

A (Loper) Bright Future?: How the Demise of Chevron Deference Will Affect the Health Care Industry

Presented by:

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Agenda

R.I.P. Chevron Deference

A look at how the overturning of Chevron has influenced Medicare litigation

How Loper is Already Affecting Healthcare Litigation

- *Lake Region*
- *Avon Nursing & Rehab*
- *Baptist Healthcare*
- *Gottlieb*

How Might Loper Bright Affect Ongoing Litigation?

- Protest requirement
- Standardized amount appeals,
- FTC Non-Compete Rule

Proof that the Agency Can Still Win Absent Chevron Deference

- *Empire Health* (Pre-Loper)
- *Advocate Christ* (Post-Loper)
- *Gottlieb Memorial Hospital*

How Might HHS Regulate in a Loper World?

- Considerations and future rulemaking
- *Skidmore* deference

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RIP Chevron

Loper Bright Enterprises v. Raimondo



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Loper Bright Enterprises v. Raimondo



RIP Chevron : June 28, 2024



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The *Chevron* Two-Step



The *Chevron* Doctrine was a two-step test for determining whether an agency is acting within its statutory authority.

Step 1: Determine “whether Congress has directly spoken to the precise question at issue.”

- Does the statute have a clear, unambiguous meaning?

“If the intent of Congress is clear, that is the end of the matter”

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The *Chevron* Doctrine (cont.)



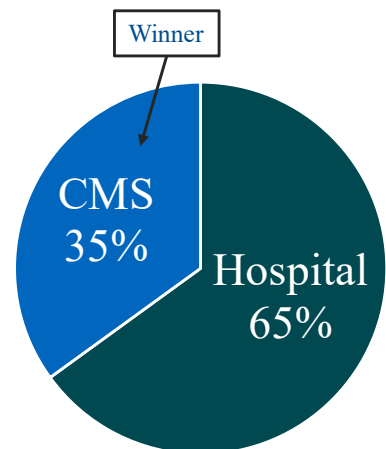
If the statute was “silent or ambiguous” → Step 2

How much ambiguity is enough?

- What if a statute likely favors hospitals but not definitively?

E.g., what if the court is 65% convinced the hospital’s interpretation is better?

- If a statute was susceptible to multiple interpretations, most courts would proceed to Step 2.



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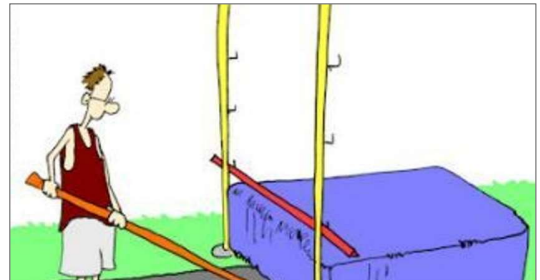
The *Chevron* Doctrine (cont.)



Step 2: Is the agency's interpretation based on a permissible/reasonable construction of the statute?

- Yes? → defer to the agency's interpretation
- Even if not the reading the court would have reached on its own.

“[A] court may not substitute its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency”



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Chevron's Dissymmetry



Chevron set a low bar for agencies to defend their regulations.

- 70% of *Chevron* cases advanced to Step 2.
- ~94% of Step 2 cases were decided in favor of agencies.
- Deference → aggressive agency Interpretations



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Loper Bright Enterprises v. Raimondo



Fisheries challenged whether statute authorized agency rule requiring them to pay for an observer to monitor their harvest

Relying on *Chevron*, lower court found that the statute is not “wholly unambiguous,” and the agency’s interpretation was reasonable.



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Loper Bright Enterprises v. Raimondo



Holding

Chevron deference violates the Administrative Procedure Act (APA)

- APA says courts must “decide all relevant questions of law” in cases challenging agency action

APA says courts must exercise “independent judgment” in deciding whether an agency has acted within its statutory authority

Courts must use every tool at their disposal to determine the “best reading” of the statute

- “[T]he reading the court would have reached’ if no agency were involved”
- “Statutory ambiguity...is not a reliable indicator of actual delegation of discretionary authority”

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Loper Limitations



The “informed judgment” of an agency is still be entitled to “great weight” if persuasive and based on agency expertise.

Only applies in cases concerning whether an agency is properly interpreting *statutory* language.

Cannot get around provisions precluding judicial review.

Holdings that relied on *Chevron* framework still have precedential value:

- “[W]e do not call into question prior cases that relied on the *Chevron* framework.” 144 S. Ct. 2244, 2273

Loper Limitations (cont.)



Only applies in the context of implicit (not explicit) delegations

“Some statutes ‘expressly delegate[]’ to an agency the authority to give meaning to a particular statutory term” or “empower an agency to prescribe rules to ‘fill up the details’ of a statutory scheme ...” by using terms “such as ‘appropriate’ or ‘reasonable.’”

In those instances, “the role of the reviewing court [is to] ... effectuate the will of Congress subject to constitutional limits.”

How Loper is Already Affecting Healthcare Litigation

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Lake Region: Loper Meets the Medicare Statute

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Loper's impact is already being felt

Lake Region v. Becerra, 113 F.4th 1002, 1004 (D.C. Cir. 2024)

Medicare statute requires CMS to “fully compensate” SCHs or MDHs for their “fixed costs” if they experience a 5% decline in discharges.

Hospitals challenged CMS’s VDA method of comparing their *total* DRG payments (payments for both fixed and variable costs) to *just* their fixed costs.



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Lake Region: Loper Meets the Medicare Statute



Loper's impact is already being felt

CMS later reversed course and agreed to compare a hospital's fixed costs to the *portion* of its DRG estimated to be for fixed costs.

CMS refused to apply that methodology retroactively, however, arguing that its old methodology was still "reasonable."

Lake Region: Loper Meets the Medicare Statute



Loper's impact is already being felt

District Court (before *Loper*): While the hospitals' interpretation

"might be better...and the Secretary might have conceded that point by prospectively adopting that method..., the "Secretary's interpretation" was nonetheless "reasonable, even if it might not be the best."

Loper was decided after the Hospital's appeal to the DC Circuit was fully briefed.

Lake Region: Loper Meets the Medicare Statute



Loper's impact is already being felt

In a 28j motion, *Lake Region* argued that HHS all but admitted that its new methodology was better and its defense that its old methodology was nonetheless “reasonable” was, per *Loper*, no longer valid.

HHS’s response:

1. Congress gave us discretion in how to calculate VDAs
2. Congress gave us discretion over all of Medicare (!):

Congress expressly delegated to HHS the authority to “prescribe such regulations as may be necessary to carry out the administration” of Medicare

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Lake Region: Loper Meets the Medicare Statute



Loper's impact is already being felt

D.C. Circuit decision:

- “Chevron has now been overruled, so we must ‘exercise independent judgment’ in construing the Medicare statute.”
- CMS does not have the best reading of the statute
- The agency “overstates the amount of a hospital’s reimbursed fixed costs and thus understates the amount of its unreimbursed fixed costs, shortchanging the hospitals.”

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How Does *Loper* Affect Interpretations of Regulations and *Auer* Deference?

Avon Nursing & Rehab. v. Becerra, 119 F.4th 286, 292 (2d Cir. 2024)

The Medicaid statute requires that there be a registered nurse on the teams that perform annual recertification surveys on SNFs

- The requirement applies to “*surveys*,” not necessarily to complaint *investigations*.

Avon, a SNF, was subject to civil monetary penalties following a complaint investigation where a registered nurse was not part of the team.

Avon argued that because HHS’s *regulation* referred to the complaint investigation as a “complaint *survey*,” a registered nurse was required.

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How Does *Loper* Affect Interpretations of Regulations and *Auer* Deference (cont)?

Avon Nursing & Rehab. v. Becerra, 119 F.4th 286, 292 (2d Cir. 2024) (Cont’d)

Second Circuit rejected that argument relying heavily on *Loper*:

- “[I]n light of *Loper* . . . our interpretation of the statute should not rest on the taxonomy developed by the agency. The registered nurse requirement only extends to *surveys as that term is used in the statute*, regardless of the terminology used by the agency.”
- “Allowing the agency’s terminology to control our interpretation of the statute would be an abdication of our duty to interpret the statute independently.”

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Plain Meaning or Spirit and Context?



Baptist Healthcare of Oklahoma, LLC v. Becerra (DDC)

What does a “hospital’s patient days” mean and is CMS’s policy of limiting it to only patients in hospital areas providing services payable under IPPS valid?

Fully briefed before *Loper* was issued and the agency defended its interpretation of the statute merely as a “permissible construction” of it under *Chevron* Step 2

D.D.C. (Jul. 2024):

- “Given this seismic change in the law,” the parties must re-brief the case because, under *Loper*, it “makes no sense to speak of a ‘permissible’ interpretation In the business of statutory interpretation, if it is not the best, it is not permissible.”

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Plain Meaning or Spirit and Context?



Baptist Healthcare of Oklahoma, LLC v. Becerra (DDC)

Upon rebriefing, hospitals emphasized plain meaning:

“[T]he Medicare statute mandates that the DSH payment calculation include the ‘hospital’s patient days,’ and neither the statutory text nor its purpose leaves room to exclude these Hospitals’ patient days based on the nature of care provided.”

HHS, instead, focused on spirit and context:

- Limiting patient days to only those days attributable to units or wards providing acute services “generally payable under the [IPPS]” excludes child and adolescent psychiatric patient days because psychiatric hospitals are excluded from the IPPS
- The agency analogized *Health Alliance*, a *Chevron*-era case where the term “bed days” was not defined in the DSH statute but was found to exclude outpatient observation services

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How Might Loper Bright Affect Ongoing Litigation?

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The “Protest” Requirement

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Does *Loper* Further Undermine CMS's Protest Requirement?

The Protest Requirement

Hospitals filed a complaint on June 28, 2022, challenging CMS's policy that hospitals must "protest" all issues they intend to appeal to the PRRB in their cost reports.

- *Froedtert Memorial Lutheran Hospital v. Becerra* (D.D.C.)
- Failure to protest → CMS will not pay *even if* the hospital wins on appeal
- Far reaching implications for hospitals



HHS rationale: Statute authorizes HHS to withhold payment if hospitals fail to present all information necessary "to determine amount due to [a] provider"

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Does *Loper* Further Undermine CMS's Protest Requirement?

The Protest Requirement

Is HHS's interpretation the "best reading" of the statute?

- Deprives PRRB of power to adjust items not considered by the MAC.
- Deprives PRRB and Courts of the power to compel payment.

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Ongoing Standardized Amount Litigation



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How *Loper Bright* Could Affect the Ongoing Standardized Amount Litigation

Issue

Alleged error #1 – HHS miscalculated the inaugural standardized amount by including transfer cases in the computation of the average cost per discharge

- Estimated impact: ~1%

Alleged error #2 – HHS erroneously carried forward budget neutrality adjustments that should've expired in 1985

- Estimated impact: ~6%

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Errors #1 and #2

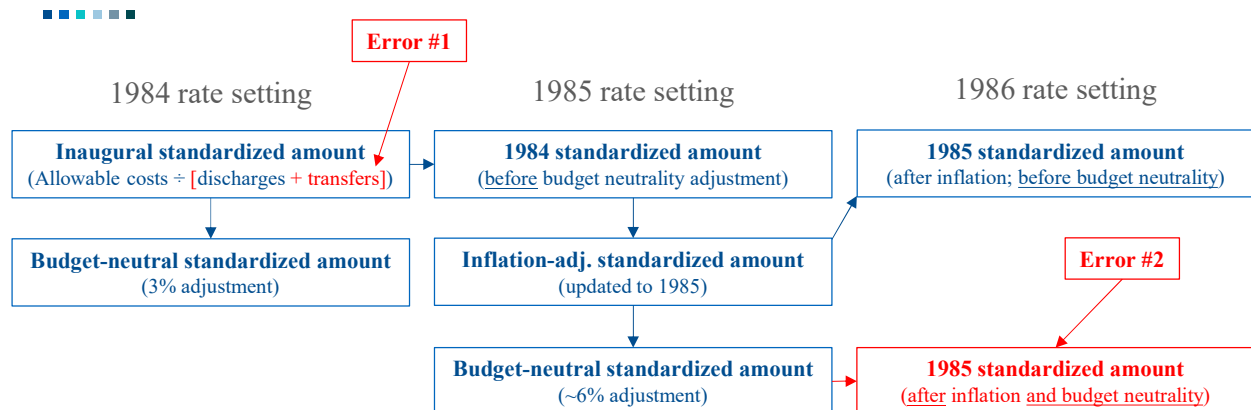
	Error #1 Transfer/Discharges	Error #2 1985 Budget Neutrality Adjustment
What was the error?	Included transfer cases in calculation of cost per discharge	Advanced FY 1985 budget neutrality adjustment into FY 1986
When did the error occur?	1984	1986
Estimated impact	~1% of IPPS payments	~6% of IPPS payments
Statutory provisions	1395ww(d)(2)(A)	1395ww(e)(1)(B)
Key merits arguments	Statute requires CMS to calculate the “cost per discharge” but transfers are distinct from (and cheaper than) discharges	Statute requires starting point for post-1985 amounts to be the non-budget-neutralized ‘85 amount.

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Errors #1 and #2



- What the statute commands
- What HHS did

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Standardized Amount Litigation



Errors #1 and #2

After *Loper Bright*, CMS must now defend its policies not just as a reasonable interpretation of the statutory provision at issue but as the best interpretation.

At least one district court Judge found that Error #2 violated the *plain meaning* of the statute:

- “[I]n computing the 1986 standardized amounts, the Secretary was required to start with the 1985 standardized amounts *unadjusted for budget neutrality*.”
- “The statute simply supplies no basis for carrying forward the budget-neutralized standardized amounts from 1985 to 1986; to the contrary, it forbade the Secretary from doing so.”
 - -*St. Mary’s Regional Medical Center v. Becerra, D.D.C., 12/20/2024*

FTC’s Non-Compete Rule



Non-Compete Rule



Ryan LLC, v. F.T.C. - Background

FTC promulgated the “Non-Compete Rule” on April 23, 2024

- The Rule enumerated that, with respect both “senior executives” and “workers other than senior executives,” noncompete agreements are “an unfair method of competition for a person”
- Based on the Rule, that made any effort to enforce a noncompete agreement a violations of Section 5 of the FTC Act, superseding “state laws that would ‘permit or authorize’ non-compete agreements.”

FTC staked its authority on two portions of FTC Act:

- **Section 5** – “The Commission is hereby empowered and directed to prevent persons, partnerships, or corporations . . . from using unfair methods of competition in or affecting commerce.”
- **Section 6(g)** – Granted FTC power “to make rules and regulations for the purpose of carrying out the provisions of this subchapter.”

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Non-Compete Rule



Ryan LLC, v. F.T.C. - Plaintiff argued that Non-Compete Rule violated the Act

Plaintiff argued that Non-Compete Rule had no basis in the statute:

- The Act did not authorize Commission power to issue substantive unfair-competition rules
- Prohibiting all workers from entering noncompete agreements is not a faithful reading of “unfair methods of competition”
- FTC lacks statutory authority to invalidate already existing contracts

Defendant argued Congress provided broad mandate and everything in the Rule fell within FTC’s traditional expertise

- Congress provided FTC with broad mandate to police “unfair methods of competition” and that all rulemaking fell “squarely within the Commission’s delegated authority and expertise”
- The Rule “is not unlawfully retroactive because it only has prospective effects”

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Non-Compete Rule



Ryan LLC, v. F.T.C.- Holding: Judge Brown, N.D. Tex., August 20, 2024

“When authorizing legislative rulemaking, Congress also historically prescribes sanctions for violations of the agency’s rules—confirming that those rules create substantive obligations for regulated parties.”

“If the statute did not include a sanction, the authority to make ‘rules and regulations’ encompassed only interpretive or procedural rules.”

“The Court concludes that the structure and the location of Section 6(g) indicate that Congress did not explicitly give the Commission substantive rulemaking authority under Section 6(g).”

FTC appealed to 5th Cir. October 24, 2024, but Trump admin. contemplating dropping case

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Recent Proof that the Agency Can Still Win Absent *Chevron* Deference



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No Deference Needed?



Recent Agency Wins Absent *Chevron*-Deference

Before SCOTUS overturned *Chevron* outright in *Loper Bright*, the Supreme Court hadn't relied on *Chevron* in many years.

Yet, the agency still won in many cases because it convinced the Court that its reading of the statute was the best.

The ongoing DSH litigation alone provides two recent examples (*Empire Health* and *Advocate Christ*).

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No Deference Needed?



DSH Background

A hospital's disproportionate share ("DSH") adjustment is based on the sum of two fractions:

$$\begin{array}{c} \boxed{\text{The Disproportionate Patient Percentage}} \\ \hline \end{array} = \frac{\boxed{\text{Patient days for patients entitled to both Medicare Part A and SSI}}}{\boxed{\text{Patient days for patients entitled to Medicare Part A}}} + \frac{\boxed{\text{Medicaid patient days for patients not entitled to Medicare}}}{\boxed{\text{Patient days for all patients}}}$$

(The Medicare Fraction) (The Medicaid Fraction)

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No Deference Needed?



Empire Health: Are patients that have exhausted their inpatient hospital Part A benefits nonetheless “Entitled to Benefits Under Part A”?

HHS

- All patients enrolled in Medicare are “entitled to benefits under Part A” regardless of whether part A makes payment for a particular day

Hospitals

- Only patients that are entitled to have their care covered during a particular day are “entitled to Part A benefits” for that day.

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No Deference Needed?



Becerra v. Empire Health (2022)

“[T]he Medicare statute uses the term ‘entitled’ to benefits in the same way as the Medicaid statute uses the term ‘eligible’ for benefits.”

“[P]atients ‘who . . . exhausted their Medicare Part A inpatient coverage may still be entitled to other Part A benefits.’”

~ Becerra v Empire Health

Notably, Court didn’t even cite *Chevron*



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No Deference Needed?



Advocate Christ: Are Patients Enrolled in SSI “Entitled to SSI Benefits” Even if They Don’t Receive a SSI Cash Benefit in a Particular Month?

Hospitals

- Since “entitled to Part A” does not require Part A payment (per *Empire*), “entitled to SSI” should not require SSI payment.

HHS

- Part A and SSI are not the same. Medicare is an insurance program, and patients remain insured even if they don’t qualify for payment for a particular hospital stay.
- SSI, instead, is solely a cash benefit plan: no cash, no benefit

No Deference Needed?



Advocate Christ Decision

7-2 Ruling written by Justice Amy Coney Barrett

"Because eligibility is determined on a monthly basis, an individual is considered 'entitled to [SSI] benefits' for purposes of the Medicare fraction only if she is eligible for such benefits during the month of her hospitalization."

The Court left open the question of whether CMS’s current policy captures all patients that are “eligible” for SSI cash benefits in a particular month.

No Deference Needed?



Advocate Christ left open the question of whether CMS appropriately captures all patients that are eligible to receive SSI cash benefits

Patients who have applied and been accepted into the SSI program may not receive a cash payment for various reasons:

- Unable to identify an authorized payee; Address unknown or check returned as undeliverable; Refused direct deposit; Nursing home resident

Under *Loper Bright*, CMS must now prove that the best reading of the statute is that these patients aren't even *eligible* to receive an SSI cash benefit.

Conflicting Statutory Provisions



Gottlieb Memorial Hospital et al. v. Becerra (DDC) - Background

Whether CMS's 2012 policy of including labor & delivery beds in the intern-to-bed ratio (IBR) used to calculate indirect medical education (IME) payments was valid

The case centers on dueling provisions of the statute



Conflicting Statutory Provisions



Gottlieb Memorial Hospital et al. v. Becerra (DDC) - Dueling provisions of the IME statute

Provision 1 said that IME payment shall be “computed in the same manner as” it was “under regulations (in effect as of January 1, 1983)” (which excluded L&D days) 1886(d)(5)(B) (adopted in SSA ’83)

But **Provision 2** seemed to give the Secretary discretion on how to calculate “hospital’s available beds” (“as defined by the Secretary”). 1886(d)(5)(B)(vi)(I)

Loper gave Gottlieb a fighting chance but district court still found in favor of HHS.

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Conflicting Statutory Provisions



Holding: Judge Bates, D.D.C. (Mar. 25, 2025) (Cont.)

The court held that Provision 2 “*explicitly* delegates bed-defining authority to the Secretary.”

But it continued stating that HHS would have authority to define beds even in the absence of an express delegation.

“Even if the statute did not explicitly grant the Secretary authority to define available beds, its silence on the definition would leave him with ‘the responsibility of filling this gap.’”

Gottlieb recently filed a notice of appeal to the DC Circuit.

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No Amount of Deference Can Help?



In many cases, plain meaning of statute controls and deference is irrelevant

Two circuit courts held that increasing the wage index values of hospitals below the 25th percentile (at the expense of other hospitals) violated the plain meaning of the wage index statute:

Kaweah Delta Health Care Dist. v. Becerra (9th Cir.):

- HHS has “stretched and twisted the plain meaning of the statutory text to pursue a policy objective not permitted under the statute.”

Bridgeport Hospital v. Becerra (D.C. Cir):

- The wage index adjustment “must be anchored to the survey of wages, and not to other policy factors.”
- “[N]othing in the wage-index provision permits HHS to change those rates simply because it would rather give preferred hospitals more money and disfavored hospitals less.”

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How Might Governance Change in a *Loper* World



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Slide 48

DH1 We'll continue to improve this section and welcome any thoughts
Daniel Hettich, 2025-05-26T17:53:30.673

No One Likes A Cloud on a (Loper) Bright Sunny Day

Unintended Consequences?

CMS likely will be more reluctant to improve its interpretations prospectively (as it did in *Lake Region* and on some of the rural floor issues)

Congress might include even more preclusion of review provisions

What about CMS regulations or policies that some hospitals like?

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Broader implications of Chevron

Chevron deference may be gone, but *Skidmore* deference remains

When *Chevron* was in effect, it was like an on/off switch; an agency either received deference, or it did not.

Skidmore deference is more like a dimmer switch – courts can decide how much they require agencies to illuminate their reasoning and holding.



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Skidmore Deference

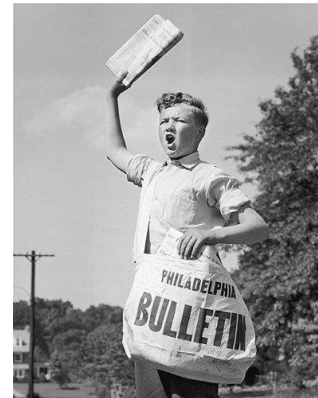


Historical Context - *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111 (1944).

Congress passed law in 1935 empowering the National Labor Relations Board (NLRB) to protect “employees” but not “independent contractors.”

Are newsboys “employees” or “independent contractors”?

NLRB interpreted term “employee” to cover newsboys.



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Skidmore Deference

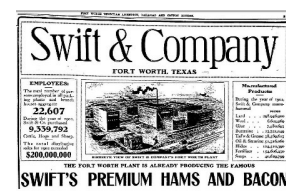


Skidmore v. Swift (1944)

Is “on call” work covered by the minimum wage provision of the Fair Labor Standards Act?

The agency issued an “interpretive bulletin” that articulated a flexible standard for addressing when “on call” time should count as protected work and submitted an amicus brief that interpreted the FLSA to cover active (as opposed to sleeping) “on call” time.

Should courts defer to the agency’s interpretation of law in its interpretive bulletin or amicus brief?



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Skidmore Deference



Skidmore v. Swift (1944)

Courts will give “great weight” to the “informed judgment” of an agency, but focus will shift to the agency’s “power to persuade”

Relevant factors—

- Thoroughness of agency’s consideration;
- Validity of reasoning;
- Consistency with earlier and later pronouncements; and
- All factors which give it power to persuade.

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Skidmore Deference



Skidmore v. Swift (1944)

Commenters could influence an agency’s ability to persuade.

- Did the agency address all comments?
- How thorough were its responses?

Will OMB play a more active role in reviewing proposed regulations?

Might courts shift their focus to the non-delegation doctrine?

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Additional Examples of the Range of *Loper*'s Impact

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Loper and the Meaning of “Sex”

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ACA's § 1557

In May 2024, HHS promulgated a final rule interpreting ACA's § 1557 nondiscrimination language, “on the basis of sex,” to include prohibiting discrimination on the basis of gender identity and sexual orientation.

Multiple states sought injunctions arguing that HHS had expanded the statute's definition of “sex.”

The four district courts faced with these requests all granted PIs and all cited *Loper*.

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Loper and the Meaning of “Sex”



ACA's § 1557

In *Texas v. Becerra*, 739 F. Supp. 3d 522 (E.D. Tex. 2024), for example, the court stated that the text of the statute and its surrounding context shows that “on the basis of sex” means only “on the basis of an individual’s biological sex,” not for gender identity:

“[A]n agency has no authority to promulgate a rule that contradicts the language of the statute.” *Id.* at 536.

Florida v. HHS, 739 F. Supp. 3d 1091 (M.D. Fla. 2024): “The new Rules must be legal; and no deference on matters of legality need be shown the agency.”

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Loper in the Context of Fraud and Abuse



AKS Safe Harbors

Loper has obvious implications in the area of fraud and abuse as well.

Some relators, e.g., have attempted to invoke *Loper* in challenging OIG’s AKS safe-harbors.

A district court rejected that challenge because the statute delegates the authority to the HHS Secretary to create regulatory safe harbors and upheld the safe-harbors applying Auer deference instead. See *United States ex rel. Schroeder v. Hutchinson Reg’l Med. Ctr.*, No. 17-2060-DDC-BGS (D. Kan. Sept. 26, 2024).

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Loper in the Context of Fraud and Abuse

Loper and Scierter under the FCA

Defendants in FCA cases have argued, e.g., that their knowledge of a regulation does not meet the FCA's *Scierter* requirement because the regulation was not a valid interpretation of a governing statute.

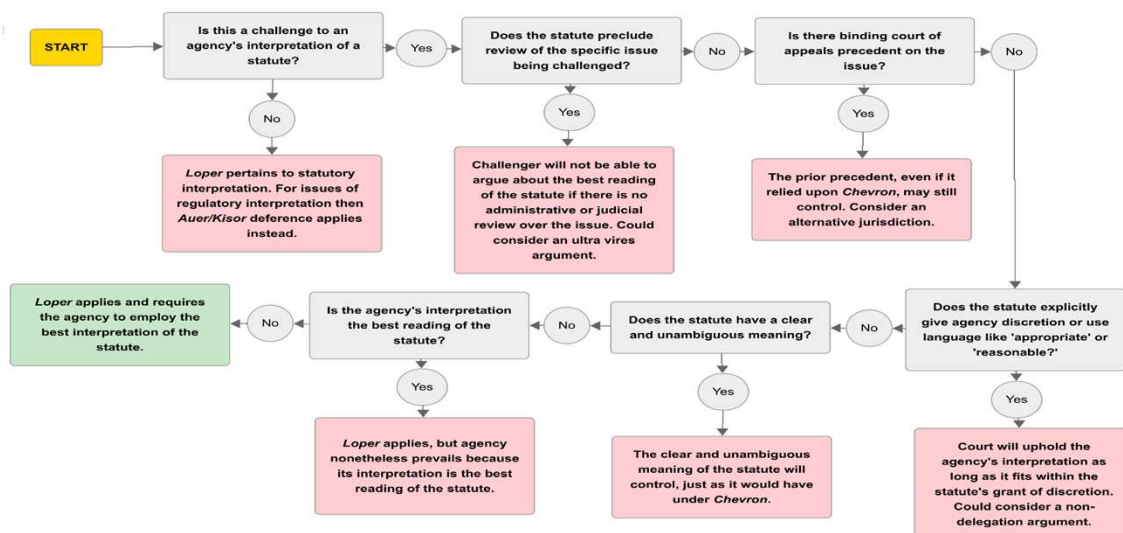
In *Sheldon*, 754 F. Supp. 3d at 615, e.g., the court agreed that:

“[R]egulatory pronouncements regarding Medicaid drug rebate statute did not cure ambiguity in statute or rebate agreement between HHS and manufacturer to make manufacturer’s familiarity with pronouncements sufficient to show that manufacturer acted with culpable mental state, as required for liability under FCA.”

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When Loper Does (and Does Not) Apply?



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QUESTIONS?

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Slide 61

DH1 Add Stephen's info here too.
Daniel Hettich, 2025-05-26T18:06:47.003