UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

Thomas Jefferson University dba Jefferson Health and Lehigh Valley Physician Hospital Organization, Inc., *Plaintiffs,* v. Aetna Health, Inc., *Defendant.*	Case No.: 5:26-cv-02215-JMG

BRIEF OF *AMICI CURIAE* AMERICAN HOSPITAL ASSOCIATION AND THE HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA IN OPPOSITION TO DEFENDANT'S MOTION TO COMPEL ARBITRATION AND TO STAY PROCEEDINGS PENDING ARBITRATION

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INTEREST OF *AMICI CURIAE*

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations across the country. Its members are committed to improving the health of the communities that they serve and to helping ensure that care is available to and affordable for all Americans. The AHA educates its members on healthcare issues and advocates on their behalf. The AHA also often participates as *amicus curiae* in cases with important and wide-ranging consequences for AHA's members and the communities they serve.

The Hospital and Healthsystem Association of Pennsylvania (HAP) is the leading voice for the health and well-being of Pennsylvanians. It advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve.

AHA and HAP have a strong interest in ensuring that insurers abide by their contracts with hospitals. Insurer policies like those at issue here impose substantial burdens on hospitals and divert resources that could be used for patient care. AHA and HAP have spent years working with their members to ensure that Medicare Advantage Organizations treat the two-midnight rule as the mandate it is, and pay hospitals appropriately for the care they provide.[1]

INTRODUCTION

This case is about Aetna's new "level of severity" policy (the "Policy"), which is a wholesale, unilateral, nationwide change in the way it pays hospitals that treat members of its Medicare Advantage plans. Several Pennsylvania hospitals seek declaratory relief and an injunction against Aetna's enforcement of the Policy, alleging that it breaches their contracts with

[1] No party's counsel authored this brief in whole or in part, and no party, party's counsel, or other person (other than *amici curiae*) contributed money that was intended to fund preparing or submitting the brief.

Aetna because it is an impermissible unilateral amendment and because it violates provisions of federal law incorporated into their contracts. Aetna has moved to compel arbitration of the Plaintiffs' claims.

The Plaintiffs' opposition to the motion to compel convincingly explains why this dispute is ineligible for arbitration under their contracts with Aetna. In this brief, AHA and HAP seek to provide this Court with broader context for how Aetna's policy change impacts hospitals other than Plaintiffs—especially hospitals across Pennsylvania and the United States that lack the financial wherewithal to arbitrate against the #6 company on the Fortune 500 list. *See* https://fortune.com/ranking/fortune500/. In particular, *amici* explain why litigating claims for declaratory and injunctive relief, rather than arbitrating them, is more efficient for both hospitals and insurers, especially when those claims apply to an insurer's nationwide policies. AHA and HAP also explain how litigation, rather than arbitration, better serves the public interest by preventing insurers from circumventing their legal obligations under the cover of confidentiality.

ARGUMENT

I. Litigation, not Arbitration, Is the Most Efficient Way to Address Disputes over Policies Like Aetna's.

The relationship between a hospital and an insurer is complex. A hospital may provide a variety of treatments to a patient with any number of medical conditions; those treatments, those conditions, and the idiosyncrasies of each patient's medical history determine how the insurer must reimburse the hospital. Because no contract could possibly cover every scenario, it is common for a contract between a hospital and an insurer to incorporate policies, drafted by the insurer, that dictate the insurer's coverage obligations in detail. When deciding whether to join an insurer's network, a hospital relies on the insurer's policies, using them to evaluate the benefits and burdens of contracting with that insurer.

Because medical standards, billing practices, and healthcare regulations change over time, it is common for a contract to permit the insurer to modify its policies or introduce new ones. But this creates a risk for the hospital. Without warning, the insurer could introduce a policy that deprives the hospital of the expected benefit of its bargain. To guard against this risk, the contract commonly permits the hospital to object to a policy that will have a material adverse impact on its finances, and to pursue dispute resolution if the objection is not resolved.

Unexpected changes to an insurer's policies not only affect the hospital's finances, but also increase a hospital's administrative burden. Billing for medical services already requires large teams of professionals who must follow requirements that vary from insurer to insurer. When an insurer changes a policy mid-contract, hospitals cannot easily absorb the change overnight. They must educate affected staff, modify internal processes, and may need to hire or reassign personnel dedicated to implementing and monitoring compliance with the new policy. Hospitals also may need to build or modify IT systems to account for the policy change, which requires substantial time, planning, and resources. These burdens extend beyond administrative teams to clinicians, who are responsible for medical record documentation that must satisfy insurer-specific requirements. While insurers may establish documentation expectations for coverage purposes, these requirements are not always aligned with established coding guidelines and, in some cases, may reflect interpretations that conflict with official coding conventions. This misalignment creates additional complexity and compliance risk for hospitals working to meet clinical, coding, and insurer expectations.

Aetna's Policy is a case in point: according to the Senior Medical Director of Utilization Management for Jefferson Health, "Aetna often requires the Hospitals' physician advisors to review MCG criteria and 'check the box' to determine whether MCG criteria are met. … [T]his

process makes discussions with Aetna much longer and more cumbersome. It also diverts the physician's attention away from other hospital patients that require close attention." Doc. 8-2, ¶ 5.

These administrative burdens make injunctive relief crucial to obtaining redress. Legal remedies are inadequate, and injunctive relief is appropriate, when "damages are impracticable because it is impossible to arrive at a legal measure of damages at all, or at least with any sufficient degree of certainty." *Sheet Metal Workers' Int'l Ass'n Local 19 v. Herre Bros.*, 201 F.3d 231, 250 (3d Cir. 1999). The Policy's administrative burdens are substantial but hard to quantify—after all, how much is a physician's attention to other patients worth? Without injunctive relief, Aetna could continue to impose these burdens even if it ultimately is found liable for damages.

Another difficult-to-quantify result of the Policy is its curtailment of hospitals' right to appeal. By ostensibly changing a coverage decision (was inpatient admission a medically necessary covered service?) to a payment decision (at what level should an inpatient admission be paid?), Aetna's Policy eliminates hospitals' access to the appeals process in the regulations governing the Medicare Advantage program. When a Medicare Advantage Organization (like Aetna) determines that a service is not covered by a plan because it was not medically necessary, patients and their providers may pursue several levels of review: reconsideration by the Medicare Advantage Organization, reconsideration by an independent outside entity, a hearing before an administrative law judge, review by the Medicare Appeals Council, and judicial review. 42 C.F.R. §§ 422.578–.612. Here, Aetna treats inpatient admission as a medically necessary covered service, but it has unilaterally amended its contracts with hospitals to pay some of those admissions at a lower rate (comparable to outpatient observation rates), transforming the issue into a dispute arising solely under its contract, which the Centers for Medicare and Medicaid Services (CMS) has deemed ineligible for this review process. *Rencare, Ltd. v. Humana Health Plan of Tex., Inc.*,

395 F.3d 555, 560 (5th Cir. 2004) (a Medicare Advantage Organization's failure to pay a contracted provider "is not an organization determination that [the provider] could appeal within the mandatory administrative review mechanism"). Cutting off legally mandated avenues of appeal is another burden that requires injunctive relief.

When an insurer's policy has far-reaching implications for hospitals nationwide, public litigation is more efficient and fairer than confidential arbitration. Arbitration is expensive. Between filing fees, attorneys' fees and other costs, arbitration can easily cost a hospital $1 million or more. If confidential arbitration is the only means to challenge the policy change, an insurer can impose a policy on these hospitals that results in a six-figure financial loss without consequence, because fighting the change will cost more than the hospital could recover by overturning the policy. If disputes can be litigated publicly, however, smaller hospitals (for whom litigation or arbitration would be cost-prohibitive) can take advantage of favorable rulings that hospitals with more resources (like the plaintiffs here) can obtain. Indeed, the ability to obtain declaratory or injunctive relief provides important widespread clarity that closed-door arbitration does not.

Insurers benefit from this efficiency as well. A major new policy like Aetna's may draw hundreds of challenges. If each challenge must be heard in a separate confidential arbitration, the insurer may litigate the same issue hundreds of times at once before separate arbitrators, creating massive inefficiencies and risking inconsistent adjudications. In public litigation, by contrast, an insurer can consolidate or coordinate the cases against it, potentially create precedent in its favor, and achieve consistency through appellate decisions, or through lower-court decisions that other courts find persuasive. An insurer that is confident that its policy is lawful and permissible under its contracts should prefer public litigation. Aetna's insistence on arbitration, notwithstanding the plain language of its contracts excluding claims for declaratory and injunctive relief from the

arbitration requirement, suggests that it either lacks confidence in the lawfulness of its Policy or seeks to take advantage of the many hospitals that cannot afford to arbitrate against it behind closed doors.

II. Arbitration Shields Potentially Unlawful Policies Like Aetna's from Public Scrutiny.

Forcing disputes over nationwide policies into confidential arbitration shields potential violations of the law from government scrutiny. In an ideal world, the choice of forum should not matter because a hospital that believes that an insurer is violating the law could report the violation to federal agencies, which would promptly enforce their regulations. In practice, however, effective enforcement is difficult to obtain.

The two-midnight rule proves this point. Since the rule became effective, Medicare Advantage Organizations have taken the position that it does not bind them because it is a payment rule and not a coverage rule. The classification matters because if the rule is understood as a coverage requirement, CMS may require Medicare Advantage Organizations to apply it when making basic benefit determinations; if it is characterized only as a payment rule, plans can argue that CMS cannot impose it without intruding on payment arrangements between Medicare Advantage Organizations and hospitals, which federal law prohibits. *See* 42 U.S.C. § 1395w-24(a)(6)(B)(iii). In other words, federal law constrains CMS from dictating the payment terms negotiated between Medicare Advantage Organizations and hospitals, but it does not give Medicare Advantage Organizations license to disregard Medicare coverage standards that define the basic benefits Medicare Advantage enrollees are entitled to receive.

In 2022, AHA raised this issue with CMS: "[M]any [Medicare Advantage Organizations] have implemented policies that further restrict inpatient care by placing additional obstacles to admission, including, as reported to the AHA by member hospitals, directly pressuring providers

to classify patients as 'under observation' prior to the submission of claims, even when the clinical criteria for inpatient care have clearly been met."[2] CMS ultimately agreed, promulgating a rule in 2023 that could not have been clearer: in a paragraph citing the two-midnight rule, CMS stated, "MA plans may not use InterQual or MCG criteria, or similar products, to change coverage *or payment criteria* already established under Traditional Medicare laws." 88 Fed. Reg. 22120, 22194 (Apr. 12, 2023) (emphasis added). Yet, three years later, Aetna is enforcing a new policy that does exactly what the regulation forbids. While agencies may eventually enforce their regulations, insurers can violate them for years before the agencies catch up. Public litigation, backed by injunctive and declaratory relief, can stop unlawful practices more quickly.

Moreover, Aetna's automatic approval of any inpatient admission of one midnight or more could be viewed as manipulation of the data it sends to CMS. Every year, Aetna must send comprehensive information to CMS regarding its enrollees, including diagnosis codes recorded in their encounters with healthcare providers. CMS uses these codes to determine the overall health of Aetna's population of enrollees, which is an important factor in determining how much Aetna will be paid. The standards for reporting diagnosis codes are different for inpatient and outpatient encounters:

> **Inpatient:** "If the diagnosis documented at the time of discharge is qualified as 'probable,' 'suspected,' 'likely,' 'questionable,' 'possible,' or 'still to be ruled out,' 'compatible with,' 'consistent with,' or other similar terms indicating uncertainty, code the condition as if it existed or was established."
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> **Outpatient:** "Do not code diagnoses documented as 'probable', 'suspected,' 'questionable,' 'rule out,' 'compatible with,' 'consistent with,' or 'working diagnosis' or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal tests, or other reason for the visit."

[2] Letter from Ashley Thompson, AHA, to Chiquita Brooks-LaSure, CMS (Aug. 31, 2022), https://www.aha.org/system/files/media/file/2022/08/aha-comments-on-cms-request-for-information-re-the-medicare-advantage-program-letter-8-31-22.pdf

CMS, ICD-10-CM Official Guidelines for Coding and Reporting (Oct. 1, 2025), 109, 111, 114, https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. By treating all inpatient admissions as medically necessary, Aetna ensures that it will capture the highest number of codes possible, even as it designates many of those encounters as "lower level of severity," with payment comparable to outpatient rates. This allows Aetna to collect more money from the government than it would if it were applying the medical necessity criteria promulgated by CMS. Litigation exposes practices like this to the light of day, while confidential arbitration hides them from federal overseers in the Executive Branch and Congress.

A case involving the insurer Anthem demonstrates the value of public litigation when an insurer issues an allegedly unlawful policy. In 2017, Anthem implemented an "ED Policy," under which it would review emergency care based on diagnosis codes in addition to medical records. *Am. Coll. of Emergency Physicians v. Blue Cross & Blue Shield of Ga., Inc.*, 2020 U.S. Dist. LEXIS 259466, at *2 (N.D. Ga. Mar. 19, 2020), *rev'd*, 833 F. App'x 235 (11th Cir. 2020). Anthem began telling its insureds, "Save the ER for emergencies – or you'll be responsible for the cost." *Id.* The American College of Emergency Physicians (ACEP) and the Medical Association of Georgia (MAG) challenged the ED Policy, alleging that it was inconsistent with the standard for coverage of emergency care set forth in regulations implemented under the Affordable Care Act. *Id.* at *2–3. The district court dismissed the complaint. *Id.* at *15. On appeal, a panel of the Eleventh Circuit unanimously reversed: "Defendants' conclusory statements about their legal compliance ha[ve] nothing to do with whether ACEP and MAG have plausibly alleged that Blue Cross Blue Shield violated the law. Because ACEP and MAG have otherwise met their burden,

this assertion is no basis for dismissing their claims." 833 F. App'x at 239. After remand, the parties settled, with Anthem agreeing to discontinue the policy.[3]

Now imagine what would have happened if this dispute had been covered by an arbitration requirement. Associations like ACEP and MAG would not have been able to bring litigation, because an association cannot bring claims that its members would be barred from asserting. *See Pa. Psychiatric Soc'y v. Green Spring Health Servs.*, 280 F.3d 278, 293–94 (3d Cir. 2002). Nor could a group of emergency physicians have sought arbitration on behalf of a class. *Stolt–Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 559 U.S. 662 (2010). Many emergency physicians, moreover, would have lacked the resources to challenge Anthem's ED Policy, which would have continued to apply to them regardless of its legality. Any group that did have the resources to challenge the ED Policy could have obtained relief only for itself, meaning the same issue would have been arbitrated multiple times in confidential silos, with no ability to develop the law through evaluation of public decisions. If an arbitrator ruled incorrectly, as the Eleventh Circuit held the judge did in the ACEP case, the group would be unable to appeal except in the most egregious circumstances. *See* 9 U.S.C. §§ 9–11; *Hall St. Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576 (2008). In the end, whether a particular group of emergency physicians would be forced to comply with Anthem's ED Policy would have depended as much on the group's resources and the luck of the draw as the merits of its claim.

The same is true for Aetna's Policy. If the Plaintiffs' claims for injunctive and declaratory relief must be arbitrated, Aetna will continue to enforce the Policy against hospitals that cannot

[3] American College of Emergency Physicians, Georgia Emergency Claims Review Program Discontinued by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., and ACEP and MAG Withdraw Suit in Response (Mar. 9, 2022), https://www.emergencyphysicians.org/press-releases/2022/3-9-22-georgia-emergency-claims-review-program-discontinued-by-blue-cross-blue-shield-healthcare-plan-of-georgia-inc.-and-acep-and-mag-withdraw-suit-in-response.

afford to fight it, and there will be no way to develop uniform decisions about its lawfulness. Only public litigation—with the possibility of injunctive and declaratory relief—creates the possibility for the same beneficial resolution that was achieved in the Anthem case.

CONCLUSION

Amici recognize that this motion turns on the interpretation of the parties' arbitration provisions. But there are important background considerations that this Court should bear in mind. Interpreting the parties' arbitration clauses as written—with a carveout for injunctive relief—promotes the efficient resolution of disputes between hospitals and insurers, as well as the public interest. For these reasons and those stated in Plaintiffs' brief, Aetna's motion to compel arbitration should be denied.

Respectfully submitted,

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/s/ Henry C. Quillen

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