

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

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|------------------------------|---|---------------------|
| ROBERT WITT, et al., |) | |
| |) | |
| Plaintiff |) | |
| |) | |
| v. |) | Civil No. 00-31-B-C |
| |) | |
| AETNA U.S. HEALTHCARE, INC., |) | |
| et al., |) | |
| |) | |
| Defendant |) | |

Revised RECOMMENDED DECISION ON DEFENDANT’S MOTION TO DISMISS FOR FAILURE TO STATE A CLAIM (DOCKET NO. 12)

Defendant Aetna U.S. Healthcare, Inc. moves pursuant to Fed. R. Civ. P. 12(b)(6) to dismiss all counts of Plaintiffs’ First Amended Complaint for failure to state claims upon which relief can be granted. Plaintiffs assert several causes of action all relating to alleged violations of the Third Party Prescription Program Act (“TPPPA”), 32 M.R.S.A. §§ 13771-13777 (1999). The complaint contains five counts: a claim directly under the TPPPA (Count I), a claim under two sections of the Maine Insurance Code, 24-A M.R.S.A. §§ 2152 & 2154 (2000) (Count II), a claim under the Uniform Deceptive Trade Practice Act, 10 M.R.S.A. §1212 (1999) (Count III), a claim for fraudulent misrepresentation (Count IV) and a claim for interference with a business expectancy or an advantageous relationship (Count V). I now recommend that the Court GRANT the Motion to Dismiss as to Counts I and II and DENY the motion as to the remaining counts of the complaint.

Standard of Review

In considering a Motion to Dismiss under Rule 12(b)(6), the Court must accept as true the well-pleaded factual allegations of the complaint, draw all reasonable inferences in the plaintiffs' favor, and determine whether the complaint, so read, sets forth facts sufficient to justify recovery on any cognizable theory. *See LaChapelle v. Berkshire Life Ins. Co.*, 142 F.3d 507, 508 (1st Cir. 1998).

Facts

Defendant Aetna U.S. Healthcare, Inc. ("Aetna"), is a Maine corporation that provides health insurance coverage within the state of Maine. Plaintiffs Robert Witt and Donald DeGolyer are both registered Maine pharmacists. Witt is the owner of the Howard's Rexall Drug Store in Farmington. DeGolyer is the owner of the Lubec Apothecary. As of at least 1996, Witt and DeGolyer (hereinafter collectively referred to as "Witt") have provided pharmaceutical goods and services to individuals insured by Aetna pursuant to Pharmacy Service Agreements entered into with Aetna, appended to the complaint as exhibits C and D.

Defendant Express Scripts, Inc. ("ESI"), is a pharmacy benefits management company based in St. Louis, Missouri. (Amended Class Action Complaint, Docket No. 5 ¶¶ 2-7.) In May 1996, Aetna entered into an exclusive agreement with ESI to provide a mail order pharmacy program to Aetna's insureds. (*Id.* ¶ 13.) Pursuant to the terms of the agreement, Aetna's insureds are able to receive lower co-payments and longer refill periods when they purchase pharmaceutical products from ESI. Aetna informed its insureds of this benefit through informational mailings. (*Id.* ¶ 14-15.) Aetna also offers more favorable terms to certain chain pharmacies and rural pharmacies than it offers to

Witt. (*Id.* at 22.) Aetna did not inform Witt of the terms of its agreement with ESI or offer Witt equal co-pay and refill terms pursuant to his contract. (*Id.* ¶ 18.) Aetna also failed to inform Witt of the preferential terms provided to the chain and rural pharmacies. (*Id.* ¶ 23.) Because of this nondisclosure, Witt was unaware of Aetna’s practice of offering different terms to other pharmacies in Maine when he entered into the Pharmacy Service Agreement with Aetna. (*Id.* ¶ 24.) Witt further alleges that he “lost customers as a result of the preferential terms of Aetna’s mail order plan and suffered financial losses as a result of the unfavorable pricing strategy contained in their contracts with Aetna.” (*Id.* ¶ 25.)

At some point between 1996 and 1998, Howard’s Rexall Drug Store filed a complaint with the Maine Bureau of Insurance and an investigation was conducted by Superintendent Alessandro Iuppa. (Docket No. 5, Exhibit B.) In a letter ruling dated December 11, 1998, Superintendent Iuppa concluded, *inter alia*, “that the Express Scripts mail order drug program . . . violates the TPPPA . . . insofar as contracted local pharmacies are not permitted to dispense drugs on the same terms available to . . . [m]embers accessing prescription drugs through the mail order program.”¹ (*Id.*) The Superintendent directed Aetna to comply with the TPPPA by January 1, 1999. (*Id.*) On February 16, 2000, Aetna and the Superintendent entered into a Consent Agreement “for the purpose of resolving, without resort to an adjudicatory proceeding, any violations . . . of the Third-Party Prescription Program Act” (*Id.*, Exhibit E.) The Agreement recited several violations of the TPPPA and contained covenants that provided, *inter alia*, that Aetna would use a uniform contract for all participating pharmacies. (*Id.*)

¹ At the time of the Superintendent’s intervention, the ESI program was being administered by NYLCare Healthplans of Maine, Inc., which had been acquired by Aetna in July 1998.

Discussion

I. Maine Insurance Code and TPPPA Claims (Counts I & II)

In Counts I and II Witt seeks declaratory relief under the respective statutory provisions and also an award of attorney fees. Aetna argues that under *Larrabee v. Penobscot Frozen Foods, Inc.*, 486 A.2d 97, 101 (Me. 1984) and *Cort v. Ash*, 422 U.S. 66 (1975) there is no private cause of action under the TPPPA nor under the cited portions of the Maine Insurance Code. Neither the TPPPA nor the two sections of the Maine Insurance Code provides expressly for a private right of action and neither provides for an award of attorney fees. Witt argues, however, that under controlling federal precedent an implied cause of action exists. *See Cannon v. University of Chicago, et al.*, 441 U.S. 677 (1979) (noting that in situations “in which it is clear that [statutory] law has granted a class of persons certain rights, it is not necessary to show an intention to create a private cause of action, although an explicit purpose to deny such cause of action would be controlling.”)

When the Maine Law Court decided the *Larrabee* case in 1984 it had the benefit of the Supreme Court’s decisions in both *Cort* and *Cannon* and adopted the approach articulated by the *Cort* decision with its emphasis on actual legislative intent. *See Larrabee*, 486 A.2d at 101 & n.7. The Law Court implicitly rejected the notion that because a plaintiff was a member of the class of individuals for whose especial benefit the statute was enacted, a presumption would arise that the Legislature intended to create a private cause of action for such individuals. *See id.* at 101. In *Larrabee*, the plaintiffs were terminated employees who attempted to bring an action pursuant to two statutory

provisions: 26 M.R.S.A. § 630, which required the employer to give the terminated employee written reasons for the termination within 15 days or face a civil forfeiture penalty, and 26 M.R.S.A. § 1051(1)(B), which provided that an employer would be guilty of unemployment fraud if it made a knowingly false statement of material fact in order to prevent the payment of unemployment benefits. *See id.* at 99 & 100-101.

The Court stressed that the key to the question of whether a private cause of action could be implied was one of legislative intent. *See id.* at 101. (“Thus if our Legislature had intended that a private party have a right of action under [the applicable statutory provision], it would have either expressed its intent in the statutory language or legislative history or, more likely, expressly enacted one.”). Applying this analysis to the relevant statutory provisions of the TPPPA and the Maine Insurance Code, Witt’s claims under Counts I and II fail to state a claim and must be dismissed.

The TPPPA is found in Subchapter VIII of the Maine Pharmacy Act (“MPA”), 32 M.R.S.A. §§ 13701-13810 (1999 & Supp. 1999), identified as Chapter 117 and containing eleven different subchapters. Subchapter III, 32 M.R.S.A. §§ 13731-13735, contains a provision directly addressing the right to seek injunctive relief under the MPA. *See id.* § 13731(5) (“The State may bring an action to enjoin any licensee or *person* from violating this chapter, regardless of whether proceedings have been or may be instituted in the Administrative Court or whether criminal proceedings have been or may be instituted.”) (Emphasis added). The State has been granted the explicit right to seek injunctive relief against nonlicensees such as Aetna and Express Scripts, the Defendants in this case, as part of the statutory scheme of enforcement for the entire chapter. Witt correctly points out that the Board of Pharmacy, the agency that regulates the conduct

and licensing of pharmacists, has no interest in enforcing the contractual obligations of insurers. However, the Maine Bureau of Insurance does have a significant interest in enforcing such obligations and may bring an action to enforce the TPPPA. In this particular situation, adjudicatory proceedings were contemplated by the State but resolved pursuant to 5 M.R.S.A. § 9053(2) (1989) without a formal hearing by means of a Consent Agreement between Aetna and the Superintendent of the Maine Bureau of Insurance.

There is nothing in the statutory scheme to suggest that private parties have the same right to seek injunctive relief under Subchapter VIII.² In a companion subchapter of the MPA, Subchapter X, the Legislature did provide for a private right of action to recover damages for “violation of this subchapter” dealing with nondiscrimination in pharmaceutical pricing. *See* 32 M.R.S.A. § 13805 (2) (1999). Significantly, the private right of action created by the Legislature was for the recovery of monetary damages, not injunctive relief.

Likewise, the two sections of the Maine Insurance Code on which Count II is predicated, 24-A M.R.S.A. §§ 2152 & 2154, express no intent to create a private cause of action. The sections of Title 24-A on which Witt attempts to base a cause of action are included in Chapter 23 of the title, entitled “Trade Practices and Fraud.” Only one

² Witt cites an Opinion and Order of the Maine Superior Court as State authority for the proposition that a private right of action exists under this statutory scheme. That opinion does not address the issue and to the extent it does discuss Witt’s cause of action, it notes that the claim against the State, one of the named parties in that case, is in the nature of an ancient writ of prohibition (procedurally identified as a Rule 80C action) and the action against the private party is “in the nature of a common law contract action by a third-party beneficiary.” *See Rite Aid v. State of Maine*, CV-92-354 (Ken. Cty., Sept. 17, 1992). The court never addresses the existence of a statutory private right of action as pled in Count I of the case now before me. In that case the State itself was a participant in a contractual relationship which the Maine Attorney General’s Office admitted was violative of the statutory scheme. If the case stands for anything relevant to this case, it is representative of the principle that a common law cause of action may be based upon a statutorily created duty. *See infra* Part II.

section of the chapter, § 2168, “Coercion in requiring insurance,” provides for a private action in the form of the entry of an injunction “on complaint of any person that *this section* is being violated.” *Id.* § 2168(3) (Emphasis added). Section 2165-A of Title 24-A spells out the statutory scheme for the enforcement of the remainder of Chapter 23 of the Title, and all of the enforcement mechanisms relate back to Section 12-A, the general civil penalty and enforcement provisions. All of those provisions contemplate the Superintendent of Insurance as the individual who will seek enforcement of the chapter. There is no additional private right created pursuant to Chapter 23, and Count II, like Count I, must therefore be dismissed for failure to state a claim.

II. Counts III - V Generally

Aetna argues that Counts III – V fail because they are all attempts to sue for violations of the TPPPA merely by changing the rubric of the claim. Aetna cites *Lovell v. OneBancorp*, 614 A.2d 56, 62-63 (Me. 1992), for the proposition that Witt is barred from using the statutory duty/obligation created by the TPPPA as a basis for his deceptive trade practice and common law claims because Witt seeks to create a remedy beyond what the statutory scheme authorizes. This argument is compelling. However, it is not supported by *Lovell* or by other authority.

In *Lovell*, depositors in Maine Savings Bank filed suit to challenge the lawfulness of Maine Savings Bank’s conversion from a mutual association to a stock corporation, a process overseen by the Superintendent of the Bureau of Banking in accordance with the enabling legislation. *See id.* at 57-58. In their suit, plaintiff-depositors in the mutual association asserted common law claims for breach of a fiduciary duty, intentional and negligent misrepresentation, tortious conversion, unjust enrichment, and breach of

contract on the ground that their interest in the mutual association's net worth was being converted to corresponding shares of stock in the corporation and sold without adequate consideration being paid to them. *See id.* at 61-62. The Maine Supreme Judicial Court held that plaintiffs' common law claims were barred by the statute because "the statutory and administrative scheme governing the conversion of a mutual savings bank to stock form has effectively displaced private rights of action relating to the conversion process." *Id.* at 62. This was so, according to the Court, because "[a] review of the plaintiffs' common law claims [made] it quite clear that their attack [was] directed to the contents of the plan of conversion[,] which was approved by the Superintendent, whose approval constituted "conclusive evidence . . . of the correctness of all proceedings." *Id.* at 62 (quoting 9-B M.R.S.A. § 343(4)(B)). The Court concluded that "[i]t would be . . . anomalous to give the certificate of conversion conclusive effect . . . but then to allow common law causes of action attacking the contents of the plan . . . and the conversion process in general." *Id.*

Although some of the language of *Lovell* is expansive enough to tempt application of it here, in this case Witt is not challenging the substance of the Consent Agreement entered into between Aetna and the Bureau of Insurance. Rather, Witt complains (1) that Aetna's failure to inform him of the preferable terms offered to other pharmacies breached the statutory duty of disclosure set out in 32 M.R.S.A. § 13773 and (2) that despite the Consent Agreement Aetna still does not afford him equal terms to those provided to other pharmacies.

The issue of whether the violation of a statutory duty can give rise to private rights of action under common law or statutory avenues independent of the statute

creating the duty is distinct from the issue presented in cases such as *Larrabee*, discussed *supra* Part I, which address whether the very statute creating the duty will support a private right of action. Of course, in the arena of torts law, it is generally recognized that the violation of a statutory duty can serve as evidence of negligence. See RESTATEMENT (SECOND) OF TORTS § 286 (1965). The comment to section 286 notes that “statutory provisions have been accepted by the courts as a basis for civil liability in actions for torts other than negligence, such as trespass, deceit, nuisance or even strict liability.” *Id.* cmt. d. The defining issue surrounding whether a standard of conduct defined by Legislation will be adopted by a court in a civil cause of action turns on whether the Legislation’s purpose was to benefit the general public or whether the Legislation’s purpose was to protect a particular class of persons against a particular type of harm. See *id.* § 288.

The statement of legislative intent that introduced the TPPPA when it was initially enacted provided:

§ 2931. Legislative Intent

The Legislature finds that certain practices and policies exist which are unfair to providers of pharmaceutical services and result in increased costs to consumers and threaten the availability of pharmaceutical services to the public. The purpose of this Act is to provide minimum standards which will apply to all 3rd-party prescription programs *for the benefit of* the general public and the *providers of pharmaceutical services*.

L.D. 1539, 111th Legislature (1983) (Emphasis added).

Thus, the duties assigned to parties intending to offer third-party prescription programs are not assigned for the benefit of the public alone, but for the benefit of pharmacies as well. It would follow from the general rule stated in section 286 of the Restatement that tort liability could arise between the pharmaceutical provider and the third-party program provider from the latter’s violation of the duties set forth in the

TPPPA. Although it is true that the entire gravamen of Plaintiffs' case is built on the Defendants' violation of the TPPPA, which does not itself provide the Plaintiffs with any remedy, there is no generally accepted rule of law that would preclude Plaintiffs from maintaining their UDTPA or common law claims in this case. For this reason, I do not recommend dismissal of Counts III-V on this basis.

III. Deceptive Trade Practices (Count III)

According to Aetna, Count III fails because it is premised on an allegation of fraud and Witt has failed to plead fraud with sufficient specificity. (Docket No. 12 at 12-13.) It is a violation of the UDTPA to make false or misleading statements of fact concerning price reductions or to engage in any other conduct which creates a likelihood of confusion or misunderstanding. *See* 10 M.R.S.A. § 1212 (I)(K) & (L). Proof of monetary damages, loss of profits, or the intent to deceive is not required. *See id.* § 1213. Contrary to Aetna's assertion, ¶ 54 of the First Amended Complaint is not an express allegation of fraud. Witt merely states that "Defendants' statements and mailings misstated and misrepresented the requirements of a third party prescription program in Maine." The elements of common law fraud do not need to be proven and Witt has stated a claim for relief under the statutory requirements.

Aetna also asserts that Count III fails to state a claim because the relief requested is moot. (Docket No. 12 at 12.) Aetna's mootness argument relies on the assertion that the First Amended Complaint contains no allegations of continued wrongful activity, and therefore the requests for declaratory and injunctive relief are moot. As already noted, I am satisfied that the Amended Complaint alleges present and ongoing conduct, notwithstanding the existence of the Consent Agreement between Aetna and the State.

(Docket No. 5, ¶¶ 8, 13, 22, 23, 45, 49, 50, 58, 64, 66, and 78.) Taken in the light most favorable to their claim, Plaintiffs have alleged sufficient facts on Count III to survive Defendant's Motion to Dismiss.

IV. Fraudulent Misrepresentation and Tortious Interference (Counts IV and V)

Defendant maintains that Counts IV and V³ fail because they are dependent on proof of fraud, but, contrary to Fed. R. Civ. P. 9(b), do not contain enough specificity as to the time of the alleged fraud and as to the specific plans as to which there was a duty to disclose under the TPPPA. (Docket No. 12 at 14-20.)

Counts IV and V of the Amended Complaint for fraudulent misrepresentation and tortious interference with a business expectancy are both allegations dependent upon an assertion of fraud. Count IV is itself a count for fraud. Under Maine law, a defendant is liable for fraud if he or she:

(1) makes a false representation (2) of a material fact (3) with knowledge of its falsity or in reckless disregard of whether it is true or false (4) for the purpose of inducing another to act or to refrain from acting in reliance upon it, and (5) the plaintiff justifiably relies upon the representation as true and acts upon it to his damage.

Grover v. Minette-Mills, Inc., 638 A.2d 712, 716 (Me. 1994). Non-disclosure when there is a duty to disclose can in some circumstances rise to the level of a false representation. See *Fitzgerald v. Gamester*, 658 A.2d 1065, 1069 (Me. 1995).

Count V (tortious interference with advantageous business relationship) requires proof of fraud as one of its elements. See *St. Hilaire v. Edwards*, 581 A.2d 806, 807 (Me. 1990). To sustain a claim for tortious interference with a business relationship, Plaintiffs

³ Aetna makes this argument with respect to the UDTPA claim as well, but as already noted, the UDTPA claim is not dependent on an assertion of fraud.

must show “the existence of a valid contract or prospective economic advantage, interference with that contract or advantage through fraud or intimidation, and damages proximately caused by the interference.” *Barnes v. Zappia*, 658 A.2d 1086, 1090 (Me. 1990).

Rule 9(b) of the Federal Rules of Civil Procedure requires that “[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity.” Fed. R. Civ. P. 9(b). To survive a motion to dismiss, the plaintiff must state the time, place, and content of the alleged misrepresentation perpetuating that fraud. *See Ahmed v. Rosenblatt*, 118 F.3d 886, 89 (1st Cir. 1997).

Aetna’s first argument, that Witt has not pled the time of the alleged fraud with sufficient particularity, does not compel dismissal of the Amended Complaint. The Amended Complaint clearly references the exclusive agreement between Express Scripts and Aetna that was executed on May 1, 1996. (Docket No. 5 at ¶ 13.) The crux of Witt’s Complaint is that Aetna has continued to act pursuant to that agreement without ever making the more preferable terms available to Witt up to and including the present date and that Aetna has therefore been in violation of the TPPPA throughout that time period. Aetna argues that Witt could not have reasonably relied upon Aetna’s “fraudulent” failure to disclose the different terms being offered to ESI and other pharmacies when they signed contracts with Aetna in 1998 because that information was already known to them. Ultimately, Witt’s proof on the issue of reasonable reliance or another of the elements of fraud may fail, but for purposes of a Rule 12(b)(6) motion he has stated the relevant time period with sufficient particularity.

Aetna's second argument as to Counts IV and V is that Witt has failed to comply with Rule 9(b) because he has failed to specify the content of the alleged fraud. (Docket No. 12 at 15-18.) Aetna argues that the TPPPA applies to only very few of the employee benefit plans administered by Aetna and that Witt has failed to indicate the existence of a fraudulent nondisclosure "in connection with a plan subject to the TPPPA" (*Id.* at 18.) Aetna takes this position for two reasons. First, 29 U.S.C. § 1144(a) (1999) provides that ERISA preempts state laws that "relate to" ERISA plans. Second, the TPPPA itself excludes from its coverage plans "subject to" ERISA. *See* 32 M.R.S.A. § 13777.

Witt responds that his case is not about an ERISA plan. Rather, he contends that the suit involves only "contracts between Aetna on the one hand, and pharmacy providers . . . on the other hand." (Docket No. 13 at 15.) Essentially, Witt argues that because he is not a party to an ERISA plan, his rights pursuant to the TPPPA cannot be preempted by ERISA and are not subject to the TPPPA's own ERISA exception. (*Id.* at 16-17.) Witt provides no authority for this assertion.

[W]hen the opposing party is the only practical source for discovering the specific facts supporting a pleader's conclusion, less specificity of pleading may be required pending discovery. Thus, even for . . . allegations of fraud, if the facts would be peculiarly within the defendants' control, a court may allow some discovery before requiring that plaintiff plead individual acts of fraud with particularity.

Boston & Maine Corp. v. Town of Hampton, 987 F.2d 855, 866 (1st Cir. 1993). ERISA preemption is a particularly murky area of law and it is frustrating that it should be raised as part of a Rule 9(b) argument in a motion to dismiss. Even assuming that Aetna's ERISA-related plans are not subject to the requirements of the TPPPA, Aetna does not suggest that it administers no other, non-ERISA plans that are subject to the TPPPA and

could serve as the basis for Witt's claims. In my view, expecting specificity to the degree that Aetna is suggesting is extreme, even for purposes of Rule 9(b). There is no reason why Witt should be required to provide the court with the specific composition of Aetna's plan portfolio in order to satisfy the enhanced pleading requirements of Rule 9(b). I therefore recommend that the court deny Aetna's motion to dismiss on this ground.

ERISA preemption

Based on the foregoing recommendation, an in-depth analysis of ERISA preemption is not required. However, because Aetna has raised the issue, albeit tersely, and because ERISA preemption will have a significant impact on the extent of any damages that might be available to Witt if he proceeds to and succeeds at trial, I will discuss the scope of any potential conflict under ERISA.

Pursuant to 29 U.S.C. § 1144(a):

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

Subsection 1144(b) provides, on the other hand, that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).⁴ This is so provided only that the

⁴ To this, the Supreme Court aptly stated:

The two pre-emption sections, while clear enough on their faces, perhaps are not a model of legislative drafting, for while the general pre-emption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation. While Congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time.

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739-40 (1985).

state law in question does not “deem” any

“employee benefit plan described in section 1003(a) . . . to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.”

Id. § 1144(b)(2)(B).⁵

Section 1003(a) “describes” employee benefit plans as plans “established or maintained [by an] employer engaged in commerce or . . . industry or [in an] activity affecting commerce; or . . . by any employee organization or organizations representing employees engaged in commerce or . . . industry or [in an] activity affecting commerce; or . . . both.” *Id.* § 1003(a).

Pursuant to 32 M.R.S.A. § 13777, the TPPPA “does not apply to . . . any employee benefit plan that is subject to [ERISA].” Presumably, this exemption is coextensive with ERISA preemption, although the TPPPA’s text and its history provide no indication. Thus, the Maine Legislature would exempt plans subject to ERISA in order to save the TPPPA from preemption and total invalidation under ERISA. Interestingly, the language of section 1144 is addressed to whether a *state law* relates to ERISA, whereas section 13777 is addressed to whether a *plan* is subject to ERISA. Many plans may be subject to ERISA although the state laws that regulate them will not be related to ERISA under the guiding precedent.⁶ Aetna argues that the TPPPA language is intended to exempt it from the statute, to the extent that Aetna administers

⁵ Because the TPPPA exempts plans “subject to” ERISA, it cannot be said that the TPPPA “deems” such plans to be insurance companies.

⁶ The Consent Agreement entered into between Aetna and the Superintendent of Insurance provided that Aetna “was not excepted under § 13777 of the Act.” (Docket No. 5, Exhibit E at ¶ 7.)

ERISA plans, regardless of whether it would be exempt under section 1144. I do not find any support for that interpretation of the Legislative enactment.

Assuming that the TPPPA exemption is coextensive with ERISA preemption, if ERISA does not preempt application of the TPPPA to ERISA plans, ERISA-governed plans will be subject to the requirements of the TPPPA and Aetna's violations of the TPPPA may be considered with respect to its ERISA plans in addition to the other, non-ERISA plans it administers. On the other hand, if the imposition of such requirements on the administration of ERISA plans would impermissibly "relate to" those plans as that clause has been interpreted, then the TPPPA duties cannot be imposed on administrators of ERISA plans unless the TPPPA is saved from preemption by the saving clause, section 1144(b)(2)(A), as a statute that regulates insurance.

Whether the TPPPA "relates to" ERISA plans

A state law "relates to" an employee benefit plan "if it has connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). Whether a law makes reference to an ERISA plan depends on whether the law acts "immediately and exclusively" on ERISA plans. *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988). It is obvious that the TPPPA does not make reference to ERISA plans for its operation. Thus, the question becomes whether the TPPPA has any "connection with" ERISA plans.

According to the Supreme Court, Congress's use of the "clearly expansive" term "relates to," was not meant to undo the "presumption that Congress does not intend to supplant state law." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-56 (1995). To determine the scope of preemption

in *Travelers*, the Court went “beyond the unhelpful text and the frustrating difficulty of defining its key term, and look[ed] instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.” *Id.* at 656. According to the Court, in passing ERISA, Congress intended “to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.” *Id.* at 657.

This limitation on the scope of ERISA meant, for the *Travelers* Court, that an “indirect economic influence” on an ERISA plan that would “not bind plan administrators to any particular choice” in plan administration would not be preempted by ERISA because it would not “function as a regulation of an ERISA plan” *Id.* at 659. Thus, the Court held that a state law regulating hospital rates and mandating that mandatory surcharges be assessed against non-Blue Cross & Blue Shield providers was not preempted by ERISA. *See id.* *Travelers* and its progeny have in this way restricted the expansive language of section 1144(a) by making it clear that a state law may “impose some burdens on the administration of ERISA plans but nevertheless . . . not relate to them within the meaning of the governing statute.” *De Buono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806, 815 (1997) (holding that statute imposing a gross receipts tax on ERISA funded medical centers was not preempted because it was a generally applicable law operating in a field traditionally regulated by the states and merely imposed a cost on ERISA plans); *see also California Div. of Labor Standards v. Dillingham*, 519 U.S. 316, 328 (1997) (holding that state prevailing wage statute “alters the incentives, but does not dictate the choices, facing ERISA plans”). On the other hand, when statutes “mandate[] employee benefit structures or their administration” they

will sufficiently relate to ERISA plan administration to be preempted by ERISA.

Travelers, 514 U.S. at 658. Thus, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985),⁷ the Supreme Court had held that a state mandated provider law clearly related to ERISA plans because “it b[ore] indirectly but substantially on all insured benefit plans [by] requir[ing] them to purchase the mental-health benefits specified in the statute” *Id.* at 739 (but finding the statute saved from preemption because it regulates insurance pursuant to 29 U.S.C. § 1144(b)(2)(A)).

Similar questions to the one presented in this case have been addressed in two District Court decisions since the *DeBuono* and *Dillingham* decisions were announced. *See Community Health Partners, Inc. v. Kentucky*, 14 F.Supp.2d 991 (W.D. Ky. 1998); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F.Supp. 60 (D. Mass. 1997).⁸ In both cases, the District Courts addressed whether state “any willing provider” statutes were preempted by ERISA. In *American Drug*, the District Court for the District of Massachusetts held that the Massachusetts “Pharmacy Freedom of Choice-Any Willing Provider Act” was not preempted by ERISA. The Act provided, *inter alia*, that a carrier offering its insureds a restricted pharmacy network must pay non-network pharmacies that provide pharmaceutical services to its insureds and that “any agreements, terms or conditions” imposed on non-network pharmacies could not be more restrictive

⁷ Although *Met Life* remains good law, it is generally recognized that it was decided under a more expansive interpretation of section 1144(a) than is currently followed by the Supreme Court in the wake of *Travelers*. *See, e.g., Carpenters Local Union No. 26 v. U.S. Fidelity & Guar. Co.*, 215 F.3d 136, 140 (1st Cir. 2000).

⁸ The Fifth Circuit has also addressed this issue, but prior to *DeBuono* and *Dillingham*. *See Texas Pharmacy Ass’n v. Prudential Ins. Co.*, 105 F.3d 1035 (5th Cir. 1997) (holding that Texas any willing provider statute related to ERISA and was not saved from preemption as a statute that regulates insurance); *Cigna Healthplan, Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996), *cert. denied*, 519 U.S. 964 (1996) (holding same for Louisiana any willing provider statute). In both cases, the insurance regulation savings clause was determined to be inapplicable because the statutes at issue expressly extended to miscellaneous entities not involved in the business of insurance. *See Texas Pharmacy*, 105 F.3d at 1038-39; *Cigna*, 82 F.3d at 650.

than those given to network pharmacies. *See id.* at 61. The court reasoned that the any willing provider act, although a relatively new legislative creation, was not preempted by ERISA because it was an “exercise of the state’s historic powers to regulate matters of health and safety,” *id.* at 65; its “goals and effects . . . [were] remote from those of ERISA,” *id.* at 66; it had general applicability, *see id.*; it had only “remote” impact on the administration of benefits, *see id.*; and it did not “mandate” a particular manner of administration, *see id.* The court also reasoned that ERISA preemption should not be extended “beyond Congressional contemplation simply because ERISA plans and related entities become involved in additional activities which they wish shielded from state regulations.” *Id.* at 67.

In contrast to this line of reasoning, the District Court for the Western District of Kentucky ruled that a Kentucky any willing provider act was less like a statute of general applicability having only an indirect economic impact on plan administration, and more like a mandated benefit law or law affecting uniform plan administration. *See Community Health*, 14 F.Supp.2d at 998. In the court’s view, “By restricting risk-bearing entities from offering health benefit plans with restricted provider networks, the [any willing provider] law effectively mandates the benefit structure of employee benefit plans.” *Id.* at 999. Thus, the court concluded the any willing provider statute at issue in *Community Health* was more akin to the mandated provider statute at issue in *Met Life* (which imposed administrative choices on plan administrators) than the gross receipts and prevailing wage acts at issue in *Dillingham* and *De Buono* (which imposed costs on plan administration, but did not mandate administrative choices).

In my view, the two requirements of the TPPPA that the Plaintiffs base their claim on differ with respect to the “relates to” issue. The duty to provide notice to non-network pharmacies is similar to the incidental costs at issue in *Dillingham* and *De Buono*; they do not mandate any form of plan administration, but essentially impose a “price” for the maintenance of pharmaceutical networks. Therefore, these duties could extend even to ERISA plans. With respect to the duty to extend equal terms to non-network pharmacies, I agree with the Western District of Kentucky that such duties impose administrative burdens on plan administrators that conflict with the intent of Congress to insure uniformity nationwide to the administration of ERISA plans. However, although the TPPPA may “relate to” ERISA in part, it will not be preempted if it is a law that “regulates insurance.” 29 U.S.C. § 1144(b)(2)(A).

Whether the TPPPA “regulates insurance”

Pursuant to § 1144(b)(2)(A), a state law that relates to ERISA plan administration may still evade preemption if it “regulates insurance, banking, or securities.” To evaluate whether a state law regulates insurance, the Supreme Court has articulated a two-part test. First, the court considers whether the law fits a common-sense definition of insurance regulation. *See Met Life*, 471 U.S. at 740-42. To meet the common sense test, “a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.” *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Second, the Court considered three criteria taken from case law interpreting the phrase “business

of insurance” as that phrase is used in section 1012⁹ of the McCarran-Ferguson Act, 15 U.S.C. § 1011-1015 (1997). *See id.* at 743. These criteria are:

- (1) whether the practice has the effect of transferring or spreading a policyholder’s risk;
- (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and
- (3) whether the practice is limited to entities within the insurance industry.

Id. (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)). Notably, “none of these criteria is necessarily determinative in itself.”¹⁰ *Pireno*, 458 U.S. at 129.

The only potential stumbling block for the TPPPA under the foregoing tests would be the common sense test, whether the TPPPA is directed toward the business of insurance, and the third criteria of the McCarran-Ferguson test, whether the TPPPA is limited to entities within the insurance industry. First, the TPPPA is not a subchapter of the Maine Insurance Code. Second, section 13772 of the Act includes within its definition of “third-party prescription programs” programs other than “insurance plans.” 32 M.R.S.A. § 13772(1).

⁹ Section 1012 provides:

§ 1012. Regulation by State law; Federal law relating specifically to insurance . . .

(a) State regulation. The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance

15 U.S.C. § 1012 (1997).

¹⁰ In *Texas Pharmacy* and *Cigna*, *supra* note 7, the Fifth Circuit ignored this statement and, instead, followed its own rule that “if a statute fails . . . any one element of the three-factor *Metropolitan Life* test, then the statute is not exempt from preemption by the ERISA insurance savings clause.” *Texas Pharmacy*, 105 F.3d at 1038; *Cigna*, 82 F.3d at 650.

With respect to the common sense analysis, in *Community Health* the Western District of Kentucky concluded that the any willing provider act at issue there met the common sense test because “[t]he statute affects specific terms of . . . insurance policies,” even though the statutory language only addressed “the relationship between insurers and providers.” *Community Health*, 14 F.Supp. at 1002. Aiding this analysis was the fact that the statute existed within the Kentucky Insurance Code.

Although the TPPPA does not exist within the Maine Insurance Code, I am comfortable concluding that it nevertheless is directed toward the business of insurance. Because the TPPPA imposes requirements only on entities accepting the risk of providing pharmaceutical benefits for a fee, it is, in fact, directed toward the business of insurance. This conclusion is supported, to a limited extent, by the fact that section 13773 requires that entities establishing third-party prescription programs provide notice to the Superintendent of Insurance.

With respect to the third prong of the McCarran-Ferguson test, in *American Drug* the District of Massachusetts reasoned that “this inquiry is intended only to ensure that the regulation is about insurance, not to draw fine lines between various entities involved in handling the risks associated with health care.” *American Drug*, 973 F.Supp. at 71. Although the TPPPA’s definition of third-party prescription plans incorporates programs other than “insurance plans,” this reference does not change the fact that any such plan would ultimately only be involved in risk management related to the provision of pharmaceutical goods and services in exchange for a fee. Although the TPPPA may fall within the breadth of ERISA’s preemption provision, the “insurance saving clause” protects it from preemption.

Conclusion

Based upon the foregoing analysis, I recommend that the Court **Grant** the Motion to Dismiss as to Counts I and II and **Deny** the Motion as to Counts III, IV, and V.

NOTICE

A party may file objections to those specified portions of a magistrate judge's report or proposed findings or recommended decisions entered pursuant to 28 U.S.C. § 636(b)(1)(B) (1988) for which *de novo* review by the district court is sought, together with a supporting memorandum, within ten (10) days of being served with a copy thereof. A responsive memorandum shall be filed within ten (10) days after the filing of the objection.

Failure to file a timely objection shall constitute a waiver of the right to *de novo* review by the district court and to appeal the district court's order.

Margaret J. Kravchuk
U.S. Magistrate Judge

Dated: October 27, 2000.

U.S. District Court
District of Maine (Bangor)

CIVIL DOCKET FOR CASE #: 00-CV-31

WITT, et al v. AETNA U S HEALTHCARE, et al
02/28/00

Filed:

Assigned to: JUDGE GENE CARTER

Demand: \$0,000

Nature of Suit: 791

Lead Docket: None

Jurisdiction: Federal

Question

Dkt # in FRANKLIN SUPERIOR : is CV-2000-1

Cause: 28:1441 Notice of Removal-Insurance Contract

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