: the American Academy of Pediatrics; the American Psychiatric Association; and GLMA: Health Professionals Advancing LGBTQ Equity. The Litigation Center also joined two briefs in support of the plaintiffs on appeal, first in support of the injunction and on the merits.

2. Bridge v. Oklahoma State Dept. of Ed. (10th Cir.)

Issue

The issue in this case is whether an Oklahoma law, which bars transgender students from school restrooms or other facilities matching their gender identity, is unconstitutional or otherwise conflicts with federal law.

AMA Interest

The AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with their gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to their gender identity.

Case Summary

In March 2022, the Oklahoma legislature passed SB 615, colloquially known as the Oklahoma Bathroom Bill. The law is like many others introduced in recent years involving transgender students and sex-segregated facilities.

In relevant part, SB 615 requires that every public school multiple-occupancy restroom or changing facility must be designated for use by male persons only or female persons only and used only by members of that "sex." Okla. Stat. tit. 70 § 1-125. Sex is defined under the law as the "physical condition of being male or female based on genetics and physiology, as identified on the individual's original birth certificate." *Id*.

SB 615 also creates a private right of action for parents who believe the school district has not complied with the law. It further requires each school board and charter school governing board to create a policy for discipline of those who violate the restriction and requires the state department of education to penalize schools that do not comply with this requirement with a five percent reduction in state funding.

On September 6, 2022, several transgender students filed a lawsuit challenging SB 615 in Oklahoma federal court. The complaint alleges that the state law violates the U.S. Constitution and Title IX. The defendants include the state superintendent of public instruction, the Oklahoma school board, the state attorney general, and several public school districts. With their complaint, the plaintiffs also moved for a preliminary injunction. The defendants moved to dismiss the complaint.

On January 12, 2024, after extensive briefing, the district court granted the defendants' motion to dismiss. The court concluded that, as a matter of first impression in the Tenth Circuit, SB 615 did not violate the Equal Protection Clause or Title IX, as it served an important government interest of protecting students and did not unlawfully discriminate on the basis of sex. The court dismissed the complaint with prejudice, meaning it cannot be amended to cure any defects. The court also dismissed the request for preliminary injunction as moot in light of the ruling on the motion to dismiss.

The plaintiffs have appealed to the Tenth Circuit Court of Appeals.

Litigation Center Involvement

The Litigation Center joined AAP and others in an *amicus* brief supporting the student plaintiffs.

3. Doe v. Horne (9th Cir.)

Issue

The issue in this case is whether an Arizona law (the Save Women's Sports Act or the Act), which bans transgender or intersex women and girls from participating in women's school athletics, is unconstitutional or otherwise conflicts with federal law.

AMA Interest

The AMA believes that transgender athletes and athletes with Differences of Sex Development ("DSD") should be permitted to compete in alignment with their identity; (2) opposes the use of specific hormonal guidelines to determine gender classification for athletic competitions; and (3) opposes satisfying third-party requirements to certify or confirm an athlete's gender through physician participation.

Case Summary

In 2022, Arizona passed A.R.S. § 15-120.02, known as the Save Women's Sports Act. This law, like similar laws in other states, was specifically intended to bar transgender or intersex girls from participating in interscholastic sports. The Arizona law states that "each interscholastic or intramural athletic team or sport that is sponsored by a public school or a private school whose students or teams compete against a public school shall be expressly designated as one of the following based on the biological sex of the students who participate on the team or in the sport: 1) 'males,' 'men' or 'boys'; 2) 'females,' 'women' or 'girls,' and 3) 'coed' or 'mixed'." The term "biological sex" is not defined in the law but has been interpreted by Arizona government agencies to mean the sex one is assigned at birth.

Athletic teams or sports designated for "females," "women," or "girls" may not be open to students of the male sex. The statute does not apply to "restrict the eligibility of any student to participate in any . . . athletic team or sport designated as being for males, men or boys or designated as coed or mixed." The law creates a private cause of action for injunctive relief and damages for any student who has been deprived of an athletic opportunity or who has suffered any direct or indirect harm as a result of a school's having knowingly violated its provisions.

On April 17, 2023, two transgender girls filed a complaint challenging the Arizona law in federal court. The plaintiffs claimed that the Act violates their rights under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, Title IX, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act. With their complaint, the plaintiffs also filed a motion for preliminary injunction. The defendants include the State Superintendent of Public Instruction and the Arizona Interscholastic Association.

On July 20, 2023, the district court granted the plaintiffs' motion for preliminary injunction. The court held that the plaintiffs were likely to succeed on their claims under both the U.S. Constitution and Title IX, as the Act impermissibly discriminates on the basis of sex. The court

also concluded that the plaintiffs would suffer irreparable harm if they were barred from participating in youth sports while the case proceeds.

The defendants appealed the injunction to the Ninth Circuit.

Litigation Center Involvement

The Litigation Center joined ArMA and others in an *amicus* brief supporting the student plaintiffs.

4. Kluge v. Brownsburg Community School Corp. (7th. Cir.)

Issue

The issue in this case is whether schools can require their staff to refer to transgender students by the names and pronouns consistent with the students' gender identity rather than their sex assigned at birth.

AMA Interest

The AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning ("LGBTQ") youth suicide and improve health among LGBTQ youth.

Case Summary

Prior to the start of the 2017 school year, the Brownsburg, Indiana school district created a policy instructing teachers to refer to students using the names and pronouns recorded in the school's "Power School" database. The database allows parents of transgender students, with the approval of a health care professional, to enter a name for the child that is consistent with the child's gender identity. The district created the policy in response to requests by students and their parents and in order to recognize and respect the identity of transgender students.

Music teacher John Kluge refused to refer to several transgender students in his class by their chosen names. Kluge cited his religious faith as the basis for his refusal, and he requested an accommodation from the school. Initially, the school district sought to accommodate Kluge's request, and he was allowed to refer to all students by their last names only.

Despite the accommodation, problems persisted, and the school district received numerous complaints from both students and faculty about Kluge's conduct. The complaints included reports that Kluge was simply not calling on or recognizing transgender students in class and that he was referring to cisgender students using gendered honorifics, such as Mr. and Ms., while refusing to do so for transgender students.

School district leaders again met with Kluge and informed him that the accommodation was harming students and the learning environment, and accordingly, he would be required to follow school policy with respect to student names and pronouns going forward. Kluge resigned his position, thus ending his employment with the district.

In June 2019, Kluge filed a complaint in Indiana federal court against the school district and

school officials seeking reinstatement and an injunction prohibiting the district from enforcing the policy going forward.

In 2021, the federal district court granted the school district's motion for summary judgment, upholding the school's policy and rejecting the plaintiff teacher's claims. The court's decision recognized the positive impact that gender-affirming names and pronouns can have on the health and well-being of young people and concluded that granting Kluge's accommodation created an undue hardship in the learning environment.

The teacher appealed the decision to the Seventh Circuit Court of Appeals, but on April 7, 2023, the Seventh Circuit affirmed the lower court ruling and remanded the case for dismissal. Before the lower court could close the matter, however, the United States Supreme Court issued a decision in the case *Groff v. DeJoy*, which involved claims for religious discrimination under Title VII. In the Groff ruling, the high court further clarified the showing needed for a plaintiff in a religious discrimination suit.

Following the *Groff* decision, Kluge sought reconsideration by the district court in his case, arguing that the school had not sufficiently demonstrated that his accommodation created an undue burden as outlined by the high court. After further briefing, the court again ruled in favor of and granted summary judgment to the school district.

Kluge has appealed this latest decision to the Seventh Circuit Court of Appeals.

Litigation Center Involvement

The Litigation Center joined AAP and others in an *amicus* brief supporting the school policy on appeal.

5. Monroe v. Bowman (7th Cir.)

Issue

The issue in this case is whether the Illinois Department of Corrections (IDOC) violated the Eighth Amendment's prohibition on cruel and unusual punishment by failing to provide transgender incarcerated individuals with medically necessary care.

AMA Interest

The AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization or otherwise undue restriction of evidence-based gender-affirming care.

Case Summary

The central issue in this case is IDOC's use of unqualified prison officials to oversee the treatment of incarcerated individuals with gender dysphoria. The prison officials, who did not include physicians, failed to meet the standards of care for gender dysphoria treatment, including

delaying or denying hormone therapy for unsuitable reasons; failing to provide adequate hormone therapy and hormone monitoring; failing to consider and provide surgery as part of medically necessary treatment; preventing and failing to facilitate necessary social transitions; and failing to provide access to competent physicians. This resulted in misdiagnosis and inappropriate treatment.

In January 2018, a group of incarcerated transgender people brought a class action on behalf of themselves and a putative class of inmates seeking evaluation and treatment for gender dysphoria within IDOC. Plaintiffs sought declaratory and injunctive relief under 42 U.S.C. § 1983, claiming that IDOC was deliberately indifferent to their serious medical needs in violation of their rights under the Eighth Amendment to the United States Constitution.

With their complaint, the plaintiffs moved for preliminary injunction. On December 19, 2019, the federal district court granted the plaintiffs' motion, ordering IDOC to immediately provide for the evaluation and provision of treatments according to the asserted standards of care.

From there, the case had a rather winding road in the federal district court, including several modifications to the injunction and multiple enforcement and contempt orders. During status reports, the defendants claimed that they were making progress in providing necessary care and revising their policies, while the plaintiffs continued to allege that they were unlawfully being denied care.

On November 16, 2023, the district court, on a motion by the plaintiffs, concluded that the defendants had not sufficiently modified their policies and practices to satisfy the court's prior orders. Accordingly, the district court converted the preliminary injunction into a permanent one. The defendants appealed.

Litigation Center Involvement

The Litigation Center joined an *amicus* brief supporting the plaintiffs on appeal to the Seventh Circuit.

6. Poe v. Drummond (N.D. Okla.; 10th Cir.)

Issue

The issue in this case is whether an Oklahoma law banning certain gender-affirming health care for minors violates the United States Constitution.

AMA Interest

The AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization or otherwise undue restriction of evidence-based gender-affirming care.

Case Summary

On May 1, 2023, the Oklahoma Governor signed into law SB 613. The law bars the use of "medical or surgical services performed for the purpose of attempting to affirm the minor's perception of his or her gender or biological sex, if that perception is inconsistent with the minor's biological sex." The law does not define "biological sex."

SB 613 prohibits the use of "puberty-blocking drugs, cross-sex hormones, or other drugs to suppress or delay normal puberty or to promote the development of feminizing or masculinizing features consistent with the opposite biological sex." The law allows the same care for minors in other situations, thus only barring the care for minors with gender dysphoria.

Under the law, physicians found in violation of SB 613 may be subject to disciplinary proceedings by the state licensing board, civil actions by the parents or guardians of the minors, and felony criminal prosecutions.

On May 2, 2023, a group of transgender minors and their families challenged the law in federal court in Oklahoma. The complaint alleged that SB 613 violates the Equal Protection Clause of the Fourteenth Amendment and the Due Process Clause of the Fourteenth Amendment.

The plaintiffs moved for a preliminary injunction, but the district court denied their motion. Plaintiffs appealed that decision to the Tenth Circuit Court of Appeals.

Litigation Center Involvement

The Litigation Center joined AAP and other Federation members in an *amicus* brief in support of the motion for preliminary injunction and on appeal to the Tenth Circuit.

7. Poe v. Labrador (D. Idaho; 9th Cir.)

Issue

The issue in this case is whether an Idaho law banning certain gender-affirming health care for minors violates the United States Constitution.

AMA Interest

The AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization or otherwise undue restriction of evidence-based gender-affirming care

Case Summary

On March 29, 2023, the Idaho legislature passed HB 71, which makes it a felony for physicians to provide medication to a minor "for the purpose of attempting to alter the appearance of or affirm the child's perception of the child's sex if that perception is inconsistent with the child's biological sex."

HB 71 defines sex as "the immutable biological and physiological characteristics, specifically the chromosomes and internal and external reproductive anatomy, genetically determined at

conception and generally recognizable at birth, that define an individual as male or female." HB 71 treats the provision of gender-affirming medical care to minors as a "crime of violence" and imposes a penalty of ten years imprisonment and up to $5,000 in fines for its violation. The same medical treatments are not banned if they are provided for any other purposes, including to affirm a minor's gender if so doing is consistent with the child's "biological sex."

On May 31, 2023, a group of transgender minors and their families challenged the law in federal court in Idaho. The complaint alleges that HB 71 violates the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment. The plaintiffs moved for a preliminary injunction, which the court granted. This was a favorable result, consistent with the Litigation Center's brief.

The defendants appealed the injunction to the Ninth Circuit Court of Appeals.

Litigation Center Involvement

The Litigation Center joined AAP and other Federation members in an *amicus* brief in support of the motion for preliminary injunction and on appeal.

8. Roe v. Critchfield (9th Cir.)

Issue

The issue in this case is whether an Idaho law, S.B. 1100, which bars transgender students from school restrooms or other facilities matching their gender identity, is unconstitutional or otherwise conflicts with federal law.

AMA Interest

The AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to their gender identity.

Case Summary

In March 2023, the Idaho legislature passed S.B. 1100, referred to as the Protecting the Privacy and Safety of Students in Public Schools Act or colloquially known as the Idaho Bathroom Bill. The law is like many others introduced in recent years involving transgender students and sex-segregated facilities.

In relevant part, S.B. 1100 requires that every public school multiple-occupancy restroom or changing facility must be designated for use by male persons only or female persons only and used only by members of that "sex." Idaho Code Ann. § 33-6603(1)(a)–(b). Sex is defined under the law as the "immutable biological and physiological characteristics, specifically the chromosomes and internal and external reproductive anatomy, genetically determined at conception and generally recognizable at birth, that define an individual as male or female." *Id*. at § 33-6602(3).

S.B. 1100 also creates a private right of action for individuals who believe they have encountered a person of the opposite sex in restrooms or other single-sex facilities. Under the law, any student who encounters someone of the opposite sex in such facilities may obtain statutory damages of $5,000 for each encounter, in addition to damages for any harm purportedly experienced, and attorneys' fees for the school's non-compliance with the terms of S.B. 1100. Idaho Code Ann. § 33-6606(1)(a)–(b).

On July 6, 2023, a transgender student and a student-run LGBTQ organization filed a lawsuit challenging S.B. 1100 in Idaho federal court. The complaint alleged that the state law violates the U.S. Constitution and Title IX. With their complaint, the plaintiffs also moved for a preliminary injunction. The defendants moved to dismiss the complaint.

On October 12, 2023, the district court denied both the motion for preliminary injunction and the motion to dismiss. The district court concluded that the plaintiffs had failed to demonstrate, at this stage of the case, that they were likely to succeed on the merits of their claims. The court also held that the plaintiffs' showing of irreparable harm if the injunction was denied was too speculative and did not outweigh the public interest in the passage of S.B. 1100. The court denied the motion to dismiss, however, finding that the plaintiffs might, in a full trial, be able to demonstrate a right to relief.

The plaintiffs appealed the district court's denial of the preliminary injunction to the Ninth Circuit, which stayed the lower court order while it considers the appeal on an expedited basis.

Litigation Center Involvement

The Litigation Center joined AAP and other Federation members in an *amicus* brief supporting the plaintiffs in the Ninth Circuit.

9. Van Garderen v. Montana (Mont. S. Ct.)

Issue

The issue in this case is whether a Montana law banning certain gender-affirming health care for minors violates the Montana Constitution.

AMA Interest

The AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization of otherwise undue restrictions of evidence-based gender-affirming care.

Case Summary

On April 17, 2023, Montana Governor Greg Gianforte signed SB 99, which prohibits physicians from providing patients under 18 with care to treat gender dysphoria. The law states that a person may not knowingly provide specific medical treatments, including the use of hormones or puberty blockers, to "address the minor's perception" that their gender is different than their sex assigned at birth. The care is only banned for individuals with gender dysphoria and would be allowed for other conditions.

Individuals who violate the law may face professional discipline, including a one-year suspension from practice, and be subject to civil lawsuits, which would include punitive damages. The law was set to take effect on October 1, 2023.

On May 9, 2023, a group of transgender young people and their families, along with a pediatric endocrinologist and an advanced practice registered nurse, filed suit challenging the law in Montana state court. The defendants include the State of Montana, the Governor of Montana, the Montana Attorney General, and the Montana Board of Medical Examiners.

The complaint includes six causes of action, all of which are under the Montana Constitution, including violations of: (1) the right to equal protection; (2) the right to parent one's children; (3) the right to privacy; (4) the right to seek and obtain medical care; (5) the right to dignity; and (6) freedom of speech and expression. The complaint does not include any federal claims.

On July 17, 2023, the plaintiffs moved for a preliminary injunction. On September 27, 2023, the state trial court granted the injunction, finding that the law likely violates the state constitutional provisions involving equal protection and the right to privacy.

The defendants have appealed the injunction to the Montana Supreme Court.

Litigation Center Involvement

The Litigation Center and Montana Medical Association joined the American Academy of Pediatrics and others in an *amicus* brief supporting the plaintiffs.

J. State Government Interference with Abortion Rights

1. Fund Texas Choice v. Garza (W.D. Tex.)

Issue

The issue in this case is whether several Texas statutes that impose criminal and civil penalties on people who assist others in obtaining an abortion outside of the state are constitutional.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In the weeks following the United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, several Texas statutes dealing with abortion either went into effect or were no longer barred by the holding in *Roe v. Wade*. The relevant statutes can be grouped into three categories: (1) the pre-*Roe* laws, which criminalized abortion in Texas in the years prior to 1973; (2) S.B. 8, otherwise known as the Texas Heartbeat Act or the Texas bounty law; and (3) H.B. 1280, often referred to as the "trigger ban," as it took effect 30 days after Roe was overruled.

Taken together, these statutes not only seek to limit abortion within the bounds of Texas, but they also provide criminal and civil penalties for those who aid pregnant individuals in obtaining an abortion outside of Texas. The pre-*Roe* laws authorize criminal penalties between two to ten years in prison for "knowingly procuring an abortion" or "furnishing the means for procuring an abortion." Similarly, S.B. 8 authorizes private civil lawsuits against anyone who "knowingly aids or abets the performance of abortion." Individuals who file civil actions under S.B. 8 may be awarded injunctive relief, statutory damages not less than $10,000 for each abortion, and costs and attorney's fees. Finally, H.B. 1280, which seeks to outlaw nearly all abortions except to prevent death or serious risk of substantial impairment to the pregnant person, carries significant criminal and civil penalties, including first degree felony charges and up to 99 years in prison.

Texas state and local officials made numerous public statements, both before and after the *Dobbs* decision, that they would enforce these laws to their fullest extent. These statements included threats to prosecute individuals who are found to provide information or other services to Texans who might need to travel out of the state to obtain an abortion. This could include physicians.

In August 2022, a group of Texas-based non-profit abortion funds and support networks and one physician filed a complaint challenging the Texas laws. The plaintiffs alleged that the collection of state abortion restrictions unlawfully infringed on the plaintiffs' constitutional rights to provide information and support to Texans who might seek to travel out of the state to obtain an abortion.

In February 2023, the district court issued an order granting limited relief to the plaintiffs, but only with respect to enforcement of the pre-*Roe* statutes, which the court found to have been repealed by later state action. In April 2023, the plaintiffs filed an amended complaint, which includes allegations detailing how the Texas laws may chill physician speech and harm patients.

The defendants moved to dismiss.

Litigation Center Involvement

The Litigation Center joined ACOG and other Federation members in an *amicus* brief supporting the plaintiffs in the district court.

2. Kaul v. Urmanski (Wis. Cir. Ct.; Wis. S. Ct.)

Issue

The issue in this case was whether a Wisconsin abortion ban from 1849 is enforceable following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

The law at issue, Wis. Stat. § 940.04, which originated in the mid-1800s, makes it a felony to destroy "the life of an unborn child" at any point after conception unless necessary to save the pregnant woman's life, as confirmed by two other physicians.

In its 1973 decision in *Roe v. Wade*, the United States Supreme Court declared most statutes that criminalized abortion to be unconstitutional. The *Roe* decision specifically listed Wis. Stat. § 940.04 as one such statute.

In the years after *Roe*, the Wisconsin Legislature passed laws prohibiting abortion either after 20 weeks or after viability. The Wisconsin Legislature also passed a series of laws providing specific parameters for how physicians should perform abortions. Wis. Stat. § 940.04 was not repealed following the *Roe* decision and remained in the books. As a result, in the weeks following the Supreme Court's decision in *Dobbs*, several Wisconsin district attorneys publicly stated that the criminal ban was still good law, and they planned to enforce it accordingly.

Following the *Dobbs* decision and public statements by state district attorneys, several Wisconsin government officials filed suit in Wisconsin state court seeking clarification on the validity of Wis. Stat. § 940.04. The plaintiffs include the Wisconsin Attorney General, the Wisconsin Department of Safety and Professional Services, the Wisconsin Medical Examining Board, and the Chairperson of the Wisconsin Medical Examining Board.

Plaintiffs' complaint includes two causes of action. First, the plaintiffs argue that the pre-*Roe* ban conflicts with later legislative action on abortion, and thus, the later statutes control. Second, the plaintiffs contend that the pre-*Roe* ban is unenforceable because it has not been enforced for decades in the wake of the *Roe* decision.

The defendants are district attorneys from various Wisconsin counties charged with enforcing the pre-*Roe* ban. The defendants moved to dismiss the complaint. The district court heard argument on that motion, and it ruled that Section 940.04 does not apply to consensual abortions, but rather, only to feticide, based on prior state court precedent. This is a favorable decision, consistent with the Litigation Center's brief.

The case is now on appeal to the Wisconsin Supreme Court

Litigation Center Involvement

The Litigation Center joined the Wisconsin Medical Society, ACOG, and the Society for Maternal-Fetal Medicine in filing *amicus* briefs supporting the challenge to the 1800s ban in both the state trial court and state supreme court.

3. Planned Parenthood of Montana v. Montana (Mont. S. Ct.)

Issue

The issue in this case is whether a Montana law that requires minors to obtain parental consent before obtaining an abortion violates the state constitution's right to individual privacy. This is one of two abortion-related cases with the same name in the Montana Supreme Court. The second case is discussed immediately below.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In Montana, as in many states, minors are empowered to consent to various health services without parental consent. This includes the "prevention, diagnosis, and treatment" of pregnancy. Mont. Code Ann. § 41-1-402(2)(c); see generally id. §§ 41-1-401 to 41-1-407. Also, they can place their children for adoption without having to notify a parent. *Id*. § 42-2-405. In addition, minors can obtain medical treatment, including surgery, for their own children without notifying the minors' parents. *Id*. § 411-402(3). There are no legal requirements for minors to involve their parents in the care of their children, including, generally, pregnancy-related care.

Abortion, however, is singled out. In 2012, the Montana Legislature proposed and voters approved a parental notification requirement, which requires minors under the age of 16 who choose to have an abortion to notify a parent or seek a waiver from a court. *See id*. §§ 50-20-221 to 50-20235(2012) (the "Notice Act"). The following year, the Montana Legislature heightened the restrictions on minors' abortion access by enacting the Parental Consent for Abortion Act of 2013. *Id*. §§ 50-20-501 to -511 (the "Consent Act").

The Consent Act is significantly more restrictive than the Notice Act. It applies to all pregnant minors who are under 18, as opposed to the Notice Act's age threshold of 16. *Id*. The required consent form must be "notarized and . . . includ[e] an acknowledgement by the parent or legal guardian affirming that the parent or legal guardian is the minor's parent or legal guardian." *Id*. § 50-20-505(3)(d). The parent or guardian must provide "government-issued proof of identity and written documentation that establishes that the parent or legal guardian is the lawful parent or legal guardian of the minor." *Id*. § 50-20-506(1). If a minor cannot obtain consent or if consent is withheld, the patient may only access abortion care by obtaining a court order, colloquially known as a judicial bypass. *See id*. § 50-20-509.

Abortion providers who do not satisfy the Consent Act's requirements are subject to civil and criminal penalties. The Consent Act provides a basis for civil liability, and violation of the act may also be evidence of "violation of a professional obligation." *Id*. § 50-20-235(2). The Consent Act also imposes strict criminal liability, including possible imprisonment, on a person who performs an abortion without complying with its requirements, regardless of the person's state of mind. *Id*. §§ 50-20-235(1), -510(1).

This litigation has a lengthy and somewhat strange procedural history. In 2013, Planned Parenthood and a Montana physician filed a complaint in Montana state court challenging both the Notice and Consent Acts under the Montana Constitution. The defendants include the State of Montana and its attorney general.

In 2013, just after the complaint was filed and before the Consent Act went into effect, the defendants agreed to an injunction with respect to only the Consent Act. The Notice Act remained in effect while the litigation proceeded.

From roughly 2013 until February 2022, the case largely stalled, as there were numerous procedural motions involving issues of collateral estoppel and judicial recusal. At one point, the case sat for three years with no activity, as there were no eligible judges to hear the case.

In 2022, the case was reassigned, and the state trial court held a hearing on cross-motions for summary judgment. In February 2023, the trial court issued a lengthy decision granting the

plaintiffs' motion for summary judgment on the Consent Act and holding the issue of the Notice Act for a full trial on the merits. The court concluded that requiring parental consent to an abortion violated the privacy rights protected under the Montana Constitution.

The defendants have appealed to the Montana Supreme Court on the issue of the constitutionality of the Consent Act. The briefing is ongoing.

Litigation Center Involvement

The Litigation Center and the Montana Medical Association joined ACOG and other Federation members in an *amicus* brief supporting the plaintiffs.

4. Planned Parenthood of Montana v. Montana (Mont. S. Ct.)

Issue

The issue in this case is whether three Montana laws that limit abortion procedures are constitutional.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In 2021, the State of Montana enacted three laws to limit access to abortion in the state. Prior to the passage of these laws, Montana had essentially no restrictions on abortion, as the Montana Supreme Court had previously found that the state constitution guaranteed the right to abortion.

The first law at issue, H.B. 136, is a ban on abortion after 20 weeks' gestation and provides criminal penalties for anyone violating the ban aside from exceptions for medical emergencies and serious health risks. The second law, H.B. 140, requires clinicians to tell their patients that they can view an ultrasound of the fetus and listen to the fetal cardiac tones. The patients must sign a state form attesting that they were given the option to view the ultrasound, and the clinician must document whether the patients viewed the images. The third law, H.B. 171, requires medication abortion to be prescribed and dispensed in-person.

Shortly after the laws were passed, Planned Parenthood of Montana and a physician filed a lawsuit in Montana state court challenging the laws on behalf of themselves and their patients.

Plaintiffs alleged that the three laws were in conflict with the Montana Constitution, including the rights to privacy and equal protection. With their complaint, the plaintiffs also moved for a preliminary injunction. The defendants included the State of Montana and the state attorney general.

In 2021, the state trial court granted the request for a preliminary injunction, halting the laws from going into effect. The defendants appealed the decision to the Montana Supreme Court, which affirmed the preliminary injunction and remanded the case for further proceedings on the merits.

In February 2024, the trial court granted the plaintiffs' motion for summary judgment and permanently enjoined the three laws. The trial court found for the plaintiffs on all counts. The defendants have again appealed to the Montana Supreme Court.

Litigation Center Involvement

The Litigation Center joined ACOG and other Federation members in an *amicus* brief supporting the plaintiffs.

5. Planned Parenthood of Utah v. Utah (Utah Dist. Ct.; Utah S. Ct.)

Issue

The issue in this case is whether a Utah law that bans and criminalizes almost all abortions violates the Utah Constitution.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In 2020, the Utah legislature passed S.B. 174, which bars abortion at any point in pregnancy with limited exceptions. Instead of making S.B. 174 immediately operative, the legislature provided that the law would take effect only upon the legislative general counsel's certification "that a court of binding authority had held that a state may prohibit the abortion of a fetus at any time during the gestational period, subject to the exceptions enumerated in" the ban. Laws such as S.B. 174 have been referred to as "trigger laws," which would go into effect if and when *Roe v. Wade* was overturned. Physicians who violate the law face one-to-fifteen-year prison terms, steep criminal fines, and loss of their professional licenses. *See* Utah Code Ann. §§ 76-7a-201(3)-(5), 76-3-203(2), 76-3-301(1)(a), 76-3-302(1).

On June 24, 2022, the United States Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*, which reversed *Roe v. Wade*. That same day, the Utah legislative general counsel sent an e-mail to Utah's Legislative Management Committee, certifying that S.B 174 had been triggered and took immediate effect.

On June 25, 2022, Planned Parenthood of Utah filed a complaint for declaratory and injunctive relief on behalf of itself, its physicians, its patients, and its staff. The complaint alleged that the Utah Constitution protects pregnant Utahns' rights to determine when and whether to have a

family and to determine what happens with their own bodies and lives. The suit further argues that the rights under the Utah Constitution are more expansive than those under federal law and remain unaffected by the U.S. Supreme Court's decision in *Dobbs*. Plaintiff also moved for a temporary restraining order.

A Utah state district court granted a temporary restraining order and then a preliminary injunction blocking the law from taking effect. This was a favorable result, consistent with the Litigation Center's *amicus* brief.

The State appealed the injunction to the Utah Supreme Court.

Litigation Center Involvement

The Litigation Center joined ACOG and the Society for Maternal-Fetal Medicine in *amicus* briefs supporting the plaintiff's motion for a preliminary injunction and on appeal.

6. United States v. Idaho (D. Idaho; 9th Cir.; S. Ct.)

Issue

The issue in this case is whether the federal Emergency Medical Treatment & Active Labor Act ("EMTALA") and subsequent HHS/CMS guidance preempts state abortion restrictions.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In 1986, Congress enacted EMTALA to ensure public access to emergency hospital services regardless of one's ability to pay. Under § 1867 of the Social Security Act, Medicare-participating hospitals that offer emergency services are required to provide a medical screening examination ("MSE") when a patient requests examination or treatment for an emergency medical condition ("EMC"). This includes active labor. The hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient so requests, an appropriate transfer should be implemented in order to provide the necessary care.

Following the U.S. Supreme Court's reversal of *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization*, HHS and CMS issued guidance reiterating EMTALA's existing obligations that require hospitals to provide stabilizing emergency treatment, including abortion, when necessary, even though state laws may ban such care.

In 2020, Idaho enacted a law that severely restricts abortion and threatens criminal prosecution against anyone who performs the procedure. The law, codified at Idaho Code § 18-622, was set

to take effect August 25, 2022.

Under § 18-622, "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion," a felony punishable by two to five years imprisonment. *Id*. § 18622(2). The law also requires that "[t]he professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense." *Id*. Idaho law defines "[a]bortion" to mean "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." *Id*. § 18-604(1).

On August 2, 2022, the federal government sued the State of Idaho, challenging § 18-622 under the Supremacy Clause of the U.S. Constitution. On August 8, 2022, the federal government moved to preliminarily enjoin § 18-622 to the extent it conflicts with EMTALA. At that time, the Litigation Center joined an *amicus* brief supporting the federal government's motion.

On August 24, 2022, the district court granted the federal government's motion, and it enjoined the Idaho law during the pendency of the litigation. The court concluded that the state law conflicted with federal law and thus violated the Supremacy Clause. This was a favorable result, and the court cited the Litigation Center's brief in its decision.

The Idaho state government appealed to the Ninth Circuit Court of Appeals, but before the court could rule on the merits the Idaho government sought review by the United States Supreme Court.

After briefing and argument, on June 27, 2024, the Supreme Court rescinded its review order as having been improvidently granted**.** The case is now back in the Ninth Circuit.

Litigation Center Involvement

The Litigation Center joined ACOG and other Federation members in *amicus* briefs in the district court, the court of appeals, and the United States Supreme Court.

K. Malpractice Insurance Coverage

1. Hoffman v. MMIC (Minn. Ct. App.)

Issue

The issue in this case was whether Dr. Hoffman's malpractice insurance policy should pay the attorney fees that he expended to defend against a lawsuit filed against him because he declined to provide breast augmentation surgery for a transgender patient.

AMA Interest

Physicians should understand that their competence depends on context. Physicians should recognize when they are unable to provide appropriate care for the patient in front of them.

Case Summary

Dr. Hoffman had an unexceptional malpractice insurance policy from MMIC Insurance, Inc. As is standard, the policy covered legal expenses as well as adverse judgments. For purposes of the instant suit, the critical part of the policy was a "Wrongful Acts" exclusion, which states: "This insurance does not apply to any claim arising out of a criminal, willful, malicious, fraudulent, dishonest or knowingly wrongful act committed by or with the knowledge of the insured." This is a common provision in liability insurance policies.

The underlying care at issue involves a request for breast augmentation surgery by a transgender woman, Christina Ginther. Dr. Hoffman, although a plastic surgeon, declined to provide the surgery. Through a phone call from his office manager (and wife), he explained that he did not provide this type of surgery. He offered to refer Ms. Ginther to an appropriate specialist. His rationale was that he was not experienced in this type of breast augmentation surgery, although it is unclear whether he explained this to Ms. Ginther.

Ms. Ginther felt that Dr. Ginther had unlawfully discriminated against her. She sued him for sex discrimination in violation of Minn. Stat. §§ 363A.17(3) and 363.11. Dr. Hoffman countersued for defamation.

Dr. Hoffman tendered defense of the Ginther suit to MMIC Insurance. MMIC refused coverage, including a refusal to pay for Dr. Hoffman's defense costs. It cited the Wrongful Acts exclusion and said that, whatever the actual reason Dr. Hoffman declined to provide the surgery, Ms. Ginther had alleged an illegal, discriminatory action. As a result, Dr. Hoffman had to pay his own defense costs to protect against Ms. Ginther's suit. Ultimately, Ms. Ginther and Dr. Hoffman dismissed their lawsuit by agreement.

Dr. Hoffman sued MMIC in Minnesota state court, alleging that MMIC breached its obligation to defend him against the Ginther lawsuit. He asserted that the claim against him had arisen out of his medical practice. As to the Wrongful Acts exclusion, he said that he had not committed a wrongful act and the Ginther claim was solely the result of a misunderstanding on the part of Ms. Ginther.

Both sides moved for summary judgment. The court sided with MMIC Insurance and entered summary judgment in its favor and against Dr. Hoffman. Dr. Hoffman appealed on February 16, 2024.

On October 14, 2024, the Minnesota Court of Appeals affirmed the trial court's decision to grant summary judgment in favor of MMIC. This is an unfavorable result and it is inconsistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined the Minnesota Medical Association and the American Society for Aesthetic Plastic Surgery in an *amicus* brief supporting Dr. Hoffman.

L. No Surprises Act

1. Guardian Flight v. Health Care Service Corp. (5th Cir.)

Issue

The issue in this case is whether two air ambulance providers (AAPs) who secured arbitration awards through the No Surprises Act (NSA) Independent Dispute Resolution (IDR) procedure could enforce those awards by a lawsuit against their patients' health insurance company.

AMA Interest

The AMA believes that any legislation addressing surprise out of network medical bills should use an independent, non-conflicted database of commercial charges. Out-of-network payments should not be based on rates determined by the insurance company.

Case Summary

The NSA limits patient cost-sharing when patients with non-governmental health insurance receive certain healthcare services from out-of-network providers. It also restricts out-of-network healthcare providers' ability to bill patients for amounts in excess of their in-network cost-sharing obligation for those services. Instead, out-of-network healthcare providers must negotiate with the patients' insurers to obtain adequate reimbursement for their services. If the negotiations fail to reach a resolution, the healthcare providers (or, possibly, the insurance companies), can institute mandatory arbitration under the NSA IDR proceedings.

The NSA does not cover services by all health care providers. Thus, it covers services by AAPs, 45 CFR § 149.440, but it does not cover services by land-based ambulances. Also, it covers services by numerous physicians.

The NSA does not explicitly state that IDR awards are enforceable under a private right of action. Conversely, it does not say they are not.

Two AAPs underwent the IDR process with Health Care Service Corporation, a private health insurer. Following the entry of arbitration awards, the AAPs asked the insurer to pay those awards. The insurer refused.

The AAPs sued the insurer in the United States District Court for the Northern District of Texas for enforcement of the IDR awards. The trial court found that there is no private right of action under the NSA. It dismissed the complaint and entered judgment for the insurer.

The AAPs appealed to the United States Court of Appeals for the Fifth Circuit.

Litigation Center Involvement

The Litigation Center will join the Texas Medical Association and the American Hospital Association in an *amicus* brief supporting the plaintiffs.

2. TMA v. HHS (TMA III) (5th Cir.)

Issue

The issue in this case was whether an interim final rule of HHS, 86 Fed. Reg. 36,872 (July 13, 2021), validly interprets provisions of the No Surprises Act (NSA) that apply to the "qualifying payment amount (QPA), 42 U.S.C. §300gg-111(c)(5)(C)(i)(I).

AMA Interest

The AMA believes that any legislation addressing surprise out of network medical bills should use an independent, non-conflicted database of commercial charges. Out-of-network payments should not be based on rates determined by the insurance company.

Case Summary

The NSA limits patient costs when a patient receives certain medical services from an out-of-network healthcare provider. It also restricts out-of-network healthcare providers' ability to bill patients for those services. Instead, out-of-network healthcare providers must negotiate with the patient's insurer to obtain adequate reimbursement for their services.

When the insurance company and the provider cannot agree on an appropriate reimbursement amount, either party may initiate arbitration before a certified independent dispute resolution (IDR) entity to determine a fair amount for reimbursement. The arbitration proceeds "baseball-style" -- after each party submits an offer, the arbitrator must select one of them as the appropriate payment amount. Per the regulations, the proper payment amount is to represent the value of the services. To guide arbitrators' decisions, Congress specified a list of factors for the arbitrators to consider. HHS is to administer the IDR program.

Under the NSA, the arbitrator should first consider the "qualifying payment amount" (QPA), which is generally the median of the insurer's contracted rate for the relevant item or service. The insurance company calculates the QPA internally, according to criteria established in the NSA. The arbitrators are then to consider five other factors in determining the value of the healthcare services. Those other factors are the subject of TMA's first two lawsuits, but not this one, which considers only the QPA.

On November 30, 2022, TMA, along with an individual physician and a hospital, sued HHS in the Eastern District of Texas, claiming inconsistencies between the NSA and the interim regulation in connection with the QPA calculation. The case was consolidated with a similar suit brought by two companies that provide air ambulance services. Furthermore, TMA asserted that the interim final rule was unreasonable because it did not include a mechanism for providers to examine the insurers' QPA calculations. This means that, in practice, the insurers can submit their QPA numbers without the providers having a meaningful ability to challenge them.

The district court entered judgment for plaintiffs in part and for HHS in part. HHS appealed portions of the judgment, but it did not appeal other provisions. TMA and the other plaintiffs

cross-appealed.

On October 30, 2024, the Fifth Circuit issued a mixed decision, reversing in part and affirming in part the lower court. The Fifth Circuit reversed the holding below addressed by the Litigation Center's *amicus* brief involving QPA calculations. Thus, this a slightly unfavorable result.

Litigation Center Involvement

The Litigation Center filed an *amicus* brief in support of TMA in the Fifth Circuit. The brief asserted that the regulation concerning the QPA calculation was invalid.

M. Anti-Tobacco

1. 21+ Tobacco and Vapor Retail Assn. v. Multnomah County (Or. Ct. App.)

Issue

The issue in this case is whether a county ordinance banning the sale of flavored tobacco products conflicts with a state law regulating the sale of tobacco and nicotine.

AMA Interest

The AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint, and wintergreen flavors; and (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products.

Case Summary

In July 2021, the State of Oregon enacted SB 587, which created a system of statewide tobacco retail licenses, including for flavored tobacco and nicotine products. On December 15, 2022, the Multnomah County Board of Commissioners, sitting as the Local Public Health Authority of Multnomah County, adopted an ordinance prohibiting the sale of flavored tobacco and nicotine products. The Multnomah County provision prohibits the sale of any flavored tobacco product, including menthol flavored products.

The plaintiffs are state licensed retail sellers of flavored tobacco and nicotine products. Following enactment of the Multnomah Flavor Ban, the plaintiffs filed suit in Oregon state court alleging that Multnomah County had exceeded its authority under SB 587.

Plaintiffs contend that SB 587 does not grant authority for a local ordinance that bans flavored tobacco and nicotine products outright. Instead, plaintiffs argue that the state law only allows the county to pass ordinances to enforce standards for how such products are sold. Plaintiffs also allege that the county ordinance is arbitrary and capricious and violates provisions of the Oregon Constitution reserving certain powers for the state government.

The defendant county moved to dismiss the complaint, contending that the Multnomah Flavor Ban is an appropriate legislative enactment within the bounds of SB 587. The circuit court granted the county's motion to dismiss, finding that the flavor ban is within the county's public

health authority. This was a favorable decision, and it is consistent with the Litigation Center's brief.

Plaintiffs have appealed to the Oregon appellate court.

Litigation Center Involvement

The Litigation Center joined the Oregon Medical Association in *amicus* briefs supporting the county's flavor ban in the circuit court and on appeal.

2. City of Columbus v. Ohio (Ohio Ct. App.)

Issue

The issue in the case is whether a state law purporting to preempt local regulation of tobacco and nicotine products violates the Ohio Constitution.

AMA Interest

The AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint, and wintergreen flavors; and (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products.

Case Summary

This case is part of a long-running dispute between several large cities in Ohio and the state legislature. In recent years, the cities, including Columbus, Cincinnati, and Cleveland, have passed measures at the local level intended to protect the citizens within their jurisdiction. The laws sought to regulates issues involving gun control, oil and gas drilling, and here, tobacco sales.

In this case, the cities all passed various measures regulating portions of commerce involving tobacco. This includes banning the sale of flavored tobacco, requiring retailers to obtain certain licenses before operating in the cities, and prohibiting smoking in certain places. These laws all included measures that were more restrictive than those set by state law.

In 2023, the Ohio legislature sought to remove the power of local jurisdictions from regulating issues involving tobacco and other smoking products. The Governor of Ohio vetoed the legislation twice, but the legislature overrode the vetoes.

The Ohio statute, O.R.C. §9.681, states, in part: "The regulation of tobacco products and alternative nicotine products is a matter of general statewide concern that requires statewide regulation. The state has adopted a comprehensive plan with respect to all aspects of the giveaway, sale, purchase, distribution, manufacture, use, possession, licensing, taxation, inspection, and marketing of tobacco products and alternative nicotine products. No political subdivision may enact, adopt, renew, maintain, enforce, or continue in existence any charter provision, ordinance, resolution, rule, or other measure that conflicts with or preempts any policy of the state regarding the regulation of tobacco products or alternative nicotine products."

The state law was set to take effect on April 23, 2024, but before the state law could take effect, several cities and municipalities banded together to challenge it. The plaintiffs included Columbus, Cincinnati, Cleveland, and a number of Columbus suburbs. The plaintiffs contended that the state law violated the home rule provisions of the Ohio Constitution, which grant municipalities rights of self-governance. The plaintiffs also sought a temporary injunction halting the law.

In April 2024, the state trial court agreed with the plaintiffs and enjoined the law with respect to the named plaintiffs. The court concluded that the state statute unlawfully infringed on the rights of cities and other municipalities to protect their citizens.

In May 2024, on cross motions for judgment by the parties, the court again ruled in favor of the cities, extending the injunction.

The State has appealed to the Ohio Court of Appeals.

Litigation Center Involvement

The Litigation Center and OSMA joined an *amicus* brief in support of the City of Columbus on appeal.

3. Philip Morris v. FDA (D.D.C.)

Issue

The issue in this case was whether an FDA rule regarding graphic warnings on cigarettes is lawful.

AMA Interest

The AMA supports explicit and effective health warnings, such as graphic warning labels, on tobacco products.

Case Summary

The 2009 Family Smoking Prevention and Tobacco Control Act (the Tobacco Control Act) requires graphic health warnings to cover the top 50 percent of the front and rear panels of the cigarette package. The same warnings are required in advertising and must comprise at least 20 percent of the advertisement's area.

After years of delays in pursuing new graphic warnings, the FDA issued a final rule with new graphic warnings. Following issuance of the new rule, tobacco manufacturers sued to challenge its validity, based largely on First Amendment grounds. The case is currently stayed.

However, in a separate case, a federal district court judge held the FDA rule to be unconstitutional, which meant that the tobacco manufacturers were no longer facing uncertainty regarding the validity of the rule. This meant that the lawsuit was no longer necessary, and on March 3, 2023, the case was voluntarily dismissed, without prejudice.

Litigation Center Involvement

The Litigation Center, along with numerous other public health organizations, filed an *amicus* brief to support the graphic warnings. The brief focused on the public health value of the graphic warnings.

N. Regulation of Flavored Electronic Nicotine Delivery Systems

1. 7 Daze v. FDA (9th Cir.)

Issue

The issue in this case is whether the Food and Drug Administration ("FDA") acted lawfully when it denied marketing approval for electronic nicotine delivery systems ("ENDS")—colloquially called "electronic cigarettes" or "e-cigarettes"—featuring non-tobacco flavors.

AMA Interest

The AMA encourages the FDA to prohibit the use of all flavoring agents in tobacco products, including in electronic nicotine delivery systems.

Case Summary

In 2009, Congress enacted the Family Smoking Prevention and Tobacco Control Act ("TCA") to regulate tobacco products. *See* Pub. L. No. 111-31, 123 Stat. 1776 (2009). In part, the TCA prohibits manufacturers from selling any "new tobacco product" without prior written authorization from the FDA. *See* 21 U.S.C. § 387j(a).

In 2016, the FDA deemed ENDS a "new tobacco product" under the TCA, thus requiring authorization ("Deeming Rule"). In determining if an e-cigarette is appropriate for authorization, the FDA must weigh two competing factors: (1) the likelihood that the product will help existing users stop using tobacco products versus (2) the likelihood that the product will lead non-tobacco users, including youth, to begin using tobacco products. *See* 21 U.S.C. § 387j(c)(4).

The FDA delayed immediate enforcement of the Deeming Rule and, instead, created a series of staggered deadlines for review. This allowed ENDS manufacturers to sell their products for several years while the FDA reviewed applications from more than five hundred companies covering more than 6.5 million products.

In August 2021, five years after promulgation of the Deeming Rule, the FDA began issuing marketing denial orders ("MDOs") banning further marketing and sale of selected ENDS products. The FDA found that any benefit to current smokers would be insufficient to overcome the public health threat posed by the anticipated use of such products by new (primarily youth) smokers. The FDA has been issuing MDOs on a rolling basis since August 2021.

On October 7, 2021, 7 Daze, LLC, an e-cigarette manufacturer, petitioned the Ninth Circuit Court of Appeals to review the FDA's MDO with respect to its ENDS. The TCA permits the manufacturer to file directly in the court of appeals, rather than with a federal district court. *See* 21 U.S.C. § 387l. 7 Daze contends that the FDA acted outside the scope of the TCA when it denied further marketing and sale of the 7 Daze products.

On April 5, 2022, 7 Daze filed an emergency request for a stay of the FDA's denial, and the FDA's response was filed on April 13, 2022. The Litigation Center submitted an *amicus* brief on April 14, 2022, to oppose the stay request.

On April 20, 2022, the court denied the request for a stay, which is a favorable result consistent with the Litigation Center brief. The court has stayed the case while it considers several other cases involving ENDS products.

Litigation Center Involvement

The Litigation Center and the California Medical Association ("CMA") joined an *amicus* brief in the Ninth Circuit, which highlighted the harm caused by flavored ENDS products, especially to young people.

2. Juul v. FDA (D.C. Cir.)

Issue

The issue in this case is whether the Food and Drug Administration ("FDA") acted lawfully when it denied marketing approval for electronic nicotine delivery systems ("ENDS")—colloquially called "electronic cigarettes" or "e-cigarettes"—featuring non-tobacco flavors.

AMA Interest

The AMA encourages the FDA to prohibit the use of all flavoring agents in tobacco products, including in electronic nicotine delivery systems.

Case Summary

The relevant history of the Tobacco Control Act and the Deeming Rule at issue here are stated above in the *7 Daze v. FDA* matter.

On June 23, 2022, Juul Labs, Inc., an e-cigarette manufacturer, petitioned the United States Court of Appeals for the District of Columbia Circuit to review the FDA's MDO with respect to its ENDS products. Juul Labs contends that the FDA acted outside the scope of the TCA when it denied further marketing and sale of the Juul Labs products. Juul Labs also sought a stay of the MDO and an expedited schedule to keep its products on the shelves. The case is currently stayed while the FDA reviews additional information from Juul.

Litigation Center Involvement

The Litigation Center and the Medical Society of the District of Columbia joined an *amicus* brief in the D.C. Circuit Court of Appeals, which highlighted the harm caused by flavored ENDS products, especially to young people.

3. MH Global LLC v. FDA (9th Cir.)

Issue

The issue in this case is whether the Food and Drug Administration ("FDA") acted lawfully when it denied marketing approval for electronic nicotine delivery systems ("ENDS")—colloquially called "electronic cigarettes" or "e-cigarettes"—featuring non-tobacco flavors.

AMA Interest

The AMA encourages the FDA to prohibit the use of all flavoring agents in tobacco products, including in electronic nicotine delivery systems.

Case Summary

The relevant histories of the Tobacco Control Act and the Deeming Rule at issue here are stated above in the *7 Daze v. FDA* matter.

On October 14, 2021, MH Global petitioned the Ninth Circuit to review the FDA's MDO with respect to its ENDS products. The TCA permits the manufacturer to file directly in the court of appeals, rather than with a federal district court. *See* 21 U.S.C. § 387l. MH Global contends that the FDA acted outside of the scope of the TCA when it denied further marketing and sale of the MH Global products.

The parties have fully briefed the case and are awaiting oral argument.

Litigation Center Involvement

The Litigation Center and the California Medical Association ("CMA") joined an *amicus* brief in the Ninth Circuit, which highlighted the harm caused by flavored ENDS products, especially to young people.

4. SWT Global Supply v. FDA (8th Cir.)

Issue

The issue in this case is whether the Food and Drug Administration (FDA) acted lawfully when it denied marketing approval for electronic nicotine delivery systems (ENDS) colloquially called "electronic cigarettes" or "e-cigarettes"—featuring non-tobacco flavors.

AMA Interest

The AMA encourages the FDA to prohibit the use of all flavoring agents in tobacco products, including in electronic nicotine delivery systems.

Case Summary

The relevant history of the Tobacco Control Act and the Deeming Rule at issue here are stated above in the *7 Daze v. FDA* matter.

On October 8, 2021, SWT Global Supply, an ENDS manufacturer, petitioned the Eighth Circuit Court of Appeals to review the FDA's MDO with respect to their ENDS products. The TCA permits the manufacturer to file directly in the court of appeals, rather than with a federal district court. *See* 21 U.S.C. § 387l. The petitioner contends that the FDA acted outside the scope of the TCA when it denied further marketing and sale of petitioners' products.

Litigation Center Involvement

The Litigation Center and the Missouri State Medical Association joined an *amicus* brief in the Eighth Circuit, which highlighted the harm caused by flavored ENDS products, especially to young people.

5. Wages & White Lion v. FDA (8th Cir.)

Issue

The issue in this case is whether the Food and Drug Administration (FDA) acted lawfully when it denied marketing approval for electronic nicotine delivery systems (ENDS) colloquially called "electronic cigarettes" or "e-cigarettes"—featuring non-tobacco flavors.

AMA Interest

The AMA encourages the FDA to prohibit the use of all flavoring agents in tobacco products, including in electronic nicotine delivery systems.

Case Summary

The relevant history of the Tobacco Control Act and the Deeming Rule at issue here are stated above in the *7 Daze v. FDA* matter.

On October 5, 2021, Wages and White Lion Investments and Vapetesia LLC, two ENDS manufacturers, petitioned the Fifth Circuit Court of Appeals to review the FDA's MDO with respect to their ENDS products. The petitioners contend that the FDA acted outside the scope of the TCA when it denied further marketing and sale of petitioners' products.

With their request for review, the petitioners also sought a stay of the FDA's MDO, which would allow the petitioners to continue selling and marketing their products while the litigation continued. In October 2021, the court granted the request for a stay, thus allowing the products to remain in the market while the litigation moved forward. At that time, the court also set an expedited briefing schedule on the merits of the case.

In July 2022, after briefing on the merits, the Fifth Circuit vacated the stay, and the court denied the petitions for review. In a 2-1 decision, the court concluded that the FDA did not exceed the scope of the authority granted under the TCA. The court recognized that the TCA was intended to protect public health and that the FDA's actions were consistent with that goal.

In September 2022, the petitioners sought *en banc* review from the full Fifth Circuit. In January 2023, the court agreed to hear the case *en banc*.

On January 3, 2024, the Fifth Circuit ruled that the FDA had exceeded its authority in issuing the MDO in this case. This was an unfavorable ruling, and it is inconsistent with the Litigation Center's brief in the case.

The federal government sought review by the United States Supreme Court, which agreed to hear the case next term.

Litigation Center Involvement

The Litigation Center and the Louisiana State Medical Society (LSMS) joined *amicus* briefs in the Fifth Circuit and United States Supreme Court, which highlighted the harm caused by flavored ENDS products, especially to young people.

O. Air Pollution

1. Competitive Enterprise Institute v. NHTSA (D.C. Cir.)

Issue

The issue in this case is whether the Environmental Protection Agency (EPA) and the National Highway Traffic Safety Administration ("NHTSA") properly relaxed vehicle emission standards under the Clean Air Act ("CAA").

AMA Interest

The AMA believes that emission limitations for motor vehicles should be maintained until scientific data demonstrate that the limitations are no longer required to protect public health.

Case Summary

The EPA and NHTSA promulgated a regulation that would relax vehicle emission standards. The plaintiffs contend that the EPA and NHTSA committed procedural violations while enacting the regulations and, further, that the regulations substantively violate the CAA.

Litigation Center Involvement

The Litigation Center and the American Thoracic Society, along with other public health organizations, submitted a brief to support the plaintiffs.

2. Ohio v. EPA (D.C. Cir.)

Issue

The issue in this case is whether the federal Clean Air Act ("CAA") allows individual states to set more stringent air pollution controls on automobiles than the standards set by the federal government.

AMA Interest

The AMA supports the EPA's authority to regulate and control greenhouse gas emissions. In addition, the AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Case Summary

First passed in 1963, the CAA is the backbone of efforts to control air pollution in the United States. The complex regulatory scheme created by the CAA and its subsequent amendments vests broad authority with the EPA to issue regulations aimed at reducing air pollution, including pollution created by automobiles.

Because of the national implications of regulating both air pollution and automobiles, the CAA generally preempts states from "adopt[ing] . . . any standard relating to the control of emissions from new motor vehicles or new motor vehicle engines." 42 U.S.C. § 7543(a). Nonetheless, the CAA permits the Environmental Protection Agency ("EPA") to waive this preemption for states with more restrictive standards than those set by the federal government. Under the CAA, once the EPA has granted a waiver to one state, other states may adopt those same standards without seeking a waiver of their own. *See* 42 U.S.C. § 7507.

In 2009, California sought and obtained a waiver that would allow the state to set an aggressive plan to regulate automobile emissions, known as the Advanced Clean Car program. Developed in collaboration with EPA and the National Highway Traffic Safety Administration, California's Advanced Clean Car program has three components: a low-emissions vehicle regulation for certain pollutants, a low-emissions vehicle regulation for greenhouse gas emissions, and a technology-promoting zero-emission vehicle regulation. More than a dozen states have since chosen to adopt California's standards.

In 2019, the EPA withdrew the waiver it had previously granted California—the first time the agency had ever withdrawn a previously-granted waiver—thus limiting the ability of individual states to set their own emissions standards. At that time, the EPA alleged that the CAA's preemption provision barred the waiver.

In 2022, the EPA changed course yet again, following a change in presidential administration. It reinstated the waiver, thus allowing California and other states to take more aggressive action on regulating air pollution created by automobiles.

In the weeks following the EPA's 2022 decision to reinstate California's waiver, three separate cases were filed in the federal District of Columbia Circuit Court, which reviews administrative

actions. *See* 42 U.S.C. § 7607(b)(1). The cases were consolidated for briefing and argument.

The plaintiffs include a coalition of Republican state attorneys general, fossil fuel companies, and major automobile manufacturers. The plaintiffs allege that the California waiver violates both the U.S. Constitution's Equal Sovereignty Doctrine and the federal Administrative Procedure Act. The plaintiffs contend that all states should be treated equally under the CAA, and thus only the federal government can set standards for automobile emissions.

Oral argument was heard on September 15, 2023, and the case was taken under advisement**.**

Litigation Center Involvement

The Litigation Center joined the American Thoracic Society and others in an *amicus* brief supporting the EPA. The brief discussed the negative health impacts of air pollution and the importance of reducing greenhouse gases.

3. Texas v. EPA (D.C. Cir.)

Issue

The issue in this case is whether the federal government has the authority under the Clean Air Act ("CAA") to set automobile emissions standards that encourage the increased production of electric vehicles, instead of internal combustion engines. This is a companion case to *Ohio v. EPA*, discussed above.

AMA Interest

The AMA supports the EPA's authority to promulgate rules to regulate and control greenhouse gas emissions in the United States. In addition, the AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Case Summary

First passed in 1963, the CAA is the backbone of efforts to control air pollution in the United States. The complex regulatory scheme created by the CAA and its subsequent amendments vests broad authority with EPA to issue regulations aimed at reducing air pollution, including pollution created by automobiles.

Title II of the Clean Air Act sets forth a comprehensive structure for regulating automobile emissions at the federal level. At the center of the federal regulatory system is Section 202, which directs the EPA Administrator to set and revise "standards applicable to the emission of any air pollutant from any class or classes of new motor vehicles or new motor vehicle engines, which in his judgment cause, or contribute to, air pollution which may reasonably be anticipated to endanger public health or welfare." 42 U.S.C. § 7521(a)(l).

In August 2021, the EPA issued a notice of proposed rulemaking for new greenhouse gas emission standards, which would be "the most stringent vehicle [greenhouse-gas] standard[s] . . . to date." 86 Fed. Reg. 43,726, 43,746 (Aug. 10, 2021). At that time, the Biden administration set

"a goal that 50 percent of all new passenger cars and light trucks sold in 2030 be zero-emission vehicles" and directed EPA to set greenhouse-gas emission standards accordingly. 86 Fed. Reg. at 43,583.

On December 30, 2021, the EPA finalized the rule at issue here setting revised greenhouse gas standards for light-duty vehicles, which includes most passenger and light cargo vehicles, for model years beginning with 2023. 86 Fed. Reg. at 74,434. Most notably, the new rule set fleetwide-average emissions standards, which means that rather than considering the emissions rate of an individual vehicle, the EPA looks at each manufacturer's entire fleet of light-duty vehicles. Thus, in order to comply with this shift and meet the regulatory standards, automakers must increase their production of electric vehicles to bring their fleetwide emissions standards down.

On March 28, 2022, a coalition of Republican state attorneys general petitioned for review of the agency's rulemaking in the federal D.C. Circuit Court of Appeals. Shortly thereafter, a number of private entities, namely energy companies and fossil fuel producers, filed their own petitions for review. The court consolidated these petitions. Notably, the vehicle manufacturers are not challenging the rulemaking here, and instead, have intervened in support of the EPA and the rule.

Oral argument was heard on September 14, 2023, and the case was taken under advisement.

Litigation Center Involvement

The Litigation Center joined the American Thoracic Society and others in an *amicus* brief supporting the EPA.

4. Union of Concerned Scientists v. NHTSA (D.C. Cir.)

Issue

The issue in this case is whether federal administrative agencies can prevent the State of California from imposing heightened air quality standards for vehicle emissions in California.

AMA Interest

The AMA supports the protection of geographic areas with air quality better than the national standards from deterioration by requiring localized restrictions on air pollution sources.

Case Summary

The Clean Air Act ("CAA") allows the Environmental Protection Agency ("EPA") to control emissions from new motor vehicles. The CAA generally preempts states from adopting these standards themselves, but the CAA requires the EPA to waive this preemption of state emission standards, so long as those standards are at least as protective as the federal standards.

In 2012, the EPA approved regulations of the California Air Resources Board, entitled the Advanced Clean Cars ("ACC") program, which imposed clean air standards that were more protective than the EPA standards. However, the EPA and National Highway Traffic Safety Administration ("NHTSA") later revoked portions of the ACC program, stating that California does "not need [those] standards to meet compelling and extraordinary conditions."

Numerous public interest organizations, industry coalitions, twenty-three states, the District of Columbia, and three California municipalities filed ten different lawsuits against NTHSA and the EPA, seeking to invalidate the revocation of California's ACC program. These cases were consolidated in the United States Court of Appeals for the District of Columbia Circuit. The defendants moved for dismissal.

The case has been in abeyance since February 8, 2021, while the Biden Administration considers whether it will voluntarily modify the applicable regulations in order to moot some or all of the issues.

Litigation Center Involvement

The Litigation Center, the California Medical Association, the American Thoracic Society, and numerous other health care organizations submitted an *amicus* brief to support the plaintiffs and the ACC program.

P. Anti-Vaccine Law

1. Montana Medical Association v. Knudsen (9th Cir.)

Issue

The issue in this case is whether a Montana law, HB 702, which prohibits physicians and hospitals from refusing to hire or from firing non-vaccinated employees, is valid.

AMA Interest

The AMA has called for all health care and long-term care employers to require their employees to be vaccinated against COVID-19. The AMA encouraged COVID-19 vaccine mandates to defeat the pandemic.

Case Summary

This case involves a legal challenge to Montana law HB 702. The most relevant provision of HB 702 is §1(b), with certain exceptions, makes it "an unlawful discriminatory practice for . . . an employer to refuse employment to a person, to bar a person from employment, or to discriminate against a person in compensation or in a term, condition, or privilege of employment based on the person's vaccination status or whether the person has an immunity passport." HB 702 thus prohibits physician-owned medical practices and hospitals (among other businesses) from taking medically appropriate actions against present or potential unvaccinated employees. HB 702 does not limit its application to immunization from or vaccination against COVID-19. It implicates all vaccine-preventable diseases.

The Montana Medical Association ("MMA") filed suit challenging HB 702 in federal court in Montana. The plaintiffs include MMA, physician practices, and individuals with health conditions that put them at greater risk of harm from COVID-19 and other communicable diseases. The complaint included both state and federal causes of action. The Montana Nurses Association also intervened as a plaintiff.

The district court found the Montana law unconstitutional and preempted by federal law. It enjoined enforcement of the law in health care settings. The trial court decision was a favorable result.

However, the defendants appealed to the Ninth Circuit. On October 9, 2024, the Ninth Circuit issued an opinion reversing the district court and vacated the injunction. The court concluded that the facial challenges to the laws were insufficient, leaving open the question of whether fact-specific, as applied challenges might be successful. This is an unfavorable result. MMA has filed a request for rehearing or rehearing *en banc.*

Litigation Center Involvement

The Litigation Center is paying for the lawsuit, and it also filed an *amicus* brief in the Ninth Circuit.

Q. Firearm Violence

1. Garland v. VanDerStok (S. Ct.)

Issue

The issue in this case is whether the federal government exceeded its authority under the Gun Control Act of 1968 when it issued an administrative rule regarding firearms manufactured and modified in one's home, often referred to colloquially as "ghost guns."

AMA Interest

The AMA will support state and federal legislation and regulation that would subject homemade firearms, including ghost guns, to the same laws and regulations and licensing requirements as traditional regulated firearms.

Case Summary

In the Gun Control Act of 1968 ("the Act"), Congress imposed requirements on persons engaged in the business of importing, manufacturing, or dealing in "firearms." 18 U.S.C. § 922, 923. Such persons must obtain a federal firearms license, keep records of the acquisition and transfer of firearms, and conduct a background check before transferring a firearm to a non-licensee. *Id*. at §§ 922(t), 923(a) and (g)(1)(A). Importers and manufacturers are also required to mark firearms with a serial number. *Id*. at § 923(i). The Act defines a "firearm" to include "any weapon . . . which will or is designed to or may readily be converted to expel a projectile by the action of an explosive," as well as "the frame or receiver of any such weapon." *Id*. at § 921(a)(3)(A)-(B).

In 2022, the Bureau of Alcohol, Tobacco, Firearms and Explosives ("ATF") issued a rule clarifying that certain products that can readily be converted into an operational firearm or a functional frame or receiver of a firearm fall within the scope of the Act. *See* 87 Fed. Reg. 24,652 (Apr. 26, 2022) (codified in relevant part at 27 C.F.R. 478.11, 478.12(c)). The rule was intended to address the public safety and law enforcement crisis posed by the exponential rise of untraceable firearms commonly called "ghost guns."

Ghost guns can be made from kits and parts that are widely available online and allow anyone

with basic tools and rudimentary skills to assemble a fully functional firearm in as little as twenty minutes. Because some manufacturers of these kits and parts asserted that they were not "firearms" regulated by federal law—and thus sold them without serial numbers, transfer records, or background checks—ghost guns were attractive to criminals, minors, and others who are legally prohibited from buying firearms.

The rule at issue provides that these kits and the partially completed frames and receivers that can readily be converted into functional firearms or complete frames and receivers qualify as regulated "firearms." The rule does not prohibit the purchase, sale, or possession of any firearm, nor does it prohibit any individual lawfully entitled to possess a firearm from making one at home; instead, it simply ensures that ghost guns are subject to the same straightforward and inexpensive administrative requirements that apply to commercial sales of all other firearms.

On August 11, 2022, several individuals and companies filed a lawsuit to challenge the administrative rule, claiming that the regulation exceeds the authority that Congress vested in the ATF. The plaintiffs claimed that the provisions of the rule clarifying that certain weapon parts kits fall within the Act's definition of "firearm" and that the statutory term "frame or receiver" includes certain partially complete frames or receivers. The complaint alleged that the rule violated the Administrative Procedure Act, the Separation of Powers Clause of the United States Constitution, and the First Amendment's free speech protections.

The district court granted the plaintiffs' motion for summary judgment, concluding that the challenged provisions of the rule contradict the Act. In its decision, the district court granted broad relief, vacating the entire rule—including its many unchallenged provisions—without addressing ATF's express specification that the provisions of the rule are severable.

The federal government appealed to the Fifth Circuit, and the appellate court affirmed in part and vacated in part the district court judgment. The court of appeals agreed with the district court's conclusion that the rule exceeded the scope of the government's authority, but it agreed with the federal government that the relief provided was overly broad. The court remanded the case for further proceedings.

Before the relief could be reconsidered by the district court, the federal government sought review by the United States Supreme Court, which agreed to hear the case.

Litigation Center Involvement

The Litigation Center joined the Texas Medical Association and others in an *amicus* brief supporting the federal government and the regulation of ghost guns.

2. Maryland Shall Issue v. Anne Arundel County (4th Cir.)

Issue

The issue in this case was whether a county law that requires gun stores to provide information to gun buyers about suicide risk factors and nonviolent conflict resolution violates the First Amendment.

AMA Interest

The AMA encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms. The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition, and other explosives in the home.

Case Summary

In April 2022, Anne Arundel County, Maryland enacted an ordinance requiring gun shop owners to provide literature to firearms customers regarding suicide prevention and nonviolent conflict resolution. Specifically, the ordinance required gun retailers to make the literature visible and available "at the point of sale" and to distribute the literature to all purchasers of guns or ammunition. The retailers received the literature from the county's health department at no cost.

Maryland Shall Issue (a non-profit organization dedicated to preserving gun owners' rights), along with four gun retailers, filed a complaint against the county, challenging the ordinance as unlawfully compelled speech under the First Amendment of the United States Constitution. The district court granted the county's motion for summary judgment.

The court held that the ordinance was permissible because the literature was: (1) commercial speech, (2) purely factual and uncontroversial information, and (3) reasonably related to the county's interests. It reasoned that all information provided in the proposed literature related to the responsible and safe use of the product at the heart of the commercial transaction, that the statement that access to firearms is a risk factor for suicide is factual and uncontroversial, and that the literature was reasonably related to the government's interest and not unduly burdensome to distribute.

The plaintiffs appealed to the Fourth Circuit, which affirmed on January 23, 2024. This was a favorable result, consistent with the Litigation Center brief.

Litigation Center Involvement

The Litigation Center and MedChi filed a brief supporting the county on appeal.

R. Medicare

1. United States v. Elfenbein (4th Cir.)

Issue

The issue in this case is whether the district court properly granted the defendant's motion for acquittal on his Medicare fraud charges.

AMA Interest

As AMA policy states, the burden of proof for proving Medicare fraud and abuse should rest with the government at all times.

Case Summary

Dr. Ron Elfenbein was the medical director of an urgent care center that submitted thousands of reimbursement claims to Medicare for patient encounters involving COVID-19 testing. Patients were briefly seen by a provider, with face-to-face time with a provider lasting only minutes. The patients were given two COVID-19 tests, a rapid test and a polymerase chain reaction ("PCR") test. These visits were billed at CPT E/M level 4 at the direction of Dr. Elfenbein.

Dr. Elfenbein was indicted and charged with five counts, including Medicare fraud. The government argued that the patient encounters described above did not qualify as level 4 visits (but rather level 1 visits), and therefore the doctor unlawfully enriched himself. After trial, the jury convicted him on all five counts. Dr. Elfenbein then moved for an acquittal. He argued that the evidence at trial did not establish that these visits did not qualify as level 4 visits.

The district court agreed with Dr. Elfenbein and acquitted him on all five counts: "The Court concludes that, because the government failed to present sufficient evidence from which a reasonable jury could conclude beyond a reasonable doubt that the Defendant's use of the level 4 code was objectively unreasonable and therefore false, judgment of acquittal is mandated on all five counts."

The government has now appealed to the Fourth Circuit Court of Appeals.

Litigation Center Involvement

The Litigation Center and MedChi filed an *amicus* brief supporting the defendant's position before the Fourth Circuit. The brief explained the background of CPT and leans on AMA policies of protecting physicians from liability.

S. False Claims Act

1. United States v. Walgreen Co. (4th Cir.)

Issue

The issue in this case was whether the federal Medicaid law allows Virginia Medicaid's prior authorization requirement for hepatitis C medications.

AMA Interest

The AMA is to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes. Also, the AMA is to reduce prior authorization administrative burdens, thereby improving patient care.

Case Summary

From January 2015 through July 2016, Amber Reilly, a Clinical Pharmacy Manager at a Walgreens pharmacy in Kingsport, Tennessee, and another employee at her direction, changed data on forms and falsified laboratory test results in order to obtain preauthorization for reimbursement for hepatitis C medications that Walgreens provided to Virginia Medicaid recipients. Reilly was prosecuted, and she pleaded guilty to health care fraud.

Walgreens refused to refund the nearly $800,000 paid to it, arising from its employees' misrepresentations.

The United States and State of Virginia sued Walgreens, alleging violations of the False Claims Act (FCA) as well as state law claims. Walgreens moved to dismiss, contending that Virginia Medicaid's prior authorization requirements for these drugs violated the federal Medicaid law. Thus, the false representations were not material, a necessary element of an FCA claim.

The district court reasoned that Virginia's prior authorization criteria went beyond a simple system for preapproval and served as a mechanism for improperly limiting or excluding coverage. This violated Section 1927 of the Social Security Act, the governing federal statute. Under Section 1927, cost is not a permissible reason for a state to limit access to a medically necessary drug, which is what Virginia Medicaid was trying to achieve. Thus, the district court held for Walgreens, dismissing the complaint. Plaintiffs appealed to the Fourth Circuit.

On October 15th, 2023, the Fourth Circuit reversed and ordered the lawsuit reinstated. It held that, under the complaint, Walgreens' statements induced payment of the Medicaid claims. Furthermore, Walgreens could not collaterally attack the validity of the Virginia Medicaid requirements. Under either basis, the complaint adequately alleged materiality.

This was an unfavorable result, inconsistent with the Litigation Center brief.

Litigation Center Involvement

The Litigation Center and the Medical Society of Virginia joined the U.S. Chamber of Commerce in an *amicus* brief in support of Walgreens.

CONCLUDED CASES
Since June 1, 2024

AMA/Stewart v. Cigna (D. Conn.)

Issue

The issue in this case was whether Cigna violated state and federal laws by 1) misrepresenting to insureds and to physicians the amount the insureds owed their physicians for the physicians' services; and 2) failing to reimburse physicians at the rates provided in the physicians' contracts with a third party, MultiPlan.

AMA Interest

The AMA is to identify wrongful behaviors of the health insurance industry and search for potential litigation partners across the medical federation. Further, physicians are to contact the Litigation Center if they have experienced improper discounts by third party payers.

Case Summary

MultiPlan, an intermediary between physicians and health insurance plans, offers network enrollment contracts to physicians at a specified percentage of billed charges (sometimes as high as 90%), with payments to be made by patients' health insurance companies. Cigna "rents" the network that MultiPlan creates with the enrolled physicians and markets this network to its insureds by, among other things, placing the MultiPlan logo on its insurance cards. When Cigna pays the bills for physicians covered under the MultiPlan contracts, it will often pay far below the rates agreed to in those contracts. Cigna then sends the patients Explanations of Benefits (EOBs) which falsely state that the patients do not owe any additional money. Sometimes, Cigna will falsely and explicitly tell the patients that the physicians have agreed to the steep discounts.

Plaintiffs are a proposed class of Cigna insureds, who sued Cigna for underpayment of promised health care benefits. The medical associations joined the suit as additional plaintiffs, seeking a declaratory judgment that Cigna's conduct is illegal and an injunction to prohibit Cigna from misrepresenting to patients that physicians who sign MultiPlan contracts have agreed to reduce their rates. The medical societies also seek a court order to require Cigna to pay physicians at the MultiPlan contract rates, going forward.

On October 26, 2022, Cigna moved to dismiss the amended complaint. On March 30, the district court dismissed the Litigation Center and the state associations, concluding that they did not have standing to pursue their causes of action. This is an unfavorable result, and Litigation Center staff and outside counsel are considering next steps.

Litigation Center Involvement

The Litigation Center, along with the Washington State Medical Society and the Medical Society of New Jersey, joined the lawsuit as named plaintiffs.

Blackston v. Doctor's Weight Loss Centers (Md. S. Ct.)

Issue

The issue in this medical malpractice case was whether the Maryland non-economic damages cap of $755,000 should apply in a Maryland court action brought by a patient who suffered an infection following a procedure performed in Virginia.

AMA Interest

The AMA is to work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

In January 2015, Shelly Blackston, a Maryland resident, traveled to Virginia to discuss possible liposuction surgery with Dr. Alba Roy Heron, Jr. Ms. Blackston visited Dr. Heron's office for two pre-operative consultations, at which time Dr. Heron explained the risks of the procedure and evaluated Ms. Blackston. After they agreed upon the surgery, Dr. Heron prescribed an oral antibiotic for Ms. Blackston, which she was to take before the surgery.

On January 30, 2015, Ms. Blackston again traveled to Virginia, this time for the liposuction. Dr. Heron did not administer any antibiotics during the procedure. He did, however, give Ms. Blackston analgesic pills two hours prior to the surgery to help with any pain.

Approximately two hours after the procedure, Ms. Blackston complained of "dizziness and excruciating pain." Dr. Heron "injected some Lidocaine to numb her and make her feel better." Following the procedure, Ms. Blackston returned to her home in Maryland. Her pain continued for the next several days.

On February 3, 2015, Ms. Blackston visited Dr. Heron for a post-operative evaluation. She reported that she was experiencing considerable pain, and she had a fever and nausea. Dr. Heron testified that Ms. Blackston had some drainage, but there were no signs of infection during that visit. He instructed her to continue to take the oral antibiotic he prescribed before the procedure.

Over the next several days, Ms. Blackston's condition worsened. She was bleeding, had developed a high fever, and was "throwing up constantly." The incisions became swollen and were oozing puss. Ms. Blackston reported her deteriorating condition to Dr. Heron and sent him photographs. On February 14, 2015, Ms. Blackston met Dr. Heron at his office in Virginia. She showed him her incisions, which were still open and draining fluid.

After leaving Dr. Herron's office, Ms. Blackston collapsed and was taken to MedStar Southern Maryland Hospital Center. She was diagnosed with methicillin-resistant Staphylococcus aureus (MRSA). Ms. Blackston required several surgeries and rounds of antibiotics to treat the infection.

On September 21, 2018, Ms. Blackston filed a complaint in the Circuit Court for Prince George's County, Maryland against Dr. Heron and various organizations that he owned. She alleged that Dr. Heron breached the standard of care in numerous respects, before, during, and after the procedure, and he failed to obtain proper informed consent.

The parties disagreed on what caused Ms. Blackston's infection, when Dr. Heron learned of the infection, and when Ms. Blackston's case was properly actionable. Ms. Blackston and her experts argued that the infection was "seeded," and thus, actionable at the time of the surgery. The defendants and their experts argued that there was no evidence of an infection until well after the procedure once Ms. Blackston returned home to Maryland. During the course of the proceedings, Ms. Blackston relied generally on Maryland substantive law, including proposed jury instructions that exclusively cited Maryland law.

Following a trial, the jury returned a verdict in Ms. Blackston's favor, awarding her a total of $2,300,900 in damages, which included: non-economic damages of $2,000,000; economic damages of $60,000; and medical expenses in the amount of $240,900. Defendants filed several post-trial motions, including a motion to reduce the non-economic damages under Maryland law. The trial court agreed with defendants and reduced the total award to $1,055,900, plus interest and costs to conform with Maryland limits on non-economic damages.

Ms. Blackston appealed to the Appellate Court of Maryland. On appeal, she argued that the reduction of damages was improper, and the trial court should have instead relied on Virginia state law, which has a different cap. The Maryland appellate court, finding this to be a matter of first impression, agreed with Ms. Blackston. The court concluded that a cause of action for medical negligence arises where the injury first comes into existence, not where the ultimate damage is suffered. The court went on to conclude that Ms. Blackston had a legally cognizable injury on the day of her procedure, rather than when the injury manifested. According to the appellate court, Ms. Blackston was injured in Virginia, and Virginia law should apply.

The defendants appealed to the Maryland Supreme Court, and on July 31, 2024, the court ruled in favor of the plaintiff, finding that Virginia law should apply. Thus, the damages would not be reduced under the Maryland cap. This is an unfavorable position, and it is inconsistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and the Maryland State Medical Society filed an *amicus* brief supporting defendants.

Braidwood Management v. Becerra (N.D. Tex.; 5th Cir.)

Issue

The issue in this case was whether the Affordable Care Act ("ACA") requirement that private insurance plans cover certain preventive care services without cost sharing violates the United States Constitution and the Religious Freedom Restoration Act.

AMA Interest

The AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces, and the community.

Case Summary

The ACA requires most private health insurance to cover certain "preventive care" services, without cost sharing from the patient. Preventive care includes a range of services, such as screening tests, immunizations, behavioral counseling, and medications that can prevent the development or worsening of diseases and health conditions. The ACA empowers three agencies affiliated with the Department of Health and Human Services to determine what services fall within this requirement. As new recommendations are issued or updated, coverage must begin in the next plan year that begins on or after one year from the recommendation's issue date.

Plaintiffs, six individuals and two businesses, challenged the legality of the ACA's preventive care service requirements and structure, based on religious, economic, and constitutional reasons. The plaintiffs focused on requirements related to contraception and preventing transmission of HIV, as they desire to purchase insurance policies on the open market that meet their specific needs and are free from the requirements of the ACA.

In September 2022, the federal district court in the Northern District of Texas, on cross-motions for summary judgment, found in favor of the plaintiffs on two of their claims. As part of its ruling, it determined that the members of the United States Preventive Services Task Force (PSTF), an agency the ACA had empowered to make certain of the recommendations at issue, should be deemed Officers of the United States under Article II, §2 of the Constitution. Thus, the PSTF members could only serve if they had been appointed under Article II, §2 protocols, but in fact they had not.

On March 30, 2023, after supplemental briefing from the parties and amici, the federal district court issued its opinion and order addressing the remedies and final judgment. Most notably, the court ordered that all actions taken by HHS to implement or enforce the PSTF recommendations were to be vacated and enjoined. The court also ordered that the named plaintiffs need not comply with the PrEP mandate, as that mandate violated their rights under the Religious Freedom Restoration Act. This result was inconsistent with the Litigation Center's brief.

On March 31, the federal government appealed to the Fifth Circuit. It then sought a partial stay of the trial court decision. Pending resolution of the full appeal, the requested stay would limit the trial court ruling to insurance policies purchased by the plaintiffs but not to insurance policies purchased by the general public.

On June 21, 2024, the Fifth Circuit issued a decision affirming in part and reversing in part the lower court decision. The appellate court agreed that the Preventive Services Task Force was unconstitutionally appointed but disagreed with the broad nationwide relief ordered by the lower court. The court of appeals also identified several items that needed further review by the district court and remanded the matter for further proceedings. This is a slightly unfavorable decision, though the result is fairly neutral as it leaves the status quo in place.

Litigation Center Involvement

The Litigation Center joined other Federation members in four amicus briefs, one in the district court, one in the court of appeals in support of the stay, and two on the merits of the case in the court of appeals.

Carter v. Wake Forest Univ. Baptist Med. Ctr. (Va. S. Ct.)

Issue

The issue in this medical malpractice case was whether the Virginia courts have jurisdiction over North Carolina health care providers that provided care in North Carolina to a Virginia resident.

AMA Interest
The AMA is to work with state medical societies and other organizations to curb lawsuit abuse.

Case Summary

In June 2016, at the recommendation of his family doctor, Mr. Worth Carter travelled to Wake Forest University Baptist Medical Center ("Wake Forest") in Winston-Salem, North Carolina to receive treatment for a skin infection. Over the next eleven months, Mr. Carter saw four different Wake Forest physicians for care related to this issue, travelling to Winston-Salem for appointments on at least eighteen occasions. Between appointments, Mr. Carter communicated with three of those physicians about his progress and about plans for future visits. With the assistance of his daughter, Mr. Carter reached out to his physicians via telephone, sent them text messages and photos, and communicated via Wake Forest's online patient portal, myWakeHealth. Ultimately, Mr. Carter was found to have cancer, and he died.

Mr. Carter's daughter, as Executor of her father's estate, brought suit in the Circuit Court of Martinsville, Virginia against two Wake Forest organizations, as well as four Wake Forest physicians. Ms. Carter later voluntarily dismissed the Wake Forest physicians from the case.

Pursuant to the motion of Wake Forest, the circuit court found that it would be inconsistent with due process to assert jurisdiction over Wake Forest. In its order granting dismissal, the circuit court noted that Mr. Carter had voluntarily sought care from Wake Forest, and that Wake Forest had neither solicited Mr. Carter as a patient nor advertised to him in Virginia. The four Wake Forest physicians who treated Mr. Carter in person did so only from their offices in North Carolina. The Wake Forest physicians never initiated any telephone calls, texts, nor other messages to Mr. Carter. All had come in response to contacts made by the Carters. The court concluded that Virginia was not the proper jurisdiction for claims against Wake Forest.

Ms. Carter appealed, and the court of appeals affirmed the trial court. The appellate court concluded this was not "a case about Wake Forest reaching into Virginia," but rather "a case of a plaintiff reaching back into North Carolina." The court recognized that the Wake Forest physicians had communicated with Mr. Carter between visits, but "[t]hese contacts were initiated by Ms. Carter" and "not Wake Forest." While acknowledging Ms. Carter's allegation that these communications constituted "additional, virtual treatment from Wake Forest," the court rejected the plaintiff's arguments that such contacts were sufficient to establish jurisdiction in Virginia.

Finally, the court discussed the significant practical effect of a ruling to the contrary, which would allow Ms. Carter's suit to proceed in Virginia. The court noted that follow-up care like Mr. Carter's is not only expected but required of physicians. If such care conferred jurisdiction

everywhere Virginia residents seek treatment, out-of-state providers could decline referrals or insist upon entirely in-person care. This would negatively "impact the care that Virginians now receive from out-of-state providers."

Ms. Carter appealed to the Virginia Supreme Court. On May 9, 2024, the state high court upheld the appellate court decision, finding that there was no personal jurisdiction over the out-of-state providers. This is a favorable result, and it is consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and the North Carolina Medical Society filed an *amicus* brief supporting the defendants.

Daher v. Prime Healthcare Services-Garden City (Mich. S. Ct.)

Issue

The issue in this case was whether, in a medical malpractice action, the estate of a 13-year-old child may recover damages for the child's lost future earnings.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Thirteen-year-old Jawad Jumaa died of bacterial meningitis shortly after being treated by Dr. Kelly Welsh and Dr. Meagan Shady of Prime Healthcare Services.

Jumaa's estate sued the doctors and hospital for medical malpractice under Michigan's wrongful death act. Defendants moved for summary disposition, arguing that the claim for lost future earnings of the deceased child was unduly speculative. The trial court disagreed and denied the defendants' motion.

Defendants appealed, but the appellate court rejected defendants' argument that the lost future earning potential of a 13-year-old who was neither working nor supporting anyone was inherently speculative. The court stated, "We hold only that it seems highly likely that the future earning potential of a 13-year-old can be proven with reasonable certainty based on personal characteristics and influences known at the time, and we unequivocally reject the proposition that the future earning potential of a 13-year-old categorically cannot be proven with reasonable certainty."

Defendants have appealed to the Michigan Supreme Court, to address the following issues: (1) whether the estate of a child may recover damages for the child's lost future earnings; and (2) to what specificity future earnings need be shown.

On July 30, 2024, the Michigan Supreme Court reversed the court of appeals, finding that the lost future earnings were not recoverable under Michigan law. This is a favorable decision, consistent with the Litigation Center's brief in the case.

Litigation Center Involvement

The Litigation Center joined the Michigan State Medical Society in an *amicus* brief supporting defendants.

Danhoff v. Fahim (Mich. S. Ct.)

Issue

The issue in this case was whether, in a medical malpractice action, a plaintiff's standard of care expert was qualified to testify without confirmation of the opinion by articles in medical journals or other established authorities.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Plaintiff Lynda Danhoff underwent spine surgery by Dr. Fahim as the lead surgeon. The surgery was a minimally invasive procedure referred to as an "extreme lateral intrabody fusion" ("XLIF"), and it was performed on her L3 and L4 vertebrae. Thereafter, she had pain, high fever, and high blood pressure. She was taken to the ICU. Another surgery was performed by another doctor who observed that, due to a hole in her sigmoid colon, her stool was leaking. In all, plaintiff required four surgeries.

Plaintiffs (Ms. Danhoff and her husband) filed a complaint alleging that Dr. Fahim committed medical malpractice by puncturing plaintiff's sigmoid colon during the first spine surgery. Defendants (Dr. Fahim and his practice) denied the allegations and after discovery moved for summary disposition, arguing that plaintiffs' standard of care expert, Dr. Koebbe, was not qualified because his standard of care opinion was based solely on his experience and background. The court agreed with defendants and granted summary disposition, on the basis that Dr. Koebbe failed to support his opinion with medical journals or other authority to establish his opinion's reliability.

Plaintiffs appealed the trial court order, and the Michigan Court of Appeals affirmed. The appellate court noted that the trial court's obligation under Michigan's rules of evidence (particularly MRE 702) is a gatekeeping role, requiring the trial court to ensure that each aspect of an expert witness's testimony, including the underlying data and methodology, is reliable.

Plaintiffs appealed, and the AMA and MSMS filed an *amicus* brief in support of the defendants during the appeal application stage and on the merits.

On July 9, 2024, the Michigan Supreme Court reversed the trial court decision, finding that the court misapplied the relevant evidentiary standard. The state high court ruled that the trial court had erred by focusing too strictly on the lack of reliance on medical literature. The court remanded the case for further review. The outcome here is slightly favorable, as the state high court did not overrule prior favorable precedent on the use of medical literature and limited the

decision to the facts of this case.

Litigation Center Involvement

The Litigation Center joined the Michigan State Medical Society in two *amicus* briefs filed with the Michigan Supreme Court to support the defendants.

Doe v. Manchester School District (N.H. S. Ct.)

Issue

The issue in this case was whether student privacy protections in a school district's nondiscrimination policy violate parental rights under the state and federal constitutions or otherwise conflict with federal education laws.

AMA Interest

The AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning ("LGBTQ") youth suicide and improve health among LGBTQ youth.

Case Summary

On February 8, 2021, the Manchester School District adopted Policy 100.1, which was derived from a model policy created by the New Hampshire School Boards Association. The policy, titled Transgender and Gender Non-Conforming Students, included a range of provisions to help "ensure the safety, comfort, and healthy development of the transgender or gender non-conforming student while maximizing the student's social integration and minimizing stigmatization of the student," including protecting student expression and the disclosure of student information.

The plaintiff, Jane Doe, had a minor child ("M.C."), who attended a school in Manchester, New Hampshire. M.C.'s age and grade level were not identified in the complaint. In the fall of 2021, the plaintiff learned that M.C. had asked teachers and fellow students to refer to M.C. by a name traditionally associated with a gender different from their gender as assigned at birth.

The plaintiff contacted M.C.'s guidance counselor and informed her that she would like the school to continue to treat M.C. according to M.C.'s birth gender, address M.C. by their given name, and address M.C. using the pronouns traditionally associated with their biological sex. The plaintiff was upset that her child might be transgender and did not want the school to support the student's requested name and pronouns.

Following this exchange, the school's principal contacted the plaintiff and explained that although the principal understood her concerns, the school policy required staff to respect the student's request and the principal could not discuss the issue further, unless authorized by the student or otherwise required by the school policy or law. Thus, under the policy, the school district was aligned with the student, and against the student's mother.

Plaintiff Jane Doe filed suit against the Manchester School District in New Hampshire state court. The plaintiff alleged that the school district's policy violated her rights to raise her child

under the New Hampshire and United States Constitutions, exceeded the school district's authority, and conflicted with federal laws regarding the collection and disclosure of student information, namely the Family Educational Rights and Privacy Act and the Protection of Pupil Rights Act. The school district moved to dismiss the complaint.

On September 5, 2022, the New Hampshire trial court granted the school district's motion to dismiss. The court concluded the policy did not infringe on the plaintiff's fundamental right to raise her child and was rationally related to the state government's interest in ensuring that schools provide a safe learning environment for all students. The court further found that the policy was aligned with other New Hampshire provisions involving non-discrimination and did not conflict with federal student privacy laws.

The plaintiff appealed to the New Hampshire Supreme Court, and on August 30, 2024, the state high court affirmed the decision of the lower court, finding the school policy did not interfere with the fundamental rights of parents in the state. This is a favorable decision, consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined the New Hampshire Medical Society and others in an amicus brief supporting the school district and its policy.

Fluhr v. Anonymous Doctor 3 (Ind. Ct. App.)

Issue

The issue in this case was whether, in light of Indiana's Covid Immunity Statute, Ind. Code § 3430-13.5-1(b)(1), a physician could be held liable for injuries to a patient thought to be infected with COVID-19.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

The plaintiff's decedent, Fluhr, presented at an Indiana emergency room on April 24, 2020, near the onset of the COVID-19 pandemic. The hospital at that time prohibited emergency care physicians from making "full contact physical examinations" of emergency patients. As a result of the hospital requirement, the physician assigned to Fluhr's case was unable to examine him thoroughly. Fluhr subsequently died of a stroke.

Following the procedures of the Indiana Medical Review Law, Fluhr's estate notified the Indiana Department of Insurance that it would sue the physician and the hospital for medical malpractice. Under the Indiana Medical Review Law, the physician was identified as "Anonymous Doctor 3" before the Indiana Department of Insurance. The estate contended that the physician's failure to examine Fluhr thoroughly was negligence. Furthermore, it contended, had Flur been given a thorough examination he would have been saved.

Still following the procedures of the Indiana Medical Review Law, the physician and the hospital sued Fluhr's estate in the Indiana Superior Court. The physician and hospital asserted that summary judgment should be entered against the estate, based on the Covid Immunity Statute.

This law foreclosed claims of negligence against physicians who treated patients suspected of carrying the COVID-19 virus. The Superior Court entered the summary judgment, and Fluhr's estate appealed.

On May 9, 2024, the Indiana Court of Appeals affirmed the trial court's decision granting summary judgment. The appellate court referenced the Litigation Center's brief during oral argument and in the decision. This is a favorable result.

Litigation Center Involvement

The Litigation Center joined the Indiana State Medical Association in an *amicus* brief supporting the physician.

Francisco v. Affiliated Urologists (Ariz. S. Ct.)

Issue

The issue in this case was whether Arizona law requires a medical malpractice plaintiff alleging lack of informed consent to prove with expert testimony that the defendant physician should have informed the patient that he was being prescribed a medication with a "black box" FDA warning.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

In 2018, David Francisco underwent a prostate procedure. The procedure was performed by Dr. Kevin Art at his urology practice, Affiliated Urologists.

Following the procedure, Dr. Art prescribed ciprofloxacin ("Cipro"), an antibiotic. Cipro has a 52-page FDA insert, which includes a "black box" warning alerting prescribing physicians to potential serious adverse reactions in patients who are taking fluoroquinolones, which David was. The "black box" warning did not prohibit the use of Cipro for David, but it identified three scenarios when the FDA recommended against using Cipro if there are viable alternatives. These included bronchitis, sinusitis, and uncomplicated UTI, none of which David had.

David allegedly experienced an adverse reaction following the procedure. He attributed this to the use of Cipro. He claimed that Dr. Art did not adequately inform him of the risk, and, if he had, David would have requested an alternative treatment.

In 2020, Francisco and his wife filed a medical malpractice action against Dr. Art and his practice. Under Arizona law, medical malpractice plaintiffs are required to certify whether expert testimony is needed to prove their claim, and if so, to provide a preliminary expert affidavit in order to proceed in the suit.

When the defendants moved to compel the required information from the plaintiffs here, the Franciscos argued that they did not need an expert, as laypeople could decide whether Dr. Art was negligent in failing to warn about the risks of Cipro based on the FDA's "black box" warning. The Superior Court in Maricopa County rejected the Franciscos' argument and dismissed their suit with prejudice.

The Franciscos appealed, and the court of appeals reversed the lower court. The court concluded that the FDA's 52-page insert, including the "black box" warning, required Dr. Art to inform the Franciscos of all of the risks associated with the medication. According to the court of appeals, "a layperson is well able to determine whether . . . the failure to warn constituted negligence." The appellate court remanded the case for further proceedings.

The defendants petitioned the Arizona Supreme Court for review. On August 16, 2024, the state high court ruled that "black box" warnings alone cannot be *prima facie* evidence of the standard of care. The court reversed the intermediate court and reinstated the trial court judgment. This is a favorable decision, and it is consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and the Arizona Medical Association joined an *amicus* brief in support of the defendants' petition for review.

Kaul v. Urmanski (Wis. Cir. Ct.)

Issue

The issue in this case was whether a Wisconsin abortion ban from 1849 is enforceable following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

The law at issue, Wis. Stat. § 940.04, which originated in the mid-1800s, makes it a felony to destroy "the life of an unborn child" at any point after conception unless necessary to save the pregnant woman's life, as confirmed by two other physicians.

In its 1973 decision in *Roe v. Wade*, the United States Supreme Court declared most statutes that criminalized abortion to be unconstitutional. The *Roe* decision specifically listed Wis. Stat. § 940.04 as one such statute. *See* 410 U.S. at 118 n.2.

In the years after *Roe*, the Wisconsin Legislature passed laws prohibiting abortion either after 20 weeks or after viability. The Wisconsin Legislature also passed a series of laws providing specific parameters for how physicians should perform abortions. Wis. Stat. § 940.04 was not repealed following the *Roe* decision and remained in the books. As a result, in the weeks following the Supreme Court's decision in *Dobbs*, several Wisconsin district attorneys publicly stated that the criminal ban was still good law, and they planned to enforce it accordingly.

Following the *Dobbs* decision and public statements by state district attorneys, several Wisconsin government officials filed suit in Wisconsin state court seeking clarification on the validity of Wis. Stat. § 940.04. The plaintiffs include the Wisconsin Attorney General, the Wisconsin Department of Safety and Professional Services, the Wisconsin Medical Examining Board, and the Chairperson of the Wisconsin Medical Examining Board.

Plaintiffs' complaint includes two causes of action. First, the plaintiffs argue that the pre-*Roe* ban conflicts with later legislative action on abortion, and thus, the later statutes control. Second, the plaintiffs contend that the pre-*Roe* ban is unenforceable because it has not been enforced for decades in the wake of the *Roe* decision.

The defendants are district attorneys from various Wisconsin counties charged with enforcing the pre-*Roe* ban. The defendants moved to dismiss the complaint. The district court heard argument on that motion, and it ruled that Section 940.04 does not apply to consensual abortions, but rather, only to feticide, based on prior state court precedent. This is a favorable decision, consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined the Wisconsin Medical Society, ACOG, and the Society for Maternal-Fetal Medicine in filing an *amicus* brief supporting the challenge to the 1800s ban.

Keyworth v. CareOne at Madison Ave. (N.J. S. Ct.)

Issue

The issue in this consolidated appeal was whether incident/investigation reports concerning two separate incidents are privileged under New Jersey's Patient Safety Act ("PSA").

AMA Interest

The AMA believes that for peer review to be effective, peer review data should be kept confidential. Moreover, the AMA supports the efforts of state medical societies in developing and implementing anti-lawsuit abuse campaigns.

Case Summary

First, with respect to *Keyworth v. CareOne at Madison Ave.*, Madeline Keyworth fell twice during her two-day admission at CareOne at Madison Avenue and sustained serious, permanent injuries, including a fractured femur. Keyworth sued CareOne and individual practitioners for negligence, among other counts. During discovery, the parties argued over two incident and investigation reports about the fall. CareOne argued that the reports were protected by the privilege of self-critical analysis and peer review privilege. The trial court disagreed and ordered the documents to be produced.

Second, regarding *Bender v. Harmony Village at Care at Paramus*, the other case, 83 year-old Diane Bender was attacked and seriously injured by another resident at Harmony Village. She was not transported to the hospital until five hours after the attack. She died five weeks after the attack. Bender's estate sued Harmony Village and individual practitioners for negligence, among other counts. During discovery, the parties argued over an incident report regarding Bender's care. Harmony Village argued that the reports were protected by the privilege of self-critical analysis and peer review privilege. The trial court disagreed and ordered the documents to be produced.

Plaintiffs in both cases appealed, and their cases were consolidated. The appellate court found that in *Keyworth*, the incident report and associated documents were developed during a process of a self-critical analysis as part of a patient safety plan that complied with the requirements of the PSA. Thus, the documents were protected from discovery. Similarly, for *Bender*, the court found that the contents of the documents were developed as part of the facility's patient safety plan that met the requirements of the PSA. Thus, these documents were also protected from discovery.

Plaintiffs appealed to the New Jersey Supreme Court. On August 5, 2024, the New Jersey Supreme Court reversed the intermediate appellate court and remanded the decision to the trial court, finding that the documents at issue were not privileged. Although this is an unfavorable ruling for the parties at issue, the court held that similar documents may be privileged under the law when hospitals have a dedicated committee to review PSA documents, which is a favorable

outcome for physicians in New Jersey.

Litigation Center Involvement

The Litigation Center joined the Medical Society of New Jersey in an *amicus* brief to the New Jersey Supreme Court, which argued that such documents are protected from discovery.

Mertis v. Oh (Pa. Super. Ct.; Pa. S. Ct.)

Issue

The issue in this case was whether a law firm that represented a physician in a medical malpractice case could simultaneously represent another treating physician in a deposition to be taken by the patient.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Dr. Eugene Kim performed knee surgery on the plaintiff, Bobbi Ann Mertis. Dr. Dong-Joon Oh provided anesthesia services for the operation. Mertis contends that the anesthesia was performed negligently and that, as a result, she suffered a nerve injury that left her disabled with persistent weakness, numbness, and pain in her left leg.

Mertis sued Oh for medical malpractice. She did not sue Dr. Kim, although her complaint criticized his care. Oh retained the law firm Scanlon, Howley & Doherty (SH&D) to defend her in the lawsuit.

In July 2020, Mertis subpoenaed Dr. Kim to appear at a discovery deposition. When he received the deposition subpoena, he asked his professional liability insurer to retain SH&D to represent him, as SH&D had represented him in a previous medical malpractice action. Dr. Kim waived any potential conflict of interest that might arise from SH&D's representation of Dr. Oh. SH&D notified Mertis that it was representing Dr. Kim in the deposition.

Mertis moved for sanctions against SH&D and asked to have SH&D disqualified from representing both Dr. Oh and Dr. Kim. Mertis contended that SH&D had violated the Pennsylvania Rule of Civil Procedure 4003.6 prohibition against *ex parte* communications with Dr. Kim, one of Mertis's treating physicians. The trial court, however, observed that there was no evidence to suggest that SH&D had communicated with Dr. Kim so as to prejudice Mertis. It denied the motion.

Mertis filed an interlocutory appeal with the Pennsylvania Superior Court, an intermediate level appellate court. The Superior Court reversed, holding that Rule 4003.6 "implicitly recognizes the privacy interest underlying the physician-patient relationship and the physician's duty of loyalty to the patient." If the defendant's attorney were allowed to communicate *ex parte* with the treating physician, irrelevant medical information might be elicited, and confidences could be breached. This would erode the trust between physician and patient. It remanded to the trial

court for determination of an appropriate remedy, in light of SH&D's violation of Rule 4003.6. Drs. Oh and Kim petitioned for rehearing in the Superior Court, but their petition was denied.

Drs. Oh and Kim petitioned the Pennsylvania Supreme Court for review, and that petition was granted. On June 18, 2024, the state high court affirmed the Superior Court decision. This is an unfavorable decision, and it is inconsistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined the Pennsylvania Medical Society in three *amicus* briefs, including supporting the petition for rehearing, supporting the petition to the state supreme court, and addressing the merits in the state supreme court.

Moschella v. Hackensack Meridian Jersey Shore Univ. Med. Ctr. (N.J. S. Ct.)

Issue

The issue in this case was whether a trial court properly dismissed a medical malpractice action for failure to comply with New Jersey's affidavit of merit ("AOM") statute.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Alexandrianna Lowe was admitted to the ER at Hackensack Meridian Jersey Shore University Medical Center ("JSUMC") from July 20, 2018 through July 22, 2018. Defendant, Michael P. Carson, M.D. was the admitting physician. Lowe died on July 22 while in the hospital.

Candace Moschella, the administrator of Lowe's estate, sued JSUMC and Dr. Carson, alleging they were negligent in their care and treatment of Lowe, resulting in her death. Plaintiff contended that JSUMC employees failed to check Lowe's blood sugar during a Code Blue after an unknown syringe was found in her intravenous line. Dr. Carson filed an unopposed motion to dismiss the complaint, leaving JSUMC as the only defendant. Plaintiff filed four different affidavits of merit ("AOM") to support her complaint, and they were all found to be deficient under the state's AOM statute. The trial court found that one AOM was submitted by a nurse, not a physician; that another AOM alleged negligence by another doctor, a non-party to the case; and that another AOM failed to mention JSUMC, the only remaining defendant. The case was dismissed.

Plaintiff appealed, and the appellate court affirmed. Plaintiff appealed to the New Jersey Supreme Court, which reversed the trial court decision. The court's ruling was highly technical and was based on the failure of the parties to hold a conference as required by the statute. Although the case was reinstated, the protections of the statute remain in place, and thus, this is a favorable result, consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and the Medical Society of New Jersey filed an *amicus* brief supporting the defendant.

Rodgers v. Orphanos (W.V. Ct. App.)

Issue

The issue in this case was whether a jury could properly infer that a physician's conduct was reckless, without direct evidence of recklessness, to circumvent the state's damages cap.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

On June 4, 2017, Michael Rodgers was injured in a motorcycle accident. Rodgers was transported to Charleston Area Medical Center ("CAMC"). When he arrived, Rodgers had sensation in his extremities and could move them.

At CAMC, Rodgers was treated by Dr. John Orphanos, a board-certified neurosurgeon and spine surgeon. An initial CT scan of Rodgers's chest revealed a spinal fracture, but it did not appear to demonstrate any neurological deficits. As a result, Dr. Orphanos initially prescribed a course of treatment that would include a back brace for six to eight weeks.

Two days after the accident, Dr. Orphanos altered his treatment plan and recommended that Rodgers undergo spinal surgery, including spinal fusion surgery to connect vertebrae in Rodgers's spine. When Rodgers awoke from surgery, he discovered that he had lost all motor function and sensation in his lower extremities.

After this surgery, Dr. Orphanos ordered an MRI, but according to the complaint, the results were distorted. A second MRI was not ordered. Rodgers continued to report a loss of motor function, and accordingly, Dr. Orphanos performed a second spinal surgery. The second surgery did not correct the loss of motor function and sensation in Rodgers's legs.

In May 2019, Rodgers sued Dr. Orphanos in West Virginia state court. Rodgers alleged that Dr. Orphanos was negligent in preoperative care, in the first surgery, and in post-operative care. Rodgers further alleged that Dr. Orphanos was grossly negligent and reckless when he ignored the standard of care at each step in Rodgers's treatment.

Dr. Orphanos made several motions to bar or limit the jury's consideration of recklessness. He argued that Rodgers did not present testimony, expert or lay, that Dr. Orphanos was reckless in his care. Rodgers countered that because Dr. Orphanos had failed to follow the standards of care at each step of the treatment, the jury could infer that he had acted recklessly. The trial disagreed with Dr. Orphanos and permitted Rodgers's attorneys to argue that Dr. Orphanos had been reckless.

On March 24, 2022, after an eight-day trial, the jury found that Dr. Orphanos was negligent, that he had breached the standard of care, and that he had acted in a reckless manner. The jury

awarded Rodgers a verdict of more than $17 million in past expenses, lost earning capacity, and future pain and suffering.

Dr. Orphanos filed a post-trial motion, renewing his objections related to recklessness and seeking to limit the non-economic damages to $750,000 pursuant to the West Virginia Medical Professional Liability Act's Trauma Cap. *See* W. Wa. Code 55-7B-8. The post-trial motion was denied, and Dr. Orphanos appealed.

On June 13, 2024, the appellate court issued a mixed opinion. The court declined to order a new trial on liability, which is unfavorable, but it remanded for a new trial on damages that would allow further expert testimony for Dr. Orphanos's position, which is a favorable result.

Litigation Center Involvement

The Litigation Center joined WVSMA and others in an *amicus* brief supporting Dr. Orphanos.

Schwartz v. Washington County (Or. Ct. Ap.)

Issue

The issue in this case was whether a county ordinance banning the sale of flavored tobacco products conflicts with a state law regulating the sale of tobacco and nicotine.

AMA Interest

The AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint, and wintergreen flavors; and (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products.

Case Summary

In July 2021, the State of Oregon enacted SB 587, which created a system of statewide tobacco retail licenses, including for flavored tobacco and nicotine products. On November 2, 2021, the Board of Commissioners for Washington County, while sitting as the local public health authority, enacted Ordinance 878 ("WCO 878"). WCO 878 bans the retail sale of flavored tobacco and nicotine products within the county. It is the most restrictive tobacco related measure in the state.

Plaintiffs are state licensed retail sellers of flavored tobacco and nicotine products. They sued Washington County, alleging that it had exceeded its authority under SB 587. They contended that SB 587 does not authorize a local ordinance that bans flavored tobacco and nicotine products outright. Instead, plaintiffs argue that the state law only allows the county to pass ordinances to enforce standards for how such products are sold. Plaintiffs also alleged that the county ordinance is arbitrary and capricious and violates provisions of the Oregon Constitution reserving certain powers for the state government.

The defendant county moved to dismiss the complaint, contending that WCO 878 was an appropriate legislative enactment within the bounds of SB 587. In October 2022, the Oregon trial court ruled that WCO 878 exceeded the authority granted to local jurisdictions under SB

587, and it enjoined the ordinance. The court concluded that although this issue significantly impacts public health, the decision to ban such products was left to the State.

The county appealed to the Oregon appellate court. On May 1, 2024, the Oregon Court of Appeals reversed the trial court decision, finding that the ordinance was not preempted by state law. This is a favorable result, consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined the OMA and others in an *amicus* brief supporting the county and its flavor ban on appeal.

Selliman v. Colton (Mich. S. Ct.)

Issue

The issue in this case was whether the standard of care in a medical malpractice suit can be established through expert testimony of a physician whose subspecialty is different from the defendant's subspecialty.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Dr. Jeffrey Colton performed rhinoplasty surgeries on Antonio Selliman from 2012 through 2017. Mr. Selliman alleged that the surgeries caused a nasal deformity, which additional surgeries failed to correct. He filed a malpractice suit against Dr. Colton, his corporation, and his medical facility.

In the trial court, defendants moved to strike the testimony of plaintiff's expert, Dr. Michael Armstrong. Defendants argued that the specialty at issue was facial plastic and reconstructive surgery and that Dr. Armstrong did not spend the majority of his professional time practicing facial plastic and reconstructive surgery in the year immediately preceding the alleged malpractice as required under MCL 600.2169(1)(b) – indeed, he testified that he devoted 90% of his practice to ENT (otolaryngology) and 10% of his practice to facial plastic and reconstructive surgery. Nonetheless, the trial court denied defendants' motion, citing confusion regarding how much time Dr. Armstrong devoted to each specialty.

Defendants appealed the trial court order. The Michigan Court of Appeals reversed and remanded, holding that Dr. Armstrong was unqualified to testify because Dr. Armstrong did not spend a majority of his time in the relevant specialty.

Plaintiff appealed to the Michigan Supreme Court. The court granted oral argument on the application, at which point the Litigation Center submitted an *amicus* brief in support of defendants. The court asked the parties to address additional issues, and the Litigation Center submitted a second brief to address those items.

On July 25, 2024, the Michigan Supreme Court reversed the intermediate appellate court's decision in part and remanded the case to the trial court to perform further inquiry as to whether facial plastic and reconstructive surgery is a subspecialty. The court, in a combined ruling with the *Stoke*s case discussed below, held that an expert need not be part of a matching subspecialty in order to be qualified to testify. The court concluded that the trial court has broad discretion in assessing whether an expert should be permitted to testify. The result in this case is slightly unfavorable, as the underlying holding is at odds with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and the Michigan State Medical Society filed two *amicus* briefs in support of the defendants.

Stokes v. Swofford (Mich. S. Ct.)

Issue

The issue in this case was whether the standard of care in a medical malpractice suit can be established through expert testimony by a physician whose subspecialty is different from the defendant's subspecialty.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Patient Linda Horn had a history of pseudotumor cerebri and suffered frequent headaches. After a shunt was implanted in her head, she experienced severe headaches, nausea, and vomiting. She reported to a hospital, and a CT scan was ordered for her. Dr. Swofford, a radiologist, interpreted the scan as showing a malfunctioning shunt. Horn's condition deteriorated, and she died two days later.

Horn's estate brought a medical malpractice action against Dr. Swofford and his practice, attaching an affidavit by its expert, Dr. Scott Berger, a neuroradiologist. Plaintiff asserted that neuroradiology was the relevant specialty or subspecialty for purposes of qualifying her expert. Defendants argued in response that the relevant specialty was diagnostic radiology, not neuroradiology. The trial court denied plaintiff's motion and ruled that the relevant specialty in this case was diagnostic radiology.

Plaintiff appealed the trial court order. The Michigan Court of Appeals reversed and remanded, holding that a neuroradiology expert (Dr. Berger) was qualified to testify against a radiologist who had interpreted a cranial CT scan (Dr. Swofford). The court reasoned that the defendant radiologist was, in fact, practicing neuroradiology when he examined and interpreted neuroimages and, consequently, neuroradiology was the relevant specialty.

The defendants then appealed to the Michigan Supreme Court. The court granted oral argument on the application, at which point the Litigation Center submitted an *amicus* brief in support of defendants.

On July 25, 2024, the Michigan Supreme Court affirmed in part and reversed in part the intermediate appellate court's decision. The court, in a combined ruling with the *Selliman* case discussed above, held that an expert need not be part of a matching subspecialty in order to be qualified to testify. The court concluded that while the intermediate appellate court reached the right outcome, it did so with the wrong rationale. It remanded the case to the trial court. This was an unfavorable ruling, and it was inconsistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined two *amicus* briefs with the Michigan State Medical Society ("MSMS") supporting the defendants.

Suarez v. State of Washington (Wash. S. Ct.)

Issue

The issue in this case was whether a residential nursing facility properly accommodated the religious beliefs of one of its employees, a nursing assistant.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse against physicians.

Case Summary

Adelina Suarez was a certified nursing assistant at a residential nursing facility for vulnerable adults owned by Yakima Valley School. Although she was a Christian, she celebrated the sabbath on Saturdays. She also worshipped on other holidays, which included the Jewish Holy Days.

Repeatedly, Suarez did not show up for work, citing religious reasons. She would also refuse mandatory overtime, without justification. This would inevitably leave the facility short-staffed. Ultimately, the nursing home terminated her employment.

Suarez sued her former employer, the Department of Social and Health Services' Developmental Disabilities Administration (the state agency that administered the nursing facility where she worked). She alleged that the state failed to accommodate her religious beliefs and practices in violation of the Washington Law Against Discrimination ("WLAD"), ch. 49.60 RCW, and, more generally, in violation of Washington public policy. The Superior Court entered summary judgment for the defendant and dismissed Suarez's claims.

The Washington Court of Appeals, by a split decision, reversed. The court invoked an "undue burden" standard that employers would have to meet to comply with WLAD. It held that the employer failed to present sufficient evidence that accommodating Suarez's request for leave would have caused it significant difficulty or expense, and further, that the employer failed to take active or affirmative steps to resolve the relevant scheduling conflicts.

On July 25, 2024, the Washington Supreme Court reversed the court of appeals and affirmed the

trial court's decision granting summary judgment to the defendant. The court concluded that the request by the plaintiff created an undue hardship under the law. This is a favorable result, consistent with the Litigation Center's position in the case.

Litigation Center Involvement

The Litigation Center and the Washington State Medical Association joined an *amicus* brief supporting the State of Washington's petition for review and on the merits.

TMA v. HHS (TMA II) (5th Cir.)

Issue

The issue in this case was whether an HHS regulation, 87 Fed. Reg. 52,618 (Aug. 26, 2022), validly interprets the dispute resolution provision of the No Surprises Act (NSA), 42 U.S.C. §300gg-111(c)(5).

AMA Interest

The AMA believes that any legislation addressing surprise out of network medical bills should use an independent, non-conflicted database of commercial charges. Out-of-network payments should not be based on rates determined by the insurance company.

Case Summary

Passed by Congress in 2020, the NSA provides federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise bills arise most frequently. The NSA established a process to resolve payment disputes between physicians (and other medical providers) and insurers for certain unanticipated out-of-network medical bills, using several different criteria.

On September 30, 2021, HHS, along with other federal agencies, released an interim final rule (IFR) regarding implementation of the NSA and the dispute resolution process between providers and insurers. In part, the rule created a rebuttable presumption that the insurers' qualifying payment amount (QPA) is the appropriate payment rate. This presumption would allow insurers to rely almost exclusively on the insurers' self-determined median in-network billing rate, while only secondarily considering the multitude of factors called for under the law.

Shortly after issuance of the IFR, the Texas Medical Association (TMA) sued to have it declared invalid as unauthorized under the NSA. According to TMA, the IFR overweighted the QPA in calculating the appropriate payment amount. On February 23, 2022, TMA secured a summary judgment, which declared the challenged portions of the IFR invalid.

In August 2022, HHS issued a final NSA regulation. In deference to the *TMA* ruling, the revised regulation alters the most offensive portions of the IFR. However, TMA contends that the revised regulation is also improper, and it brought a new lawsuit, to challenge the regulation. According to TMA, the final NSA regulation still overweights the QPA in the calculation of the correct payment amount.

TMA moved for summary judgment against HHS in the district court, and on February 7, 2023,

the district court granted TMA's motion. The federal government appealed to the Fifth Circuit. On August 2, 2024, the Fifth Circuit affirmed the lower court decision. This is a favorable result, and it is consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and AHA filed an *amicus* brief in support of TMA in the Fifth Circuit.

United States v. Idaho (D. Idaho; 9th Cir.; S. Ct.)

Issue

The issue in this case was whether the federal Emergency Medical Treatment & Active Labor Act ("EMTALA") and subsequent HHS/CMS guidance preempts state abortion restrictions.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In 1986, Congress enacted EMTALA to ensure public access to emergency hospital services regardless of one's ability to pay. Under § 1867 of the Social Security Act, Medicare-participating hospitals that offer emergency services are required to provide a medical screening examination ("MSE") when a patient requests examination or treatment for an emergency medical condition ("EMC"). This includes active labor. The hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient so requests, an appropriate transfer should be implemented in order to provide the necessary care.

Following the U.S. Supreme Court's reversal of *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization*, HHS and CMS issued guidance reiterating EMTALA's existing obligations that require hospitals to provide stabilizing emergency treatment, including abortion, when necessary, even though state laws may ban such care.

In 2020, Idaho enacted a law that severely restricts abortion and threatens criminal prosecution against anyone who performs the procedure. The law, codified at Idaho Code § 18-622, was set to take effect August 25, 2022.

Under § 18-622, "[e]very person who performs or attempts to perform an abortion . . . commits the crime of criminal abortion," a felony punishable by two to five years imprisonment. *Id*. § 18622(2). The law also requires that "[t]he professional license of any health care professional who performs or attempts to perform an abortion or who assists in performing or attempting to perform an abortion in violation of this subsection shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently

revoked upon a subsequent offense." *Id*. Idaho law defines "[a]bortion" to mean "the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child." *Id*. § 18-604(1).

On August 2, 2022, the federal government sued the State of Idaho, challenging § 18-622 under the Supremacy Clause of the U.S. Constitution. On August 8, 2022, the federal government moved to preliminarily enjoin § 18-622 to the extent it conflicts with EMTALA. At that time, the Litigation Center joined an *amicus* brief supporting the federal government's motion.

On August 24, 2022, the district court granted the federal government's motion, and it enjoined the Idaho law during the pendency of the litigation. The court concluded that the state law conflicted with federal law and thus violated the Supremacy Clause. This was a favorable result, and the court cited the Litigation Center's brief in its decision.

The Idaho state government appealed to the Ninth Circuit Court of Appeals, but before the court could rule on the merits the Idaho government sought review by the United States Supreme Court.

After briefing and argument, on June 27, 2024, the Supreme Court dismissed the case as improvidently granted and lifted its stay on the lower court injunction. The case will return to the Ninth Circuit for further proceedings.

Litigation Center Involvement

The Litigation Center joined ACOG and other Federation members in *amicus* briefs in the district court, the court of appeals, and the United States Supreme Court.

United States v. Rahimi (S. Ct.)

Issue

The issue in this case was whether a federal law, 18 U.S.C. § 922(g)(8), which prohibits the possession of firearms by persons subject to domestic violence restraining orders, violates the Second Amendment.

AMA Interest

The AMA supports prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms.

Case Summary

In 2020 and 2021, Zackey Rahimi engaged in five shootings, prompting police to obtain a warrant to search his home. They found a rifle and a pistol, and Rahimi admitted to possessing those firearms. He also admitted that he was subject to a civil protective order after his alleged assault of his ex-girlfriend. Rahimi was charged and convicted for possessing a firearm while under a domestic violence restraining order in violation of 18 U.S.C. § 922(g)(8).

Rahimi appealed his conviction, bringing a facial challenge to 18 U.S.C. § 922(g)(8) in the Northern District of Texas on Second Amendment grounds. The court rejected his challenge.

The Fifth Circuit reversed and vacated Rahimi's conviction. Relying on *N.Y. State Rifle & Pistol Ass'n, Inc. v. Bruen*, 142 S. Ct. 211 (2022), the court reasoned that the challenged statute did not have a similar historical analogue, and therefore it violated the Second Amendment. According to the Fifth Circuit, 18 U.S.C. § 922(g)(8) does not inherently require a predicate act of violence or a threat of violence, and it therefore infringed Rahimi's Second Amendment rights.

The federal government appealed to the Supreme Court. On June 21, 2024, the United States Supreme Court ruled in favor of the federal government, finding that individuals under domestic violence restraining orders can be prohibited from possessing or purchasing firearms. This is a favorable decision, and it is consistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center and TMA, along with AAP and the American College of Surgeons, filed an *amicus* brief in the Supreme Court to support the federal government.

United States ex rel. Fesenmaier v. Cameron-Ehlan Group (8th Cir.)

Issue

The issue in this case was whether the trial court erred in allowing excessive damages under the False Claims Act ("FCA"), where the government did not prove causation or that any "kickbacks" resulted in the claims at issue.

AMA Interest

The AMA is to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes.

Case Summary

Precision Lens, owned by Paul Ehlen, was the exclusive distributor of certain medical supplies used in cataract surgeries. Ehlen was long-time friends with approximately three dozen of the hundreds of ophthalmologists who purchased ocular lenses and viscoelastic gel from Precision Lens, and he and they (often with their spouses or children) organized many trips together over the years. Ehlen and the doctors often split costs when they did so. Precision Lens also held holiday parties, which some of the doctors attended.

Relator Kipp Fesenmaier brought a qui tam suit against Ehlen and Precision Lens, and the U.S. Department of Justice intervened. The government alleged that the trips and other conduct from 2006 to 2015—including the company at one point providing a soda and a salad to a doctor at a holiday party—constituted "kickbacks" under the Anti-Kickback Statute. According to the government's theory, these supposed kickbacks tainted—and thus rendered false—every Medicare claim connected to every cataract surgery that each ophthalmologist performed for a one-year period following the kickback, despite evidence that the physicians' lens usage was unaffected. Based on this "taint" theory, the Government pursued defendants under the False Claims Act for nearly 100,000 claims. The district court agreed with the government's theory of

liability and initially awarded damages of $487 million.

Defendants argued that the award violated the Eight Amendment's Excessive Fines clause. Almost a year later, the trial court amended the award to $216 million. It reasoned, "After consideration of the appropriate factors—the reprehensibility of defendants' conduct, the harm to the victim, the ratio of punitive damages to actual damages, legislative intent, the financial status of the defendants, and the penalties imposed in similar cases—the Court concludes that the Excessive Fines Clause permits recovery of no more than $216,675,248.55 in this matter."

Defendants appealed to the Eight Circuit; however, the parties settled the case while the appeal was pending.

Litigation Center Involvement

The Litigation Center and the Minnesota Medical Association planned to join the United States Chamber of Commerce in an *amicus* brief supporting the defendant, but the brief was unnecessary in light of the settlement.

Vasquez v. Iowa Department of Human Services (Iowa S. Ct.)

Issue

The issue in this case was whether the Iowa Constitution requires Medicaid coverage for medically necessary gender-affirming surgery.

AMA Interest

The AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization of otherwise undue restrictions of evidence-based gender-affirming care.

Case Summary

Aiden Vasquez, who is transgender, requested Medicaid coverage for surgical care to treat his gender dysphoria. Five health-care providers agreed that the surgical procedure Vasquez sought was medically necessary. Despite this consensus, the Iowa Medicaid program denied coverage for the surgery.

In April 2021, Vasquez filed suit in Iowa state court, asserting that the coverage denial violated the Iowa Constitution. In November 2021, the Iowa district court ruled in favor of Vasquez.

The State appealed to the Iowa Supreme Court, but while the appeal was pending, the State agreed to pay for the care, and the court dismissed the case as moot.

Litigation Center Involvement

The Litigation Center and the Iowa Medical Society ("IMS") joined an *amicus* brief in support of the plaintiffs.

Zahara v. Advanced Neurology Specialists (Mont. S. Ct.)

Issue

The issue in this case was whether Montana's statutory cap of $250,000 on non-economic damages in medical malpractice cases violates the Montana Constitution.

AMA Interest

The AMA will work with state medical societies and other organizations to curb lawsuit abuse.

Case Summary

On June 5, 2013, 27-year-old Joey Zahara suffered a stroke following a series of strenuous physical tests associated with firefighter training. Zahara was rushed to the emergency room at Benefis Hospital in Great Falls, Montana, arriving at 6:32 PM. Zahara was evaluated by an emergency room physician, Dr. Takakuwa, who consulted by phone with the on-call neurologist, Dr. Henning. During that call, Dr. Henning recommended administration of tissue plasminogen activator (tPA), a drug that dissolves stroke-causing clots. The drug should be administered within the first four hours after the onset of stroke symptoms, which Zahara was at the time.

Before the tPA was delivered and administered, however, Zahara's condition improved, and the drug was withheld. Dr. Takakuwa observed that Zahara had returned to a baseline condition around 8:40 PM, and Zahara was admitted to the hospital for observation. Zahara and his family believed that he should be released and sent home.

At 10:00 PM, the stroke symptoms reoccurred, and Dr. Henning was again contacted by phone. At that time, Dr. Henning recommended against the use of tPA because more than four hours had now elapsed from the initial onset of the symptoms. Dr. Henning had not seen Zahara in person.

Although Zahara was ultimately stabilized and released from the hospital, he continues to experience injuries resulting from the stroke, including limited mobility in the right side of his body, memory loss, and emotional distress and depression.

In 2016, Zahara filed a lawsuit against Dr. Henning and his employer, Advanced Neurology Specialists, for negligence. Zahara alleged that Dr. Henning's failure to observe and evaluate Zahara's condition in person prevented Zahara from receiving the potential benefits of the tPA. After a four-day trial, a jury found in favor of Zahara and awarded him $6 million in damages, including compensation for emotional distress and loss of established course of life.

The defendants filed a motion after trial to reduce the damages to $250,000, pursuant to Mont. Code Ann. § 25-9-411. Section 25-9-411 states that "in a malpractice claim or claims against one or more healthcare providers based on a single incident of malpractice, and award for past and future damages for noneconomic loss deriving from injuries to a patient are subject to an award

not to exceed $250,000." Zahara responded by arguing that the damages cap violates the Montana Constitution's provisions regarding trial by jury, due process, and equal protection.

On January 22, 2024, the trial court agreed with the defendants and ruled that the state damages cap required reduction of the jury's verdict to $250,000. The court held that the statutory cap applied to all three forms of damages awarded by the jury – emotional distress, pain and suffering, and loss of established course of life. The court entered judgment against defendants in the amount of $250,000, plus costs of $7,166.60 and statutory interest.

Zahara appealed the decision to the Montana Supreme Court**,** but while the appeal was pending, the parties settled the case. This is a favorable result, as it leaves the trial court decision in place.

Litigation Center Involvement

The Litigation Center and MMA filed an *amicus* brief in support of the defendants.

Zurawski v. Texas (Tex. S. Ct.)

Issue

The issue in this case was whether Texas law prohibits pregnant Texans with emergent medical conditions from receiving abortions.

AMA Interest

The AMA: (1) recognizes that health care, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; and (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion.

Case Summary

In the weeks following the United States Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, several Texas statutes dealing with abortion either went into effect or were no longer barred by the holding in *Roe v. Wade*. The relevant statutes can be grouped into three categories: (1) the pre-*Roe* laws, which criminalized abortion in Texas in the years prior to 1973; (2) S.B. 8, otherwise known as the Texas Heartbeat Act or the Texas bounty law; and (3) H.B. 1280, often referred to as the "trigger ban," as it took effect 30 days after Roe was overruled (collectively, "the Texas bans"). Physicians and their employers feared criminal, civil, or administrative penalties for providing an abortion in the face of the Texas bans. These laws, which generally ban abortions, have limited exceptions that arguably legalize abortions in narrow circumstances. Further, the laws are confusing.

As a result of these laws, Texas physicians and their patients have been left with significant uncertainty about whether and when an abortion would be lawful in Texas if a patient faces an emergency medical condition that might impact her life or health in some way. News media have reported situations in which pregnant patients seeking care while in medical distress were told to wait in their car in a health care facility parking lot or return to the health care facility if and

when their condition had worsened and placed them at greater risk of death or serious injury.

In March 2023, several patients and two physicians sued for a declaration that would allow abortion care for pregnant persons with emergent medical conditions. The plaintiffs argued that the Texas bans contain conflicting language and non-medical terminology, making it unclear when physicians are permitted to provide care in emergency circumstances. The state has also failed to provide any guidance to doctors on this issue, despite repeated requests. The defendants include the State of Texas and several state government officials.

In May 2023, the plaintiffs moved for a temporary injunction while the litigation proceeds. They also amended their complaint to add more patient plaintiffs. On July 19-20, the Texas trial court held a hearing on the motion for an injunction with several fact and expert witnesses testifying.

On August 4, 2023, the trial court granted the injunction and held that physicians should be permitted to provide abortion care where, in the physician's good faith judgment and in consultation with the pregnant person, a pregnant person has a physical emergency. The court went on to find that these circumstances include, at a minimum: a physical medical condition or complication of pregnancy that poses a risk of infection, or otherwise makes continuing a pregnancy unsafe for the pregnant person; a physical medical condition is exacerbated by pregnancy, cannot be effectively treated during pregnancy, or requires recurrent invasive intervention; and/or a fetal condition where the fetus is unlikely to survive the pregnancy and sustain life after birth.

The defendants appealed the temporary injunction to the Texas Supreme Court. On May 31, 2024, the Texas Supreme Court vacated the lower court injunction, finding that Texas law was not sufficiently uncertain or in conflict to warrant judicial intervention. This is an unfavorable result, and it is inconsistent with the Litigation Center's brief.

Litigation Center Involvement

The Litigation Center joined ACOG and other Federation members in *amicus* briefs supporting the plaintiffs.

THE LITIGATION CENTER OF THE AMERICAN MEDICAL ASSOCIATION AND THE STATE MEDICAL SOCIETIES

OPEN MEETING (I-24)

Speaker Biographies

Erin Shriver, MD

Erin M. Shriver, MD, FACS is a Clinical Professor, the Jim O'Brien Gross and Donnita Gross Chair in Ophthalmology, and Vice Chair of Faculty Affairs within the Department of Ophthalmology and Visual Sciences at the University of Iowa. After graduating from Pomona College, Stanford University School of Medicine, ophthalmology residency at the University of Iowa, and an American Society of Ophthalmic Plastic and Reconstructive Surgery fellowship at Bascom Palmer Eye Institute, Dr. Shriver stayed on faculty at University of Miami for several years before returning to Iowa City in 2012. She is actively involved in clinical practice, teaching, research, and advocacy at the University of Iowa and the Iowa City Veteran's Affairs Health Care System.

Dr. Shriver has worn many hats for various organizations within ophthalmology and joined the American Academy of Ophthalmology (AAO) Board of Trustees as a Trustee-at-Large in 2024. She has served AAO through numerous roles including Interim Governor to the American College of Surgeons (ACS) Board of Governors and membership on the AAO DEI Task Force and ACS Intimate Partner Violence Task Force.

She was on the Board of Directors of the Iowa Academy of Ophthalmology (IAO) for ten years and during that time she held numerous positions including President and AAO Councilor. She has advocated against optometric scope expansion bills for 6 of her years on the IAO board and has traveled to the State Capitol on numerous occasions with residents and fellows to meet with legislators and testify in House and Senate subcommittee hearings. Dr. Shriver has also met with her legislators in Washington DC regularly to advocate for her patients.

Dr. Shriver has been passionately involved in Women in Ophthalmology (WIO) for many years. She chaired the Summer Symposium, served on the Board of Directors for 9 years, and was President of WIO in 2020. The organization experienced significant growth during her tenure on the Board, and she has enjoyed staying engaged both nationally and internationally. She is currently the only Honorary Advisor to the Asia-Pacific Association of Ophthalmology WIO Committee from outside the region.

Dr. Shriver has also served the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) as their American Medical Association Alternate Delegate (2016-2019) and Delegate (2020-present), Secretary of the ASOPRS Foundation, Vice Chair of the Government Affairs Committee, past Chair of the Thesis Committee, and as an ASOPRS Fellowship Preceptor.

She also serves on the University of Iowa Carver College of Medicine Executive Promotion and Tenure Committee and the Graduate Medical Education Expansion Committee.

She has published extensively and lectured internationally on her research interests including: establishing novel metrics for eyelid position and aesthetics, thyroid eye disease, and intimate partner violence in ophthalmology patients. She serves on the Editorial Board for Ophthalmic Plastic and Reconstructive Surgery and Orbit.

When she is not engaged in ophthalmology and advocacy activities, she enjoys traveling, exercising, and spending time with her husband and sons.

Michaela ("Kai") Sternstein, JD

Kai Sternstein is the Vice President of the American Medical Association's (AMA) Advocacy Resource Center, the state legislative and regulatory arm of the AMA. In that capacity, Kai oversees Advocacy Resource Center staff attorneys' development and execution of strategies for achieving AMA goals through state legislation and regulation. To achieve its goals, the Advocacy Resource Center not only develops strategic collaborations aimed at influencing external policy-making organizations (e.g., National Governors Association, National Association of Insurance Commissioners, etc.), but also tailors solutions to the political, economic, and health care environments of the individual states. All this work is done in close consultation and partnership with state and national medical specialty societies across the country. The Advocacy Resource Center's work is focused on critical issues such as physician wellness, scope of practice, prior authorization, and telehealth. Under her direction, Kai's team also focuses on state-level health system reform, ending the opioid overdose epidemic, combating harmful health insurer practices, antitrust, reforming Medicaid, advocating for sensible medical liability reforms, protecting the patient-physician relationship, opposing the criminalization of the practice of medicine, public health improvement, and more.

Kai received her undergraduate degree at Southern Methodist University in Dallas, TX, and her law degree at IIT-Chicago Kent College of Law in Chicago, IL. Before coming to the AMA, Kai practiced law for close to six years as a litigator, including over half of that time practicing medical malpractice defense at one of Chicago's oldest defense law firms.

Leonard A. Nelson

Leonard Nelson is Senior Assistant General Counsel at the American Medical Association. His duties include service as the Director of the Litigation Center of the American Medical Association and the State Medical Societies. Mr. Nelson has presented and written for many legal organizations and medical societies about health law issues and his work at the Litigation Center. He has also taught in three law schools and had several scholarly articles published on legal subjects. He is a former Chair of the Health Care Section Council of the Illinois State Bar Association and is a former President of the American Society of Medical Association Counsel. Mr. Nelson graduated from Dartmouth College, and he received a master's degree in physics from the University of Illinois. He received his law degree from Harvard Law School.