UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

TAQUERIA EL PRIMO LLC, VICTOR MANUEL DELGADO JIMENEZ, MITCHELLE CHAVEZ SOLIS, EL CHINELO PRODUCE, INC., VIRGINIA SANCHEZ-GOMEZ, and BENJAMIN TARNOWSKI, on behalf of themselves and others similarly situated,

Case No. 19-cv-3071

Plaintiff,

v.

FARMERS GROUP, INC., TRUCK INSURANCE EXCHANGE, FARMERS INSURANCE COMPANY, INC., FARMERS INSURANCE EXCHANGE, ILLINOIS FARMERS INSURANCE COMPANY, and MID-CENTURY INSURANCE COMPANY,

Defendants.

AMICUS CURIAE BRIEF BY COALITION AGAINST INSURANCE FRAUD

I. INTERESTS OF AMICUS CURIAE

Established more than twenty-five years ago, the Coalition is a national organization that draws upon the combined energy and resources of consumers, government organizations, and insurers. The membership of the Coalition encompasses a broad array of consumer groups, governmental organizations (including insurance regulatory agencies and the offices of state Attorneys General), insurance providers, and related organizations. The Coalition's aims are to: (1) combat all forms of insurance fraud, (2) reduce costs for consumers, and (3) promote fairness and integrity in the insurance system.[1] To this end, the Coalition plays an active role in advocating for laws, regulations, and policies that help detect, prevent, deter, and prosecute insurance fraud.

II. SUMMARY OF ARGUMENT

No-fault insurance fraud schemes involving health care providers, runners and attorneys are rampant in Minnesota. *See infra* at Section III, p. 5. These schemes pose serious threats to the broad array of the Coalition's constituents – consumers, insurers and government agencies – who have common interests in combatting insurance fraud to protect consumers from higher premiums and other serious harms that flow from these activities, and promote fairness and integrity for all participants in the no-fault system as a whole.

The pervasiveness of these schemes in Minnesota has been on full display through

[1] *Members*, COALITION AGAINST INS. FRAUD, https://insurancefraud.org/members/ (last visited Mar. 2, 2022) (comprehensive list of the Coalition's constituent organizations, including insurance organizations, state and federal law enforcement and regulatory agencies, as well as many state and national consumer and public advocacy organizations).

several high-profile criminal prosecutions, civil lawsuits by insurers and statistics from the Department of Commerce Fraud Bureau. Through these public and private sector anti-fraud efforts, it is clear these schemes cause the following harms: (1) consumers injured in auto accidents get treatment that they do not need designed to max-out their limits quickly, rather than treatment they may need, which depletes their limited no-fault benefits; (2) the depleted limits may not allow for necessary treatment; (3) the public safety for all consumers is threatened by accidents that are deliberately caused to manufacture fraudulent claims; (4) insurers and the courts are forced to incur additional costs and allocate their finite resources to claims, arbitrations and lawsuits stemming from fraudulent claims; and (5) consumers ultimately are left to pay higher premiums. Unfortunately, honest consumers, insurers and the system as a whole are left holding the proverbial bag, so a relatively small number of greedy health care providers, along with runners and attorneys, can line their pockets with the ill-gotten proceeds from these schemes.

The Coalition believes the agreements at issue in this case, in which health care providers suspected of fraud voluntarily agreed not to bill Farmers or its insureds for various periods of time, in exchange for a release from liability from Farmers for fraud claims ("Billing Moratoria"), do not violate Minnesota's No-Fault Act, Minn. Stat. § 65B.44 and are consistent with the public policy of Minnesota, as well as the shared interests of the Coalition's constituents, to combat insurance fraud. Such actions, which successfully stop fraudulent insurance practices, should in turn result in lower insurance premiums for all Minnesota citizens.

While the Coalition supports the public disclosure of the Billing Moratoria, here it

appears to be undisputed the health care providers and their attorneys are the ones who have insisted on the confidentiality of these agreements as a condition of settlement. Defs.' Mot. Summ. J. at 1, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19 cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373. The Coalition further notes plaintiffs in this case reported their lawsuit and Farmers' Billing Moratoria to the Department of Commerce Fraud Bureau, which investigated the plaintiffs' report and, eight months later, announced that it "closed the file without further action." *Id.* at 10-11.[2]

The Coalition believes that the purposes and interests served by the Billing Moratoria are consistent with efforts of other federal and state health care insurance programs to protect insureds from health care providers suspected of fraud, kickbacks and other misconduct. In fact, over the last 40-plus years, federal and state governments have excluded thousands of health care providers, either by unilateral action by the government or by agreement with the providers, from billing insureds for the express purpose of protecting against fraud and securing the integrity of their programs.

Finally, the benefits of Billing Moratoria for consumers, insurers and the system as a whole far outweigh the adverse impacts, if any, of such agreements. In that regard, the Coalition notes that Farmers' Billing Moratoria have been in place for approximately ten years and, after two and a half years of litigation, the plaintiffs and the organizations who

[2] Apparently, Plaintiffs' counsel – who negotiated several of these agreements – did not believe there was anything inappropriate with these agreements, given counsel did not contemporaneously report these allegedly unlawful agreements to the Department of Commerce Fraud Bureau. Quite the opposite, counsel demanded confidentiality as a condition to settlement.

have filed an amicus brief supporting their motion for summary judgment have identified at most two people who *allegedly*[3] were prevented from treating with their provider of choice because of a Billing Moratoria, and offered no evidence of any actual impact on any particular community. This is not surprising when comparing the relatively small number of health care providers who have been parties to Billing Moratoria with the tens of thousands of other health care providers in Minnesota who were not parties to those agreements. To illustrate, throughout the past ten years, there have been 25,000 to 30,000 licensed health care providers in Minnesota. *See* Defs.' Mot. Summ. J. at 7-8, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373. In contrast, during this same ten-year time period, a total of forty-three (43) individual health care providers have agreed to Billing Moratoria for different periods, but typically time periods of less than eight months. *Id.* at 7-8; Damages Class's Mot. Partial Summ. J. at 9, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 389. In each of the last six years, no more than six individual health care providers have been parties to Billing Moratoria at any one point in time, and there are currently only two such providers across the entire State. Thus, at any point in time over the past ten years, the percentage of health care providers subject to Billing Moratoria was no greater than .02% of available health care

[3] The parties dispute whether these two insureds—plaintiffs Michelle Chavez Solis and Victor Manuel Delgado Jimenez—were prevented from treating with their provider of choice. *Compare* Damages Class's Mot. Partial Summ. J. at 16, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 389, *with* Defs.' Mot. Summ. J. at 9-10, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373.

providers in Minnesota. Put a different way, this means that at any point in time over the past ten years, 99.98% of the health care providers in Minnesota were available to potentially provide treatment and were not prevented from billing Farmers or its insureds if they chose to treat the insureds after an auto accident.

III. NO-FAULT INSURANCE FRAUD IS RAMPANT IN MINNESOTA

Insurance fraud is a pervasive nationwide problem, and Minnesota is a particular hotbed for auto and health care fraud. A study published in 2015 identified Minnesota as having the fourth highest percentage of auto insurance fraud, at 22% of its paid claims. David Corum, *Insurance Research Council Finds That Fraud and Buildup Add Up to $7.7 Billion in Excess Payment for Auto Injury Claims*, INSURANCE RESEARCH COUNCIL (Feb. 3, 2015) https://www.insurance-research.org/sites/default/files/downloads/IRC%20Fraud%20News%20Release.pdf. In its latest Annual Report, the Department of Commerce Fraud Bureau identified auto and health care insurance fraud as the two most commonly reported fraud in the State, respectively, outpacing all other fraud by a wide margin. *Commerce Fraud Bureau Annual Report 2020*, MINN. DEP'T OF COMMERCE, COMMERCE FRAUD BUREAU (2021), https://mn.gov/commerce-stat/pdfs/2020_MN Fraud Bureau_Annual_Report.pdf. According to the report: "Typical fraud reports involved fraud claims from 'staged accidents for fictional injuries and fraudulent inaccurate claims for injury treatment;' 'falsifying a patient's diagnosis to justify tests . . . or procedures that aren't medically necessary,' and 'billing for services not actually performed.'"

Due to the pervasive harms flowing from no-fault fraud schemes, federal, state and local law enforcement agencies have worked together to prosecute and obtain criminal

convictions of a host of medical providers, "runners" and attorneys who have created a cottage industry of no-fault fraud through which they line their own pockets without regard to the harm to consumers, insurers or the integrity of the no-fault system. These criminal cases demonstrate that rings of health care providers, runners and attorneys operate independently of each other but follow the same fraud script: the health care providers pay kickbacks to runners to refer patients from staged or real accidents for treatment that is not needed or is not rendered, and lawyers pay kickbacks to runners to refer those patients as clients to make fraudulent injury claims.

For instance, in 2016, the United States Attorney for the District of Minnesota announced criminal charges arising from a joint federal and state investigation named "Operation Back Cracker." As a result, twenty-one chiropractors and runners were charged with various federal offenses for engaging in multiple independent – but virtually identical – schemes to steal more than $20 million through fraudulent no-fault claims based upon individuals who were in real and staged auto accidents and either did not need or get the chiropractic treatment that was billed. *See* Press Release, U.S. Attorney's Office for the Dist. of Minn., Chiropractic Ins. Fraud Conspiracies Cracked by Minn. Commerce Fraud Bureau and FBI (Dec. 21, 2016), https://www.justice.gov/usao-mn/pr/chiropractic-insurance-fraud-conspiracies-cracked-minnesota-commerce-fraud-bureau-and-fbi.

In announcing the indictments, the United States Attorney stated that:

> State and federal law enforcement are cracking down on no-fault automobile insurance fraud. The charges unsealed today represent a serious effort to expose crooked billing abuses that harm consumers. The Commerce Fraud Bureau and FBI continue to work closely with my office to ensure that our efforts to stop fraud and

abuse are aligned with the interests of all Minnesotans.

Id.

The Coalition notes that Michael Rothman, who was then the Commissioner of the Commerce Department, was quoted in the same press release about the need to crack down on these rings because they "threaten public safety and prey on Minnesota consumers." Specifically, Rothman stated: "We will not tolerate those who perpetrate staged-car accidents, illegal kickbacks nor fake medical billing. . . . Today's crackdown will help stop these fraud schemes that threaten our public safety and prey on Minnesota consumers. . . "

The Operation Back Cracker schemes involved chiropractors paying "runners" to steer individuals from real and staged accidents to their clinics for treatment that they did not need. The chiropractors paid runners up to $1,000 per patient, but often only after the patient appeared for a minimum number of visits. The chiropractors then billed more than $20 million to insurers for chiropractic services that either were not medically necessary or not rendered.

Other criminal indictments and convictions have followed similar patterns of medical providers paying runners to steer individuals in real and staged accidents to their clinics for treatment that is not needed or not rendered to exploit their no-fault benefits. *See* Press Release, U.S. Attorney's Office for the Dist. of Minn., Inver Grove Heights Chiropractor Charged In No-Fault Auto. Ins. Fraud Scheme (Mar. 23, 2017), https://www.justice.gov/usao-mn/pr/inver-grove-heights-chiropractor-charged-no-fault-automobile-insurance-fraud-scheme.

For instance, in March 2017, a federal grand jury charged a Minnesota chiropractor with mail fraud and conspiracy to commit health care fraud based upon his payments to runners of up to $1,500 for each individual steered to his clinics from real and staged accidents. *Id.* The chiropractor demanded refunds of the kickbacks if the patients did not attend a minimum number of treatments, and billed no-fault insurers for treatments that were not needed or were not rendered. *Id.; see also* Information, *United States v. Bradley Meskimen*, No. 0:20-cr-00256-NEB (D. Minn. filed Dec. 1, 2020), https://mn.gov/commerce-stat/pdfs/fraud-complaint-bradley-meskimen.pdf; Press Release, U.S. Attorney's Office for the Dist. of Minn., Two Twin Cities Chiropractors Sentenced To Prison For Orchestrating Ins. Fraud Schemes (Oct. 2, 2018), https://www.justice.gov/usao-mn/pr/two-twin-cities-chiropractors-sentenced-prison-orchestrating-insurance-fraud-schemes.

Corrupt personal injury attorneys also participate in and profit from these schemes, which increase the value of claims and the attorney's contingency fees. In February 2020, the United States Attorney announced a Minnesota personal injury attorney pleaded guilty to conspiracy to commit healthcare fraud for his role in an "all too common healthcare fraud scheme involving a network of chiropractors and runners." Press Release, U.S. Attorney's Office for the Dist. of Minn., Minnetonka Personal Injury Attorney Pleads Guilty To Health Care Fraud Conspiracy (Feb. 3, 2020), https://www.justice.gov/usao-mn/pr/minnetonka-personal-injury-attorney-pleads-guilty-health-care-fraud-conspiracy. In that case, the attorney admitted that he conspired with chiropractors who paid runners up to $1,500 for each individual referred to their clinics to manufacture claims for

unnecessary treatment, while the attorney paid the runners an additional $300 to refer these individuals to become his clients. As Minnesota Department of Commerce Commissioner Steve Kelley noted, "[t]he conduct perpetrated by [the attorney] makes it harder for the legitimate lawyers and health care providers to help Minnesotans who really are injured." *Id.*; *see* Nick Ferraro, *S. St. Paul Boys Basketball Coach Pleads Guilty to Conspiracy to Commit Health Care Fraud*, TWIN CITIES PIONEER PRESS (Jan. 19, 2022), https://www.twincities.com/2022/01/19/south-st-paul-boys-basketball-coach-pleads-guilty-to-conspiracy-to-commit-health-care-fraud/.

These criminal indictments and convictions, coupled with the civil litigation noted below, and the state-wide statistics reported by the Department of Commerce Fraud Bureau, demonstrate the pervasiveness and harms resulting to consumers from predatory health care providers involved in no-fault fraud schemes in Minnesota. As the United States Attorney's Office of Minnesota has noted, these schemes affect both the injured individuals who have been in accidents and need their benefits for necessary treatment, but also Minnesota consumers as a whole:

> The #1 goal of the scheme was to steal money from insurance providers, resulting in higher premiums for Minnesota consumers. This is unacceptable. I applaud the diligent investigators and prosecutor who continue to pursue these cases.

Press Release, U.S. Attorney's Office for the Dist. of Minn., Minnetonka Personal Injury Attorney Pleads Guilty To Health Care Fraud Conspiracy (Feb. 3, 2020), https://www.justice.gov/usao-mn/pr/minnetonka-personal-injury-attorney-pleads-guilty-health-care-fraud-conspiracy.

II. MEDICAL PROVIDERS WHO ENGAGE IN NO-FAULT INSURANCE FRAUD PREY ON AND HARM CONSUMERS

Medical providers are legally and ethically bound to act in the best interests of their patients. When they participate in no-fault fraud schemes to line their own pockets (like those described above), they do the opposite and as a result individuals who are injured in accidents: (1) receive treatments they do not need; (2) do not get treatment they do need; and (3) their limited no-fault benefits are consumed for care that is not provided or not needed, and therefore is not available for care that is needed. Such actions drive up the cost of insurance for all Minnesota residents. In contrast, fighting insurance fraud and stopping such fraudulent practices should equally lead to lower insurance premiums for consumers.

These very concerns were highlighted by the Eighth Circuit in upholding the criminal convictions of chiropractors and runners who were the subject of Operation Back Cracker indictments. Specifically, the Court not only noted the lack of medical necessity of the treatment and the patients' distress and pressure at being forced to continue to receive treatment (*United States v. Kidd*, 963 F.3d 742, 746 (8th Cir. 2020)), but also observed that a major concern with the use of runners and kickback schemes is that "accident victims might seek treatment, not because they actually need it, but based on pressure from recruiters or a desire to put money in their own pockets." *United States v. Luna*, 968 F.3d 922, 927 (8th Cir. 2020). Thus, the dangers to individuals and the public at large from the participation of predatory medical providers in these schemes are tangible, real, and should be of concern to all Minnesotans.

III. FARMERS HAS THE RIGHT TO ENTER INTO BILLING MORATORIA WITH MEDICAL PROVIDERS WHO ARE ENGAGED IN FRAUD TO PROTECT ITS INSUREDS, ITSELF AND THE SYSTEM FROM CONTINUING EXPLOITATION AND HARM.

A. Minnesota Imposes Statutory Obligation On Insurers To Investigate, Report, And Attempt To Prevent Ongoing Insurance Fraud.

Insurers are required by both Minnesota state laws and regulations to investigate, prevent, and report insurance fraud to protect Minnesota consumers, insurers and the system at large. Specifically, insurers *must* develop and implement an antifraud plan. Minn. Stat. § 60A.954. This antifraud plan must establish procedures to (1) prevent insurance fraud, including claims fraud; (2) report insurance fraud to appropriate law enforcement authorities; and (3) cooperate in the prosecution of insurance fraud cases. Furthermore, insurers are required to report any reasonable beliefs regarding the commission of insurance fraud to the Commerce Fraud Bureau, the state law enforcement agency empowered to conduct criminal investigations concerning insurance fraud and related crimes. Additionally, insurers must cooperate fully with any subsequent investigation. Minn. Stat. § 60A.952. Indeed, the statutory provisions mandate that an insurer's failure to report any incidents of insurance fraud or provide relevant information is punishable as a misdemeanor offense. Minn. Stat. § 60A.953.

It appears Farmers complied with these very requirements in the investigations relevant to this case. Indeed, Farmers indicates that it reported the findings of its investigations to the Department of Commerce Fraud Bureau which, in turn, initiated the Operation Back Cracker investigations with the federal government. Defs.' Mot. Summ.

J. at 6, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373.

B. Consistent With Their Statutory Duties, Insurers Have Investigated And Civilly Prosecuted Medical Providers Engaged In No-Fault Fraud Schemes.

Consistent with their statutory duties, insurers in Minnesota, like Farmers, have formed Special Investigations Units ("SIU") to combat insurance fraud. These efforts have led to several civil actions exposing significant no-fault fraud schemes designed to exploit consumers and insurers. Indeed, at least some of the Billing Moratoria at issue in this case arose from settlements that Farmers reached with health care providers who were the subjects of seven civil lawsuits that Farmers filed between 2009 and 2017. Defs.' Mot. Summ. J. at 6, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373.

Similarly, in 2015 State Farm sued a chiropractor and his related clinics based upon their involvement in a no-fault fraud scheme involving the payment of kickbacks for patient referrals to facilitate billing for services that were not rendered or were not necessary. *See State Farm Mut. Auto. Ins. Co. v. Healthcare Chiropractic Clinic, Inc*., No. 0:15-cv-02527-SRN-HB, 2015 WL 6445324, at *2 (D. Minn. Oct. 23, 2015). In March 2018, the chiropractor sued by State Farm pleaded guilty to a federal wire fraud charge and admitted that he paid "runners" kickbacks to refer patients from auto accidents, and at times paid the patients themselves after they had attended a minimum number of visits. *See* Plea Agreement and Sentencing Stipulations, *United States v. Huy Ngoc Nguyen*, No. 0:16-cr-00340-MJD-BRT-1 (D. Minn. entered Mar. 7, 2018), ECF No. 254. Furthermore, the

chiropractor admitted to participating in a meeting with a "runner," an officer of a MRI provider, and a personal injury attorney, in which the chiropractor agreed to pay the runner $1,600 to refer a patient to his clinic, and the officer of the MRI provider agreed to pay the runner $200 for each MRI performed by his business on the same patient. The officer of the MRI provider also discussed paying the runner additional amounts for injections done by a related pain management clinic. *See also State Farm Mut. Auto. Ins. Co. v. Lake St. Chiropractic Clinic, P.A. et al.*, No. 0:16-cv-04017-JNE-BRT, 2017 WL 1014336 (D. Minn. Mar. 14, 2017) (alleging chiropractic and MRI clinics engaged in no-fault fraud scheme by billing for services that were neither rendered nor necessary); *Liberty Mut. Fire Ins. Co. v. Acute Care Chiropractic Clinic P.A.*, 88 F. Supp. 3d 985 (D. Minn. 2015) (alleging defendants engaged in no-fault fraud scheme by billing for treatment by clinics that were secretly and unlawfully owned and controlled by a layperson).

C. The Billing Moratoria Do Not Violate The No-Fault Act

Billing Moratoria do not prevent an insured from receiving any less than the full amount of no-fault benefits for expenses they actually incur for necessary medical services. Minn. Stat. § 65B.44. The agreements do not limit reimbursements for medical expenses *actually incurred* by the insureds, and therefore do not constitute "pre-established limitations" on reimbursements which would be prohibited. *See* Minn. Stat. § 65B.44(1)(c). In fact medical providers agree not to bill Farmers or its insureds if any services are rendered. Under these circumstances, the insured does not "incur" any medical expenses or liabilities.

Furthermore, the Billing Moratoria do not result in no-fault insurance policies that provide, or have the effect of providing "managed care services" which are defined as "any program of medical services that uses health care providers managed, owned, employed by or under contract with a health plan company." Minn. Stat. § 65B.44(1)(c).[4]

Farmers is not a health plan company, and it does not have a program in which it uses health care providers whom it manages, owns, employs or contracts with to manage the services delivered to its insureds. The Billing Moratoria result in two groups of health care providers in Minnesota: (1) health care providers who are parties to the agreements, which currently consists of two chiropractors; and (2) health care providers who are not parties to No-Bill Agreements, which currently consists of more than 30,000 providers. Farmers does not use any health care provider in either group to manage the delivery of services to its insureds, and the providers in both groups are free to choose whether to treat any Farmers' insured at any time and in any manner they deem appropriate. The only effect of the Billing Moratoria is to prohibit the health care providers who have agreed to them, currently two chiropractors, from billing Farmers' or its insureds.

Finally, the No-Fault Act does not require any health care provider to treat any patient. It is axiomatic, the No-Fault Act does not guarantee anyone – whether they are

[4] "Managed care service" programs typically involve complex and comprehensive terms pursuant to which the participating providers agree to deliver their services and the insurer or plan agrees to pay for those services, including: (1) the scope of services to be provided by the participating providers; (2) which services will be covered by the plan; (3) when pre-authorization of services is required or allowed; (4) fee schedules or fee formulas for covered services that the participating providers agree to accept for their services; (5) patient cost-sharing responsibilities; and (6) a host of other rules and guidelines governing the delivery, payment and process of delivery health care services to members of the plan.

insured by Farmers or any other insurer – the right to treat with any provider they choose. To the contrary, providers are free to decide not to treat or bill insureds who are eligible for No-Fault benefits, for many reasons, or for no reason at all. In fact, medical providers have complete discretion to choose who they will treat – other than for prohibited discriminatory reasons. Health care providers routinely choose not to treat patients who are uninsured or insured by a wide variety of public and private health insurance programs. It has been stated, "[a]s is true of all callings, physicians are not obligated to practice their profession or render services to everyone who asks." *St. John v. Pope*, 901 S.W.2d 420, 423 (Tex. 1995); *see also Williams v. United States*, 242 F.3d 169, 176 (4th Cir. 2001) ("[A] physician has no duty to render services to every person seeking them . . . a physician's decision of whether to treat a person amounts to a decision of whether to enter into a contractual relationship."); *Fought v. Solce*, 821 S.W.2d 218, 220 (Tex. Ct. App. 1991) ("Absent an agreement between a physician and an individual, the physician has no duty to treat the individual."); *Salas v. Gamboa*, 760 S.W.2d 838, 841 (Tex. Ct. App. 1988) (same); *Oliver v. Brock*, 342 So.2d 1, 3 (Ala. 1977) ("A physician is under no obligation to engage in practice or to accept professional employment.").[5]

[5] *See also Neocare Health Sys., Inc. v. Teodoro,* 2006 WL 198329, at *3 *(*Mich. Ct. App. Jan. 26, 2009) (affirming denial of defendant nurse's motion for summary judgment in case brought by former employer alleging violation of noncompete agreement and rejecting nurse's argument that noncompete violated public policy by "infring[ing] upon a patient's right to choose a provider" under Medicare statute because statute "allows a patient to choose their health care provider, so long as that provider agrees to provide service to the patient; it does not give the patient an absolute right to the provider of their choosing, but allows providers to decline to undertake the provision of services") (emphasis added); *Orthopedic Specialists of S. Cal. v. Cal. Pub. Employees' Ret. Sys.,* 228 Cal. App. 4th 644, 649 (2014) (out-of-network provider challenged reduced payment from insurer and

Here, it also is important to note the Billing Moratoria were negotiated and voluntarily entered into during settlement conferences with several Magistrate Judges in this District in which the healthcare providers were represented by legal counsel, including the plaintiffs' counsel in this case who are now arguing the terms they negotiated, demanded confidentiality for, and advised their clients to sign are unlawful. *See* Defs.' Mot. Summ. J. at 6, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373. The legal effect of the healthcare providers' decisions to enter the Billing Moratoria is no different than if they had decided on their own volition for their own reasons not to bill any insured of Farmers or any other auto insurer.

IV. BILLING MORATORIA ARE CONSISTENT WITH MEASURES TAKEN BY GOVERNMENT PROGRAMS AND HEALTH INSURERS TO EXCLUDE PROVIDERS ACCUSED OF FRAUD FROM BILLING FOR TREATMENT TO THEIR BENEFICIARIES.

Billing Moratoria are consistent with the efforts of federal and state governments to exclude health care providers from billing beneficiaries of their government health care programs to protect their beneficiaries and the integrity of the programs. In 1977, in the

---

appellate court affirmed dismissal of complaint, distinguishing plaintiff from emergency room physicians who "are required by law to render services to all [ER] patients without regard to the patient's insurance status or ability to pay," because a non-emergency physician is "free to pick and choose its patients and focus on those with the greatest ability to pay its charges") (emphasis added); *Kelly Kare, Ltd. v. O'Rourke,* 930 F.2d 170 (2d Cir. 1991) (government "properly cancelled" healthcare provider's contract, patients did not have a property interest in their freedom to choose plaintiff provider as their healthcare provider because while patients "suffered an incidental burden on their right to choose among qualified and participating health-care providers[, t]heir direct benefits . . . have not been altered" since they continued to receive government-sponsored services "albeit from a different provider").

Medicare-Medicaid Anti-Fraud Abuse Amendments, Public Law 95-142, Congress first mandated the exclusion of health care providers convicted of program-related crimes from participation in Medicare and Medicaid. Through a series of new laws and amendments, Congress expanded and strengthened the authority of the federal government ("OIG") to exclude health care providers from participating in all federal health care programs for many reasons, including the submission of fraudulent claims, claims for unnecessary services, excess charges, or kickbacks. *See*, *e.g.*, Civil and Monetary Penalties Law, Pub. L. No. 97-35 (1981) (a 1981 law expanding authority of HHS OIG to exclude providers who submit fraudulent claims for Medicare or Medicaid payment); Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93, 101 Stat. 680 (establishing mandatory and discretionary exclusions for additional forms of misconduct); Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191; Balanced Budget Act of 1997, Pub. L. No. 105-33 (expanding the authority of the OIG to exclude providers from all federal health care programs); and 42 U.S.C. § 1320a-7(b)(6)(7) (authorizing discretionary authority for the OIG to exclude providers for billing for excessive charges or services that were unnecessary or based on prohibited kickbacks). While the federal government has authority on a mandatory or discretionary basis to exclude providers from billing federal health care programs depending on the circumstances, providers also have the unilateral right to agree to exclusion from billing these programs. *See* 42 U.S.C. 1395a (providing that practitioners and Medicare beneficiaries may privately agree not to bill Medicare for services); *Medicare Benefit*

Policy Manual, CTRS. FOR MEDICARE & MEDICAID SERVS., Ch. 15 § 40 (Rev. 11181, Jan. 14, 2022), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf (describing Medicare opt-out procedure for physicians). In either scenario, whether the provider is excluded for mandatory or discretionary reasons by the OIG or by agreement of the provider, the purpose and result is the same: the programs and their beneficiaries are protected from fraud and abuse by these providers. "The purpose of exclusion is to protect the Medicare, Medicaid, and all Federal health care programs from fraud and abuse, and to protect the beneficiaries of those programs from incompetent practitioners and from inappropriate or inadequate care." *Anderson v. Thompson*, 311 F. Supp. 2d 1121, 1124 (D. Kan. 2004).

As explained by Inspector General June Gibbs Brown in 1997, "[e]xclusion is one of the most important tools we have to protect beneficiaries and stem fraud and abuse in federal health care programs. . . To ensure that Medicare, Medicaid and other federal health care programs are protected, we need the cooperation of the entire health care community to make sure excluded individuals are not involved in any way in the care of federal program beneficiaries." *See* Press Release, Office of Inspector Gen., U.S. Dep't of Health and Human Servs., Special Advisory Bulletin Outlines Effects of Exclusion from Federal Health Care Programs (Sept. 28, 1999), https://oig.hhs.gov/documents special-advisory-bulletins/890/exclude2.htm; *see also Special Advisory Bulletin Outlines Effects of Exclusion from Federal Health Care Programs*, 64 Fed. Reg. 52791-02 (Sept. 30, 1999). The same policies are served through No-Bill Agreements—they are important tools to

protect consumers, insurers and the public at large from the harms caused by medical providers engaged in no-fault fraud.[6]

V. THE ARGUMENTS MADE BY THE AMICUS CURIAE IN SUPPORT OF THE PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT TURN LOGIC ON ITS HEAD.

While the Coalition admires the work to extend medical care to underserved communities, the position taken here by the amicus curiae, Voices for Racial Justice, Health Access MN, and Clues raise several incorrect arguments, namely that the Billing Moratoria: (1) create pre-established limitations on consumers' benefits; and (2) impair consumers' rights to competent medical care. As discussed above, the Billing Moratoria does not create pre-established limitations on no-fault benefits. Nor do the agreements impair consumers from obtaining access to medical care that is geographically convenient, culturally competent, or from a provider who speaks the same language. After two and a half years of litigation in this case, neither the plaintiffs nor the amicus curiae have identified any person who, as a result of a Billing Moratoria, was unable to locate a healthcare provider who was geographically convenient, culturally competent or spoke their language. Although Plaintiffs and amicus curiae allege that two plaintiffs were refused care due to a Billing Moratoria, the providers who purportedly refused to provide care were not subject to a Billing Moratoria with Farmers. Defs.' Mot. Summ. J. at 9-10,

[6] For the same reasons, health insurers have the right to exclude from their networks medical providers who have engaged in fraud, and providers have the right to voluntarily agree to be excluded from those networks.

Taqueria El Primo LLC v. Farmers Group, Inc., No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373.

Beyond that, statistics and logic suggest that purported impairment in consumers' right to competent medical care does not exist here. Farmers currently has Billing Moratoria with ***two*** chiropractors in Minnesota, and over approximately the last ten years, has had such agreements with fewer than 0.02% of all licensed physicians, physician assistants and chiropractors in Minnesota. Defs.' Mot. Summ. J. at 7-8, *Taqueria El Primo LLC v. Farmers Group, Inc.*, No. 0:19-cv-3071-JRT-BRT (D. Minn. filed Feb. 11, 2022), ECF No. 373. During the same period, more than 25,000 physicians, physician assistants and chiropractors in Minnesota have not been subject to Billing Moratoria and have been available to bill Farmers' insureds if they chose to do so. *Id.*

The Coalition shares amicus curiae's concerns about ensuring that consumers have access to healthcare providers who are geographically convenient, culturally competent, and speak the same language. However, there is no evidence the Billing Moratoria have prevented consumers from having that access at any time during the last decade.

Dated: March 9, 2022

Respectfully submitted,

By: */s/Tiffany A. Blofield*

Tiffany A. Blofield
Greenberg Traurig, LLP
90 South 7th Street, Suite 3500
Minneapolis, MN 55402
Telephone: 612.259.9721
blofieldt@gtlaw.com

Attorney for Amicus Curiae

CERTIFICATE OF SERVICE

I hereby certify that on March 9, 2022 I electronically filed the foregoing with the Clerk of Court using the CM/ECF system which will send notification to all counsel of record.

By: */s/Tiffany A. Blofield*

Tiffany A. Blofield
Greenberg Traurig, LLP
90 South 7th Street, Suite 3500
Minneapolis, MN 55402
Telephone: 612.259.9721
blofieldt@gtlaw.com

Attorney for Amicus Curiae

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

TAQUERIA EL PRIMO LLC, VICTOR MANUEL DELGADO JIMENEZ, MITCHELLE CHAVEZ SOLIS, EL CHINELO PRODUCE, INC., VIRGINIA SANCHEZ-GOMEZ, and BENJAMIN TARNOWSKI, on behalf of themselves and others similarly situated,

Plaintiff,

v.

FARMERS GROUP, INC., TRUCK INSURANCE EXCHANGE, FARMERS INSURANCE COMPANY, INC., FARMERS INSURANCE EXCHANGE, ILLINOIS FARMERS INSURANCE COMPANY, and MID-CENTURY INSURANCE COMPANY,

Defendants.

Case No. 19-cv-3071

CERTIFICATE OF COMPLIANCE WITH LOCAL RULE 7.1

Pursuant to Local Rule 7.1(f)(2), the undersigned hereby certifies that the Amicus Curiae Brief by Coalition Against Insurance Fraud was prepared in Microsoft Office 365 using a 13-point, proportional font in compliance with Local Rule 7.1(h). The undersigned further certifies that the foregoing document complies with the word limits in Local Rule 7.1(f)(1), as it contains 5,500 words, according to Microsoft Office 365's word count function, including all text, headings, footnotes, and quotations.

Dated: March 9, 2022

Respectfully submitted,

By: */s/Tiffany A. Blofield*

Tiffany A. Blofield
Greenberg Traurig, LLP
90 South 7th Street, Suite 3500
Minneapolis, MN 55402
Telephone: 612.259.9721
blofieldt@gtlaw.com

Attorney for Amicus Curiae