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The Affordable Care Act may very well reshape the landscape of the health care industry, deeply impacting providers, payers, and Medicare/Medicaid and other government programs. Putting aside the myriad questions raised by health care reform, it is readily apparent is that the Affordable Care Act will put significant economic pressure on the health insurance industry—an industry that has become highly concentrated and thus may have come to enjoy market power and the concomitant ability to alleviate health care reform's economic pressures by shifting their burden to health care providers.

Dealing With Antitrust Fallout From Health Care Reform



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Health care reform has landed. Launched by the dissatisfaction expressed by Americans and their politicians with the state of health care, the meteor of comprehensive reform known as the Affordable Care Act may very well reshape the landscape of the health care industry, deeply impacting providers, payers, and Medicare/Medicaid and other government programs. Perhaps the recently enacted legislation will

eliminate the inefficiencies that have received public scrutiny. Perhaps millions of Americans will get the quality health insurance coverage and medical care they need at an acceptable cost while supporting a robust and competitive insurance industry. The answers to these questions lie years ahead; however, what is readily apparent is that the Affordable Care Act will put significant economic pressure on the health insurance industry—an industry that has become highly concentrated and thus may have come to enjoy market power and the concomitant ability to alleviate health care reform’s economic pressures by shifting their burden to health care providers.

This article will note some of the economic pressures on health insurers created by the Affordable Care Act; briefly describe the antitrust laws that can be employed against insurers’ exercise of market power, whether real or perceived; discuss recent cases brought by health care providers against insurers; and discuss the benefits and challenges to health care providers of employing the class action vehicle in lawsuits against insurers.

I. HEALTH CARE REFORM’S ECONOMIC PRESSURES ON HEALTH INSURERS

The economic pressures that health care reform will place on health insurers are direct and substantial. The legislation directly limits insurers’ profits while also imposing regulations on insurance companies’ business practices, which regulation will increase insurers’ costs. Probably the most prominent reform is the regulation of insurance premiums. The Secretary of the Department of Health and Human Services, in conjunction with the states, will annually review health insurance companies to ensure that no unreasonable and unjustifiable increases in health insurance premiums occur. Patient Protection and Affordable Care Act § 1003 “2794,” 42 U.S.C. § 300gg-94. Moreover, the reform generally requires that at least 80 percent or 85 percent (depending on the type of insurance plan) of every dollar received as an insurance premium is spent on reimbursements or improving health care; otherwise, the insurance companies must provide rebates to consumers. *Id.* § 1001(5) “2718,” 42 U.S.C. § 300gg-18. The legislation also prohibits insurance companies from scouring an individual’s health insurance application for an inadvertent error in order to rescind coverage and avoid payment. *Id.* § 1001(5) “2712,” 42 U.S.C. § 300gg-12. This prohibition will increase the net amount insurance companies must pay on behalf of individuals to whom they would have previously denied coverage.

Health insurance companies must adapt quickly to this changing economic environment. But they will continue to have the ability to drive lower provider payments by exercising market power over price-taking health care providers. In a recent study by the American Medical Association,¹ nearly all health insurance markets were found to be highly concentrated when analyzed using the Herfindahl-Hirschman Indices (“HHI”) in the guidelines promulgated by the Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”). Specifically, the study found high market concentration in 99 percent of the combined HMO+PPO

markets analyzed, 99 percent of the HMO markets analyzed, and 100 percent of the PPO markets analyzed. Since the publication of the study and as of this writing, the FTC and DOJ have revised the Horizontal Merger Guidelines. In addition to many other changes, the HHI level triggering a general classification of a “highly concentrated market” has increased. Even under these new standards, high market concentration exists in approximately 81 percent of the combined HMO+PPO markets analyzed, approximately 94 percent of the HMO markets analyzed, and approximately 92 percent of the PPO markets analyzed.

Within these highly concentrated insurance markets there is also a high frequency of a single insurer holding a substantial market share. For example, the same AMA study found that, in 92 percent of metropolitan statistical areas analyzed, a single insurer maintains a market share of at least 30 percent. Insurance markets are also characterized by high barriers to entry, namely the large amount of capital required to profitably pool and mitigate risk, as well as the need for a large network of providers and a large number of enrollees.²

Federal antitrust enforcers have strongly expressed their concerns over market concentration in the health care industry. Commissioner Thomas Rosch of the Federal Trade Commission has cited the AMA study in stating his position that “private insurers have a monopoly or duopoly in some portion of all 50 states.”³ And the head of the Department of Justice’s Antitrust Division, Christine Varney, has stated, “If health care reform is to harness the power of competitive markets to produce more and more efficient systems, then [the Justice Department] must be up to the challenge of ensuring that our health care markets are, in fact, as competitive as possible—protected from undue concentration or anti-competitive conduct with vigorous but responsible enforcement and effective competition advocacy.”⁴

II. THE ANTITRUST LAWS

The large number of patients covered by a particular health insurer eliminates the ability of health care providers to check that insurer’s exercise of market power by refusing to accept that insurer. The antitrust laws, however, are designed to prevent entities with market power from flexing that power in certain ways that harm competition. The antitrust laws provide for: injunctive relief to stop anticompetitive business practices; monetary triple damages suffered by the plaintiff as a result of business practices found to be unlawful; and mandatory attorneys’ fees for the successful plaintiff (but not for a successful defendant). 15 U.S.C. § 15(a).

² Hon. C. Varney, “Antitrust and Healthcare Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference,” at 9 (May 24, 2010) (“[T]he biggest obstacle to an insurer’s entry or expansion in the small- or mid-sized-employer market is scale. New insurers cannot compete with incumbents for enrollees without provider discounts, but they cannot negotiate for discounts without a large number of enrollees. This circularity problem makes entry risky and difficult, helping to secure the position of existing incumbents.”), available at <http://www.justice.gov/atr/public/speeches/258898.pdf>.

³ Hon. T. Rosch, “A Healthcare Triptych,” at 1 (Sep. 28, 2009), available at <http://www.ftc.gov/speeches/rosch/090928roschhealthcetriptych.pdf>.

⁴ Varney, *supra* note __, at 15-16.

¹ American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2009 Update* 3-5.

Examples of harm to competition include higher prices to customers—and lower prices to providers, as the United States Court of Appeals for the Third Circuit very recently held. In *West Penn Allegheny Health System, Inc. v. UPMC* (3d Cir., No. 09-4468, 11/29/10), plaintiff West Penn, Pittsburgh's second-largest hospital system, sued Pittsburgh's largest hospital system alleging that UPMC conspired with the region's dominant insurer, Highmark, to "maintain[] West Penn's reimbursement rates at artificially depressed levels" and to pay UPMC higher reimbursement rates in exchange for UPMC's refusing to accept other insurers. Slip op., at 4-5, 8-11. West Penn also alleged that Highmark took other actions, at UPMC's behest, specifically to harm West Penn financially and weaken it as a competitor to UPMC. *Id.* at 10-11.

The Third Circuit held that "artificially depressed" reimbursement rates constitute "antitrust injury," i.e., "an 'injury of the type the antitrust laws were intended to prevent and that flows from that which makes [the] defendants' acts unlawful.'" *Id.* at 25-26, 29 (quoting *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 489 (1977)); see also *Atl. Richfield Co. v. USA Petroleum Co.*, 495 U.S. 328, 334, 344 (1990) (holding that simple causation of injury is insufficient under the antitrust laws, and that there must be an "'antitrust injury' . . . attributable to . . . a competition-reducing aspect or effect of the defendant's behavior"). Importantly, the Third Circuit rejected the defendants' argument that low reimbursement rates cannot be redressed by the antitrust laws because they can result in lower insurance premiums for employers and consumers. See *West Penn*, slip op., at 30. To the contrary, artificially low provider reimbursements result in "suboptimal output" and "reduced quality" of care—anticompetitive effects in themselves that also can lead to "higher prices for consumers in the long run" because of reduced output. See *id.* at 31-32.

In *West Penn*, as in many antitrust cases, there were claims under both Sections 1 and 2 of the Sherman Act. Section 1 of the Sherman Act can be used to remedy anticompetitive conduct by entities acting in concert.⁵ A Section 1 claim requires three elements: (1) concerted action, (2) which unreasonably restrains competition, i.e., the harm to competition outweighs the procompetitive aspects of the challenged conduct, and (3) which affects interstate commerce. See *Texaco Inc. v. Dagher*, 547 U.S. 1, 5 (2006). The element of concerted action can be satisfied by evidence of concerted action among health insurers or by concerted action between an insurer and another entity. See, e.g., *Am. Med. Ass'n v. United Healthcare Co.* (S.D.N.Y., No. 00 Civ. 2800 (LM-M)(GWG)) (denying defendants' motion to dismiss Sherman Act claims that defendants conspired to artificially depress the rates reimbursed to health care providers). It is important to note that intent to harm competition is unnecessary for a Section 1 claim.

In addition, Section 2 of the Sherman Act can be used to remedy anticompetitive unilateral conduct by a single health insurance company that creates or maintains a monopoly or constitutes an attempt to monopolize. 15 U.S.C. § 2. A monopolization claim requires: (1) the possession of monopoly power in the relevant mar-

ket; and (2) the willful acquisition or maintenance of that power, not including growth due to a superior product, business acumen, or historic accident, i.e., anticompetitive conduct. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). Again, intent to harm competition is not required. An attempted monopolization claim requires (1) anticompetitive conduct (2) creating a dangerous probability of monopolization with (3) a specific intent to monopolize the market. *Spectrum Sports, Inc. v. McQuillan*, 506 U.S. 447, 456 (1993). While "specific intent" to harm competition is a stated element of an attempted monopolization claim, that element can be satisfied by inference via proof of the mere fact of the anticompetitive conduct by itself. E.g., *M & M Med. Supplies & Serv. v. Pleasant Valley Hosp.*, 981 F.2d 160, 166 (4th Cir. 1992) (en banc).⁶

III. RECENT CASES BROUGHT BY HEALTH CARE PROVIDERS AGAINST HEALTH INSURANCE COMPANIES

Recent cases brought by health care providers and trade associations present illustrative examples of how health insurance companies may have been exercising their market power over health care providers to deny or reduce payments for the provision of health care.

In the matter of *Love v. Blue Cross Blue Shield Ass'n* (S.D. Fla., No. 03-21296-CIV-MORENO) individual provider plaintiffs and trade associations brought RICO claims against numerous insurance entities and their local subsidiaries and affiliates for the denial, delay, and abatement of payments rightfully due to physicians for the treatment of covered patients. Pls.' Sixth Am. Class Action Compl., at 3, 12. A majority of the original defendants have since settled with plaintiffs. HMO Settlements.com, <http://www.hmosettlements.com/pages/bluecross.html> (last visited Nov. 1, 2010).

The plaintiffs claimed that payments for valid, medically necessary procedures were manipulated by automated programs to systematically and inappropriately decrease the amount due to the providers and to purposefully delay payments. Pls. Sixth Am. Class Action compl. at 4-5. The plaintiffs alleged that the insurers represented to health care providers that they would be "paid in a timely manner for rendering covered, medically necessary services to enrollees. . . ." *Id.* at 22-23. To facilitate payment, the health care providers were required to use codes in accordance with the American Medical Association's Current Procedural Terminology ("CPT") to identify what procedures were performed on patients. *Id.* at 26. The plaintiffs alleged that the insurers "knowingly and systematically implemented practices and procedures which [were] designed to ensure that payment decisions [were] based on criteria unrelated to medical necessity and that payments and reimbursements [were] reduced, delayed and denied in a manner that [was] inconsistent with CPT standards." *Id.* at 28. The complaint avers that the practice of using software to automatically "downcode" or "bundle"

⁵ Section 1 declares illegal "[e]very contract, combination, . . . or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations." 15 U.S.C. § 1.

⁶ In the event of further insurance market consolidation via merger, private plaintiffs may also bring an action under Section 7 of the Clayton Act to challenge the merger of health insurers. 15 U.S.C. § 18. In addition to federal antitrust claims, health care providers can bring state antitrust claims and state law claims for deceptive trade practices or unfair competition. A detailed analysis of these widely variable laws is beyond the scope of this article.

claims for payment lead to arbitrary and unjustified denials and abatements of reimbursements that “cheat[ed] physicians out of payment for services rendered.” *Id.* at 33.

Critically, the plaintiffs alleged that the defendants collectively achieved market dominance through their enrollment rates and market concentration, thus preventing the market from resolving the situation because the plaintiffs could not simply reject the reimbursement mechanism by switching to competing payors. *Id.* at 9. The plaintiffs cited statistics provided by the Blue Cross Blue Shield Association to establish that “Defendants and their [alleged] co-conspirator Blue Plans collectively insure over 100 million patients, or about one in three Americans.” *Id.* As alleged, this market power was used to pressure health care providers into performing care under the insurance companies’ prescribed policies, lest the providers risk being denied patient referrals by the insurance companies. *Id.* at 38. The plaintiffs also alleged that the insurers’ market power gave the insurers the ability to refuse to negotiate specific terms of their contracts. *Id.* Namely, the plaintiffs alleged that the insurance companies “reserv[ed] the right to unilaterally amend contracts with physicians, refus[ed] to provide information concerning pricing or fee structures . . . , and fail[ed] to provide any feasible mechanism for review of the automated payment reductions. . . .” *Id.*

While the plaintiffs were clear that the suit was a result of a market failure in the relationship between health care providers and insurance companies, the complaint nevertheless appealed to the notion that insurers’ anticompetitive practices negatively impacted the health of patients and the welfare of the general public. *Id.* at 2. Although alleging and proving such harm to public welfare is not a necessary component of an antitrust claim, it does bolster the case of competitive harm using a fact with valuable appeal to jury sentiments.

Similar claims have been brought by plaintiffs in the pending matter of *Franco v. Connecticut General Life Insurance Co.* (D.N.J., No. 07-cv-6039 (SRC)(PS)). Here, the plaintiffs claim that the defendant insurance companies unlawfully engaged in practices to decrease the amount paid to health care providers for “out-of-network” (“ONET”) health care services. Consolidated Am. Class Action Compl., at 2. According to the complaint, CIGNA insurance contractually promises subscribers paying a premium for the ability to receive ONET services that it will pay non-participating health care providers the lesser of their billed charge or the usual, customary and reasonable amount (“UCR”) for services rendered. *Id.* at 4. The plaintiffs allege that CIGNA promises its members that the UCR represents the prevailing charge “of comparable services in the locality where the Member received the service, with consideration given to the nature and severity of the Member’s condition, as well as any complications or unusual circumstances that would require additional time, skill, or experience on the part of the [non-participating health care provider].” *Id.* at 4-5. As a result, many non-participating health care providers routinely accept an assignment of the subscriber’s benefits rather than require patients to pay the full bill out-of-pocket. *Id.* at 4.

Allegedly, the defendants made payment determinations that strayed from the appropriate reimbursement rates. *Id.* at 5. The plaintiffs cite the defendants’ use of

a computer database licensed from Ingenix, Inc., a third party wholly owned and operated by UnitedHealth Group, Inc. that allegedly maintains an 80 percent market share in the market for data services, as the engine driving the inappropriate reimbursements. *Id.* at 5, 81. In particular, the plaintiffs allege that “the Ingenix Database inappropriately averages the charges of all providers regardless of provider type or specialty” and “fails to consider provider-specific, patient-specific, and procedure-specific factors that affect charges.” *Id.* at 6. To buttress their claims, plaintiffs cite independent investigations of Ingenix conducted by Congress and the New York Attorney General for the proposition that “the Ingenix databases in fact under-reimburse consumers.” *Id.* at 67 (quoting N.Y. Office of the Att’y Gen., *Health Care Report: The Consumer Reimbursement System is Code Blue* (Jan. 13, 2009)).

As in *Love*, the plaintiffs allege that the defendants’ market power and the lack of competition in the data market provide the means for insurance companies to improperly and artificially reduce provider payments because health care providers are left with no viable alternatives and must accept the artificially reduced payments. *Id.* at 84-86. The plaintiffs assert that the lack of competition in the data market harms competition in the market for the provision for out-of-network services by allowing inefficient and improper practices to linger. *Id.* at 85.⁷

A motion to dismiss the case was filed on September 9, 2009. In this motion and subsequent briefing, the defendants assert that, at its core, the matter is merely an ERISA breach-of-contract case. Defs.’ Mem. In Supp. Of Mot. To Dismiss The Consolidated Compl., at 1. The defendants characterize the plaintiffs’ Sherman Act and RICO claims as “nothing more than add-ons, solely designed to allow [p]laintiffs to seek a windfall through trebled damages and thereby increase their settlement leverage.” *Id.* The defendants argue that, under the recently articulated “plausibility” pleading standards of *Twombly*, *Iqbal*, and their progeny, the plaintiff’s antitrust allegations amount to conclusory statements that should be dismissed. *Id.* at 19, 32. Such a characterization will likely be a common obstacle that similarly situated plaintiffs will have to overcome. As of this writing, the court has not ruled on the defendants’ motion to dismiss.

Private parties are not the only plaintiffs to bring lawsuits against insurance companies. On October 18, 2010, the United States Department of Justice (“DOJ”) filed an antitrust lawsuit against Blue Cross Blue Shield of Michigan (“Blue Cross”) in federal court. *United States v. Blue Cross Blue Shield of Michigan* (E.D. Mich, No. 10-cv-14155). The complaint attacks the insurance company’s practice of inserting “most favored nation” or “MFN” clauses in its contracts with hospitals. Compl., at 3-4. These clauses require the health care providers to charge other insurance companies either higher prices than those Blue Cross pays or prices at least as high as what Blue Cross pays. *Id.*

⁷ The New York Attorney General’s investigation resulted in settlement agreements that aim to reform the insurers’ reimbursement procedures by establishing an independent, non-profit organization to establish the usual, customary and reasonable reimbursement rates. However, this independent system has not yet been established, and its effects remain to be seen.

The complaint alleges that, given Blue Cross's strong position in the market, the MFN clauses stifle competition in the health insurance market and increase health insurance premiums. The DOJ asserts that "Blue Cross is far and away the largest provider of health insurance in Michigan, with more than 60% of commercially insured lives (including lives covered under self-insurance arrangements administered by Blue Cross)." *Id.* at 15. As alleged, Blue Cross's MFN clauses harm competition by "[m]aintaining a differential between Blue Cross' hospital costs and its rivals' costs," "[r]aising hospital costs to Blue Cross' competitors," "[e]stablishing a price floor," "[r]aising the price floor for hospital services to all commercial health insurers," and "[l]imiting the ability of other health insurers to compete with Blue Cross . . ." *Id.* at 19-20.

The proverbial jury is still out on whether MFNs implemented by a party with significant market share necessarily harm competition; however, this case may provide resolution. While MFNs such as Blue Cross's may benefit health care providers in the short term by establishing a price floor for reimbursement rates, hindering robust competition among insurers may harm providers in the long term.

As of this writing, the matter is pending. On October 18, 2010, Blue Cross of Michigan issued a news release defending its use of "deepest discount contract provisions."⁸ Blue Cross stated, "This lawsuit is without merit, and we will vigorously defend our ability to negotiate the deepest possible discounts for our members and customers with Michigan hospitals." The combination of vigorous political scrutiny, the public's desire for satisfaction, and private insurers' desire to assert spirited defenses for their practices suggests that this lawsuit may be a significant battleground in the war to establish industry standards.

IV. BENEFITS AND CHALLENGES OF THE CLASS ACTION DEVICE

While there are legal remedies available to health care providers to check insurers' exercise of market power, the costs of antitrust litigation are often significant enough to dissuade even truly damaged plaintiffs from bringing suit against massive insurance companies. Litigation, particularly antitrust litigation, has always been an expensive proposition; however, the advent of electronic documents and data—more specifically the preservation of, and need to produce, this evidence—has sent litigation costs to previously unimaginable levels. This has further emboldened entities with market power to exercise it unlawfully without fear of a lawsuit—it is as if David had to spend his life savings for the privilege of fighting Goliath. The class action device allows David's comrades to join the battle.

The class action vehicle allows those with similar legal claims against a common entity or entities to press their claims collectively in order to preserve judicial efficiency and economic feasibility. As stated in *Moore's Federal Practice*, "the class action device enhances access to the courts by spreading litigation costs among

numerous litigants with similar claims." 5 James Wm. Moore, *Moore's Federal Practice* § 23.02 (3d ed. 1997). To further ease the financial burden borne by plaintiffs, the attorneys are typically paid out of any common fund created by judgment or settlement, with the amount of the fees subject to the court's approval. Essentially, the attorneys bear the financial risk of the litigation, while also sharing in any financial reward. Plaintiffs with particularly large and strong claims sometimes negotiate a hybrid fee arrangement, whereby they bear some portion of the attorneys' fees and/or other costs while retaining a greater share of any recovery.

Class action certification is governed by Rule 23 of the Federal Rules of Civil Procedure. Rule 23(a) provides four requirements for class certification: (1) numerosity of parties; (2) commonality of legal and factual issues; (3) typicality of the claims of the class representatives; and (4) adequacy of representation. In addition, a proposed class action must fall within at least one of the three prescribed categories found in Rule 23(b). First, a Rule 23(b)(1) class action is one where proceeding individually would create a risk of either (A) incompatible standards flowing from inconsistent adjudications; or (B) individual adjudications affecting the interests of non-parties.⁹ Second, a Rule 23(b)(2) class action is one where the party opposing the class acted consistently toward the members of the class. This category is used for actions for injunctive relief or certain declaratory relief. Finally, a Rule 23(b)(3) class action is one where common questions of law or fact predominate over any questions affecting only individual members, and where a class action is superior to resolving claims individually. This category is primarily used for actions for monetary damages.

The decision regarding class certification is made on a case-by-case basis, given the particular facts at issue. But there are certain common hurdles that a proposed class action must clear. One hurdle is the potential for legal and factual variety. For example, variety as to an insurance company's exclusion of certain providers may convince a court to deny class certification. If some health care providers in the class are excluded to a different magnitude than others, or are excluded in a different manner than others, or are excluded for different reasons than others, a valid objection may lie as to the commonality, predominance, and superiority requirements for class certification. Similarly, variety in the reimbursement rates provided to different health care providers may create variability in market power and damages. Providers may also vary in their efforts and ability to mitigate damages by collecting unreimbursed amounts from patients.

A second hurdle is the growing trend among federal courts to scrutinize more closely whether class certification is appropriate. See *In re Initial Public Offering Securities Litig.*, 471 F.3d 24, 41 (2d Cir. 2006) (promul-

⁸ News Release, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of Michigan Defends Use of Deepest Discount Contract Provisions To Secure Lowest Hospital Costs For More Than 4 Million Michigan Consumers (October 18, 2010) (available at http://news.bcbsm.com/news/2010/news_2010-10-18-11474.shtml) (last visited Nov. 3 2010).

⁹ Although the language of Rule 23(b)(1) at first blush suggests it may be a vehicle for health care providers to bring a class action against insurers, class certification under Rule 23(b)(1) is generally, although not exclusively, reserved for injunctive or declaratory relief, with the exception of the relatively rare "Limited Fund" or "Limited Generosity" cases certified under Rule 23(b)(1)(B). Any variability as to facts, such as inconsistencies in the damages calculation as to different individual plaintiffs, will likely take the matter out of the Rule 23(b)(1) realm.

gating class certification standard requiring district court to resolve underlying factual disputes relevant to class certification, even if they involve merits of case); see also *Dukes v. Wal-Mart Stores, Inc.*, 603 F.3d 571, 594 (9th Cir. 2010), *petition for cert. granted* 79 USLW 3342 (Dec. 6, 2010). Defense teams have hired experts to engage in multifaceted statistical analyses to alert the court to reasons why class certification is inappropriate because of the variability of individual claims or the lack of common proof. This almost always requires the plaintiffs to provide at least a rebuttal expert opinion, and it is advisable for plaintiffs to put forward an affirmative expert opinion why class certification is appropriate.

In addition to the above challenges to class certification, courts exercise greater scrutiny¹⁰ of a proposed settlement when the settlement is negotiated prior to class certification. *D'Amato v. Deutsche Bank*, 236 F.3d 78, 85 (2d Cir. 2001). As settlement negotiations advance, intraclass inconsistencies may surface, which may expose the settlement agreement to objections. In *American Medical Ass'n v. United Healthcare Corp.* (S.D.N.Y., No. 00 Civ. 2800 (LMM) (GWG)), the settling plaintiffs and the defendants made a joint motion for conditional certification of the settlement class, preliminary approval of the settlement agreement, and approval of the form of class notice to settlement class members. The non-settling plaintiffs opposed this joint motion. In response to the opposition, the court requested additional information as to the expected size of the plaintiff class and the "difference between all of the bills for out-of-network services or supplies submitted to defendants [and] all of the amounts allowed," i.e., information as to the total number of plaintiffs and their

damages. *Am. Med. Ass'n v. United Healthcare Corp.*, No. 00 Civ. 2800, 2009 WL 1437819 (S.D.N.Y. May 19, 2009). Although the court ultimately approved the settlement in this case, potential disagreement over the propriety of a settlement agreement as well as increased scrutiny by the court must be expected and managed.

Another hurdle that has received recent attention is the use of arbitration agreements to bar class actions. In *Laster v. AT&T Mobility LLC*, the Ninth Circuit affirmed the district court's denial of AT&T's motion to compel arbitration. 584 F.3d 849, 859 (9th Cir. 2009). The court invalidated the arbitration agreement on the grounds that the arbitration agreement's provision waiving class action was unconscionable and unenforceable under California law. The Ninth Circuit rejected AT&T's argument that the Federal Arbitration Act preempted California law, but the Supreme Court has granted certiorari on the preemption issue.

CONCLUSION

While health care reform may foster substantial changes throughout the industry, many of them likely will not occur for several years, if at all. Immediate change is coming for health insurers, however, and they will be forced to adapt to tremendous strains on their economics. In their struggle to do so, health insurers may cross the line of lawful business conduct. Whether insurers cross this line intentionally to harm competition or inadvertently is not determinative, and an anti-trust violation may exist even if the insurer acted unintentionally. Recovering damages in a court of law, however, is not cheap and may be prohibitively expensive in many cases. The class action vehicle provides a possible solution to health care providers who cannot alone afford such litigation. But there are challenges to health care providers' bringing class actions, ones that must be negotiated with care.

¹⁰ Rule 23(e) requires court approval of a proposed class action settlement.