SB 167

Relating to the Board of Pharmacy; to amend Section 34-23-30 of the Code of Alabama 1975, relating to persons required to have a permit issued by the board to perform pharmacy services; to provide that an entity providing pharmacy services to residents of this state, rather than a person, would be required to have a permit issued by the board.

HB 518

Regarding health insurance; to provide for a state health care exchange pursuant to the federal Affordable Care Act; to establish a governing board of directors and an executive director and require the board to operate the exchange; and to provide for coordination with and assistance from the Department of Insurance.

HB 475

Relating to rural hospitals; to provide for funding of rural hospitals by creating the Rural Hospital Investment Program; to establish a governing board to administer the program, to provide for a state income tax credit in exchange for donations to rural hospitals; and to provide for coordination with the Department of Revenue

SB 77 (see companion bill HB 126)

To create the Medicaid Emergency Reserve Fund and to provide for the withdrawal and use of amounts deposited into the fund. The Legislature finds that it is in the best interest of the State of Alabama that the Alabama Medicaid Agency is not forced to reduce payments to medical providers or eliminate optional but essential medical benefits to Medicaid recipients when the fiscal year appropriation is insufficient to continue the operations of the Medicaid program. It is the intent of the Legislature that there be a Medicaid Emergency Reserve Fund to ensure the continued operation of the Alabama Medicaid Agency during budget shortfalls.

HB 126 (see companion bill SB 77)

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Agency during budget shortfalls.

Midwest hospital M&A market heats up, but faces policy hurdles

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Blue Cross of Michigan Antitrust Suit Joins Others in Alabama

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More Call For 11th Circ. To Redo $2.67B BCBS Deal

Major Insurers See Antitrust

Enforcement Action Headed to Appeals

We ended 2022 with an update on trends in healthcare provider consolidation and enforcement actions. In this inaugural 2023 issue of Litigation and Enforcement Highlights, we turn to the latest action in healthcare payer enforcement and litigation. Major insurers UnitedHealth and Blue Cross Blue Shield experienced similar antitrust woes lately, as both insurers saw their seemingly finalized lawsuits headed to the appeals court.

UnitedHealth Merger Challenge Continues Post-Acquisition

The UnitedHealth and Change Healthcare merger lawsuit grabbed headlines at the end of last year. The deal was officially consummated in October after receiving court approval in the District Court for the District of Columbia. Per court order, Change Healthcare divested its claims-editing subsidiary ClaimsXten to private equity firm TPG Capital, and UnitedHealth also completed its acquisition of Change Healthcare. Just as we were about to close the case on the merger challenge as a valiant but failed effort on the part of antitrust enforcers, the Department of Justice (DOJ) announced in late November that it would appeal the lower court decision to the D.C. Circuit court. While the DOJ had 60 days after the initial ruling to file an appeal, the appeal was deemed unlikely and somewhat of a surprise, because the government would face the challenge of "unscrambling the egg" after both the acquisition and divestiture were finalized in October. Nonetheless, following President Biden's executive order to revitalize competition in the healthcare industry, federal regulators signaled that they would step up its enforcement efforts including challenging anticompetitive transactions

even after they are consummated.

Joined by the attorneys general of New York and Minnesota, the DOJ appeal seeks review of the decision by the U.S. District Court entered in September and the accompanying 58-page court opinion. The issue to be raised on appeal is whether the district court erred in denying the federal and state regulators relief under Section 7 of the Clayton Act. The appeals court docket has not seen action since before the holidays and no litigation timeline or substantive filings have been made as of this writing. It remains to be seen whether the DOJ will appeal the decision on the grounds of horizontal integration concerns (i.e., whether the divestiture was sufficient) or vertical integration concerns (i.e, the potential misuse of Change Healthcare data to benefit UnitedHealthcare), or both. If the appeal challenges the decision as to vertical merger concerns, it could be another shot at moving the law forward on vertical merger challenges, though it would be interesting to see how the government reframes what District Court Judge Carl Nichols called "serious flaws" in its legal arguments. For more analysis of the horizontal vs. vertical legal arguments considered at trial, see The Source's previous blog post.

Aside from its spotlighted acquisition of Change Healthcare, as a major healthcare conglomerate, UnitedHealth faces heightened regulatory scrutiny. Just after the announcement of the Change acquisition appeal, UnitedHealth announced that it would delay its proposed $5.4 billion acquisition of LHC Group, a home health provider. Similar to the Change Healthcare deal, the acquisition of LHC is a vertical integration with the Optum subsidiary of UnitedHealth. Originally announced in March 2022 and expected to close by end of 2022, the deal met scrutiny from the FTC, which has issued two requests for additional information as it reviews the proposed merger for regulatory concerns. As UnitedHealth continues to expand its footprint in the healthcare industry

through both horizontal and vertical consolidation, we may be seeing just the beginning of antitrust actions.

BCBS of Alabama Antitrust Settlement Hits Roadblock

Another case that keeps coming back for more action is the private antitrust lawsuit alleging anticompetitive conduct against Blue Shield Blue Cross (BCBS) of Alabama. After a decade of litigation, a final settlement was entered in August last year for class action plaintiffs consisting of employers and individuals who subscribed to BCBS health plans. The settlement terms included $2.67 billion in monetary compensation billion (of which $627 million is allocated for plaintiffs' attorneys) and injunctive relief that targets BCBS' alleged horizontal market allocation practice to boost competition in the insurance market. Notably, the settlement agreement does not address the contested practice of BCBS Association's licensing setup, which gives BCBS licensed insurers exclusive rights within a certain geographic territory, essentially carving up the country by markets. See detailed breakdown and analysis of the settlement terms in previous Source blog post. Case closed? Not so fast. Home Depot and some of the represented class plaintiffs were not satisfied with the settlement terms for reasons including the licensing setup and opted out of the final judgment. In September, four appeals were filed in the 11th Circuit, urging the court to reverse and vacate the final judgment.

In opening briefs filed last month, the appellants detailed their objections to the settlement, which include:

1. improper perpetual relief of rights barring individual class members from pursuing further injunctive relief for antitrust claims and future competitive restraints (including the alleged anticompetitive licensing practice which the settlement did not remedy);

2. inadequate representation in settlement terms: the same plaintiffs and counsel cannot represent injunctive relief and damages classes (financial relief) that have different and competing settlement priorities;
3. unequal distribution of the settlement funds among class members: 93.5% of the payout goes to fully insured claimants, even though class members are almost equally divided between self and fully funded subscribers;
4. improper determination of the reasonable amount of attorney fees (23.5% of settlement amount).

The slew of appeals also brought attention to the terms of the settlement from state insurance regulators. Led by Oklahoma, the department of insurance from a dozen states weighed in on the settlement with an amicus brief shortly after appellant briefs were filed in the 11th Circuit in December. The state regulators focused on a statement in the district court's opinion that said self-funded plans, which purchased only administrative services from BCBS, "did not buy insurance from the Blues". They claim this statement is problematic because self-funded plans, which is outside of state regulatory oversight due to ERISA preemption, frequently purchase stop-loss insurance, which is subject to state regulation. This statement would risk placing stop-loss insurance outside of state regulatory oversight. The states call for correction of that statement to avoid unnecessary misinterpretation.

As this case is only one of two parallel court actions against BCBS over the same conduct—the second of which was filed by healthcare providers—the BCBS antitrust saga is promised to continue in the new year. Stay tuned to The Source Litigation and Enforcement Highlights for the latest developments.

State Regulators Want 11th Circ. To Tweak $2.67B BCBS Deal