CLARK A. GUNDERSON, M.D. (A MEDICAL CORPORATION), ET AL.

VERSUS

F.A. RICHARD & ASSOCIATES, INC., ET AL.

FILED: ______________________________

14TH JUDICIAL DISTRICT COURT

PARISH OF CALCASIEU

STATE OF LOUISIANA

NO. 2004-002417, DIV. "D"

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DEPUTY CLERK

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DEFENDANT FIRST HEALTH GROUP CORP.'S MEMORANDUM IN OPPOSITION TO THE MOTION FOR PARTIAL SUMMARY JUDGMENT FILED BY THE PLAINTIFF CLASS

MAY IT PLEASE THE COURT:

This Memorandum is filed by defendant First Health Group Corp. ("First Health") in Opposition to the Motion for Partial Summary Judgment filed against it by the Plaintiff Class through representative plaintiffs Beutler-England Chiropractic Clinic ("Beutler") and Dr. Frank W. Lopez ("Lopez").

INTRODUCTION

On November 25, 2008, the United States Court of Appeals for the Fifth Circuit affirmed a grant of permanent injunctive relief against plaintiffs Clark Gunderson and Lake Charles Memorial Hospital, barring them from pursuing claims under Title 40 against First Health Group Corp. ("First Health"). The injunction stemmed from a February 2006 summary judgment ruling by Judge Trimble rejecting *on the merits* Gunderson and LCMH's claims that Title 40 applied to First Health and that they had failed to receive pre-treatment notice for services provided to injured workers. On the merits, the plaintiffs' claims against First Health have been found legally unsupportable.

Although three of the original six defendants have entered class-wide settlements, paying tens of millions of dollars, unlike Judge Trimble (who has filed several detailed opinions) this Court has not previously had an opportunity to reach the merits. That is, the Court has still before it whether the notice provisions of Title 40 apply to First Health and, if so, the kinds of pre-treatment notice that satisfy Title 40 when notice is required. Specifically, there has been no decision whether, as the plaintiffs claim, the statute requires point-of-service notice, either in the form of a benefit card or patient specific written notice. The Louisiana Third Circuit seems to have rejected plaintiffs' interpretation in its class certification opinion, instructing that Title 40 liability "hinges on whether or not adequate notice of a discount taken pursuant to a PPO

agreement was given to the healthcare provider, *either* "when medical care is provided" - in instances where a benefit card has been issued - *or* "at least thirty days prior to accessing services through a participating provider"-where no benefit card has been utilized."[1] Similarly, there has been no decision whether the first Explanation of Review ("EOR") provided to a medical provider identifying a particular insurer or third-party administrator ("TPA") satisfies the notice requirement for all future employer clients of that insurer or TPA. Nor has there been a decision whether the periodic written client lists distributed by First Health to the providers in hard copy and via web access for many years before the statute was enacted satisfies the notice requirement.[2] But when the Court writes, it will not write on a blank slate. Judge Trimble's comprehensive rejection of the plaintiffs' theories (indeed, his barring of two of the four plaintiffs *in this action*) should be a touchstone — where the plaintiffs in their papers have provided virtually no guidance to this Court, Judge Trimble has provided a roadmap.

On November 5, 2008, class representatives Beutler-England Chiropractic Clinic ("Beutler") and Dr. Frank W. Lopez ("Lopez") — that is, the two class representatives who have not yet been permanently enjoined — filed a motion for partial summary judgment against defendant First Health ("First Health"), purportedly on behalf of the plaintiff class. Beutler and Lopez did so after the Third Circuit's mandate affirming the Court's November 28, 2006 certification had issued and after the October 27, 2008 class notice had been dispatched, but before the opt-out period had expired and before the Third Circuit had disposed of a writ filed by First Health attacking the asymmetry between the class certification order's silence concerning a defendant class and the class notice's assertion that there was still a potential for such a class.

On January 9, 2009 (prior to the initially-scheduled hearing on the Beutler/Lopez partial summary judgment motion), the Third Circuit granted First Health's writ in part, finding the certification order and the class notice "conflicting" and directing the Court to "clarify its November 28, 2006 ruling as it pertains to defendant class certification before the case is heard on the merits." On February 5, 2009, the Court ruled that it had denied a defendant class back in 2006, but deferred the issue whether a new class notice was required. That issue is now squarely

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[1] *Dr. Clark Gunderson et al. v. F. A. Richard & Associates, Inc., et al.*, 2007-331 (La. App. 3 Cir. 2/27/080; 977 So.2d 1128, 1137 (emphasis added).

[2] Notably, however, this Court has itself rejected the providers' notion that patient specific notice is required, approving as it has the providers' class action settlement with Focus Healthcare Management wherein non-patient specific forms of notice directed only toward identification of entities granted access to the Focus Network were specifically approved by this court.

before the Court based on First Health's Motion requiring the issuance of a new corrective class notice.

The plaintiffs subsequently re-noticed their partial summary judgment motion for March 30, 2009. For multiple independent procedural and substantive reasons, the Court should deny the plaintiffs' motion. First, Beutler and Lopez seek relief on behalf of the class, excepting the dozen or so medical providers who opted out under the October 28, 2008 notice. But to bind members of the class (who, should the Court follow Judge Trimble's guidance will receive nothing), there must be proper notice and an opportunity to opt out. The Third Circuit's writ grant confirms that the October 27, 2008 notice was defective — there was no reason to issue the writ were disposition of the defendant class issue immaterial to the decision whether to opt out. Until and unless a proper notice has issued, the Court should not reach the merits.

Second, the motion is procedurally defective. The plaintiffs purported to supplement their November 5, 2008 memorandum (itself a scant few pages citing not a single supporting authority) on March 13, 2009 by serving a massive *expert* report, depriving First Health of any meaningful opportunity to conduct discovery, traverse the expert's qualifications and conclusions by *Daubert* hearing, or to respond on the merits. Indeed, the report comes fewer than 30 days before the equivalent of a trial and fewer than 15 days (when service was received) before the hearing. Moreover, as will be demonstrated below, plaintiffs' argument misinterprets the underlying spreadsheet data and consequently the data does not prove what plaintiffs represent.

Third, the motion seeks affirmative relief without addressing the predicate statutory interpretation question. In affirming the Court's class certification order, the Third Circuit made clear that the Court must decide the meaning of Title 40. The Third Circuit did not decide the issue because this Court had yet to address the merits, but it did identify the question of what constitutes adequate notice as the "predominant" common question. The plaintiffs' motion implies that the Court can simply enter judgment for hundreds of millions of dollars first and decide what the statute means later. But that is backwards. Before determining liability, the Court must decide whether Title 40 applies at all to First Health and, if so, the form of notice it requires. And if the Court determines that Title 40 permits notice broader than the benefit card and first-EOR-for-unique-patient-unique-employer theories the plaintiffs implicitly advance in their damages estimates — theories rejected by both the statutory language, the Louisiana Third

Circuit's class certification opinion, Judge Trimble's several federal court rulings, and the class fairness rulings in this case wherein this Court approved other forms of notice — then the court must deny the partial summary judgment request. Indeed, as posited by plaintiffs, the court must deny the class-wide motion if it finds that a single class member's claim fails. That is in fact the case for many, as demonstrated below. In point of fact, though it was not required to do so because First Health already embraced the providers disdain for "silent" PPOs and thus was not an entity whose actions were contemplated by La. R.S. 40:2203.1, First Health nevertheless provided notice to all its providers at the time they joined the network and thereafter whenever it accorded network access to a new payor.

Fourth, it is improper to seek as a "partial" summary judgment damages on a part of a single claim, reserving the right to seek additional damages. The Court must resolve all of the issues in the case (including First Health's affirmative defenses) for each plaintiff individually before entering judgment. Moreover, the plaintiffs' purported reservation exposes the "partial" summary judgment request for what it truly is: a demand that the Court hand the plaintiffs a massive club to beat a settlement out of First Health, one of the cardinal class action abuses.

For these and many other reasons outlined below, First Health respectfully submits the Plaintiffs' Motion for partial Summary Judgment must be denied.

I. FACTUAL BACKGROUND

(i) The First Health Network

First Health is a national health benefits service company offering a variety of services to its clients.[3] First Health clients in the workers' compensation sector include workers' compensation payors and third party administrators that process and pay workers' compensation claims.[4] Though First Health offers numerous services to its workers' compensation clients, including bill review, claims administration services, software access and support, and utilization review, the product offering of greatest relevance herein is First Health's offering of a health care provider network designed to address the health care needs of injured workers.[5] Through the First Health network, health benefits are delivered to injured workers by health care providers

[3] Exhibit 1, Affidavit of Arthur J. Lynch.

[4] Exhibit 1, Affidavit of Arthur J. Lynch.

[5] Exhibit 1, Affidavit of Arthur J. Lynch.

who have been carefully screened and credentialed by First Health for its payor/TPA clients.[6] First Health continually manages and oversees its network of providers who have agreed to provide services to injured workers. While network providers often agree to a discount from their customary fee, First Health in turn publicizes the providers' availability as a network provider to its large base of payors, including insurers, third party administrators and self-insureds. Providers contract with First Health to gain steerage of patients by virtue of their published participation in the First Health network and to gain increased access to the large base of potential patients available through First Health clients, which include large insureds and TPAs such as Liberty Mutual, Travelers, Gallagher Bassett, The Hartford, AIG and others. [7]

A health care provider who wishes to join the First Health Network completes an application designating whether he wishes to see group health members or injured workers or both. After First Health completes its review of the provider's credentials, the provider executes a "Participating Provider Agreement" with First Health by which he signifies his assent to receive patients from the payor/TPA clientele of First Health.[8] First Health's Louisiana network is 100% directly contracted with its participating Louisiana providers or provider groups and does not rely upon use of the provider networks of others (leased networks).[9] Patients are directed to First Health providers through provider directories, workplace posters and through the efforts of First Health clients to direct patient care.[10]

The direct Provider Agreements between First Health and its provider panel do not, standing alone, constitute a preferred provider organization. First Health supplies patient volume to providers only through clients such as insurers and TPAs with whom it contracts; First Health does not pay the providers' medical bills, or take discounts against those medical bills.[11] First Health must contract with workers' compensation payors and third party administrator clients to form the provider network; absent these payor agreements the providers receive no financial benefits from participation in the network. Patient referrals to First Health payors drive revenue

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[6] Exhibit 1, Affidavit of Arthur J. Lynch.

[7] Exhibit 29, Affidavit of Gregory C. Mast.

[8] Exhibit 2, First Health Provider Agreement with Carol Beutler, D.C., and Exhibit 3, First Health Provider Agreement with Dr. Frank W. Lopez are examples of such contracts.

[9] Exhibit 1, Affidavit of Arthur J. Lynch.

[10] Exhibit 13, Affidavit of Robert Evans.

[11] Exhibit 1, Affidavit of Arthur J. Lynch.

for both the providers and First Health, who receives as its compensation a negotiated percentage of the savings realized by its Louisiana payor clients accessing the First Health network.[12]

The First Health Provider Agreement reflects the providers' understanding that First Health must contract with "payor" entities to develop and expand the PPO and with it the providers' potential patient base. The "Participating Provider" acknowledges and agrees that First Health will "offer to certain Payors the opportunity to contract with First Health to utilize the services of the health care providers participating in the Preferred Provider Panel."[13] Paragraph 2.7 of First Health's Participating Provider Agreement broadly defines the term "Payor" to include "… an employer, trust fund, insurance carrier, health care service plan, trust, nonprofit hospital service plan, a governmental unit, any other entity which has an obligation to provide medical services or benefits for such services to Participating Patients, or any other entity which has contracted with First Health to use First Health's PPO Plan."[14] The "Payor" field thus is composed of two groups: (1) an entity "which has an obligation to provide medical services or benefits to a Participating Patient;"[15] and (2) "any other entity which has contracted with First Health to use First Health's PPO plan."

A "Payor Agreement" is "… an instrument between a Payor and First Health or its authorized representative which provides for Participating Providers to render health care services pursuant to this Agreement to Participating Patients at the reimbursement amounts set forth herein."[16] The term thus contemplates there be a writing between the Payor and either First Health, or First Health's "authorized representative," that gives formal expression to the right to access the First Health Network. These broad definitions allow First Health to maximize its preferred providers' potential patient base while maintaining traceable, verifiable written arrangements. Thus, the Plaintiff Class providers contractually authorized a broad group of First Health "Payors" to access the alternative rates of payment below the Louisiana Workers'

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[12] Exhibit 1, Affidavit of Arthur J. Lynch.

[13] Exhibit 2, First Health Provider Agreement with Carol Beutler, D.C., and Exhibit 3, First Health Provider Agreement with Dr. Frank W. Lopez, at ¶ 1.5.

[14] Exhibits 2 and 3, at ¶ 2.7.

[15] A "Participating Patient" is defined to mean "those employees or members and their dependents who have elected to receive care from Provider and who are covered by the Payor's Benefit or Insurance Plan." Exhibits 2 and 3, at ¶ 2.6.

[16] *See* Exhibits 2 and 3 at ¶ 2.8, defining "Payor Agreement" to mean "… an instrument between a Payor and First Health or its authorized representative which provides for Participating Providers to render health care services pursuant to this Agreement to Participating Patients at the reimbursement amounts set forth herein."

Compensation Reimbursement Schedule, [17] receiving in return increased patient volume and other "tangible benefits."

(ii) Joining the First Health Network

In completing their applications for participation in the First Health Network, providers such as Lopez and Beutler-England, indicate whether they are willing to see injured workers compensation patients. The application permits the would-be network provider to decline treatment of work-related injuries.[18] Applicant providers submit extensive information concerning licensure and prior claims histories to First Health.[19] First Health conveys notice of a provider's acceptance into the network by correspondence by which the provider receives a fully executed version of his Provider Agreement, as well as payor listings and the First Health Network Reference Manual for Registration/Front Office, Billing/Collections, and Utilization Management Staff Acceptance[20] into the network.[21] Approximately 30 days or more after receipt of these materials and the executed contract, the contract takes effect and bills for injured workers of First Health payors may begin to be discounted pursuant to the terms of their Provider Agreement.[22] First Health notifies its providers that new payors have contracted for network access by written updates and/or website publication.[23]

(iii) Providers Treat First Health Payors' Injured Workers

There is no dispute that Plaintiff Class representative plaintiffs Beutler and Dr. Lopez routinely treat both group health and workers' compensation patients.[24] An intake form is completed any time a workers' compensation patient presents for treatment.[25] The providers obtain employment and billing information from the workers' compensation patient and payment

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[17] *See* Exhibits 2 and 3 at ¶ 4.3 and Appendix A, subsection (D), reciting that "Provider agrees to accept the reimbursement amounts specified in Appendix A as payment in full for Covered Medical Services rendered to Participating Patients."

[18] *See* First Health Provider File for Carol Beutler.

[19] *Id.*

[20] See Exhibit 15.

[21] New network providers either receive a hard copy version of this Manual or are directed to its location on the First Health website and given an opportunity to request a hard copy version. Exhibit 13, Affidavit of Robert Evans.

[22] *See* Exhibit 13, Affidavit of Robert Evans.

[23] *See* Exhibit 13, Affidavit of Robert Evans.

[24] Fed. R. Civ. P. 30(b)(6) Deposition of Carol Beutler, Exhibit 4, at 22-23; 30-32; Fed. R. Civ. P 30(b)(6) Deposition of Dr. Lopez, Exhibit 5, at 41, 104.

[25] Deposition of Carol Beutler, Exhibit 4, at 21-23; Deposition of Dr. Lopez, Exhibit 5, at 103-04.

authorization from the insurance representative.[26] In Dr. Lopez' case, the payment information is gathered before he sees the patient, "Because it does take one month plus before a patient is seen."[27] The information gathered from a workers' compensation patient differs from the information gathered from a group health patient.[28] The providers do not expect a workers' compensation patient to present a benefit card;[29] they know benefit cards are not used and never have been used for workers' compensation patients. Information regarding billing, verification, and payor identity is gathered at intake prior to rendering treatment, as required by the Louisiana Administrative Code.[30] Each payment for a workers' compensation patient is accompanied by documentation identifying the payor and explaining how the payment was calculated.[31]

Beutler and Dr. Lopez conceded they reviewed their First Health contracts prior to agreeing to participate in the First Health network.[32] Beutler and Dr. Lopez each concede that their First Health provider agreements provide for payments below the Louisiana workers' compensation reimbursement schedule.[33] Dr. Lopez takes the additional step of educating his staff regarding the discounts applied through the several PPO contracts he has signed and integrating the discounts into the office billing system.[34] Beutler admittedly does nothing to inform its employees that the facility has joined a network or that a fee reduction might be taken against workers' compensation charges.[35] Both providers' staff investigate perceived incorrectly

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[26] Deposition of Carol Beutler, Exhibit 4, at 24; Deposition of Dr. Lopez, Exhibit 5, at 41, 105-06.

[27] Deposition of Dr. Lopez, Exhibit 5, at 104. *See also* at 106, where Dr. Lopez' representative admits that payment authorization and information reflecting where to mail the bill is received thirty days before he sees the patient. ("Q. So, you know about a month before the patient arrives whether you're dealing with a group health person or a workers' comp person? A. Yes."). Thus, Dr. Lopez has confessed to receiving actual notice of the pertinent information more than 30 days before he treats the patient.

[28] Deposition of Carol Beutler, Exhibit 4, at 29.

[29] Deposition of Carol Beutler, Exhibit 4, at 25; Deposition of Dr. Lopez, Exhibit 5, at 108.

[30] Deposition of Carol Beutler, Exhibit 4, at 24-27; Deposition of Dr. Lopez, Exhibit 5, at 103-06. LAC 40:I.2521 (Hospital Reimbursement Schedule; Hospital Billing Instructions); LAC 40:I.5105 (Medical Reimbursement Schedule; Verification of Coverage) require that "Prior to the provision of medical services, supplies, or other nonmedical services, the determination that the illness, injury, or condition is work-related must be made, and must be accomplished in the following manner: (a) carrier/self-insured employer should be contacted for verification of coverage; (b) the name and title of the individual verifying coverage/liability must be recorded in the claimant's records …."

[31] Deposition of Carol Beutler, Exhibit 4, at 34; Deposition of Dr. Lopez, Exhibit 5, at 108-10.

[32] Deposition of Carol Beutler, Exhibit 4, at 44; Deposition of Dr. Lopez, Exhibit 5, at 38, 39, 43, 121-22.

[33] Deposition of Carol Beutler, Exhibit 4, at 37, 38, 44, 58; Deposition of Dr. Lopez, Exhibit 5, at 43, 44, 121-22.

[34] Deposition of Dr. Lopez, Exhibit 5, at 114.

[35] Deposition of Carol Beutler, Exhibit 4, at 70.

discounted payments by contacting the payor directly.[36] Notably, representative plaintiff Dr. Gunderson's[37] office manager admitted that once the office made inquiry to a payor regarding a fee reduction, it was on notice of the billing relationship.[38]

Dr. Lopez' practice differs from most in that he relies almost exclusively on referrals from other physicians, adjustors, or attorneys.[39] Dr. Lopez receives complete patient files from the referring physicians, which include the name of and telephone number for the adjuster and the insurer responsible for payment.[40] Dr. Lopez conceded that billing problems are "probably already known" by the time he sees a referral patient.[41] Moreover, Dr. Lopez confessed "[a]ny procedure that I am going to perform on the patient requires an authorization."[42] This testimony refers to the fact that many of the CPT codes for treatment of injured workers have no dollar specific reimbursement value under the Louisiana Reimbursement Schedule. Such charges are reimbursed by First Health payors only after direct negotiation with the provider.[43] In these circumstances, the identity of the end payor and the specific terms of payment are available to the provider (such as Dr. Lopez) before treatment is authorized. Because plaintiffs' motion strategically refuses to parse the particulars of any of the more than 130,000 billing transactions at issue there is no telling how many other claims similarly fail.

A provider is typically enrolled in as many as ten or more provider networks.[44] Carol Beutler enrolled in the First Health network in 1998. By that time, she was familiar with how PPO networks contracted their service to other client companies that actually paid the bill, and understood that the payor entity differed from the company (such as First Health) that was on the

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[36] Deposition of Carol Beutler, Exhibit 4, at 72-73; Deposition of Dr. Lopez, Exhibit 5, at 73, 112.

[37] Dr. Gunderson remains a certified class representative as to defendants Cambridge and National Loss.

[38] Fed. R. Civ. P. 30(b)(6) Deposition of Dr. Clark A. Gunderson, AMC, Exhibit 6, at 115.

[39] Deposition of Dr. Lopez, Exhibit 7, at 14.

[40] Deposition of Dr. Lopez, Exhibit 7, at 14.

[41] Deposition of Dr. Lopez, Exhibit 7, at 29.

[42] Deposition of Dr. Lopez, Exhibit 7, at 30.

[43] Affidavit of Arthur J. Lynch, Exhibit 1. Such payments are negotiated on a dollar specific basis with individual providers. *Id.* Hospital treatment of injured workers is reimbursed via per diems, percent of billed charges not to exceed reasonable and customary, or direct negotiation.

[44] Deposition of Carol Beutler, Exhibit 4, at 58; Deposition of Dr. Lopez, Exhibit 5, at 50. The Any Willing Provider law of which La. R.S. 40:2203.1 forms a part, permits providers to become participants in any network they desire, so long as network qualifications are met.

contract.[45] Dr. Lopez did not enroll in the First Health network until 2002, but he has understood his workers' compensation bills were being discounted below the Reimbursement Schedule since 1995.[46] Other Plaintiff Class members such as Dr. Thomas Nosser admit to awareness of the practice since 1996.[47] Indeed, the Plaintiff Class members are highly educated sophisticated business people. To suggest that a single highly-educated Plaintiff Class member was not on notice that his, her, or its medical bills for treatment of workers' compensation patients would be discounted under the terms of their provider agreements from the day the agreement was signed or the day the first discount was taken is ludicrous. Plainly, they knew. And yet until attorneys became involved not a single Plaintiff Class provider termed the workers' compensation aspects of a First Health provider agreement. No such step was taken even though the providers acknowledge terming the agreement meant no First Health payor could ever again discount their workers' compensation medical bills.[48]

(iv) First Health's Notice Program

First Health has long provided the notice contemplated by the Act. Long before application of any contractual discount, First Health furnishes its participating providers written notice of the entities authorized to utilize the First Health network.[49] A participating provider's

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45 Deposition of Carol Beutler, Exhibit 4, at 95-97. Beutler even signed a PPO agreement providing for fee reductions against workers' compensation charges one month *after* this suit was filed. Exhibit 4, at 103-04. Other providers also admit to understanding that their bills are not paid by First Health. *See, e.g.*, Deposition of Charles Whitson, Exhibit 8, at 27-28.

46 Deposition of Dr. Lopez, Exhibit 5, at 72.

47 Deposition of Thomas Nosser, D.C., Exhibit 9, at 92-93.

48 *See e.g.,* Deposition of Dr. Lopez, Exhibit 7, at 77-85; Deposition of Thomas Nosser, D.C., Exhibit 9, at 71. Both Lopez and Nosser described terming a PPO contract because workers' compensation bills were discounted as "cutting off my nose to spite my face." Quite obviously, the failure to term raises enormous mitigation problems which are discussed in greater detail, *infra*.

49 Indeed, it was not unusual for a payor to notify the provider directly that it had signed up with the First Health network. *See* Exhibit 10, Correspondence dated August 2, 1999, from CNA to "Preferred Provider, advising the provider "We have chosen a new PPO network administrator, First Health, to replace PCHS." *See also* Exhibit 36, Correspondence dated June 12, 2003, from State Farm Ins. Co., to Class member Mark Kruse, D.C., advising "We recently entered into an agreement with First Health Network Preferred Provider Organization (PPO) in your state. This PPO includes hospitals and medical professionals that treat work-related injuries." Exhibit 11, Correspondence from Travelers Property Casualty, stating, "I am writing to you on behalf of Travelers Property Casualty to encourage you to become a participating provider in The First Health Network. As the largest workers' compensation carrier in the nation, Travelers has selected The First Health Network as our exclusive preferred provider organization in 37 states and the District of Columbia." In addition, Louisiana PHOs routinely identify for member providers important clients that are members of the First Health network before the provider accepts participation in the First Health network. *See* Exhibit 12, Acadian Health Care Alliance Physician Agreement Amendment with Dr. Louis C. Blanda, advising, "AHCA is entering into an agreement with First Health Network to participate in their National PPO Network. The First Health Network is one of the nation's oldest and largest PPO networks with over 3,000 clients and 15 million covered lives. All employers that access First Health, direct their employees "in network" with financial incentives. There are no additional or incremental UR functions or rules for physician staff. Claims are forwarded to First Health and Payors are then required to process claims within 30 days. Some of the current Acadiana/Louisiana employers accessing First Health include Liberty Mutual Insurance, Mailhandlers, UPS, The Travelers, Walgreens, State Farm, Sherwin-Williams, Albertson's, and many others." Thus, all Acadian Health Care Alliance member providers knew the score long before the first patient appeared.

bills are not discounted through the First Health network until 31 days after the provider agreement is fully executed, unless requested otherwise.[50] All First Health network providers receive a "welcome packet" when they are accepted into the network.[51] The welcome packet historically contained a comprehensive client list of authorized First Health payors.[52] New provider members also received a First Health Network Reference Manual for Registration/Front Office, Billing/Collections, and Utilization Management staff.[53] The Reference Manual contained instructions for billing workers' compensation matters to "a payor-specific claim address," [which address was provided] but also counseled each provider to "[o]btain prior authorization from the workers' compensation payor for all proposed services" and to "[f]amiliarize yourself with the workers' compensation payors accessing First Health …."[54] The provider could become familiar with workers' compensation payors by consulting and maintaining the included comprehensive client list, which "indicates workers' compensation payors accessing The First Health Network in your state."[55] The comprehensive payor list was updated quarterly by direct mailings to all First Health providers to show additions and deletions from the list of authorized First Health payors.[56] *See*, Exhibit 13, Affidavit of Robert Evans. The payor list identified several hundred First Health workers' compensation payor clients. The payor list was updated monthly.[57] The Reference Manual provided step-by-step directions for obtaining a current client listing from the First Health website, or via electronic mail.[58] The phone number for the Provider Relations department was also included. In later years, as First Health shifted to a web-based procedure, the payor list referred First Health Participating

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Moreover, the Acadian advice supports First Health's view that the "entity accessing the network" is the payor, not the individual patient.

[50] Affidavit of Robert Evans, Exhibit 13.

[51] Affidavit of Robert Evans, Exhibit 13.

[52] Affidavit of Robert Evans, Exhibit 13. An exemplar welcome packet with payor list is attached as Exhibit 14.

[53] Affidavit of Robert Evans, Exhibit 13. An exemplar Reference Manual is attached as Exhibit 15.

[54] Exhibit 15 at IV-5, IV-2, and IV-3.

[55] Exhibit 15, at IV-3.

[56] Affidavit of Robert Evans, Exhibit 13. Exemplar First Health payor lists from 2003 through January 2008 are collectively attached at Exhibit 16. The First Health payor list produced by Plaintiff Class representative LCMH is attached as Exhibit 17.

[57] Affidavit of Robert Evans, Exhibit 13.

[58] Exhibit 15, at IV-3.

Providers to the First Health website, and was password protected by provider.[59] More recently, the password protection has been removed to improve ease of access.[60]

The plaintiffs testified that they received First Health updated payor lists over time. While some discarded the lists, others constructed databases so they would know the networks used by each payor.[61] Beginning in 2003, in response to individual provider demand, First Health also began publishing these materials on its web site and First Health direct mailings to individual and small group providers began to refer those providers to the web site for payor and related information.[62] By 2005, hospitals expressed a preference for web-based payor updates and First Health complied with that request as well.[63] In fact, internet-based writings have become the industry norm for communications with providers.[64]

It is against this backdrop that the Plaintiff Class seeks summary judgment claiming that none of its members received the notice plaintiffs claim is due under their twisted construction of La. R.S. 40:2203.1. Plaintiffs base their motion on affidavits submitted by 5 Plaintiff Class

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[59] Affidavit of Robert Evans, Exhibit 13.

[60] Affidavit of Robert Evans, Exhibit 13.

[61] *See e.g.* ,Deposition of Thomas Nosser, D.C., Exhibit 9, at 67-69 (Q. Have you ever seen a payor list or a payor listing come into your office? A. Yes. Q. What is done with that list when it is received? A. I may read it and throw it away. Q. Do you retain it anywhere? A. I might. Q. Well, do you, is that part of your practice? A. Not always.); Deposition of Dr. Lynn Foret, Exhibit 18 at 48-49 (payor lists are received and go to his "business office" because "I don't need to see it."); Deposition of Mark Kruse, D.C., Exhibit 19, at 27-31 (admitting he "probably did" receive the Comprehensive Listing included in the First Health "Welcome Packet" and that he received updated client lists from First Health, which he stuffed in a drawer and did "not really" review.); Deposition of David Duhon, D.C. Exhibit 20, at 42 ("They'll send a list of like what companies are enrolled with them as far as their, you know, employers, yes, they'll send us those lists. I think maybe only one or two companies might send us a list of companies that are their insurers or insurees."); Deposition of Charles Whitson, Exhibit 8, at 43 (conceding that Plaintiff Class representative LCMH received updated First Health payor lists "periodically"). Exhibit 21, Affidavit of Robert Porcaro, where the former Director of Managed Care Contracting for Ochsner Clinic Foundation in New Orleans states that networks such as First Health "furnished advance written notice to Ochsner of the identity of payors accessing their network contracts with Ochsner by providing payor lists with periodic updates and by publications on their web site" and that "When an injured worker presents for treatment covered by workers' compensation at an Ochsner Hospital or at the Ochsner Clinic, Ochsner personnel ascertain who will be responsible for payment of Ochsner's bills. Ochsner inputs payor and employer information into its computerized billing system. Payor information is stored in the computer database as part of the patient's record." Exhibit 22, Affidavit of Gary M. Stein, where the President Emeritus of Touro Infirmary, a 329 bed teaching hospital in New Orleans, Louisiana describes First Health's business as a "full health plan benefits administrator" and its practices in dealings with Touro. Mr. Stein details First Health's disclosures and Touro's long-term receipt and use of payor information from First Health. Mr. Stein affirmatively attests as an industry expert involved first hand in the legislative process leading to La. R.S. 40:2203.1, that the legislative intent "was to regulate 'silent' PPOs by requiring disclosure to providers of the entity that is permitted to access the providers network contract." Mr. Stein also attests that First Health met the disclosure requirements, and is *not* a silent PPO.

[62] Affidavit of Robert Evans, Exhibit 13.

[63] Affidavit of Robert Evans, Exhibit 13. The website is updated to reflect monthly additions or deletions form the First Health payor community. *Id.*

[64] Affidavit of Robert Evans, Exhibit 13. Notably, Louisiana law specifically approves internet notice in the nearly identical situation involving provider access to a health insurance issuer's "payor companion guide." *See* La. R.S. 22:1833(A)(1) stating, "A health insurance issuer shall allow a health care provider access to information in the issuer's Payer's Companion Guide, or its successor, listing issuer-specific data requirements for accepted electronic claims. Such access shall be provided through a written notice to the provider or through Internet access."

members, representing less than .01% of the total Plaintiff Class membership. Those Plaintiff Class members aver that they "never received 30 days prior written notice indicating that First Health PPO contractual discounts would be taken before providing medical services to the various workers' compensation *patients* incurring medical bills …." After misreading the statute, plaintiffs extrapolate that no Plaintiff Class member received notice, again despite contradictory testimony and other contrary evidence. These semantic riddles are of course at variance with the fact that these and other Plaintiff Class members received notice over time, even if many ignored it.[65] Plaintiffs further simplify their evidentiary burden by misconstruing the Act to require point-of-service per patient notice exclusively, rather than the one-time written advice "of the entity accessing the network" the Act and common sense[66] plainly require and First Health plainly furnished, and by improperly citing and then misrepresenting testimony given in other cases where First Health was not party.

II. LEGAL ARGUMENT

The Motion for Partial Summary Judgment filed by the Plaintiff Class suffers from several notable shortcomings, including:

(1) The evidence relied on by the Plaintiff Class is not competent evidence under Louisiana Code of Civil Procedure article 966;

(2) A contract is the law between the parties and First Health fully complied with the respective contract terms, including the contractual notice terms, where applicable;

(3) By approving the Focus settlement, this Court determined Exhibit 7 entitled "Notice Procedures" constituted "adequate notice" under the Louisiana Any Willing Provider Act, and First Health's notice program meets these requirements;

(4) Louisiana's Any Willing Provider Act is not limited to point-of-service patient specific notice; rather, as recognized by the Louisiana Third Circuit, the Act's language contemplates point-of-service notice by benefit card *or* where no benefit card is used, one-time written notice of the entity accessing the preferred provider network 30 days before that entity

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[65] *See* footnote 53, *supra.*

[66] Plaintiffs' interpretation requires patient specific point-of-service written notice provided 30 days before an unplanned employee accident occurs to a particular employee. This twisted logic is of course impossible absent divine providence. In fact, the statute requires notice of "any entity" accessing the network, not of any "patient" accessing the network. Simply, why would a provider want patient specific notice? They do not; providers want to know which insurers and TPAs will be accessing the network (and sending the providers their clients) so they can gauge the value of panel participation. Moreover, the only way plaintiffs' interpretation is correct is if the Court impermissibly rewrites the statutory language. The payor lists issued by First Health, together with the 31 day waiting period before fee reductions are in effect, plainly conform to the notice requirements of the Act.

applies the initial alternative payment rate to the provider's medical bills. The one-time notice under La. R.S. 40:2203.1(B)(5) "shall be required of any entity *accessing* an existing group purchaser's contractual agreement or agreements …." An individual patient does not access the Provider Agreement or the Payor Agreement and thus is not the "entity" that need be identified under the Act. Similarly, First Health does not access its own agreements to pay medical bills and thus does not owe the notice required by the Any Willing Provider Act;

(5) Louisiana's Any Willing Provider Act does not apply to medical bills for treatment rendered to occupationally ill or injured workers;

(6) First Health is exempt from the notice requirements of the Any Willing Provider Act under La. R.S. 40:2203.1(A) because it is directly contracted with its Louisiana preferred provider panel;

(7) Plaintiffs' attempt to have this Court award class-wide damages for every alternative payment made through the First Health network begs the essential question of whether the particular provider received the notice required by the Any Willing Provider Act. La. Code Civ. P. art. 592(E)(5) and well-settled Louisiana law prohibits this Court from entering the class-wide order plaintiffs demand.

(8) Plaintiffs' attempt to have this Court award class-wide damages against First Health for every alternative rate payment made through the First Health network ignores this Court's ruling making multiple industry participants "group purchasers" potentially responsible for furnishing the notice required by the Any Willing Provider Act, thus making that "group purchaser," but not First Health, liable under the Act. At minimum, the Court's group purchaser ruling raises issues of comparative fault allocation that cannot be resolved on summary judgment;

(9) Plaintiffs' theory for awarding class-wide damages further violates Louisiana law because each plaintiff is subject to the affirmative defenses of waiver and equitable estoppel and has a duty to mitigate his, her, or its damages, including terminating a contract if plaintiffs are dissatisfied with its terms;

(10) The statutory damages under La. R.S. 40:2203.1(G) are unconstitutional in that the payments required from a group purchaser bear no rational relationship to the nominal harm allegedly suffered by the plaintiffs; and

(11) La. R.S. 40:2203.1 is overbroad and vague, failing to give adequate notice of either the proscribed conduct or the severity of the punishment that may be imposed, and accordingly, violates federal and state due process guarantees and the state right to property.

A THE EVIDENCE RELIED ON BY THE PLAINTIFF CLASS IS NOT COMPETENT SUMMARY JUDGMENT EVIDENCE UNDER LA. CODE CIV. P. ART. 966(B)

Neither the McCarthy deposition nor an affidavit made by an affiant without personal knowledge citing and inaccurately characterizing a spreadsheet containing hearsay billing data represents competent summary judgment evidence

The Plaintiff Class' Motion for Partial Summary Judgment relies chiefly upon deposition testimony given by a First Health representative in the matter entitled *Thomas Medical Group v. Emerson Electric Company*.[67] First Health had not appeared in and was not a party to that matter. Indeed, the Louisiana Supreme Court has ruled that the Office of Workers' compensation lacks subject matter jurisdiction over entities such as First Health that are neither the employee's employer nor insurer.[68] Louisiana law is well-settled that under such circumstances, the deposition may be used for impeachment purposes, but it is not "on file" and thus cannot be used in support of a motion for summary judgment.

In *Bell v. Gold Rush Casino, et al.*,[69] an injured patron filed suit against the defendant casino. Plaintiff filed a motion for partial summary judgment claiming the defendant was on notice that a protruding bolt, defective light fixture, and lack of handrail created an unreasonably dangerous condition. The district judge granted the motion. The defendant appealed, alleging as error the district court's reliance on deposition testimony from a separate civil action against the same defendant.[70] The Third Circuit agreed:

> Plaintiff introduced these collateral depositions in an attempt to prove the existence of a defect or condition in the case at bar. The trial court took these depositions into consideration when it ruled, in part, "[t]he risk that patrons would fall was greatly and clearly foreseeable, given past occurrences in which other people had fallen on those stairs." Depositions in other proceedings can be used for other purposes, such as impeachment. ***Depositions in other proceedings are, however, collateral depositions and are not depositions "on file" for use in summary judgments as required by La. Code Civ. P. art. 966(B) and should not be considered in a motion for summary judgment. The trial court erroneously relied upon***

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[67] Office of Workers Compensation, State of Louisiana, No. 07-05498, District 02.

[68] *Broussard Physical Therapy v. Family Dollar Stores, Inc.*, 2008-1013 (La. 12/2/08); 2008 WL 5146651, -- So.2d --.

[69] 2004-1123 (La. App. 3 Cir. 2/205); 893 So.2d 969.

[70] 893 So.2d at 970, 971.

the collateral depositions of Mr. Williams and Mr. Dupre in making its determination.[71]

ii. Plaintiffs misrepresent Ms. McCarthy's testimony.

The collateral deposition testimony of First Health representative McCarthy thus cannot be considered by this court in reaching its conclusion, meaning plaintiffs essentially present no evidence whatsoever. But it also bears noting that Class counsel has misrepresented the cited testimony, which like all testimony must be considered in context and in its entirety. Plaintiffs' counsel cites the McCarthy testimony for two propositions: (1) First Health does not provide "health benefits" and thus is not covered by the exemption from notice found in La. R.S. 40:2203.1(A); and (2) First Health has never furnished its providers any written notice whatsoever. Both propositions are false, and Class counsel knows they are false. Fundamentally, the question posed by Class counsel regarding benefits did not address "health benefits;" the question asked whether First Health provided *workers' compensation* benefits to its payors' employees.[72] Ms. McCarthy answered "no" and that is the correct and logical response to a very different question than what Class counsel represents to this Court. Similarly, Ms. McCarthy acknowledged that First Health does not provide point-of-service patient specific written advice, but the statute requires 30 day advance notice "of an entity accessing the network." It does not require patient-specific advance written notice.

Moreover, Ms. McCarthy's entire testimony does nothing to support plaintiffs' motion. She testified that First Health furnishes 31 days advance notice identifying entities authorized to access the First Health network.[73] She further identified several letters mailed to providers naming select First Health's payors and enclosing a comprehensive client list even before the relationship is created.[74] Ms McCarthy also discussed First Health periodically mailing each enrolled provider its comprehensive payor list, and how the practice changed in 2005 only after

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[71] 893 So.2d at 973 (emphasis added). *See also Marshall Gqs & Oil, LLC v. Corporation of Haverford College*, 2006-392 (La. App. 3 Cir. 10/25/06); 945 So.2d 743, 748; *Yarbrough v. Louisiana Cement Company, Inc.*, 370 So.2d 602 (La.App.4 Cir. 1979)("Louisiana Code of Civil Procedure Article 1450 permits a deposition taken in one case to be used in another case brought against the same parties involving the same subject matter, but it is apparent that in this case that none of the defendants were parties to the litigation in which the deposition was taken, and the proffered deposition should not be considered by us.").

[72] Indeed, when asked the question regarding whether First Health provides health benefits to its payors' employees, Ms. McCarthy responded "I don't know." Exhibit 23, Deposition of Shelly McCarthy, at 73. Moreover, as reflected by the Affidavit of Arthur J. Lynch, Exhibit 1, First Health is a national health benefits service company. *See also* Exhibit 22, Affidavit of Gary M. Stein (same).

[73] Exhibit 23, Deposition of Shelly McCarthy, at 24-25.

[74] *Id.* at 33-39.

the providers requested web-based publication.[75] She also identified the Provider Manual discussed above, which "gave information on sending in HCFAs, UBs, any other billing form. It gave information on how to make sure [the bills] were completed comprehensively, that their TIN number was represented on that particular billing form, where to mail those for our specific clients."[76] This information is more than what the statute required, and properly managed allowed the provider to know who was paying the medical bill and at what rate. Those who remained ignorant did so due to poor record-keeping, not because notice of the pertinent relationships was not communicated. Ms. McCarthy's deposition testimony plainly refutes and does not support plaintiffs' claims.

iii. An affidavit made without personal knowledge citing and inaccurately characterizing hearsay billing data is not competent evidence

During the recent hearing on defendant First Health's Motion to Continue Hearing of the instant motion, Plaintiffs called CPA and database expert Lester Langley to the stand, ostensibly to testify to the simplicity of his task. Mr. Langley stated unequivocally that he has no opinions to offer in this case and that he had no personal knowledge as to what was depicted on the spreadsheets provided by First Health's Greg Mast in response to discovery issued by plaintiffs. While First Health has had little opportunity to conduct a proper *Daubert* inquiry into Mr. Langley's assignment, his report makes it unequivocally clear that certain expert assumptions undergird his computations and conclusions, despite his disclaimers. It is difficult to imagine a more crystal clear example of a situation where a witness testimony should be excluded than one in which the witness admits that he has no personal knowledge of any relevant matter and that he has no opinions to offer.

The difficulty with Mr. Langley's proffered report does not, however, stop with the lack of relevant testimony or expertise, but also extends to his reliance on the date of spreadsheets that reflect nothing more than rank hearsay. As noted elsewhere, First Health's role in proffering medical benefits to its clientele is one of managing the provider network and contracting relationship. First Health has repeatedly explained that its role in this relationship does not extend to the issuance of checks in payment of provider medical bills, nor to the receipt of such medical bills, or the issuance of explanations of review to accompany payment of such medical

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[75] *Id.* at 45. "It was in the end of 2004 that we started making changes."

[76] *Id.* at 44.

bills. First Health spreadsheets represent nothing more than electronic data feeds of information provided by third parties and by the providers themselves. Since the plaintiffs and Mr. Langley asked this court to accept the truth of the underlying data, it is clear that Mr. Langley's affidavit, and indeed the provider's entire position, is premised upon inadmissible hearsay. Moreover, as attested to by Mr. Gregory Mast in the attached affidavit, First Health's computations of discounts available under its provider contracts do not equate to the actual payment of claims at the suggested amounts. First Health has no information as to whether a given payor actually accepted payment amount suggested by First Health and paid the provider at a discount or not, without reference to the Explanation of Review by which payment for the transaction was processed. This has been a particularly large problem in Louisiana since the inception of this litigation, as several payors have decided to stop taking the discounts available under the First Health network contracts.[77]

iv. Plaintiffs must establish the contract chain for each claim in order to prove that each payment was made pursuant to a PPO agreement or agreement covered under the Any Willing Provider Act

The Plaintiff Class' "proof" is further defective because plaintiffs fail to establish the "contract chain" required for a Preferred Provider Organization covered by the Any Willing Provider Act. In *CCN Managed Care, Inc. v. Shamieh, et al.*,[78] network plaintiff CCN obtained judgment declaring that it was exempted from the notice requirements of La. R.S. 40:2203.1(B) because it was directly contracted with the providers and that alternative rates of payment contained in its provider contracts were enforceable under Louisiana law against several Plaintiff Class member providers. Thereafter, CCN moved for summary judgment on its claim for attorneys' fees and costs against certain of the defendant providers. The providers opposed the motion, with Plaintiff Class counsel vigorously contending that CCN was required to establish a "contract chain" linking each payor to CCN.[79] In other words, class counsel posited that CCN could not recover unless it showed that an agreement providing for alternative rates of payment

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[77] *See*, Affidavit of Gregory C. Mast, appended hereto as Exhibit 29. Moreover, the fields analyzed by Mr. Langley do not purport to depict PPO savings but only PPO Allowables as calculated by First Health.

[78] Civil Action No. 06-CV-0519, United States District Court for the Western District of Louisiana.

[79] Exhibit 24, Memorandum in Opposition to Motion for Summary Judgment, filed by Dr. Fayez Shamieh, et al., at 3-6. There, Class counsel argues "requiring notice in a 'silent PPO' situation (i.e., where the entity applying the discount does not contract directly with a provider) was the very purpose of enacting La. R.S. 40:2203.1. ***The Court*** has not addressed in this action the validity of various unnamed payors' application of CCN's rate in this silent PPO context, and ***cannot do so until the various chains of contracts are submitted and evaluated***." Plaintiffs' counsel further contends that "Without proof of contracts linking payors to CCN's network, it cannot be determined whether Defendants have breached their contracts by way of simply seeking payment from payors in accordance with Louisiana law."

was in place when the rate of payment was applied. Similarly, the Plaintiff Class must demonstrate the contract chain ***for each claim*** to show that a "Preferred Provider Organization" covered by the Any Willing Provider Act existed. Absent the "agreement or agreements" providing for alternative rates of payment, there is no Preferred Provider Organization regulated by La. R.S. 40:2203.1, no notice requirement, and no issue for this Court to address.

B. THE FIRST HEALTH PARTICIPATING PROVIDER AGREEMENTS REPRESENT THE LAW BETWEEN THE PARTIES AND FIRST HEALTH COMPLIED FULLY WITH THE TERMS OF THOSE AGREEMENTS

"Parties are free to contract for any object that is lawful, possible, and determined or determinable."[80] "A contract is formed by the consent of the parties established through offer and acceptance."[81] Contracts may be vitiated by an error in consent, but "a party who signs a written instrument is presumed to know its contents and cannot avoid its obligations by contending that he did not read it, that he did not understand it, or that the other party failed to explain" its meaning.[82]

An agreement between the parties should be interpreted by using ordinary contract principles.[83] "Interpretation of a contract is the determination of the common intent of the parties."[84] "The words of a contract must be given their generally prevailing meaning."[85] "When the words of a contract are clear and explicit and lead to no absurd consequences, no further interpretation may be made in search of the parties' intent."[86] Thus, the meaning and intent of the parties to a written and signed instrument, such as the First Health Provider Agreements, "is ordinarily determined from the instrument's four corners, and extrinsic evidence is inadmissible either to explain or to contradict the instrument's terms."[87]

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80 La. Civil Code art. 1971.

81 La. Civil Code art. 1927.

82 *Aguillard v. Auction Management Corp.,* 2004-2804, 2004-2857 (La. 6/29/05); 908 So.2d 1, 17; *Dulin v. Levis Mitsubishi, Inc.,* 2001-2457 (La.App. 1 Cir. 12/20/02); 836 So.2d 340, 345, *writ denied,* 2003-0218 (La. 3/28/03); 840 So.2d 576; *Morin v.Foret*, 98-0120 (La. App. 3 Cir. 4/14/99); 736 So.2d 279, 289, *writ denied,* 99-2022 (La. 10/29/99); 748 So.2d 1165; *see also* La. Civil Code art. 1948.

83 *See Henly v. Phillips Abita Lumber Co.,* 2006-1856 (La. App. 1 Cir. 10/3/07); 971 So.2d 1104, 1108.

84 La. Civil Code art. 2045.

85 La. Civil Code art. 2047.

86 La. Civil Code art. 2046.

87 *Abshire v. Vermilion Parish School Board,* 2002-2881 (La. 6/27/03); 848 So.2d 552, 555 n. 5; *Ortego v. State, Department of Transportation and Development,* 96-1322, (La. 2/25/97); 689 So.2d 1358, 1363.

As detailed above, the First Health Participating Provider Agreements reflects the providers' understanding (and agreement) that First Health must contract with "payor" entities to develop and expand the PPO and with it the providers' potential patient base. The "Participating Provider" acknowledges and agrees that First Health will "offer to certain Payors the opportunity to contract with First Health to utilize the services of the health care providers participating in the Preferred Provider Panel." The broad definitions within the Participating Provider Agreement allow First Health to maximize its preferred provider's potential patient base while maintaining traceable, verifiable written arrangements. In sum, the Plaintiff Class providers contractually authorized a broad group of First Health contracted "payors" to access the alternative rates of payment below the Louisiana Workers' Compensation Reimbursement Schedule, receiving in return "tangible benefits." The Provider Agreements further specified the notice that would be communicated between First Health and the participating provider,[88] and First Health has demonstrated above the notice it delivered to the entire "Participating Provider" community. That the contractually agreed notice furnished by First Health also complies with the terms of La. R.S. 40:2203.1 merely strengthens the enforceability of the parties' contractual agreement.

C. THIS COURT HAS PREVIOUSLY RULED THAT THE NOTICE FURNISHED BY FIRST HEALTH WAS ADEQUATE NOTICE UNDER THE ANY WILLING PROVIDER ACT

This Court already held, when it approved the Focus Settlement with the Plaintiff Class, that the notice measures observed by First Health satisfy the statutory requirements.[89] There is no legal or logical reason for revisiting that conclusion. Exhibit 7 to the Focus Settlement is entitled "Notice Procedure" and recites that "Notices to Providers purportedly required under La. R.S. 40:2203.1 shall be provided pursuant to the following procedures:

> 1. For all Providers joining the Focus PPO network in Louisiana through a contract directly between Focus and such Providers, Focus will give such Providers a copy of its current Louisiana Provider Update, which will include the names of all entities that have directly contracted with Focus to access its PPO network in Louisiana, at or by the time the Provider becomes members of Focus's PPO network in Louisiana.
>
> 2. Focus will mail or email to all its Louisiana participating Providers four times a year (quarterly) copies of its Louisiana Provider Updates, which will include the names of all entities that have

[88] Certain agreements provide that payor lists will be furnished to the provider, but others do not.

[89] The Focus Settlement is a contract. This Court could not have approved contract terms in derogation of law and cannot impose greater notice obligations on First Health than it approved for Focus. *See e.g., Baker v. Maclay Properties Company*, 94-1529 (La. 1/17/95); 648 So.2d 888, 895-896 (observing that contracts in derogation of law are absolutely null and cannot be confirmed).

directly contracted with Focus to access its PPO network in Louisiana.

3. In each of its Louisiana Provider Updates, Focus will include a notation substantially similar to the following: "A listing of the current names of all entities that have directly contracted with Focus to access its PPO networks in Louisiana may be found on the following website: www.focusppo.com. As this listing is updated no less than every thirty days, Focus encourages you to refer to the listing on this website for more current information."

4. Focus will include on its website the names of all entities that have directly contracted with Focus to access its PPO network in Louisiana. (For purposes hereof, the term "directly contracted with Focus" means the entity has signed a contract that also bears the signature of a Focus or Concentra party, acting as a representative for a party to the contract.)

5. Within twenty days after the end of each calendar month, Focus will update its website to reflect the names of all entities that have directly contracted with Focus to access its PPO network in Louisiana during such calendar month.

6. Subsequent to the provision of medical services subject to a Focus PPO discount, Focus will send to is clients, for purposes of creating Explanations of Review, data that include the patient name, dates of service, and all PPO networks involved in the discount."

The Affidavit of Robert Evans plainly demonstrates that First Health satisfied the "Notice Procedures" this Court approved in the Focus Settlement and thus that First Health complied with the notice requirements of La. R.S. 40:2203.1. Moreover, the Any Willing Provider Act does not require, as the Plaintiff Class apparently contends, point-of-service patient-by-patient notice — and this Court plainly did not require it as part of the Focus settlement (or any other settlement for that matter). A benefit card is point-of-service notice, but La. R.S. 40:2203.1(B)(5) provides that when there is no benefit card "written notification shall be required of any entity accessing an existing group purchaser's contractual agreement or agreements at least thirty days prior to accessing services through a participating provider under such agreement or agreements." This requirement is met by a payor list, followed by a 31 day waiting period. That is what First Health has always done and it complies with the Act.

(i) The Act does not require point-of-service notice

Fundamentally, if point-of-service notice was the only notice permitted by the statute, La. R.S. 40:2203.1(B)(5) would be superfluous because a benefit card would be the only form of notice allowed. The Louisiana Third Circuit's opinion on class certification plainly recognized

that the statute allowed notice to be given other than by benefit card and thus that point-of-service notice was not the only type notice that satisfied the statute.[90]

By its terms, La. R.S. 40:2203.1(B)(5) plainly contemplates notice is adequate if it is furnished 30 days before treatment, not at the point-of-service. Moreover, La. R.S. 40:2203.1(B)(5) requires the notice identify "any entity accessing" the network. If the "written notification" was required to identify the particular "patient being treated by a provider contracted with" the network, the statute would say so. It does not read that way. But of course the patient does not access the network; the patient accesses his or her health benefits plan or workers' compensation program, as the case may be. The patient's insurer or third party administrator accesses the contractual agreement or agreements allowing a negotiated fee to be paid to the participating provider.[91] Similarly, First Health does not access its own network for any reason and thus is not the entity responsible for the written notification La. R.S. 40:2203.1(B)(5) demands.

The 30 day advance notice requirement also belies the Plaintiff Class's claim the statute mandates point-of service notice. As noted above, the initial workers' compensation injury is never planned, nor can it be predicted. It makes no sense to interpret the statute to require 30 days notice of an unforeseeable, purely fortuitous event. The function of the court is to interpret the laws so as to give them the meaning which the lawmakers obviously intended them to have and not to construe them so as to give them absurd or ridiculous meanings.[92] To require point-of-service patient-by-patient notice 30 days in advance of an unforeseeable event is an illogical interpretation of the statute. And more importantly, it is not what the statute says. First Health satisfied the statutory notice requirements.[93]

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[90] *Gunderson v. F. A. Richard & Associates, Inc., et al.,* 2007-331 (La. App. 3 Cir. 2/27/08); 977 So.2d 1128, 1137 ("As discussed above, defendants' liability under La. R.S. 40:2203.1in the instant case hinges on whether or not adequate notice of a discount taken pursuant to a PPO agreement was given to the healthcare provider, either "when medical care is provided"-in instances where a benefit card has been issued-or "at least thirty days prior to accessing services through a participating provider"-where no benefit card has been utilized.")
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[91] This interpretation is in keeping with the objective of the legislation to put at an end "silent PPO" activity. A "silent PPO" is by definition not an existing PPO network payor. Thus, it must furnish the provider "written notification" of its intent to access the network and receive in return the provider's written permission before it can apply alternative rates of payment to the provider's medical bill. La. R.S. 40:2203.1(C).

[92] *Webb v. Parish Council of Parish of East Baton Rouge*, 217 La. 926, 47 So.2d 718, 720 (1950).

[93] In the event that this court should for some reason determine that the First Health is subject to the statute and that its notices do not comply with the statute, First Health shows herewith that numerous other forms of notice to providers exist that afford the provider notice of the entity accessing the network. *See,* Exhibits 10, 11, 12, 21, 34, 36, 38, 40, 43, and 44. Plaintiffs themselves take the position in this motion, as they have previously, that an initial Explanation of Review to a provider may afford the type of notice that they contend is required. The Louisiana workers compensation act itself requires prior authorization of all medical procedures costing in excess of $750 and virtually all providers have procedures in place by which they ascertain the identity of the payor and direct

D. THE ANY WILLING PROVIDER ACT WAS NOT INTENDED BY THE LEGISLATURE TO APPLY TO WORKERS' COMPENSATION

(i) Background to Enactment of La. R.S. 40:2201 et seq:

Beginning in the mid to late 1990's, so- called managed care organizations began to arise that sought only to access the discount afforded by health care providers network contracts without the usual services provided by entities such as First Health. Rather than contract with providers directly in exchange for steerage of patients in an environment of true network management, these entities merely sought access to discounts through brokers or other network access agreements that afforded no direction of patient care. Amidst rising protest against non-directed care afforded through leased networks, the American Medical Association jumped into the fray, encouraging providers to pay careful attention to the breadth of contracts that they signed.[94] First Health, then still known as Affordable, also admonished its providers to be on the lookout for such "silent" PPO activity. In fact, First Health moved at the forefront of legislative action to curtail such non-directed care absent notice to providers.[95]

It was against this background that the Louisiana legislature considered HB 1072 of 1999, a bill initially proposed by the Louisiana Hospital Association, represented by then HCA hospital counsel Greg Frost. Notably, the legislature characterized the bill as relating to Health and Accident insurance and accordingly assigned the bill to Insurance Committee in each house. No input from the Department of Labor or Office of Worker's Compensation was ever sought as to any provision of HB 1072, nor was any mention made of application of the provisions of La. R S. 40:2203.1 to workers compensation.[96] Proponents of the bill from both the Louisiana Hospital Association and the Department of Insurance attest to the fact that there was no

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their invoices to that payor. For additional possible notice examples, see First Health's exhibits and memoranda submitted in opposition to the request for class certification, incorporated by reference.

[94] *See* Exhibit 25, *American Medical Association Model Managed Care Contract: Supplement 2*.(2002) stating "A Provider can prevent most silent PPO situations by clearly and narrowly defining the terms "Payor," "Plan" and "Member." An example of a definition of Payors:

> *Payor" means an insurance company, employer, health & welfare trust fund, government unit, or agency, or any other entity or plan this is contractually obligated to indemnify or make payment on behalf of Covered Persons with respect to Covered Service, and that has contracted directly or indirectly with PPO to arrange for the provision of Covered Service to Covered Persons*. See 1.2 Health L. Prac. Guide § 29:42 (2009).

[95] *See* Exhibit 26, Correspondence from Lee Dickerson to various (in globo), authenticated by Exhibit 13, Affidavit of Robert Evans.

[96] *See,* Tapes of Proceedings, House Committee on Insurance, May 5, 1999, appended hereto as Exhibit 27.

intention to apply this Health and Accident provision, placed in Title 40, to the realm of workers compensation governed by Title 23.[97]

(i) The Workers' Compensation Act Provides the Exclusive Remedy for Recovery of Provider Fees for Treatment of Occupational Injuries

Louisiana's Workers' Compensation Act is a self-contained Act that, excepting intentional acts, provides the exclusive remedy for workers who suffer on-the-job injuries.[98] The Workers' Compensation Act provides procedural guidelines as well as substantive remedies and penalties for a health care provider's action to recover unreimbursed medical expenses. For example, the Act provides that a claim for the recovery of medical expenses can be asserted by the injured worker or the health care provider.[99] La. R.S. 23:1201(E) mandates that "Medical benefits payable under this Chapter shall be paid within sixty days after the employer or insurer receives written notice thereof." La. R.S. 23:1201(F) recites that "[f]ailure to provide payment in accordance with this Section [1201] …," exposes the payor to a penalty equaling "the greater of twelve percent of any unpaid … medical benefit, or fifty dollars per calendar day for each day in which any … medical benefits remain unpaid … together with reasonable attorney fees for each disputed claim." The penalty assessed under La. R.S. 23:1201(F) "shall not exceed a maximum of two thousand dollars in the aggregate for any [single] claim" and "regardless of the number of penalties which may be imposed" the aggregate penalty for multiple violations shall not exceed eight thousand dollars.

The Any Willing Provider Act, on the other hand, states that payments under Preferred Provider Organization agreements covered by it "shall be subject to the standards for claims submission and timely payment according to the provisions of Part VI-D of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950."[100] Part VI-D, entitled *Standards for Health Insurance Coverage*[101] specifically applies to benefits paid "under any … preferred provider organization agreement or health maintenance contract *offered by a health insurance issuer*" but

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97 *See* Exhibit 22, Affidavit of Gary M. Stein; Correspondence to Department of Insurance, Exhibit 28.

98 *See* La. R.S. 23:1032 (A)(1)(a); *Deshotel v. Guichard Operating Company, Inc.,* 2003-3511 (La. 12/17/04); 916 So.2d 72.

99 La. R.S. 23:1021, *et seq.*

100 La. R.S. 40:2203.1(E).

101 When doubt exists as to the proper interpretation of a statute, the title or preamble may be used to determine legislative intent. *See, Deculus v. Welborn*, 2007-1888 (La. 10/1/07); 964 So.2d 930, 933; *Green v. Louisiana Underwriters Insurance Company,* 571 So.2d 610, 614 (La. 1990).

expressly disclaims application to benefits due under the Louisiana Workers' Compensation Act.[102] If the Any Willing Provider Act was intended to apply to workers' compensation claims these same claims submission and payment standards would apply to *workers' compensation* insurance, *or* the Any Willing Provider Act would "be subject to the standards for claims submission and timely payment according to the provision of" Title 23, too. But the standards specifically incorporated into the Any Willing Provider Act expressly *disclaim application to workers' compensation benefits*, no doubt because the payment procedures and the substantive law governing payment are already addressed and governed by the Louisiana Workers' Compensation Act.

Moreover, the claims submission and payment provisions made part of the Any Willing Provider Act differ markedly from the claims submission and payment provisions that govern workers' compensation claims. La. R.S. 22:1832 (Non-electronic claims submission standards) and La. R.S. 1833 (Electronic Claims Submission Standards) mandate payment within forty-five (45) days for non-electronically submitted claims and thirty (30) days for electronically submitted claims, respectively. Under La. R.S. 22:1834, the "*health insurance issuer"* may elect to utilize a standard thirty (30) day payment window for both non-electronic and electronic claims by notifying the Commissioner of Insurance in writing. These time periods are, of course, entirely *inconsistent* with the sixty (60) day payment window established under La. R.S. 23:1201(E). Stated simply, the workers' compensation payor might comply with La. R.S. 23:1201(E) but still violate La. R.S. 22:1832, 22:1833 and 22:1834, thereby subjecting that payor to the Draconian penalties imposed under La. R.S. 22:1837.[103]

Once again, the procedural mechanisms and substantive mandates and remedies (here, the bill submission and payment mechanisms and penalties for non-compliance) specifically incorporated into the Any Willing Provider Act are inconsistent with parallel requirements of the Workers' Compensation Act, and by their terms do not apply to workers' compensation, underscoring that the two Acts are designed for disparate application. It is no retort that "damages" under La. R.S. 40:2203.1(G) are not available for violating La. R.S. 40:2203.1(E)

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[102] La. R.S. 22:1831(13), formerly La. R.S. 22:250.31(5).

[103] The Title 22 penalties may be imposed by the Commissioner of Insurance (and not by the Director of the Office of Workers' Compensation) against "any *health insurance issuer* … not in full compliance with the requirements of this Part." There is no mechanism by which the Commissioner of Insurance may impose similar penalties against a *workers' compensation insurance issuer*, and the specific penalties allowed differ materially from the penalties that might be imposed by the Office of Workers' Compensation under La. R.S. 23:1201(F) for improper payment or nonpayment of workers' compensation benefits.

because timely payment under La. R.S. 23:1201(E) still violates the Title 22 payment parameters, meaning the payor is exposed to Title 22 penalties and the provider is not bound to accept the agreed alternative rate of payment under La. R.S. 40:2203.1(D).[104]

"La. Civ. Code art. 13 provides where two statutes deal with the same subject matter, they should be harmonized if possible. However, if there is a conflict, the statute specifically directed to the matter at issue must prevail as an exception to the statute more general in character."[105] Had the Louisiana legislature intended for the Any Willing Provider Act to apply to workers' compensation claims, it presumably would not have made Part VI-D of Chapter I of Title 22 the source articles for billing and payment periods and procedures for *all* Any Willing Provider Act claims; rather, La. R.S. 40:2203.1(E) would have made La. R.S. 23:1201(E) applicable to workers' compensation claims covered under the Any Willing Provider Act. The reference to private and group health billing and payment guidelines, combined with the absence of any reference to the workers' compensation billing and payment standards, is compelling evidence that the Any Willing Provider Act was intended to apply only to private or group health insurance and not to workers' compensation claims.

(ii) The Provider to Payor Notice Requirements Found in the Workers' Compensation Act are at Variance with the Payor to Provider Notice Requirements Found in the Any Willing Provider Act.

The notice mandates of La. R.S. 23:1201, and all other pertinent notice requirements imposed under the Workers' Compensation Act, are diametrically opposed to the notice provisions found in the Any Willing Provider Act. La. R.S. 23:1201(E) plainly states payment for medical services to a workers' compensation patient is not due until sixty days after the healthcare provider furnishes "written notice thereof" to the "employer or insurer." The requirement that the provider furnish written notice to the employer or insurer is consistent with several other requirements of the Workers' Compensation Act, including (1) the employee's right to select his or her physician granted under La. R.S. 23:1121(B)(1); and (2) the provider's obligation to request approval from the payor prior to rendering non-emergency care in excess of

[104] La. R.S. 40:2203.1(D) provides "In no instance shall any provider be bound by the terms of a preferred provider organization agreement that is in violation of this Part."

[105] *Pumphrey v. City of New Orleans*, 2005-979 (La. 4/4/06), 925 So.2d 1202, 1210; *Kennedy v. Kennedy*, 96-0732, 96-0741 (La. 11/25/96), 699 So.2d 351, 358.

$750.00 to the workers' compensation patient.[106] It is, however, entirely *incompatible* with the notice procedure contemplated by the Any Willing Provider Act, whereby, in the absence of a benefit card, "written notice shall be required by *any entity accessing an existing group purchaser's contractual agreement or agreements at least thirty days prior* to accessing services through a participating provider …."[107] In sum, the Workers' Compensation Act requires the *provider* give written notice to the *employer or insurer* to trigger the sixty (60) day payment window, while the Any Willing Provider Act mandates the *employer or insurer* (as the entity accessing the PPO network) give written notice to the *provider* at least thirty (30) days before treatment is sought from that provider by an employee or insured. The advance notice requirement of the Any Willing Provider Act seems particularly ill-suited to the workers' compensation arena since the employee/insured — and not the employer/insurer — selects the provider and thus the employer/insurer (much less the network administrator) has no way of knowing beforehand which provider will render the treatment for which advance notice is allegedly required. Similarly, workers' compensation injuries are *accidents* and there is no way to predict the need for medical services 30 days before the *accident* occurs. It is difficult to comprehend how the respective notice schemes could be more different, much less how the respective obligations can be reconciled.

A further distinction is that the Any Willing Provider Act allows benefit cards to serve as notice, while the Workers' Compensation Act makes no mention of, and nowhere requires, benefit cards. A benefit card has never been a feature of the workers' compensation marketplace, but has long been a fixture within the private and group health insurance community. This divergence begs the essential question: Why would a benefit card be the first form of notice if the Any Willing Provider act was intended to apply to a system, such as workers' compensation, that did not use benefit cards? The only logical answer is that the Any Willing Provider Act was not intended to apply to workers' compensation. This conclusion is supported by considering how the different systems operate.[108]

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[106] La. R.S. 23:1142. Requiring the health care provider to furnish written notice to the workers' compensation employer or insurer — and not the other way around — is also consistent with the duties for verification of coverage, itself a species of notice, imposed under the Louisiana Administrative Code.

[107] La. R.S. 40:2203.1(B)(5).

[108] For example, group health plan premiums are fixed based on a "Per Member Per Month" ("PMPM") calculation. This calculation is an approximation of average cost, payment or utilization obtained by taking the total costs, payments or use of services and dividing by the number of members enrolled in the health plan for the month or months under review. Workers' compensation premiums are determined by an "experience rating" which analyzes the actual payroll and loss data for the individual employer over a period of time. Typically, the latest

A benefit card is a commitment to pay the medical bill consistent with the terms of the underlying health plan; the commitment can be given in private or group health because private and group health is supported by a health benefits plan that defines between the plan and its enrolled members the eligible expenses covered by the plan. Thus, the plan underwriter's liability for the treatment expense is determined at the moment the plan member enrolls and the plan accepts the member's initial premium.[109] No benefit card is issued for workers' compensation because, unlike group health, compensability for the workers' compensation claim has not been determined at the time the patient presents for treatment. Moreover, the scope of covered treatment for the injured worker is not pre-defined by plan terms; it is by operation of law unrestricted. Thus, whether the workers' compensation payor will be responsible for the medical bill, and in what amount, is not known.[110] The workers' compensation payor does not commit to pay the medical bill until these variables are determined. Louisiana law recognizes this distinction by requiring the provider contact the responsible party for authorization before treatment is rendered to workers' compensation patients and by staging a series of checks and balances thereafter.[111]

Additional clues that the "benefit card" referenced by the Any Willing Provider Act is a group health benefit card is found in the text of the statute itself. La. R.S. 40:2203.1(B)(1) (in-state PPOs) and (B)(2) (out-of-state PPOs) provide the matrix for determining the "applicable contractual agreement that shall be binding on a provider" where multiple preferred provider organizations are listed on a single benefit card. Multiple group health plan options is a common strategy for a large employer with geographically diverse facilities or employees with special health concerns. Conversely, that same large employer would have but a single workers' compensation insurance policy because its workers' compensation premium is calculated on the experience rating underwriting model.

Even more compelling evidence is found in La. R.S. 40:2203.1(B)(3) and (B)(4). Each section refers to the "plan sponsor" and (B)(3) refers to the "plan sponsor and beneficiary." Both

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available three years of data for each employer are compared to similarly profiled risks to calculate the experience modification. *See* Affidavit of Gregory C. Mast, Exhibit 29.

[109] *See* Affidavit of Gregory C. Mast, Exhibit 29.

[110] *See* Affidavit of Gregory Mast, Exhibit 29.

[111] *See* Footnote 22, *supra*.

"plan sponsor" and "beneficiary" are defined terms under ERISA.[112] Both have specific meaning in the group health context; neither applies to workers' compensation. Moreover, Part VI-E of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950, the "Health Care Consumer Billing and Disclosure Protection Act," proscribes in substantial detail the information that must be shared between and among the provider, the health insurer, and the enrolled member, including that a benefit card "shall contain sufficient information to clearly identify the health insurance issuer."[113] There is no parallel requirement in the Workers' Compensation Act. But if a workers' compensation benefit card was prescribed, it would in default of a preferred provider organization be required to identify the patient's employer or workers' compensation insurer, not the "plan sponsor."

The distinction between health insurance and workers' compensation insurance is drawn in relevant manner by the Workers' Compensation Act, too. La. R.S. 23:1205 provides that in the event the workers' compensation insurer or the employer denies the worker's claim, the worker's health insurance policy will by operation of law "drop down" to cover the medical benefits. The health insurer is thereafter granted a right of action to recover from the employer or workers' compensation insurer the amounts paid on the employee's behalf. In such circumstances, the payor or worker's compensation insurer becomes obligated to reimburse only the amount advanced by the group health insurer, despite the fact that such amount is typically less than the reimbursement levels stated in the Louisiana Worker's Compensation fee schedules. Moreover, the language of La. R.S. 23:1205(C) plainly distinguishes between "health benefits" available and payable under group or private health insurance and "medical benefits" owed the employee (or his or her provider) under the Workers' Compensation Act. [114] This distinction is further drawn by La. R.S. 22:1061, where payments under "Workers' compensation or similar insurance" are "excepted benefits" from Louisiana's requirements for portability, availability and

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[112] 29 U.S.C. § 1002(8) defines "beneficiary" as "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(16)(B) defines "plan sponsor" as (i) the employer in the case of an employee benefit plan established or maintained by a single employer (ii) the employee organization in the case of a plan established or maintained by an employee organization, (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan."

[113] *See,* La. R.S. 22:1873(B), formerly La. R.S. 22:250.43(B).

[114] The only reference to "benefits" found in the Any Willing Provider Act is the term "health benefits" found in La. R.S. 40:2203.1(A). There is no parallel reference in the Act to "workers' compensation benefits." A "health benefit plan" is defined only in La. R.S. 22:1091(6), and there to exclude from the definition "workers' compensation or similar insurance…."

renewability.[115] Plainly, Louisiana law treats “health benefits” under group or private health insurance differently from “medical benefits” due under workers’ compensation insurance. This is important because the Any Willing Provider Act, by its terms, applies only to “health benefits”. These legislatively created distinctions should be maintained.

(iii) The Negotiated Alternative Rates of Payment Concept of the Any Willing Provider Act and its Damages Provision Predicated on Evaluating Fair Market Value are Inconsistent with the Fixed Fee Schedule Approach Under the Workers Compensation Act

The Workers’ Compensation reimbursement schedule is administratively established based on “the mean of the usual and customary charges” for medical services.[116] There is but one mandatory schedule for the entire state of Louisiana. In stark contrast, a “Preferred Provider Organization” is a contract or series of contracts providing “alternative rates of payment,” defined as “the rate at which or sum for which the provider agrees to perform specified services.”[117] The “alternative rates … shall be negotiated between purchaser and provider and shall be in effect for a fixed term” and “may, but need not, include a discount from the provider’s customary fee.”[118] In short, there is one workers’ compensation fee schedule but as many different “alternative rates of payment” as there are provider agreements and customary fees.

Permitting each provider to negotiate “alternative rates”, including a fee below the provider’s customary rate, is facially incompatible with the reimbursement schedule mandate contained in the Workers’ Compensation Act. The divergence is underscored by the different methods found in the respective statutory schemes for calculating liabilities for the same dereliction — improper payment of the provider’s medical bills. Any Willing Provider Act “damages” allow for “double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars ….”[119] The Workers’ Compensation Act calculates penalties in a materially different manner from the “damages” available under the Any Willing Provider Act and those penalties are capped at a maximum amount.[120]

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[115] La. R.S. 22:1061(3)(a)(iv) , formerly La. R.S. 22:250.1(3)(a)(iv).

[116] La. R.S. 23:1034.2.

[117] La. R.S. 40:2202(5).

[118] La. R.S. 40:2202(1).

[119] La. R.S. 40:2203.1(G).

[120] La. R.S. 23:1201(F).

Moreover, the concept of "fair market value" as a means for establishing the penalty amount is completely foreign to a statutory scheme that schedules prices based on a statewide consensus. "Fair market value" for a service contemplates the actual cost, including general overhead attributable to the service, and a reasonable profit; it is an individual determination, not a state-wide mean value. "Fair market value" is frequently defined in terms of what a reasonable buyer would pay for the service in light of the surrounding circumstances.[121] "Fair market value" thus factors regionalism, timing, availability, and in the highly competitive health care community, provider or institutional reputation and specialization, as well as insurance and private provider contracting relationships. This multifaceted determination is wholly inconsistent with the pre-determined, scheduled, fixed fee approach adopted by the Workers' Compensation Reimbursement Schedule. Moreover, the Any Willing Provider Act provision, which must be strictly construed, does not refer to the Workers' Compensation Reimbursement Schedule as a source for determining the appropriate liability where the claim arises from treatment of a workers' compensation patient, and thus a Court may not infer that the Reimbursement Schedule represents an appropriate source.[122]

(iv) The Any Willing Provider Act only applies to Preferred Provider Organization Agreements having "Members"

The hasty, but incorrect, retort to arguments against applying the notice requirements of the Any Willing Provider Act to workers' compensation claims is that La. R.S. 40:2203.1 recites that "the requirements of this section apply to all preferred provider organization agreements …."[123] The "cardinal rule" for interpreting a statute is "that a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context."[124] The rules of statutory construction are designed to ascertain and enforce the intent of the legislature.[125] The meaning and intent of a law is determined by considering the law in its entirety and all other laws

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[121] *See, e.g., Morphy, Makofsky & Masson, Inc. v. Canal Place 2000,* 538 So.2d 569 (La.1989); *Cox v. Secretary, Louisiana Dep't of Health and Hospitals*, 41,391 (La. App. 2 Cir. 8/25/06); 939 So.2d 550 (defining "fair market value" as "the value of an asset, if sold at the prevailing price at the time it was actually transferred.").

[122] The AWPA is a penal statute that must be strictly construed. *See, Bonnette v. Conoco, Inc.*, 01-2767 (La. 1/28/03); 837 So.2d 1219. Under general principles of statutory construction, the AWPA thus should not be extended to workers' compensation matters absent *an express declaration that it was intended to apply to workers' compensation matters*. No such declaration appears in the text of the Act.

[123] La. R.S. 40:2203.1(A).

[124] *King v. St. Vincent's Hospital*, 502 U.S. 215, 221, 112 S.Ct. 570, 574 (1991); *see also, Shell Oil Co. v. Iowa Dep't. of Revenue*, 488 U.S. 19, 26, 109 S.Ct. 278, 282 (1988).

[125] *SWAT 24 Shreveport Bossier, Inc. v. Bond*, 2000-1695 (La.6/29/01); 808 So.2d 294, 302; *Succession of Boyter*, 99-0761 (La.1/7/00); 756 So.2d 1122, 1128; *Stogner v. Stogner*, 98-3044 (La.7/7/99); 739 So.2d 762, 766.

on the same subject matter and by placing a construction on the law that is consistent with the express terms of the law and with the obvious intent of the legislature in enacting the law.[126] The United States Supreme Court has repeatedly stressed that "[s]tatutory interpretation 'is a holistic endeavor,' and, at a minimum, must account for a statute's full text, language as well as punctuation, structure, and subject matter."[127]

Thus, while "all" connotes broad coverage, it cannot be read in isolation. "[I]t is the duty of this court to restrict broad statutory language if [it is] convinced the legislature did not intend such an effect."[128] "Words are not pebbles in alien juxtaposition; they have only a communal existence; and not only does the meaning of each interpenetrate the other, but all in their aggregate take their purport from the setting in which they are used …."[129] Here, the word "all" modifies the defined phrase "preferred provider organization agreements." These terms must be read together to gauge the statutory reach. "Preferred provider organization" is defined by the Any Willing Provider Act to mean:

> a contractual agreement or agreements between a provider or providers and a group purchaser or purchasers to provide for alternative rates of payment specified in advance for a defined period of time in which
>
> (i) The provider agrees to accept these alternative rates of payment offered by group purchasers ***to their members*** whenever a ***member*** chooses to use its services and
>
> (ii) There is a tangible benefit to the provider in offering such alternative rates of payment to the group purchaser.[130]

The term "preferred provider organization agreements" thus embraces an offer and acceptance of alternative rates of payment made to group purchaser ***members***. Offer and acceptance occurs in group health when the member enrolls in the plan and pays the initial and continuing premium; it does not occur in the workers' compensation context, which is simply an employee benefit.

The Any Willing Provider Act maintains this distinction, guaranteeing "Group purchaser ***members*** participating in preferred provider organizations" access to "their standard benefits

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[126] *SWAT 24 Shreveport Bossier*, 808 So.2d at 302; *Succession of Boyter*, 756 So.2d at 1129.

[127] *United States Nat'l. Bank of Oregon v. Indep. Ins. Agents of America, Inc.,* 508 U.S. 439, 455, 113 S.Ct. 2173, 2182 (1993).

[128] *Green v. Louisiana Underwriters Insurance Company,* 571 So.2d 610, 614 (La. 1990)(although a literal reading of La. R.S. 49:258 required the office of risk management to concur in the appointment of private legal counsel to represent the Commissioner of Insurance "we are convinced the legislature did not intend such a result.").

[129] *NLRB v. Federbush Co.*, 121 F.2d 954, 957 (2nd Cir. 1941) (L. Hand, J.).

[130] La. R.S. 40:2202(5)(a) (emphasis added)

under the terms of their policy, employee benefits, self funded organization benefits or Taft-Hartley trust benefits."[131] "Employee benefits" are by definition discretionary non-wage compensation[132] provided to employees in addition to wages or salaries. "Taft-Hartley trust benefits" refer to health benefits drawn from a self-funded union-management welfare fund organized under the Taft-Hartley Act of 1947,[133] all of which constitutes a welfare benefit plan as defined by ERISA.[134] None of these terms relate in any way to workers' compensation, nor does the statute use any terms suggesting it applies to workers' compensation.

The term "members," is not defined in the Any Willing Provider Act, but clearly references membership in group health benefit plans. The term enjoys commonplace usage in the group health arena. The term is used pervasively in the group health case law.[135] The Louisiana Administrative Code, at Title 32 (Employee Benefits), Part III, entitled "Preferred Provider (PPO) Plan of Benefits" defines "Group Health Plan" as

> "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families."

Part III defines a "plan member" as "a covered person other than a dependent." [136] A "covered person" is in turn defined as "an active or retired employee, his/her eligible dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed and for whom the required contribution is made."[137] A "covered person" includes "eligible dependents" and plainly differs from an "employee" covered by workers' compensation. This distinction is maintained in the First Health Provider Agreements, which

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131 La. R.S. 40:2203(C).

132 These include group insurance (health, life, dental, or vision), disability income protection, retirement benefits, daycare, tuition reimbursement, sick leave, vacation (paid and non-paid), social security, profit sharing, company vehicles, or expense accounts. Workers' compensation coverage is not a "benefit;" it is statutorily required.

133 61 Stat. 136 (1947).

134 29 U.S.C. § 1002(1).

135 *Arana v. Ochsner Health Plan*, 338 F.3d 433, n. 2 (5th Cir. 2003) (quoting Group Health Services Agreement's reference to participants and beneficiaries of the plan as "members"); *Walker v. Wal-Mart Stores, Inc.*, 159 F.3d 938 (5th Cir. 1998); *Trivette v. State, Office of Group Benefits*, 2005-2245 (La. App. 1 Cir. 1/24/07); 952 So.2d 731 (describing plan enrollees as "members"); *Louisiana Health Services and Indem. Co. v. Brown Builders, Inc.*, 32,575 (La. App. 2 Cir.12/8/99); 747 So.2d 708 (discussing health plan "membership").

136 LAC 32:I.601. The term "plan member" appears throughout Title 32, each time in reference to specific group health PPO features. *See* LAC 32:I.303 (Fee Schedule); LAC 32:I. 307 (Utilization Review); and LAC 32:I.309 (Outpatient Procedure Certification).

137 *Id.*

defines a "Participating Patient" as "those employees *or* ***members and their dependents*** who have elected to receive care from Provider and who are covered by the Payor's Benefit or Insurance Plan."[138] Moreover, Part III excludes from the state-sponsored Preferred Provider Organization coverage "injury compensable under any workers' compensation program, regardless of whether the patient has filed a claim for benefits."[139]

The term "member" has no significance whatsoever to worker's compensation. One searches the worker's compensation laws and case law in vain for the term in the context of medical benefits to "employees" or to "injured workers." Similarly, workers' compensation coverage never extends to *retired* employees, dependents, or "other individual[s] eligible for coverage," nor is the employee required to make co-payments or achieve deductibles before coverage is extended. These are features of private and group health programs and thus the only preferred provider organization with "members" are in private or group health. Consequently, these are the only preferred provider organization covered by the Any Willing Provider Act.

Plaintiffs in this case have also conceded that provider contracting for the care of injured employees fails the second prong of the Preferred Provider Organization definition provided by La. R.S. 40:2202(7) because such contracting fails to afford a "tangible benefit" to the provider. "Tangible benefit" is defined as "any reasonable expectation of a demonstrable increase in or maintenance of usage of the provider's services" -- what the industry commonly refers to as "steerage." Steerage is a conceptual benchmark for managed care.[140] But throughout this litigation, the providers have contended the "steerage" requirement necessary for a "preferred provider organization agreement" is irreconcilable with the mandate of La. R.S. 23:1121(B), which grants the injured worker an absolute right to select his or her treating physician in any field without the involvement or approval of the employer or its insurer. Plaintiff Lake Charles Memorial Hospital's Chief Financial Officer contended that there is no "steerage" in Louisiana workers' compensation, testifying:

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138 *See* Exhibits 2 and 3, at ¶ 2.6.

139 LAC 32:I.317(A)(1).

140 *See e.g. HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 987 (11th Cir. 2001)(" The PPO providers furnish their services at discounted rates because they expect to receive a higher volume of patients …. The increase in the volume of patients is a result of third party payors, who pay the bills for medical services plan participants receive, directing plan participants to providers in the PPO network through marketing materials and financial incentives.")

A. If I understand your question, we realized that workers' comp, because there is no steerage in Louisiana, that workers' comp could come from anywhere.[141]

Plaintiff Carol Beutler even more pointedly claimed the absence of steerage in Louisiana's workers' compensation laws:

Q. So even discounted, why wouldn't you want as many workers' compensation patients as you could possibly get?

A. I don't get workers' compensation patients from employers; I get patients because they personally choose my office. If someone had a hundred employees and those employees got hurt and the employer said, "Go see Dr. Beutler," that would be an advantage to me to be part of their group. But if these people get hurt on the job and they choose to pick me, you haven't done anything to send me that business, so I don't have a contract with you. I haven't agreed to take your injured employees and reduce my fees.[142]

The providers' testimony that steerage does not exist in workers' compensation takes their claims outside the definition of a "preferred provider organization" and removes it from the reach of the Any Willing Provider Act. Thus, while the Any Willing Provider Act references *all* preferred provider organization agreements, that reference must be judged against the Any Willing Provider Act's definition of preferred provider agreement — a context which embraces only group health plans because only group health plans have ***members*** and, according to the plaintiffs provide the "tangible benefit" necessary to the statutory definition.

The function of the court is to interpret the laws so as to give them the meaning which the lawmakers obviously intended them to have and not to construe them so as to give them absurd or ridiculous meanings.[143] "Laws are presumed to be passed with deliberation and with full knowledge of all existing ones on a subject when reasonably possible."[144] It is inconceivable that the Louisiana legislature would intentionally promulgate contradictory, dysfunctional laws in different chapters of the Revised Statutes, but intend both to address the same subject matter — fees for medical services rendered to occupationally ill or injured workers. It is equally inconceivable that the legislature would sanction substantial recovery to the providers under both Title 23 and Title 40 for precisely the same relatively minor dereliction — improper payment of a workers' compensation bill, or expose those entities that operate in workers' compensation but

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141 Deposition of Charles Phillip Whitson, Exhibit 8, at 27.

142 Deposition of Carol M. Beutler, Exhibit 4, at 42.

143 *Webb v. Parish Council of Parish of East Baton Rouge*, 217 La. 926, 47 So.2d 718, 720 (1950).

144 *Theriot v. Midland Risk Ins. Co.,* 95-2895 (La. 5/20/97); 694 So.2d 184, 186.: *Louisiana Municipal Assoc. v. State of Louisiana*, 2004-0227 (La. 1/19/05), 893 So.2d 809, 837.

also meet the definition of "group purchaser" to both the penalty provisions of Title 23 and the Draconian "damages" available under Title 40.[145] The common sense conclusion is that the Any Willing Provider Act — as is the balance of Title 40 — was drawn to cover private and group health insurance, while La. R.S. 23:1201 — as is the balance of Title 23 — was intended to provide a recovery for medical bills for treatment rendered to occupationally ill or injured workers. Any other result is an absurd one.

E. PAYMENTS MADE PURSUANT TO FIRST HEALTH'S DIRECT CONTRACTS WITH PROVIDERS ARE EXEMPT FROM THE NOTICE REQUIREMENTS OF La. R.S. 40:2203.1

"A Preferred Provider Organization (PPO) is a health care system that operates by inducing institutional and other providers to provide services at reduced cost in exchange for membership in a limited provider network. Membership in such a network results in increased patient volume, stimulated in turn by the provision of lower cost services for plan participants at the institutions that constitute the network of preferred providers."[146] This "steerage" [147] is the core of the managed care concept, and is accomplished by the network through contracts with its payor clients. As one court explained:

> In essence a PPO is a network of health care providers organized to offer medical services at discount rates. The PPO providers furnish their services at discounted rates because they expect to receive a higher volume of patients, i.e., participants in the welfare benefit plan offered by the insurance company. The increase in the volume of patients is a result of third party payors, who pay the bills for medical services plan participants receive, directing plan participants to providers in the PPO network through marketing materials and financial incentives. Because third party payors, such as insurance companies, are financially responsible for the costs of a plan participant's covered medical care, it is in the third party payor's best interest for the plan participant to receive medical care from a provider who has promised to accept a discounted fee. The use of financial incentives and other measures to direct plan participants to providers in the PPO is known in the health care industry as "steerage." [148]

In 1984, the Louisiana legislature voted to "assist in reducing health care costs by authorizing the formation of preferred provider organizations."[149] Such organizations have been

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145 For example, a Third Party Administrator that handles workers' compensation billing transactions.

146 *HCA Health Services of Va., Inc. v. Metropolitan Life Ins. Co.,* 752 F. Supp. 202, 204 (E.D.Va. 1990), *appeal dismissed.,* 957 F.3d 120 (4th Cir. 1992).

147 "Steerage" is more limited in the workers' compensation system since the injured employee is free to select his or her physician. La. R.S. 23:1121(B)(1). *See also* Exhibit 22, Affidavit of Gary M. Stein.

148 *HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 987 (11th Cir. 2001). *See also Levine v. Central Florida Medical Affiliates, Inc.*, 72 F.3d 1538, 1546 (11th Cir. 1996).

149 La. R.S. 40:2201(C).

a legitimate fixture of the health care markets ever since, saving both Louisiana employers and insurers contracted to the Preferred Provider Organization and Louisiana's citizenry enrolled in it substantial amounts.

(i) The Any Willing Provider Act and the "Silent" PPO

The legislative history of the Any Willing Provider Act demonstrates that it was drawn not to punish legitimate organization participants, but to deter "silent PPO" activity.[150] The term "silent PPO" is somewhat misleading because a "silent PPO" is not a true preferred provider organization. The "silent PPO" is a secondary market vendor that does not establish contractual privity with either the provider or the network organizer prior to accessing the network and applying an alternative rate of payment to the provider's medical bill. The result is the provider's bill is discounted without contractual authority and the network such as First Health receives no compensation. The "silent PPO" must be distinguished from the directed or non-directed preferred provider organization. The United States Inspector General's 1998 Report on "silent PPO" activity in the Federal Employees Health Benefits Program explains the distinction:

> ***A "silent" PPO is distinguished from a "non-directed" PPO by the nature of the contractual relationship between the parties***. As stated above, in a "non-directed" relationship, discounts are taken pursuant to contractual arrangements that can be traced from the payer (i.e., the insurance carrier) to the medical provider. ***In a "silent PPO," a contractual relationship cannot be traced from the payer to the medical provider from whom the discount is taken. Typically, in a silent PPO arrangement, another PPO will sell its medical provider's names and discounted fee information, often without the provider's knowledge and permission, to a secondary market of vendors***. These vendors then access the information on behalf of their payer clients, recalculating the provider's fee based on the discounted fee information. It has been alleged that sometimes, the payer may claim a non-existent affiliation with the provider by inaccurately declaring that the patient is a member of a PPO to which the provider is a member.[151]

Following the Inspector General's report, several states enacted legislation designed to deter "silent PPO" activity.[152] Louisiana's "silent PPO" legislation is La. R.S. 40:2203.1.[153] The

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[150] Class Counsel previously expressed agreement with First Health's position the Any Willing Provider Act was designed to address only the "silent PPO" and that directly contracted networks, such as First Health, are exempted from the Act. At a hearing while this matter was pending in federal court, counsel stated with specific reference to the Focus network: "They did an end around. *It's called a silent PPO, and that's actually what the statute was meant to prevent*, doctors signing up for one network and having that network go and sell their network to another network that they didn't want to be a part of, … The doctors did sign network agreements. The network agreements did have discounts in them." *See, Transcript of Proceedings, Oral Argument, Clark A. Gunderson, et al. v. F. A. Richard & Assoc., Inc., et al.*, CA No. 04-1242, *March 17, 2005*, at 78, 79, attached hereto as Exhibit 30.

[151] Office of the Inspector General, Office of Personnel Management, Rep. No. 99-00-97-054, Report on the Use of Silent PPOs in the Federal Employees Health Benefits Program 20-23 (1998).

[152] A total of seven states enacted "silent PPO" legislation in apparent response to the federal inquiry. North Carolina enacted the first such legislation in 1997. In 1999, California, Louisiana, and Texas enacted similar bills, and Kentucky, Oklahoma, and Wisconsin followed in 2000.

[153] *See, e.g.,* Exhibit 22, Affidavit of Gary M. Stein.

legislative history of La. R.S. 40:2203.1 supports First Health's position that directly contracted networks with verifiable payors making payments pursuant to those agreements are exempt from its notice provisions. The Louisiana Supreme Court has consistently held that "the paramount consideration in interpreting a statute is ascertaining the legislature's intent and the reasons that prompted the legislature to enact the law."[154] La. R.S. 40:2203.1 was introduced through House Bill No. 1072, first proposed during the 1999 Regular Session. The original version of the Act did not contain the second sentence to La. R.S. 40:2203.1(A) found in the enrolled version.[155] The second sentence was introduced through amendments to House Bill No. 1072 authored by the House Committee on Insurance.[156] The pertinent Minutes from the May 6, 1999 meeting of the House Committee on Insurance reflect the reasons for and intent behind amending House Bill No. 1072 to add the direct contract exemption:

> **House Bill No. 1072 by Representative Alexander**
>
> At the request of Representative Alexander, Mr. Greg Frost, representing Columbia Health Care Association, no address given, presented House Bill No. 1072, which prohibits certain practices by preferred provider organizations.
>
> Dr. Jack Finn, representing Metropolitan Hospital Council, 2450 Severn Avenue, Metairie, LA 7001, (504) 837-1171, and in support of the proposed legislation stated that ***the purpose of House Bill No. 1072 is to seek [to] void the use of PPO contracts by parties that are not part of that contract***.
>
> Representative Donelon informed the committee that ***amendments have been drafted to try to accomplish the original goal of the legislation***.
>
> Mr. Frost stated that the amendments remove State Group Benefits because they have their own direct contracts and, typically, a labor union health benefit plan will have its own direct contracts. ***He further stated that the point of the amended version of the bill is to eliminate those who have assembled their own networks***.
>
> Representative Donelon offered ***amendments*** to House Bill No. 1072, which ***make proposed law inapplicable to a group purchaser when providing health benefits through its own network or direct provider agreements and to such agreements of a group purchaser. It also provides for enforceability of the application of alternative rates of***

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[154] *SWAT 24 Shreveport Bossier, Inc. v. Bond*, 2000-1695 (La. 6/29/02); 808 So.2d 294; *see also Exxon Pipeline Co. v. Louisiana Public Service Comm'n.*, 98-1737 (La. 3/2/99), 728 So.2d 855, 860; ("…in many cases, the legislative history of an act and contemporaneous circumstances may be helpful guides in ascertaining legislative intent."); *Theriot v. Midland Risk Ins., Co.*, 95-2895 (La. 5/20/97); 694 So.2d 184, 186 ("One particularly helpful guide in ascertaining the intent of the legislature is the legislative history of the statute in question and related legislation.").

[155] *See,* Exhibit 31, Original Version, H.B. No. 1072, HLS 99-1876.

[156] *See,* Exhibit 32, Engrossed Version of H.B. No. 1072, HLS 99-1876. The comments to the engrossed version note the "Proposed law provides that it shall not apply to a group purchaser when providing health benefits through its own network or direct provider agreements or to such agreements of a group purchaser" while the "Summary of Amendments Adopted by House" recites the same limits on the application of La. R.S. 40:2203.1.

> ***payment in a PPO agreement*** for medical services claims paid within the time period specified by the agreement or within 30 days if not so specified.[157]

The "direct contract" exemption speaks directly to the legislative concern, which was to protect Louisiana health care providers from the "silent PPO", i.e., the secondary market vendor that brokers (for a fee) the discount to an end payor (or is itself the payor) so that the payor takes a discount against the provider's bills despite the absence of an established contractual relationship. The amendment is designed to exempt from the Any Willing Provider Act's notice requirements "those who have assembled their own networks" ***or*** who have "direct provider agreements" — First Health in this case — and those who take discounts through "such agreements of a group purchaser." This describes precisely the primary preferred provider organization markets; a market which the Louisiana legislature has praised, not condemned and the arrangement the providers expressly sanction under the terms of their provider agreements.

First Health's interpretation of the "direct contract exemption" is in harmony with the rest of the Any Willing Provider Act, as well as the definition of "group purchaser" adopted by this Court in its prior rulings. The Act defines a "preferred provider organization" as "a contractual agreement or agreements between a provider or providers and a group purchaser or purchasers" in which the providers accept a discount from the provider's customary fee in return for a tangible benefit to the provider.[158] Thus, the Any Willing Provider Act recognizes that more than a single agreement is necessary to create a preferred provider *organization* and embraces both directed and non-directed preferred provider organizations within the statutory definition.[159]

First Health's argument is complemented by the broad definition of "group purchaser" adopted by this Court. The Court's prior rulings recognize that more than one group purchaser participates to form the organization and that the group purchaser field "may include … brokers for the formation of such [PPO] contracts, including health care financiers, third party

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[157] Exhibit 33, at 2, Legislative History for H. B. No. 1072, House Committee on Insurance, Minutes of Meeting, 1999 Regular Session, May 6, 1999, at 7. *See also,* Audio Tapes of Insurance Committee Hearings on HB 1072 and transcripts thereof attached as Exhibit 27.

[158] La. R.S. 40:2202(5)(i) and (ii) and La. R.S. 40:2202 (1)(for definition of "alternative rates of payment") and La. R.S. 40:2202(7)(for definition of "tangible benefit").

[159] This reading is further supported by the definition of the term "Network of providers" found in La. R.S. 22:1381(16), which is incorporated into La. R.S. 40:2203.1 by La. R.S. 40:2203.1(E). The term is defined to mean "an entity, including but not limited to a preferred provider organization as defined in R.S. 40:2202(5) and (6), other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by individuals or groups of individuals eligible for health insurance coverage to health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer."

administrators, providers or other intermediaries."[160] The Court's definition of "group purchaser" embraces the secondary market vendor that brokers the provider's discount. The statute sensibly exempts from the notice requirements the group purchaser directly contracted to the provider because that group purchaser has the provider's contractual consent to discount charges and contractual permission to extend the discount to a contractually defined group of contracted payors. The secondary market group purchaser, on the other hand, enjoys no pre-existing contractual authorization from the provider. Moreover, a directly contracted network such as First Health neither takes the discount nor pays the provider's medical bill.[161] It would be impractical to require the network organizer to provide advance notice of a discount sequence it did not initiate and has no notice of until after-the-fact. A true "silent PPO" scenario presents an even more attenuated scenario. There, the network (like the provider) has no existing written relationship authorizing the end payor to discount the medical bill and never receives notice that the contested discount has occurred.[162] That was precisely why the amendment to the original version of H.B. No. 1072 was passed and precisely why cases such as this one (at least as against one who has assembled its own network, such as First Health) represent an abusive extension beyond the intended scope of La. R.S. 40:2203.1.

This very point was recognized by United States District Judge Trimble in *Liberty Mutual Ins. Co. v. Gunderson*.[163] At issue there was whether the First Health Provider Agreements signed by Plaintiff Class representatives Dr. Clark Gunderson and Lake Charles Memorial Hospital were exempt from the notice requirements of the AWPA and whether the Provider Agreements violated Louisiana's workers' compensation laws. Judge Trimble reviewed the legislative history of the AWPA, as well as the "Legislative considerations" stating the purpose of the PPO statutes is to control the rising costs of providing quality health care benefits.[164] Judge Trimble recognizing that the AWPA was intended to address "silent" PPO

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160 La. R.S. 40:2202(3)(b). First Health takes no position on the correctness of this Court's interpretation, but recognizes it as controlling in this case until reversed.

161 Thus, First Health can never be the "entity accessing an existing group purchaser's contractual agreement or agreements" from whom written notification is required under La. R.S. 40:2203.1(B)(5).

162 This also begs the essential question of which of the several "group purchasers" identified by this court is responsible for giving whatever notice might be required by La. R.S. 40:2203.1 for the particular transaction. It certainly makes no sense to require the network group purchaser furnish notice of a transaction it does not even know has occurred.

163 2006 WL 367700 (W.D.La. February 15, 2006)(No. 04-2405).

164 La. R.S. 40:2201 states:

activity:

> A "group purchaser" is defined as "an organization or entity which contracts with providers for the purpose of establishing a preferred provider organization." First Health is a group purchaser. The PPO Contract between Liberty Mutual and First Health is an "agreement of [a] group purchaser [*i.e.* First Health]. Accordingly, the language of the ***statute is clear that the notice requirements do not apply to group purchasers when providing health benefits through their own network or to such agreements of group purchaser***. ***This is the logical and reasonable interpretation of the statute and is in line with the Legislature's intent to contain escalating health care costs***.[165] Furthermore, and more significantly, this was the expectation of the parties when they entered into the PPO Contract and Provider Agreements.
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> * * *
>
> We are further persuaded by First Health's arguments concerning the intent of the legislature that the notice provision at issue here applies to a "**silent PPO**" where there is no direct contract between the provider and the PPO. For example, when a PPO (such as First Health) makes an assignment to another PPO network. It is in those instances that the notice requirement provisions of Louisiana Revised Statute § 40:2203.1 become applicable because there is no direct contract between the provider and the PPO assignee.[166]

A. The legislature recognizes that health care costs have risen greatly over the past decade and must be contained without jeopardizing:

(1) The quality of care received by the patients.

(2) The ability of health care providers to maintain, update, and expand their facilities to serve their patients and communities and to meet federal and state standards and regulations.

B. The legislature further recognizes that there must be some incentive for purchasers and providers to strive for more cost-efficient and effective methods of providing quality patient care and more efficient payment for services rendered.

C. Therefore, the state can assist in reducing health care costs by authorizing the formation of preferred provider organizations.

D. The legislature further recognizes that the state and governmental bodies can educe the cost of providing health care benefits for their employees by contracting with a preferred provider organization.

[165] Many states have adopted provisions similar to the Louisiana Reimbursement Schedule and those states nevertheless require that health care providers honor legitimate PPO contract terms. *See* California, West's Ann. Cal. Labor Code § 5307.1(h)("Nothing in this section shall prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule"); Fla. Stat. § 440.13(12)(a)("An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule"); Ky. Revised Stat. Ann. § 342.020(4)(h)(Managed care health systems include "A schedule of fees for all medical services to be provided under this chapter which shall not be subject to the limitations on medical fees contained in this chapter"); Massachusetts G.L.A. Ch. 152, § 13(1)"The rate of payment by insurers for health care services adjudged compensable under this chapter shall be established by the division of health care finance and policy under the provisions of chapter one hundred and eighteen G; provided, however, that a different rate for services may be agreed upon by the insurer, the employer and the health care service provider"; Mont. Stat. 39-71-704(5)("Payment pursuant to reimbursement agreements between managed care organizations or preferred provider organizations and insurers is not bound by the provisions of this section"); New Mexico Stat. Ann. 1978 §52-4-5(H)(Nothing in this sections shall prevent an employer from contracting with a health care provider for fees less than the maximum charges allowable"); New York McKinney's CL Work Comp § 355 ("The medical fee schedules authorized pursuant to section thirteen of this chapter shall not apply to any medical services provided by a preferred provider organization pursuant to the provisions of this article"); North Carolina Gen Stat. § 97-26(c)(Each health care provider subject to the provisions of subsection (a) of this section shall be reimbursed the amount specified under the fee schedule unless the provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology"); Oregon Revised Stat. § 656.248(2) and Admin. Reg. 436-009-0040(1)("For all MCO enrolled claims, payment of fees shall be at the provider's usual and customary fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract"); 77 Penn. Stat. § 531(4)("Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above"); and West Virginia Code § 23-4-3(2)(allowing employer to join PPO).

[166] 2006 WL 367700, at 6-8 (W.D.La. February 15, 2006)(No. 04-2405)(emphasis original).

The direct contract exemption from the notice requirements of La. R.S. 40:2203.1(B) supplied by La. R.S. 40:2203.1(A) logically applies to First Health. First Health has assembled its own preferred provider network through direct contracts with Louisiana providers. Those contracts authorize First Health to extend the negotiated payment rate to a defined group of payors; without payor agreements there are no patients for the doctors to treat, and no *quid pro quo* for the provider's agreement to accept reduced fees. Under such circumstances, First Health is not obligated to give notice to the provider and it is impractical to require it. As Judge Trimble stated, "[t]his is the logical and reasonable interpretation of the statute and is in line with the Legislature's intent to contain escalating health care costs."

F. LIABILITY AND DAMAGES MUST BE TRIED INDIVIDUALLY AND CANNOT BE TRIED CLASS-WIDE

The testimony from the few Plaintiff Class members deposed to date demonstrates that First Health met the statutory notice requirements. Such testimony demonstrates the existence of material fact issues precluding summary judgment, and that liability based on what a particular plaintiff knew and when he, she, or it knew it is an individualized inquiry that cannot be determined by groups. Moreover, the evidence demonstrates that the only trustworthy evidence of a particular transaction are the original HCFA 1500 or UB 92 billing forms and the Explanation of Review issued by the payor entity, all supported by authenticating testimony. Plaintiffs offer no such evidence. Plaintiffs' assertion that the fee schedule amount less the "Allowable" column found in the First Health spreadsheet equals the discount taken or is evidence of the fact that a discount was taken is, as discussed above, inacurate. Consequently, plaintiffs attempt to use the spreadsheet as support for their self-serving characterization of the underlying data is misleading.

Under such circumstances, this Court cannot enter the class-wide relief plaintiffs demand. La. Code Civ. P. art. 592(E)(5) provides this Court "may not order the class-wide trial of issues dependent for their resolution on proof individual to a member of the class, including but not limited to the causation of the member's injuries, the amount of the member's special or general damages, the individual knowledge or reliance of the member, or the applicability to the member of individual claims or defenses."

La. Code Civ. P. art. 592(E)(5) merely recites the well-settled proposition that liability must be tried individually because proof of individual causation and damages underlies the system of delictual liability embraced by Louisiana law.[167] Plaintiffs propose to artificially close these evidentiary loopholes through probabilistic evidence imposed in a summary proceeding. Plaintiffs submit five (5) identical affidavits attesting that the provider did not receive notice and from that ask the Court to extrapolate the conclusion that none of the several thousand Plaintiff Class members received notice. Plaintiffs cite this Court no authority for such a procedure because there is none. Indeed, La. Code Civ. P. art. 592(E)(5) clearly provides otherwise.

Even before Louisiana adopted article 592(E)(5), class action case law rejected as violating due process efforts to invoke the class action procedure to subvert the requirement that each plaintiff prove his, her, or its entire case. In *In re Fibreboard Corp.*,[168] the district court approved a trial plan whereby 11 asbestos plaintiff's cases would be tried as representative of the claims of a class of 2,900, supplemented by "such evidence as the parties wished to offer from 30 illustrative plaintiffs, 15 chosen by each side. The jury was to use the evidence developed at the trial along with damages data compiled by "experts" to calculate the total damages suffered by the class.

The Fifth Circuit rejected the proposed plan as violating federal due process. The panel noted that the state of Texas, like Louisiana, has made policy choices "reflected in the requirement that a plaintiff prove both causation and damages."[169] "These elements focus upon individuals, not groups."[170] The panel also observed that the procedures reflected by these policy choices cannot be abandoned for the sake of convenience because "cumulative changes in procedure work a change in the very character of a trial" and that changing "the mode of proof may alter the liability of the defendants in fundamental ways."[171] The court observed that "changes in substantive duty can come dressed as a change in procedure" and rejected the

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[167] *See Thompson v. Johns-Manville Sales Corp.*, 714 F.2d 581, 583 (5th Cir. 1983)(holding theories that dispense with proof of causation are "radical departures from traditional theories of tort liability" and are not recognized in Louisiana.)

[168] 893 F.2d 706 (5th Cir. 1990).

[169] 893 F.2d at 711.

[170] *Id.*

[171] *Id.*

proposed procedure because "we are persuaded that [the proposed procedure] would work such a change"[172] and

> … the only "fact' that can be proved is that *in most cases* the defendant's asbestos *would have been* the cause. This is the inevitable consequence of treating discrete claims as fungible claims. Commonality among class members on issues of causation and damages can be achieved only by lifting the description of the claims to a level of generality that tears them from their substantively required moorings to actual causation and discrete injury. Procedures can be devised to implement such generalizations, but not without alteration of substantive principle.[173]

This case requires that each individual case be examined to determine whether the particular transaction is covered by Title 40 (i.e., whether a contract chain existed when the discount was taken), whether the particular provider received the notice contemplated by the Act, and whether the fee reduction represents an alternative rate of payment or some other agreed reduction. There is no escaping the need for individualized proof of liability and causation.

G. CLASS-WIDE DAMAGE RELIEF IS IMPROPER BECAUSE INDIVIDUAL CLAIMS MUST BE INVESTIGATED TO DETERMINE IF DEFENSES SUCH AS WAIVER, ESTOPPEL, ACCORD AND SATISFACTION, COMPROMISE, CONFUSION, OFFSET OR FAILURE TO MITIGATE DAMAGES APPLY

La. Code Civ. P. art. 592(E)(5) further provides that class-wide relief is improper where individual class members face "individual claims or defenses." Defendants argued that class certification was improper due to individual defenses such as waiver and estoppel. That has not changed; this court is still required to determine factually whether those defenses apply.[174] Waiver is "the intentional relinquishment of a known existing legal right, power or privilege which, but for the waiver, the party would have enjoyed."[175] Waiver occurs when there is knowledge of the existence of a right and either an actual intention to relinquish it, or conduct "so inconsistent with the intent to enforce the right as to induce reasonable belief that is has been relinquished."[176] Equitable estoppel is similarly based on considerations of good faith and is designed to prevent injustice by barring a party from taking a position contrary to his prior acts,

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[172] *Id.*

[173] 893 F.2d at 712 (emphasis original).

[174] *See Box v. City of Baton Rouge*, 02-0198 (La. App. 1 Cir. 1/15/03); 846 So.2d 13, 16 (applying equitable defenses to statutory claim); *Mix v. Mougeot*, 446 So.2d 1352, 1356 (same).

[175] *Allstate Indem. Co. v. Knighten*, 30,012 (La. App. 2 Cir. 12/10/97); 705 So.2d 240, 243.

[176] *Id.* at 243.

admissions, representations, or silence.[177] First Health has demonstrated that certain of the providers knew discounts were being taken against their workers' compensation medical bills long before the statute was passed; each had ample opportunity to object to the discounts or term their provider contracts. These plaintiffs failed to act, as did many others, and thus all are exposed to these equitable defenses.

In addition, an injured party has a duty to mitigate his damages.[178] The "victim" has an affirmative responsibility to make every reasonable effort to mitigate damages, but the care and diligence required of him is the same as that which would be used by a man of ordinary prudence under like circumstances.[179] More completely stated, the consequences of an injury are recoverable where the injured party acts with such care and diligence as a man of ordinary prudence would under the circumstances, and his efforts to minimize damages are determined by the rules of common sense, good faith, and fair dealing. What constitutes reasonable care depends upon the circumstances of the particular case, taking into consideration time, knowledge, opportunity, and expense.[180]

The universe of First Health provider agreements includes many dating to the 1990s. The Louisiana Workers' Compensation Reimbursement Schedule was enacted in 1989. The effective date of the Any Willing Provider Act was January 1, 2001. In other words, medical bills for treatment of workers' compensation patients submitted by Plaintiff Class members were being discounted below the Reimbursement Schedule for more than 10 years before Title 40 was enacted. Carol Beutler entered into her First Health agreement in 1998, more than two years before the effective date of La. R.S. 40:2203.1. Presumably, numerous discounts were applied to Beutler's medical bills for treatment of workers' compensation patients before the effective date of the statute. As discussed above, many Plaintiff Class members, including Dr. Lopez, were aware medical bills for treatment of workers' compensation patients were being discounted years before the effective date of the Act.[181] If any of these providers objected to payors reducing

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177 *See e.g., Stevenson v. Lavalco, Inc.*, 28,020 (La. App. 2 Cir. 2/28/96); 669 So.2d 608, 612. The three elements for equitable estoppel are (1) representation by conduct or word by person sought to be estopped; (2)justifiable reliance thereon; and (3) change in position because of that reliance to the detriment of the party asserting estoppel.

178 *Aisole v. Dean*, 574 So.2d 1248 (La. 1991).

179 *Id.*

180 *Unverzagt v. Young Builders, Inc.*, 252 La. 1091, 215 So.2d 823, 825-26 (La. 1968).

181 *See e.g.,* Deposition of Dr. Lopez, Exhibit 7, at 71, 77-85; Deposition of Thomas Nosser, D.C., Exhibit 9, at 71, 92-93.

payments on workers compensation medical bills to levels below the Reimbursement Schedule, they could stop the practice by simply terming their First Health provider agreements. Once the agreement was termed, no one could discount medical bills for treatment rendered to workers' compensation patients, with or without the notice required by the Act. The providers understood this, as the following testimony revealed:

> Q. But if I understand your testimony you have not termed any of the contracts that are at issue in this case, have you?
>
> A. No.
>
> Q. And if you termed those contracts then nobody would be authorized to take any discounts against your charges, would they?
>
> A. If I termed the contracts for the few workers' compensation patients that I see, then I'm going to cut my nose off to spite my face and cut out the other patients that I do get from that in a private pay, a private insurance setting.
>
> Q. But you haven't done that?
>
> A. No, because I still get patients in the other networks that are not workers' comp. So in four years time I have nine workers' comp cases only. And I may have 50 insurance cases that are not workers' comp related.
>
> Q. So the fact is that it is in your business interest to maintain those contracts, isn't it?
>
> A. Correct.[182]

Plaintiff Class members could easily term their provider agreements, and by doing so not just mitigate but end completely the damage each claims in this case.[183] Louisiana law permits Plaintiff Class members to promote their business interests, but it does not allow them to concurrently pile up easily avoided damage claims.[184] Moreover, Plaintiff Class members, including class representative Beutler, knew their medical bills for treatment to workers' compensation patients were being discounted below the Reimbursement Schedule long before the effective date of the Any Willing Provider Act. Plaintiff Beutler had nearly three (3) years to act; others had longer to eliminate or mitigate the loss. Their inaction demands individualized scrutiny and precludes recovery here.

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[182] Deposition of Thomas Nosser, D.C., Exhibit 9, at 71.

[183] Since part of plaintiffs' contention is that there exists no steerage in workers' compensation, there really is no reasonable explanation for not terming the agreements.

[184] *See Philippe v. Browning Arms Co.*, 395 So.2d 310, 318 (La. 1981)(" The doctrine of avoidable consequences bars recovery of those damages which occurred after the initial injury and which might have been averted by reasonable conduct on the part of the plaintiff.").

Similarly, Plaintiff Class members had available the information (in the form of comprehensive payor listings) to identify First Health's payors, and many did so. The providers reasonably could be expected to consult the payor listings to reconstruct billing relationships. Ignoring or discarding the payor lists is immaterial; the information was available to mitigate (indeed, to eliminate) their damages. The providers' failure to do so bars recovery in this case.

Limitations of remedy provisions in the provider contracts also preclude the recovery sought here.[185] Typically, by these provisions the provider agrees that he will not recover more than the amount of any discount applied to his bill. No reason has been demonstrated as to why these contractual provisions should be ignored.

Many of the claims contained in the cited spreadsheets were the subject of individual negotiation and compromise;[186] some members of the plaintiff class have compromised any claims they may have had prior to certification of this action.

H. THE STATUTORY DAMAGES UNDER LA. R.S. 40:2203.1(G) ARE EXCESSIVE IN VIOLATION OF THE DUE PROCESS CLAUSES OF THE UNITED STATES AND LOUISIANA STATE CONSTITUTIONS

Louisiana's basic law of reparations permits only the award of compensatory damages.[187] "The word 'damages' is defined as meaning pecuniary, compensation, recompense, or satisfaction for an injury sustained."[188] Damages awarded in lawsuits are either ordinary (compensatory) or exemplary (punitive).[189] Compensatory damages are "designed to place the plaintiff in the position in which he would have been if the tort had not been committed."[190] "Compensatory damages are further divided into the broad categories of special damages and general damages."[191] The former can be established with relative certainty; the latter are inherently speculative in nature and cannot be fixed with mathematical certainty.[192]

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185 *See* Exhibits 2 and 3.

186 See Affidavit of Art Lynch; confidential settlement documents will be provided to this Court under seal if desired.

187 *Billiot v. B.P. Oil Co.*, 93-1118 (La. 9/29/94); 645 So.2d 604, 612.

188 *Fogle v. Feazel*, 201 La. 899, 10 So.2d 695, 698 (La. 1942).

189 *Billiot*, 645 So.2d at 612.

190 *Wainwright v. Fontenot*, 2000-0492 (La. 10/17/00); 774 So.2d 70, 74. *See also Cooper Industries, Inc. v. Leatherman Tool Group, Inc.*, 532 U.S. 424, 432, 121 (2001)(Compensatory damages "are intended to redress the concrete loss that the plaintiff has suffered by reason of the defendant's wrongful conduct.").

191 *Id.*

192 Frank L. Maraist, Jr., and Thomas C. Galligan, Jr., *Louisiana Tort Law*, § 7.2 (Michie 1996).

This Court has previously determined that the sums called for by La. R.S. 40:2203.1(G) are statutory "damages." Plainly, a compensatory damage in this context would be restoration of the difference between the fee schedule amount and the amount paid, typically a 10 or 20 percent discount below the fee schedule amount. Such a damage would place the provider in the position he would have been if the alleged act had not been committed. But plaintiffs make plain that they are not seeking true compensatory damages, but only the statutory damages provided by the Act. La. R.S. 40:2203.1(G) contemplates that a violation of the Any Willing Provider Act will result in payments "of double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars, together with attorney fees to be determined by the court."[193]

The United States Constitution prevents "grossly excessive" damage awards of any character because such awards "further no legitimate purpose and constitutes an arbitrary deprivation of property."[194] Due process entitles a party to "fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty that a State may impose."[195] There is no fixed formula for determining whether a *statutory* damage is excessive, but the Court should consider three "guideposts," established in the context of *punitive* damage awards: (1) the degree of reprehensibility of the defendant's misconduct; (2) the disparity between the actual or potential harm suffered by the plaintiff and the punitive damages award; and (3) the difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in similar cases."[196] The analysis for the reasonableness of the statutory damages provided by La. R.S. 40:2203.1, by analogy, should be no different.

(i) Enforcing legal contract rights is not "reprehensible" conduct.

The United States Supreme Court has identified "the most important indicium of the reasonableness of a punitive damages award is the degree of rephrehensibility of the defendant's conduct."[197] "This principle reflects the accepted view that some wrongs are more blameworthy

[193] The $50 per day assessment alone equals $18,250.00 per year. Thus, a claim for the typical $12-20 underpayment incurred the day this case was filed (April 15, 2004) draws a La. R.S. 40:2203.1(G) assessment on April 15, 2009 of at least $91,250.00.

[194] *State Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408, 416 (2003).

[195] *State Farm*, 538 U.S. at 417.

[196] *State Farm*, 538 U.S. at 418, *citing BMW of North America, Inc. v. Gore*, 517 U.S. 559, 574-75 (1996).

[197] *State Farm*, 538 U.S. at 419; *Gore*, 517 U.S. at 575.

than others."[198] For example, "nonviolent crimes are less serious than crimes marked by violence or the threat of violence" and "trickery and deceit are more reprehensible than negligence."[199] In evaluating the reprehensibility of a defendant's conduct, the Supreme Court has instructed that a court should look to whether: "the harm caused was physical as opposed to economic; the tortuous conduct evinced an indifference to or a reckless disregard of the health or safety of others; the target of the conduct had financial vulnerability; the conduct involved repeated actions or was an isolated incident; and the harm was the result of intentional malice, trickery, or deceit or mere accident."[200] "The existence of any one of these factors weighing in favor of a plaintiff may not be sufficient to sustain a punitive damages award; and the absence of all of them renders any award suspect."[201]

Fundamentally, the only language approaching a "standard of conduct" required by La. R.S. 40:2203.1(G) is the phrase "failure to comply."[202] Even if First Health's conduct "failed to comply" with the notice provisions of the Any Willing Provider Act, such conduct was merely negligent, not "reprehensible," and most certainly was not so reprehensible as to justify the damages claimed. These plaintiffs sustained no physical injury and any economic loss was nominal.[203] First Health did not act with "reckless indifference," and there was no "trickery or deceit." First Health merely applied contract terms the providers agreed to and understood. Those few providers who continue to plead ignorance of the contract terms are deemed by operation of law to have understood them. The "targets" of this conduct, to the extent any healthcare professional who signs a provider agreement which is then applied consistent with its terms can be called a "target" is among the most financially secure groups in American society. No one has testified that their businesses failed because workers' compensation bills were discounted consistent with the contract terms. Moreover, First Health can hardly be found in bad

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198 *Gore*, 517 U.S. at 575.

199 *Gore*, 517 U.S. at 575-76.

200 *State Farm*, 538 U.S. at 419.

201 *Id.*

202 This language indicates that an omission, i.e., a delictual act, subjects the actor to the statutory "damages." First Health submits that purely negligent conduct, without deliberation or intent, is not "reprehensible conduct" and is constitutionally inadequate for the imposition of punitive damages. A statute that speaks in such terms is unconstitutional on its face.

203 Most of the providers deposed to date have indicated that workers' compensation represented no more than 10-15% of their overall practice and as reflected by the Plaintiff Class' EOB submission, most of the "discounts" are for less than $20.

faith where a federal district court has validated and held lawful the very conduct at issue in this case.

(ii) The ratio of statutory damages to harm is excessive and certainly cannot be judged on the summary basis the Plaintiff Class proposes

The second prong of the punitive damages test considers the difference between the damages and the actual or potential harm suffered by the plaintiff. Courts must "ensure that the measure of punishment is both reasonable and proportionate to the amount of harm to the plaintiff and to the general damages recovered."[204] The constitutionally acceptable range is not reducible to a simple mathematical formula and the Supreme Court has been "reluctant to identify concrete constitutional limits on the ratio."[205] Lower compensatory damages tend to support higher ratios where the defendant's conduct is deemed "particularly egregious" while in contrast substantial compensatory awards compel a lower ratio.[206] In practice, the Supreme Court has made clear "the precise award in any case, of course, must be based upon facts and circumstances of the defendant's conduct and the harm to the plaintiff," and that "few awards exceeding a single-digit ratio between punitive and compensatory damages, to a significant degree, will satisfy due process."[207]

While statutory damages remain uncharted territory, post-*State Farm* courts have significantly reduced punitive damage awards under the ratio analysis. In *Romo v. Ford Motor Co.*,[208] the appellate court initially upheld a $5 million compensatory award and a $290 million punitive damage award against Ford arising from a rollover accident resulting in 3 deaths and 3 serious injuries, based on clear and convincing evidence that the defendant knew of the defect in the vehicle and the likelihood of serious injuries and death. The Supreme Court accepted review and remanded the case to the appellate court for redetermination in light of the *State Farm* decision. On remand, the appellate court cut the punitive award from $290 million to $23.7 million, reasoning *State Farm* requires a single digit multiplier that is generally no greater than

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[204] *State Farm*, 538 U.S. at 426; *Gore*, 517 U.S. at 580 ("The principle that exemplary damages must bear a 'reasonable relationship' to compensatory damages has a long pedigree.").

[205] *State Farm*, 538 U.S. at 424.

[206] *State Farm*, 538 U.S. at 424.

[207] *State Farm*, 538 U.S. at 425.

[208] 99 Cal. App. 4th 1115, 122 Cal.Rptr.2d 139, *cert. granted, judgment vacated*, 538 U.S. 1028 (2003).

4:1.[209] Both Louisiana[210] and other state and federal courts have dramatically reduced punitive damage awards in order to conform to the *State Farm* guidelines.[211]

In the instant case, a $20 discount taken the day this case was filed nets "damages" of at least $91,250.00, for a ratio of 4,562:1.[212] This of course (1) overlooks the fact that La. R.S. 40:2203.1(G) does not require that the discounted amount be refunded, i.e., that there be payment of any compensatory damages whatsoever; and (2) pre-supposes that First Health must compensate the provider the full amount of the discount, even though another group purchaser actually received the benefit of the discount and First Health's compensation was, on average 16-20% of the discount amount[213] (i.e., $3.20 to $4.00 for each $20 discount, yielding a ratio as high as 28,516:1). That is neither a reasonable relationship nor a rational result.

In addition, the need to evaluate the ratio between the compensatory damage and the statutory damage award, as well as the need to evaluate whether some other "group purchaser" involved in the transaction shares blame for the event preclude the Plaintiff Class' request that the Court enter what amounts to a partial damage award in connection with the pending motion. Fundamentally, the Louisiana Code of Civil Procedure authorizes no such procedure. Plaintiffs' request is akin to asking the court in a back injury case to award the plaintiff general damages in whatever amount the particular circuit has authorized as the minimum award for a single disc injury, while retaining the right to increase the award at some unspecified future date, all against only one of several parties engaged in the fact pattern.

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209 *Romo v. Ford Motor Co.*, 113 Cal. App. 4th 738, 6 Cal.Rptr.3d 793 (5th Dist. 2003).

210 The most visible post-*State Farm* Louisiana case is probably *Grefer v. Alpha Technical, et al.*, 2002-1237 (La. App. 4 Cir. 8/8/07); 965 So.2d 511, where after the original $1 billion punitive award was vacated and the case remanded by the United States Supreme Court, the Louisiana Fourth Circuit reduced the award to 2 times the compensatory damage figure.

211 *See e.g., Conseco Finance Servicing Corp. v. North American Mtge. Co.*, 381 F.3d 811 (8th Cir. 2004)(Court characterized as significantly reprehensible defendant's conduct in stealing plaintiff's employees to gain access to its customer's private financial information, but reduced punitive award from $18 million to $7 million — against a $3.5 million compensatory award — a 2:1 ratio); *Republic Tobacco Co. v. North Atlantic Trading Co.*, 381 F.3d 717 (7th Cir. 2004)($10 million punitive award in defamation case reduced to $2 million against compensatory award of $1 million); *Harris v. Archer*, 134 S.W.3d 411 (Tex. App. Amarillo 2004)(reducing punitive damage award to $400,000, a 4:1 ratio against compensatory award despite the defendant's intentional and deliberate breach of fiduciary duty to his partners, the plaintiffs). Notably, the *State Farm* award was itself reduced by the Utah Supreme Court to a 9:1 ratio. *See* 98 P.3d 409, 418 (Utah 2004); *Major v. Western Home Ins. Co.*, -- Cal.Rptr.3d --, 2009 WL 26744 (Cal. App. 4 Dist., January 6, 2009)(approving punitive to compensatory ratio of 1:1).

212 The class plaintiffs' reliance on the difference between the applicable fee schedule amount and the PPO Allowable as a basis for its determination that a claim was discounted finds no factual basis either. As noted previously, the amount reported as Fee Schedule on the spreadsheets produced by First Health is not necessarily reflective of a precise figure established by the Louisiana Fee Schedule as many medical procedures lack precisely defined reimbursement figures. Moreover, the Allowable column embraces a number of possible discounts, not simply a contractual PPO discount. See Exhibit , Affidavit of Gregory C. Mast, at ¶

213 *See* Exhibit 1, Affidavit of Arthur J. Lynch, at ¶ .

Here, the reviewing court must consider the activities of all other group purchasers identified by the Court to determine the reasonableness of First Health's assigned percentage of fault. As the Court can easily discern from the spreadsheet plaintiffs failed to attach to the Langley exhibit, numerous other group purchasers participated in each and every transaction.[214] Under plaintiffs' theories of recovery, every group purchaser is liable for their "damages" irrespective of what they did or did not do. Under such circumstances, Louisiana law mandates that the Court assess fault to all involved entities, and reduce First Health's percentage accordingly.[215] Moreover, the reviewing court must have the full measure of whatever damages this Court awards, if any, in order to measure the reasonableness of that determination. Under such circumstances, plaintiffs' request is procedurally and substantively unsound and must be denied.

(iii) Comparable statutory damages are capped at substantially lower amounts

There are several comparable civil statutes, most notably La. R.S. 23:1201(f) and La. R.S. 22:1837 (formerly La. R.S. 22:250.37).[216] The former provides similarly to La. R.S. 40:2203.1(G) that failure to timely pay a workers' compensation medical bill "shall result in the assessment of a penalty in an amount up to the greater of twelve percent of any unpaid compensation or medical benefits or fifty dollars per calendar day for each day in which any and all compensation or medical benefits remain unpaid…." The workers' compensation statute also provides for attorney fees "for each disputed claim; however, the fifty dollars per calendar day penalty shall not exceed a maximum of two thousand dollars in the aggregate for any claim" and the maximum amount that might be imposed under the statute "regardless of the number of penalties that might be imposed under this Section is eight thousand dollars."[217]

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[214] The actual spreadsheet underlying plaintiffs' claims is attached as Exhibit 34 (under seal) .

[215] *See e.g., Wooley v. Lucksinger*, 2006-1167 (La. App. 1 Cir. 5/4/07); 961 So.2d 1228, 1244 ("Each co-obligor in a joint and divisible obligation involving negligence only pays that portion of the plaintiff's damages which correspond to the percentage of negligence attributed to that co-obligor. If a co-obligor is not a party to the principal demand, as in the instant case, the percentage of negligence of the co-obligors who are parties to the principal demand will be reduced by the amount of negligence assigned to the non-party co-obligor; *no damage award can be paid directly to a co-obligor like Health Net when the obligation is joint and divisible*.")(Emphasis original).

[216] Other "statutory damage" statutes in Louisiana also have such caps. *See e.g.,* La. R.S. 51:1409 (assessing triple damages and attorney fees for the knowing use of an unfair or deceptive trade practice); La. R.S. 3:4278.1 (allowing triple damages for cutting down trees on the land of another, knowingly and without authorization); La. R.S. 9:3552 (permitting triple finance charges plus attorney fees for bad faith violations of consumer credit transaction laws); La. R.S. 51:137 (providing for triple damages plus attorney fees for violations of the monopoly laws). Simply, the damages under La. R.S. 40:2203.1(G) are ridiculously excessive no matter the comparison.

[217] La. R.S. 23:1201(f).

La. R.S. 22:1837 provides civil penalties for a health insurer's failure to pay a provider's "clean claim" medical bills within the respective payment standard limitations of La. R.S. 22:1832, 22:1833, and 22:1834. Those penalties require payment of one thousand dollars "for each and every act or violation, not to exceed an aggregate penalty of one hundred thousand dollars." Where the insurer knew or should have known that its activities failed to comply with the payment standards "the penalty shall not be more than twenty-five thousand dollars for each and every act or violation, but not to exceed an aggregate penalty of two hundred fifty thousand dollars in any six month period."[218]

The foregoing penalty statutes suggest the effectively uncapped statutory damages imposed under La. R.S. 40:2203.1(G) are grossly excessive. Accordingly, the statute is unconstitutional both on its face and as applied to the situation at hand.

I. THE STATUTE IS VOID FOR VAGUENESS

La. R.S. 40:2203.1 further violates the due process clause both on its face and as applied in that it is void for vagueness and fails to describe sufficiently either the proscribed conduct, i.e., who must perform and who is legally responsible for non-performance, or the damages that might be imposed. Case law distinguishes between the situations in which criminal and economic statutes should be considered unconstitutionally vague in violation of due process. In *Grayned v. City of Rockford*,[219] the Supreme Court described the situations in which criminal statutes should be considered unconstitutionally vague. First, a criminal law should "give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." Second, a criminal law must "provide explicit standards for those who apply them" in order to avoid arbitrary and discriminatory enforcement. Purely economic regulations, however, are "subject to a less strict vagueness test because [their] subject matter is often more narrow, and because businesses, which face economic demands to plan behavior carefully, can be expected to consult relevant legislation in advance of action."[220] But the rationale for lowered scrutiny toward purely economic regulations applies only where the consequences of a violation of a civil statute are much less severe than the consequences of a violation of a criminal counterpart. That is not the case here; heightened scrutiny should apply.

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[218] La. R.S. 22:1837(A)(1).

[219] 408 U.S. 104, 92 S.Ct. 2294, 2298-99 (1972).

[220] *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 102 S.Ct. 1186, 1193 (1982).

"[V]agueness challenges to statutes which do not involve First Amendment freedoms must be examined in the light of the facts of the case at hand."[221] To sustain such a challenge, the complainant must prove that the enactment is vague "'not in the sense that it requires a person to conform his conduct to an imprecise but comprehensible normative standard, but rather in the sense that no standard of conduct is specified at all.'"[222] As the Supreme Court put it, "[s]uch a provision has *no* core."[223]

A key factor in the "void for vagueness" analysis is whether courts have varied in their interpretation of the statute, such that there has been arbitrary or discriminatory enforcement.[224] Here, the answer is plainly yes. First, the federal court has exonerated First Health under the direct contract exemption; if this court decides the issue differently the same question will have been answered inconsistently. Second, this court held several former defendants, including AIG to be "group purchasers" reading the statutory definition to include virtually all industry participants. The federal court thereafter ruled that AIG's insurance subsidiary, American Home, was not a group purchaser, rejecting specifically the arguments accepted by this Court in its earlier summary judgment ruling.[225] Third, the statute, at least as interpreted by this Court, extends the term "group purchaser" to a wide variety of industry participants, but imposes liability without specifying which of the several group purchasers involved in each and every transaction is the one that either must give whatever notice is required or be held liable for a failure to do so. Fourth, the statute is so vague regarding the form and timing of notice required that while the United States Fifth Circuit has affirmed Judge Trimble's opinion finding uncontested that First Health gave notice to certain of the class representatives, this court might very well reach an opposite result on precisely the same facts. Fifth, as discussed in greater detail below, the statute employs terminology consistent with its application to group health, is contained in a chapter of the Louisiana Revised Statutes dedicated to group health, and was not intended by the drafters to apply to workers' compensation claims. Under such circumstances, it is not surprising that industry participants such as First Health would not believe the statute

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221 *United States v. Mazurie*, 419 U.S. 544, 550, 95 S.Ct. 710, 714 (1975).

222 *Coates v. City of Cincinnati*, 402 U.S. 611, 614, 91 S.Ct. 1686

223 *Smith v. Goguen*, 415 U.S. 566, 578, 94 S.Ct. 1242, 1249 (1974).

224 *Grayned*, 92 S.Ct. at 2298.

225 *See American Home Assurance Co. v. Bernauer, et al.*, No. 06-579 (W.D. La. Sept. 5, 2007) attached hereto as Exhibit 35.

applied to workers' compensation claims. For all these reasons, La. R.S. 40:2203.1 should be declared unconstitutionally vague and thus void.

J. FURTHER DISCOVERY IN THIS ACTION IS REQUIRED

Undersigned counsel has already filed into the record his La. C.C. P. Art 966(C) affidavit attesting to the reasons why plaintiffs' partial summary judgment motion should be deferred pending discovery into the both the types of notice that class members may have received and damages in the event this Court considers that inquiry appropriate for this stage of the proceedings. First Health resubmits this Affidavit and reasons in support of its Motion for Continuance in further support of this request here.

III. CONCLUSION

The Court must impermissibly rewrite the notice provisions of La. R.S. 40:2203.1 to grant plaintiffs' motion for partial summary judgment. The Court must also ignore the weight of the evidence presented, the evidentiary problems inherent in plaintiffs' incompetent evidence, the conclusions reached by the only court to reach the merits of this type dispute, longstanding Louisiana legal tradition requiring each class member prove his, her, or its claim individually, and rejecting group liability or damages determinations based on probabilistic evidence, and class action specific statutory guidance precluding the Court from entering the order plaintiffs demand, to name but a few complications. First Health's evidence shows conclusively that Plaintiff Class members had available more than 30 days before a particular patient appeared the information management tools necessary to determine who would pay the patient's bill and in what amount and that many used the information as the statute intended. Indeed, La.R.S. 40:2203.1 changed little for already compliant networks such as First Health, which had long furnished its preferred providers written notice of the entities authorized to access its network, while aggressively opposing silent PPO activity.

In the end, a minute percentage of the Plaintiff Class ask this Court to reward the entire Plaintiff Class, and to destroy First Health, solely because these few plaintiffs failed to professionally manage information given them. But plaintiffs should not and cannot be rewarded for poor record-keeping, particularly when other Plaintiff Class members concede First Health made the information available to them in a timely fashion, and used it appropriately. In short, Louisiana law pretermits procedurally and substantively the unconstitutionally excessive relief

plaintiffs request based on a statute that is substantially incomprehensible. Plaintiffs' motion for partial summary judgment must be denied.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I do hereby certify that a copy of the above and foregoing pleading has been served on all counsel of record via United States mail, first class postage prepaid, or hand delivery, directed to their address of record in these proceedings, or via facsimile, on Wednesday, March 25, 2009.

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