



Issue Date: 14 February 2019

CASE NO.: 2017-ACA-00003

In the Matter of:

PEGGY OBERG,
Complainant,

v.

QUINAULT INDIAN NATION,
Respondent.

ORDER GRANTING RESPONDENT'S
MOTION FOR SUMMARY DECISION

This is a claim under the whistleblower protections of Section 1558 of the Patient Protection and Affordable Care Act of 2010 ("ACA")¹, codified at Section 18c of the Fair Labor Standards Act, 29 U.S.C. § 218c, and the implementing regulations found at 29 C.F.R. Part 1984. Attorney Kevin Johnson represents Complainant Peggy Oberg. Attorney Daniel Hasson represents Respondent Quinault Indian Nation. The matter is currently scheduled for hearing for February 26 to 28, 2019, in Tacoma, Washington.

On January 14, 2019, Respondent filed a Motion for Summary Decision ("R. Mot."). On January 28, 2019, Complainant filed a Response to Respondent's Motion for Summary Decision and a Cross Motion for Summary Decision ("C. Resp. & Mot."). On January 29, 2019, Respondent filed a Response to Complainant's Cross-Motion for Summary Decision ("R. Resp.>").

As explained below, Respondent's Motion for Summary Decision is granted. Complainant's Motion for Summary Decision is denied as untimely, but in the alternative would be denied on substantive grounds. All dates are vacated.

Complainant's Supporting Documentation

Initially, I must address an issue regarding the supporting documentation of Complainant's Response and Motion. Complainant's Response and Motion was delivered to this office in an envelope on January 28, 2019. Exhibits numbered 26 through 41 arrived separately in a box that had apparently opened during transit. On January 28, 2019, my staff informed Complainant's

¹ As amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

counsel via email that the box had broken open during transit and that it contained the binder of exhibits. Complainant's counsel responded that the box contained the exhibits, but did not address the fact that the box had been damaged.

In her Response and Motion, Complainant repeatedly refers to her "declaration" in support of her assertions. *See, e.g.*, C. Resp. & Mot. at 8, line 4 ("Oberg Declaration, ¶ 8, Exhibit A"), at 8, line 16-17 ("Oberg Declaration, Exhibit B, ¶ 14"), at 9, line 1 ("Oberg Declaration, ¶ 14"), at 9, line 17-18 ("Oberg Declaration Exhibit B, Item 1, section D"), at 9, line 26 ("Oberg Declaration Exhibit B, ¶ 15), and so forth. Attached to the Response and Motion was a declaration from her counsel averring "that the documents and exhibits from tab 26 to 41 are true and correct." No other declaration was attached. I had my staff contact Complainant's counsel about this apparent oversight. Voicemail messages were left for Complainant's counsel at his place of business on February 4 and 5, 2019, but no response from Complainant's counsel regarding these messages was received.

On February 11, 2019, Complainant's counsel telephoned this office after noticing some pre-hearing documents he intended to file had not been received. He was informed again that the box the exhibits arrived in had broken open. He now indicated that there were other documents in the box. He was also asked about the declaration referenced in the Response and Motion, and he suggested that the only relevant declaration was his one-page declaration averring that the exhibits were true and correct.² He was given permission to send in documents that this Office had not received. On February 12, 2019, Complainant's counsel submitted a copy of the Response and Motion that was filed on January 28, 2019, along with a copy of the exhibit index and a declaration by Complainant, signed January 23, 2019.³ This declaration appears to correspond with the citations in Complainant's Response and Motion. As stated above, it was not attached to the original Response and Motion received in an envelope on January 28, 2019.

According to this Office's rules, Complainant's January 23, 2019 Declaration was not timely filed. Respondent's motion was served on January 10, 2019, both via email and U.S. mail. A response or opposition, accompanied by declarations or other evidence, was due no later than January 28, 2019. *See* 29 C.F.R. §§ 18.33(d), 18.32(c). Complainant's declaration was filed with this Office on February 12, 2019, and is therefore 15 days late.

Complainant's counsel's repeated failure to fully respond to this Office's communications is troubling and has resulted in unnecessary confusion and delay.⁴ Complainant's counsel appeared confused as to what declaration was missing, a confusion that may have been able to be resolved

² He asserted he had not received the voicemail messages, however it is not clear if there is a different number at which he should be reached or if he is simply not checking his messages. The number called is the one provided on his moving papers and the outgoing message indicated it was the "Law Offices of Kevin Johnson."

³ Complainant's counsel also submitted a new declaration regarding the identification and veracity of exhibits 26 through 41. This declaration was dated February 11, 2019, and differed in content from the previous (undated) declaration signed by Complainant's counsel.

⁴ Complainant's counsel's briefing in this matter is also at times unclear and generally unhelpful to the resolution of the issues. Additionally, the quality of her counsel's performance has occasionally fallen below that I would expect from a licensed attorney. Ultimately, Complainant is represented by counsel and she is not therefore entitled to the latitude that would be given to a pro se litigant.

had he returned the voicemail messages left at his place of business on February 4 and 5, 2019. It is still unclear why Complainant's declaration was not included in the original filing. It appears that it should have been attached to the Response and Motion, although it could have been a document lost when the box containing the exhibits broke open in transit. Complainant's counsel has not provided any insight. However, in the interest of justice and because the actual Response and Motion was timely filed, I will consider the Complainant's declaration filed on February 12, 2019. I have also considered all evidence made available to me in the file, including the evidence submitted by Respondent, by Complainant, and Complainant's previous declaration, dated April 11, 2018, submitted in support of her opposition to Respondent's earlier motion to dismiss.

*Factual Background*⁵

Complainant's Employment and Termination

Respondent is a federally-recognized Indian Tribe that operates the Roger Saux Health Clinic ("the Clinic"). R. Mot. at 2-3. Complainant is a nurse practitioner who started working at the Clinic on December 10, 2008, as a contract worker. Oberg Dep. at 33, 73. Respondent hired her as a regular employee on March 15, 2009. *Id.* at 73.

Complainant's supervisor changed in November 2015 and in the less than six weeks that followed, the Clinic received three complaints about Complainant from patients. Oberg. Dep. at 99, 112, 114. The first was a report from a mother and father who complained about Complainant not giving their daughter an antibiotic; the second was regarding Complainant's refusal to prescribe an antibiotic for a patient who was planning a trip to Hawaii; and the third was related to Complainant's refusal to sign a workers compensation form because she believed she would be committing perjury by signing off on the form.⁶ Oberg. Dep. at 114-115.

On January 7, 2016, Complainant attended a meeting with her supervisor, Ledora McDougle, her co-supervisor, Noreen Underwood, and Human Resources employee Raven Bryson. Oberg. Dep. at 112, 163-166. They all met again a week later, after which Ms. McDougle required Complainant to participate in Respondent's Tribal Employee Assistance Program ("TEAP") in order to continue working. Oberg Dep. at 112, 164, 166; C. Resp. & Mot., Ex. 28 at 76. Complainant had indicated that she was dealing with a lot of stress, so she was referred to the TEAP program to deal with the stress.⁷ *See* R. Mot., Ex. A at 156; C. Resp. & Mot., Ex. 28 at 76.

⁵ All facts are drawn from the filings in this case, the submitted motions, and the exhibits attached to the motions. All evidence is viewed the light most favorable to the non-moving party. *Matsushita Elec. Indus. Co v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986). Irrelevant facts are omitted.

⁶ Complainant argues that "[t]hese complaints were not only untrue but were fabricated by Respondent." C. Resp. & Mot. at 7. However, she later states that Respondent's assertion that three complaints were received is "true," but that "the three complaints are not 'alleged', the names were provided by the Clinic Manager (Noreen Underwood) to the Complainant." *Id.* Considering these statements together, it is unclear if Complainant disputes that the complaints actually happened. However, for the purposes of this order, the dispute, if genuine, is irrelevant as this matter is dismissed based on Complainant's failure to engage in protected activity under the ACA.

⁷ Respondent also asserted that in September 2016, a paramedic submitted a complaint about Complainant. R. Mot. at 4; *see* Oberg Dep. at 145. Complainant asserts that "this complaint was never researched at the time in question," but does not deny that there was a complaint filed. C. Resp. & Mot. at 9-10. Instead, Complainant argues that this complaint "was not a subject of disciplinary hearing in October 2016, nor was it present in the copy of Complainant's

On October 24, 2016, Respondent terminated Complainant's employment. Oberg Dep. at 12. The termination followed a disciplinary meeting attended by Ms. McDougle, Ms. Bryson, Ms. Underwood, and Dr. Barbara Givens.⁸ Oberg Dep. at 90. The termination letter stated that she was terminated "for poor performance and behavior/conduct infractions," noting that "[i]n January 2016, [Complainant] was reprimanded for similar reasons." R. Mot., Ex. A at 156. The letter indicated that Complainant had been counseled about "making judgement calls about patients about why they are seeking care" but that "[t]his type of behavior continues" and that "[p]atients are now refusing to see you." *Id.* The letter concluded that "I am now concerned for the health, safety and wellbeing of our patients under your care. Because of these concerns and the ongoing issues, you are hereby terminated." *Id.* Ms. McDougle and Dr. Givens signed off on the termination letter. *Id.* The parties dispute the underlying reasons for Complainant's termination.⁹ *See* C. Resp. & Mot. at 10-13.

In the termination letter, Complainant was informed of her right to file a grievance, which is also described in the Human Resources manual that Complainant received and read. R. Mot., Ex. A at 156, Oberg Dep. at 74-78. The grievance procedure has two steps. First, the employee files a written grievance with Human Resources within ten days of the termination, after which the grievance is investigated. R. Mot., Ex. A at 139-140, 154-155. If the employee is dissatisfied, he or she may appeal the decision to the Tribal Grievance Board or a Hearing Officer, who will hold a hearing to determine an appropriate remedy and issue a decision within ten business days. R. Mot., Ex. A at 155.

On November 4, 2016, Complainant filed a formal grievance. R. Mot., Ex. A at 168; Oberg Dep. at 189. She had requested an extension of the ten business day deadline because her attorney was unavailable until November 9, 2016. R. Mot., Ex. A at 162; C. Resp. & Mot. at 375-378. On November 9, 2016, Andrea Halstead,¹⁰ Respondent's COO, emailed Complainant stating that she had received the grievance, and asked to set up a meeting with Complainant. *Id.* at 161. On November 18, 2016, Ms. Halstead wrote Complainant again asking again for a time to meet and stating that unless she heard from Complainant, she would have to make a determination on the grievance without having Complainant's input. *Id.* at 160. Complainant responded informing Ms. Halstead that her attorney was recovering from surgery and that he was in the hospital. *Id.* at 165. She asked "for a delay until he can be present." *Id.* Ms. Halstead responded that she "requested a 10 day expansion" which would expire on December 9, 2016. *Id.* She informed Complainant that if her attorney was not available within that time frame and Complainant chose not to meet with her,

personal file," and that the "complaint was retaliatory and was added after the fact." *Id.* at 10. Again, this dispute does not implicate whether or not she engaged in protected activity.

⁸ The former medical director for the Clinic had left in November 2015, and the Clinic was without a medical director until March 2016, when Dr. Barbara Givens became the new medical director. Oberg Dep. at 98-99, 120. Complainant believed Dr. Givens was "over her head" and "not up to date on current practice." Oberg Dep. at 121.

⁹ Complainant asserts that the statement that patients were refusing to see her is "not true" because "the patients that refused to see Complainant are those patients that wanted opioids and antibiotics for colds" or refused to see her because they were patients of Dr. Givens. C. Resp. & Mot. at 10-11. Complainant also argues that the complaint from the paramedic was not a subject of the disciplinary meeting, although this is not what Respondent argued. According to Complainant, she is currently unemployed. C. Resp. & Mot. at 19; compare with Oberg Dep. at 56, R. Mot. at 8.

¹⁰ Andrea Halstead is also referred to as Andrea Ebling in the record. Oberg Dep. at 191.

she would issue her decision with the information she had. *Id.* Complainant did not respond, and Ms. Halstead issued her decision on December 9, 2016, finding that Dr. Givens “was within her authority to terminate [Complainant’s] employment” and denied her wrongful termination claim. *Id.* at 171; Oberg Dep. at 195. Ms. Halstead notified Complainant of the procedures for appealing her decision, but Complainant did not appeal. R. Mot., Ex. A at 171; Oberg Dep. at 197. Complainant did not appeal because she believed “[i]t would have been absolutely useless” because “a tribal board would not rule in [her] favor”¹¹ and it was “pretty obvious that nobody read [her] responses” Oberg Dep. at 197-198, 201, 204; *see also* Oberg Dep. at 206, 208; C. Resp. & Mot. at 11-12.

Complainant’s Asserted Protected Activity

On April 9, 2017, Complainant filed her whistleblower complaint with OSHA. In her OSHA complaint, Complainant alleged she was terminated for:

“[R]efusing to violate federal law regarding rules for prescribing prescription medication as regulated by the US Department of health and Human Services, Drug Enforcement Agency (DEA), Federal Center for Disease Control, the State of Washington, Indian Health Services and the Affordable Care Act.”

R. Mot., Ex. A at 158. She also alleged she was terminated for refusing to violate federal law by providing prescription drugs. *Id.*

During her deposition, Complainant confirmed that her “predominant” concerns related to her refusal to overprescribe opioids and antibiotics, but that there were a variety of issues she complained about.¹² Oberg Dep. at 142-147. In response to Respondent’s motion to dismiss filed earlier in this matter, Complainant alleged that her complaints while employed by Respondent related to: 1) the number of deaths resulting from opioid use; 2) inappropriate use of antibiotics; 3) refilling medications without proper patient follow-up; 4) finding deceased and non-existent patients included in the patient database; 5) falling short of quality of care standards; 6) not following requirements necessary for federal designation as a clinic; 7) denying patients referrals when required; 8) mismanagement of clinic funds by the tribe; 9) inadequate stocking of medicines at the pharmacy; 10) a lack of a team approach to pain management; 11) dismissing Complainant’s ideas for addressing chronic health conditions (suggesting “[t]arget issues where those identified as quality targets under ACA”); 12) insufficient training for the chemical dependence unit; and 13) being left on-call despite Complainant’s ADA-protected sleep disorder.¹³ *See* Complainant’s Response to

¹¹ Complainant admitted that there is nothing in the HR manual about the hearing officer or members of the tribal grievance board being tribal members, but she said she “did not have any reason to believe otherwise.” Oberg Dep. at 201.

¹² Respondent asserted in its motion that Complainant has “confirmed that her retaliation claim is based only on events that occurred between her change in supervisors in November 2015, and the October 24, 2016 date of her termination.” R. Mot. at 6, citing Oberg Dep. at 156. Complainant contends that this is a “false statement” because her “position is that she reported to management over 8 years of employment issues which deviated from clinic standard operation in the guidelines.” C. Resp. & Mot. at 14. Construing the evidence in the light most favorable to Complainant, I will consider all her alleged instances of protected activity as articulated in her declarations and the other submissions in this matter.

¹³ Respondent argues that it is not subject to the ADA since “the ADA expressly and unequivocally excludes Indian tribes from the definition of an ‘employer’ for purposes of the [ADA],” citing 42 U.S.C. § 12111(5)(b)(i). Complainant’s

Respondent's Motion to Dismiss, Exhibit B (Oberg Decl., Apr. 11, 2018).¹⁴ She repeats these claims in her January 23, 2019 Declaration. *See* Oberg Decl., Jan. 23, 2019, ¶ 1, a – m.

In her declarations, Complainant asserted that regarding deaths resulting from opioid use, she provided “copies of regulatory license, CDC, DEA, and multiple other sources recognized as credible authorities as well as laws relating to this.” Oberg Decl., Apr. 11, 2018 ¶ 3; Oberg Decl., Jan. 23, 2019 ¶ 1.a. Regarding inappropriate use of antibiotics and associated risks, she provided information from the “World Health Organization, CDC, and multiple other credible sources” Oberg Decl., Apr. 11, 2018 ¶ 4; Oberg Decl., Jan. 23, 2019 ¶ 1.b. She also “pointed out to management of the clinic that this¹⁵ was part of the quality metrics for which they were claiming credit as meeting the standard for increased reimbursement amounts.” Oberg Decl., Jan. 23, 2019 ¶ 1.b. Regarding the quality of care issues, she stated: “See ‘rewarding quality through market-based incentives of ACA.’” Oberg Decl., Apr. 11, 2018 ¶ 7; Oberg Decl., Jan. 23, 2019 ¶ 1.e.

Complainant did not complain about insurance violations, has no complaints about the insurance benefits that were provided her, and has confirmed that insurance benefits are not part of her claim. *See* Oberg Dep. at 225; Complainant's Response to Respondent's Motion to Dismiss at 2 (“Oberg never plead insurance violations. Oberg's issue was safety.”). Complainant agrees that her “13 reported examples” of whistleblowing “DID concern quality of patient care as well as general mismanagement of the clinic” C. Resp. & Mot. at 15. She contends that her whistleblowing concerned “issues related to the health safety and welfare of the Respondent's citizens of the QIN nation [sic].” *Id.* at 3. Similarly, in her response to Respondent's earlier Motion to Dismiss, she stated her claim “involves her whistleblowing in her position as a health care provider under § 1558 of the ACA” Complainant's Response to Respondent's Motion to Dismiss at 3. She also stated that “Part 2 § 1311(g) involves Medicaid and Medicare fraud,” and that Respondent “claimed compliance with the Meaningful Use provision which qualifies it for additional payments” and that her “whistleblower complaint alleged that [Respondent] is not following quality guidelines under the NQU 0058, of the primary care measures which addresses an avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.” *Id.*

Prior Ruling on Motion to Dismiss

I denied Respondent's earlier motion to dismiss, referenced above, based on the low threshold required of whistleblower complainants in this forum. Order Denying Respondent's Motion to Dismiss, *Oberg v. Quinault Indian Nation*, 2017-ACA-00003 (Apr. 30, 2018). Respondent argued that Complainant's concerns had nothing to do with Title I of the ACA. Complainant argued that the whistleblower protections of the ACA were not limited to Title I of that statute, but

arguments for why the ADA should apply are not persuasive, *see* C. Resp. & Mot. at 15-16, but this dispute is irrelevant to the resolution of the pending motions.

¹⁴ Respondent designates Complainant's Response to its Motion to Dismiss as Exhibit B, but it was not attached as an exhibit to Respondent's Motion for Summary Decision. *See* R. Mot. at 7, n.54. Since Complainant's Response to Respondent's Motion to Dismiss is part of the file and notice was given to Complainant that the document was part of Respondent's exhibits, I find it appropriate to take judicial notice of the document. *See* 29 C.F.R. § 18.84.

¹⁵ Presumably, “this” refers to the appropriate use of antibiotics, but it is not clear exactly what Complainant is referring to in this portion of her declaration.

apply to the entire ACA. I noted that the whistleblower provision was limited to Title I, and that Title I, in general, implements systemic reforms in the health insurance market and details the requirements of individuals and employers under this new regulatory regime. I noted that Title I does not appear to regulate health clinics' quality of care, prescription of medication, poor or fraudulent management, unresponsiveness to innovation, insufficient supply of medication, or scheduling practices. However, I found that given the low threshold to survive a motion to dismiss as determined by the ARB, Complainant had alleged sufficient information to provide "fair notice" of her claims and denied Respondent's motion.¹⁶

Legal Standard

Summary Decision

Summary decision may be entered for either party if the pleadings, affidavits, material obtained by discovery or otherwise, or matters officially noticed show there is no genuine issue as to any material fact and that a party is entitled to summary decision. 29 C.F.R. § 18.72(a); *see also* Fed. R. Civ. P. 56(c). In cases before this Office, the standard for summary decision is analogous to that developed under Rule 56 of the Federal Rules of Civil Procedure. *Mara v. Sempra Energy Trading, LLC*, ARB No. 10-051, ALJ No. 2009-SOX-18, slip op. at 5 (ARB June 28, 2011). The primary purpose of summary judgment is to isolate and promptly dispose of unsupported claims or defenses.¹⁷ *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986).

The initial burden is on the moving party to demonstrate that there is no genuine issue of material fact. *Celotex Corp.*, 477 U.S. at 323. Once this burden is met, the non-moving party must establish the existence of a genuine issue of material fact. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986). The non-moving party may not rest upon mere allegations or denials, but instead must cite to particular materials in the record or show that materials cited do not establish the absence of a genuine dispute. 29 C.F.R. § 18.72(c); *see Anderson*, 477 U.S. at 250. A dispute of a material fact is genuine "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson*, 477 U.S. at 248. "Factual disputes that are irrelevant or unnecessary will not be counted." *Id.* at 249. In assessing a motion for summary decision, all evidence is viewed the light most favorable to the non-moving party. *Matsushita Elec. Indus. Co v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Anderson*, 477 U.S. at 255; *Mara*, ARB. No. 10-051, slip op. at 5.

¹⁶ Complainant argues that Respondent's motion to dismiss "was denied based on facts and not on a 'low threshold' for evidence." C. Resp. & Mot. at 19. This is inaccurate. I was clear in my order denying Respondent's motion to dismiss that the ARB has held whistleblower complainants are entitled to a liberal pleading standard given the nature of whistleblower complaints before this Office, and that she had met that pleading standard. *See Evans v. U.S. EPA*, ARB No. 08-059, ALJ No. 2008-CAA-003, slip op. at 10 (ARB July 31, 2012) (A motion to dismiss is based "solely on the allegations in the complaint, its amendments, and the legal arguments the parties raised—not whether evidence exists to support such allegations."). Complainant also references the requirements for filing a complaint with OSHA, but it is not clear for what purpose. *See id.* This claim is not currently before OSHA and Complainant is no longer at the pleading stage.

¹⁷ Complainant recites the standard for evaluating motions to dismiss, which is a relatively low threshold. *See C. Resp. & Mot.* at 1-2. The summary judgment stage is different. *See Evans*, ARB No. 08-059, slip op. at 10-11 (discussing how motions to dismiss differ from motions for summary decision).

Protected Activity Under the ACA

Section 1558 of the ACA amended the Fair Labor Standards Acts of 1938 by inserting Section 18c, which states:

- (a) No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting at the request of the employee) has—
- (1) received a credit under section 36B of Title 26 or a subsidy under section 18071 of Title 42;
 - (2) provided, caused to be provided, or is about to provide or cause to be provided to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the employee reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);
 - (3) testified or is about to testify in a proceeding concerning such violation;
 - (4) assisted or participated, or is about to assist or participate, in such a proceeding; or
 - (5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this title (or amendment), or any order, rule, regulation, standard, or ban under this title (or amendment).

29 U.S.C. § 218c; *see also* 29 C.F.R. § 1984.102(2). Complaints arising under this provision proceed according to the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth under the whistleblower provisions of the Consumer Product Safety Improvement Act (“CPSIA”) at 15 U.S.C. § 2087(b). 29 U.S.C. § 218c(b)(1).¹⁸

As I stated in the order denying Respondent’s motion to dismiss, the reference to “this title” in the statute and the implementing regulations refers to Title I of the ACA. *See* Order Denying Respondent’s Motion to Dismiss, *Oberg v. Quinault Indian Nation*, 2017-ACA-00003 (Apr. 30, 2018); *Banks v. Society of St. Vincent de Paul*, 143 F. Supp. 3d 1097, 1103-04 (W.D. Wash. 2015); *Rosenfield v. GlobalTranz Enterprises, Inc.*, No. CV 11-02327-PHX-NVW, 2012-WL-2572984, at *1-4 (D. Ariz. July 2, 2012); Final Rule, *Procedures for the Handling of Retaliation Complaints Under Section 1558 of the Affordable Care Act*, 81 Fed. Reg. 70607, 70608, 70611 (Oct. 13, 2016); 29 C.F.R. § 1984.100 (Section 18c of the FLSA provides protection for an employee “because the employee has engaged in

¹⁸ Complainant appears to dispute Respondent’s observation that the CPSIA is not incorporated into the ACA. C. Resp. & Mot. at 22, citing R. Mot. at 15. The CPSIA was not incorporated into the ACA; the whistleblower procedures and burdens of proof under the ACA merely conform to those under the CPSIA whistleblower provision.

protected activity pertaining to title I of the Affordable Care Act or any amendment made by title I of the Affordable Care Act.”).

Title I includes health insurance reforms such as prohibiting lifetime dollar limits on coverage, requiring most plans to cover recommended preventive services with no cost sharing, permitting access to health insurance premium tax credits, establishing state and federal health plan exchanges, mandating individual enrollment in a qualified plan, requiring employee coverage for qualified employers, prohibiting denial of coverage due to pre-existing conditions, and proscribing the use of factors such as health status, medical history, gender, and industry of employment to set premium rates. *See* Interim Final Rule, *Procedures for the Handling of Retaliation Complaints Under Section 1558 of the Affordable Care Act*, 78 Fed. Reg. at 13223, 13225; *Dewolf v. Hair Club for Men*, 2012-ACA-00003, at 12 (Apr. 1, 2014).

To establish protected activity under the ACA, the complainant must show she had a “reasonable belief” that a violation of Title I of the ACA occurred. This includes “both a subjective, good faith belief and an objectively reasonable belief that the complained-of conduct violates one of the listed categories of law.” *See* Final Rule, 81 Fed. Reg. at 70611-12, citing *Sylvester v. Paraxel Int’l LLC*, ARB No. 07-123, ALJ Nos. 2007-SOX-39, -42, slip op. at 14-15 (ARB May 25, 2011); *see also Melendez v. Exxon Chems.*, ARB No. 96-051, ALJ No. 1993-ERA-006, slip op. at 28 (ARB July 14, 2000). A complainant has a subjective, good faith belief “so long as the complainant actually believed that the conduct complained of violated the relevant law.” *Id.* The objective reasonableness is “evaluated based on the knowledge available to a reasonable person in the same factual circumstances with the same training and experience as the aggrieved employee.” *Sylvester*, ARB No. 07-123, slip op. at 15. An employee’s whistleblower activity is protected when it is based on a reasonable, but mistaken, belief that a violation of the relevant law has occurred or is likely to occur. *Id.* at 16. Often, objective reasonableness involves factual issues that cannot be decided absent an adjudicatory hearing. *Id.* at 15. However, if no reasonable person could have believed that the facts amounted to a violation, the issues of objective reasonableness can be decided as a matter of law. *See id.*, citing *Livingston v. Wyeth Inc.*, 520 F.3d 344, 361 (4th Cir. 2008).

Section 2717 of Title I of the ACA, entitled “Ensuring the Quality of Care,” requires the Secretary of Health and Human Services to develop reporting requirements “for use by a group health plan, and a health insurance issuer offering group or individual health insurance, with respect to plan or coverage benefits and health care provider reimbursement structures” that:

- (A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives . . . , for treatment or services under the plan or coverage;
- (B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;
- (C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and
- (D) implement wellness and health promotion activities.

42 U.S.C. §§ 300gg-17(a)(1)(A)-(D). Under Section 2717, “[a] group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D).” 42 U.S.C. § 300gg17(a)(2)(A).

Section 1311, titled “Affordable Choices of Health Benefit Plans,” requires the Secretary of Health and Human Services to establish criteria for the certification of health plans as qualified health plans. 42 U.S.C. § 18031. One such criteria is for health plans to “implement a quality improvement strategy” by “[r]ewarding quality through market-based incentives.” 42 U.S.C. § 18031(c), (g).

Contentions of the Parties

Respondent’s Motion

Respondent argues that summary decision should be granted in its favor because the undisputed facts show that Complainant cannot establish that she engaged in protected activity under Title I of the ACA as a matter of law. R. Mot at 2. Respondent argues that since Section 218c(a)(2) and (5) of the ACA whistleblower provisions are limited to Title I of the ACA, it only applies to health plans and health insurers and is “not a vehicle for assertion of general concerns regarding quality of care.”¹⁹ *Id.* at 10-12. Respondent argues that “Complainant has not and cannot produce any admissible evidence sufficient to create a triable issue of fact on how [her complaints], even if true, implicate Title I of the ACA.” *Id.* at 14.

Respondent contends that even if Complainant’s concerns were considered protected activity, she lacked a “reasonable belief” that the complained of conduct violated Title I of the ACA. R. Mot. at 2. Relying on case law under the Sarbanes-Oxley Act (“SOX”) holding that the complaint must relate to one of the “listed categories of law,” Respondent argues that the “listed category of law” in this case is Title I of the ACA, and that Complainant lacked an “objectively reasonable” belief that the complained-of conduct violated Title I “given that patient quality references in Title I of the ACA only apply to health *insurers*, not health care *providers*.”²⁰ R. Mot. at 18 (emphasis in original).

¹⁹ Respondent quotes from the healthcare.gov website:

It’s against the law for your employer to fire or retaliate against you because you get a premium tax credit when you buy a health plan in the Marketplace. It’s also against the law for your employer to fire or retaliate against you if you report violations of the Affordable Care Act’s health insurance reforms to your employer or the government. These health insurance reforms appear in Title I of the Affordable Care Act. They don’t include the Medicare or Medicaid reforms, and don’t relate to quality of patient care.

R. Mot. at 11-12, citing PROTECTION FROM EMPLOYER RETALIATION, <https://www.healthcare.gov/health-care-law-protections/protection-from-retaliation/>.

²⁰ Respondent also argues that Complainant failed to exhaust the tribal administrative remedies available to her as required by “the nature of tribal sovereignty.” R. Mot. at 2, 21-25. Complainant replied that proceeding with the second stage of the grievance procedure would have been futile. C. Resp. & Mot. at 3, 24. Since I find Complainant cannot establish that she engaged in protected activity, I need not reach this argument.

Complainant's Response

Complainant responds that the ACA whistleblower protections apply to her because Section 2717 under Title I addresses “ensuring the quality of care” and that “general concerns regarding quality of care” are a part of Title I.²¹ C. Resp. & Mot. at 20. Complainant references CMS.gov and the “Medicare and Medicaid reform that fulfills the directive of ACA in title 1 to develop measures to improve quality and patient outcomes,” which according to Complainant, includes a quality metric indicating “‘quality’ is when you DON’t [sic] prescribe antibiotics for viral illnesses.” *Id.* She argues that “Respondent claims they meet the metrics and qualify for increased rates of reimbursement while firing Complainant, the only provider Respondent had who was meeting that metric.” *Id.* at 20-21. Complainant also argues that the three complaints that formed the basis for Respondent’s termination of her employment are without merit, and goes through Respondent’s brief page by page and indicates where she believes there is a genuine dispute of fact.²²

Complainant also contends that Respondent “mischaracterized” her deposition testimony, and “left out pages that raises [sic] a serious genuine issues [sic] of material fact.” C. Resp. & Mot. at 3. Complainant contends that this conduct is troubling since Respondent “did not submit all of the deposition, wanted to continue it, and did not have the completion of review by Complainant’s counsel.” *Id.* She stated in her January 23, 2019 declaration that “[t]he piece of deposition submitted by [Respondent] was not complete, nor did it include the cross by my attorney and was missing many pages that created the context for the statement. We can provide that piece at the ALJ hearing.” Oberg Decl. Jan. 23, 2019 ¶ 12. If there were portions of the deposition that Complainant wished to offer, she was free to submit them in opposition to Respondent’s motion. The time for disputing facts asserted by the Respondent is now. I have noted where Complainant disagreed with Respondent’s characterization of her deposition testimony, but find that these disagreements do not present a dispute over a material fact, materiality here being defined as relating to the issue of whether she engaged in protected activity under the ACA. *See, e.g.*, C. Resp. & Mot. at 11 (noting there are two pages omitted from deposition relating to Complainant’s assessment of Dr. Givens’ practice); C. Resp. & Mot. at 7, 8-9 (quarreling with Respondent’s characterization of parts of her deposition testimony regarding her prior employment, her meeting with her supervisor, and her opinion of Dr. Givens). It is also not clear what Complainant refers to when she states it, presumably the deposition transcript, “did not have the completion of review by Complainant’s counsel.” Complainant’s counsel’s failure to review the deposition transcript is not grounds for a denial of Respondent’s motion.

²¹ Complainant includes a summary of the procedures that apply to the investigation of complaints, which is irrelevant at this stage of the proceeding. *See* C. Resp. & Mot. at 5-7, 19. She also cites cases published by the Office of the Inspector General regarding two tribes where there was no medical director, and asserts that there was also no medical director at the Clinic. *See* C. Resp. & Mot. at 8. I do not find this assertion relevant to the resolution of Respondent’s motion for summary decision based upon whether Complainant engaged in protected activity.

²² Additionally, Complainant also asserts that sanctions against Respondent are appropriate as “[a]fter two years Respondent has no issues to try and no defenses to present.” C. Resp. & Mot. at 6. This request is denied as it is completely unsupported.

Complainant's Cross-Motion for Summary Decision

In her January 28, 2019 filing, Complainant also sought summary decision, “in light of the overwhelming evidence that show that reasonable minds cannot differ that Respondent retaliated against Complainant for her whistle blowing activity.”²³ C. Resp. & Mot. at 27. Respondent argues that Complainant’s motion is untimely according to the pre-hearing order in this matter, and that in the alternative, it should be denied on substantive grounds since Complainant did not engage in protected activity as contemplated under Title I of the ACA and there are “obvious factual disputes” regarding why Complainant was terminated. R. Resp. at 2-3.

Discussion

1. Complainant's Cross-Motion for Summary Decision

For expediency, I first address Complainant’s Cross-Motion for Summary Decision and deny it as untimely. Under 29 C.F.R. § 18.72(b), the time to file a motion for summary decision is any time until 30 days before the hearing, “[u]nless the judge orders otherwise.” In my Notice of Hearing and Pre-Hearing Order issued on August 29, 2018, I ordered any motion for summary decision to be filed no later than January 18, 2019. Complainant filed her Response to Respondent’s Motion for Summary Decision and Cross-Motion for Summary Decision on January 28, 2019, well beyond the January 18 deadline. See 29 C.F.R. § 18.30(b)(2) (“A paper is filed when received by the docket clerk . . .”).

In the alternative, for the same reason that I find Respondent is entitled to summary decision in its favor, Complainant is not entitled to summary decision. As explained below, she did not engage in any protected activity under the meaning of the ACA whistleblower provision. Further, even if she had engaged in protected activity, there are genuine disputes as to whether that activity contributed to her termination, and whether Respondent would have taken the same actions against her absent any protected activity. Therefore, Complainant would not be entitled to summary decision in her favor.

2. Respondent's Motion for Summary Decision

Based on the record before me as submitted by both Respondent and Complainant, I find there are no genuine disputes of material fact regarding whether Complainant engaged in protected activity under the ACA.

Scope of Protected Activity

In order to adequately address Respondent’s arguments, a brief discussion about how the ARB has interpreted the scope of protected activity is necessary.

²³ I note that in the sentence immediately preceding this assertion, Complainant states that “there are genuine issues of material fact that needs [sic] to be tried.” C. Resp. & Mot. at 27. Complainant’s argument therefore appears internally inconsistent: she contends on one hand that there is no need for a hearing because “reasonable minds cannot differ” regarding the evidence, and at the same time, argues that there are genuine issues that need to be decided at hearing.

The ARB has addressed the requirements for sufficient “relatedness” to the ACA’s general “subject matter” in the context of a motion to dismiss. *Gallas v. The Medical Center of Aurora*, ARB Nos. 15-076, 16-012, ALJ Nos. 2015-ACA-005, 2015-SOX-013 (ARB Apr. 28, 2017). In *Gallas*, the complainant was a psychiatric evaluator and was directed by the respondent to conduct her evaluations via a video conference system, Telemental Health. *Gallas v. The Medical Center of Aurora*, ALJ No. 2015-ACA-00005, slip op. at 2 (ALJ July 15, 2015). The complainant alleged that she refused to perform emergency psychiatric evaluations via Telemental Health and complained of violations of the ACA, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act (“EMTALA”), Medicare/Medicaid fraud, a substandard level of care, and that doctors were refusing to provide medical care to patients without health insurance. *Id.* The ALJ granted the respondent’s motion to dismiss, concluding that the complainant “failed to identify any specific provisions of the ACA which she reasonably believed the Respondent violated” and that any complaints related to violations of HIPAA and EMTALA were not protected because those statutes were not incorporated under the ACA. *Id.* at 5. The complainant also did not “point[] to anything that shows the ACA protects employee who report substandard care or insurance fraud involving billing, fees or costs.” *Id.* at 6. Finally, the ALJ stated “[b]efore there can be a valid whistleblower claim under the ACA, there must first be a violation of the ACA.” *Id.*

The ARB vacated this decision, noting that in *Sylvester* it held that a whistleblower complainant “need not identify a specific provision of law, nor even an actual violation at the pleading stage.” *Gallas*, ARB Nos. 15-076, 16-012, slip op. at 11. The ARB explained that according to the liberal pleading standard described in *Sylvester* and *Evans*,²⁴ the complainant “need only allege activity or disclosures ‘related’ to ACA’s subject matter” to state a claim. *Id.* The ARB held that “[a] disclosure is protected by the ACA if it ‘relate[s] to a general subject that was not clearly outside the realm covered by the [statute].’” *Id.* at 10, citing *Klopfenstein v. PCC Flow Techs. Holdings, Inc.*, ARB No. 04-149, ALJ No. 2004-SOX-011, slip op. at 17 (ARB May 31, 2006); *see also Williams v. Dallas Indep. Sch. Dist.*, ARB No. 12-024, AU No. 2008-TSC-001, slip op. at 9 (ARB Dec. 28, 2012) (a complainant must have a “reasonable good faith belief that his conduct was in furtherance of the purposes of the act under which he seeks protection[]”).

The ARB found that the complainant’s claims relating to EMTALA, HIPAA, and improper pre-authorization, while not “explicitly incorporate[d]” in Title I of the ACA, dealt with subject matter “explicitly addressed” in the ACA. *Gallas*, ARB Nos. 15-076, 16-012, slip op. at 11. As the ARB explained:

Indeed, HIPAA access to coverage reforms provided both the ACA’s legislative precedent, as well as its federal/state enforcement framework. And the ACA either extended or rendered moot many of HIPAA’s [sic] portability rules, which require outright elimination of preexisting condition exclusions. In addition to the more publicized reforms that the ALJ noted, the ACA includes many other general reforms, including the use of best clinical practices and quality care reporting, patient protections related to emergency care, and ten specified coverage categories known as “essential health benefits” that include emergency services and mental health and substance use disorder services and behavioral health treatment. *Gallas* alleged protected activity related to all of these reforms.

²⁴ *Evans v. U.S. EPA*, ARB No. 08-059, ALJ No. 2008-CAA-003 (ARB July 31, 2012).

Id. (internal footnotes omitted). The ARB quoted as an example a section of Title I of the ACA and then concluded: “Gallas’s alleged protected activity relating to EMTALA, HIPAA, and pre-authorization (by insurer of services) are sufficiently related to matters contained in ACA to invoke protection under the ACA’s whistleblower provisions and to satisfy the threshold requirements to survive a motion to dismiss under the *Evans* standard.” Slip op. at 13.

On remand in *Gallas*, the ALJ held a hearing and issued a Decision and Order. *Gallas v. The Medical Center of Aurora*, ALJ No. 2015-ACA-00005 (Aug. 9, 2018). She found that the complainant “consistently made internal and external complaints alleging that TMCA’s use of TeleMental Health violated EMTALA, HIPAA, CMS regulations, Colorado state laws, and state board and ethical guidelines,” as well as two instances where a physician required pre-authorization before admitting a patient to the hospital. Slip op. at 33. The complainant also referenced the ACA in one of her internal complaints to the ethics hotline where she stated Telemental Health violated “title one patient protections, 2717 quality of care.” *Id.* The ALJ interpreted the ARB’s statements in vacating her earlier order “to mean that the underlying subject matter of the different statutes cited by the Complainant must be considered when determining whether a violation of the ACA was alleged.” *Id.* at 34. She then determined that she did not find the provisions cited by the ARB established protected activity because the three sections cited “only apply to health insurers and not to health care providers like [the respondent].” *Id.* at 36. The complainant only complained about the provider’s “rendering of medical services, and not any part of its insurance benefits plan.” *Id.* The ALJ explained:

While Section 2717 contains the terms “Quality of Care,” and “best clinical practices,” it does not mandate health care *providers* provide a certain quality care, or exercise best practices. Instead, the purpose of Section 2717 is to develop requirements for all health *insurers* to report on how they are using plan or coverage benefits and health care provider reimbursement structures to, among other things, improve patient safety through the appropriate use of best clinical practices. Thus, the focus is not on actions by health care providers, but rather on indirect actions by health insurance issuers through the use of incentives, to improve quality of care. In addition, while Sections 2719A and 1302 state that pre-authorization cannot be required for emergency services, as stated above, the statutory sections state that a health insurance issuer may not require pre-authorization for emergency services, not health care providers. There is no discussion in these three sections, or anywhere else in Title I of the ACA, on the use of TeleMental Health for emergency services and/or mental health services, nor is there reference to the admittance of pregnant women to a hospital, or addressing informed consent

Id. (emphasis in original). The ALJ thus found that the complainant’s concerns and her refusal to perform Telemental Health services did not “fall within the purview of Title I of the ACA.”²⁵ *Id.*

The ARB has explained that other whistleblower statutes with similar language “allow[] the complainant to be wrong as long as he held a reasonable belief of a violation of the [relevant statute]” *Saporito v. Publix Super Markets, Inc.*, ARB Case No. 10-073, ALJ No. 2010-CPS-1, slip op. at 6

²⁵ The ALJ went on to address the reasonableness of the complainant’s belief assuming, *arguendo*, that the complaints could be construed to fall within the purview of Title I of the ACA.

(Mar. 28, 2012). In *Saporito*, which involved a whistleblower complaint under the CPSIA, the ARB said it was error to solely focus on whether a complaint about a product would come under the jurisdiction of the Consumer Product Safety Commission because the relevant question is whether the complainant “held a reasonable belief of a violation of the Act or other act enforced by the Commission.” *Id.*; see also *Sylvester*, ARB No. 07-123, slip op. at 16 (an employee’s whistleblower activity is protected when it is based on a reasonable, but mistaken, belief that a violation of the relevant law has occurred or is likely to occur). *Id.* at 16. See also *Minard v. Nerco Delamar Co.*, No. 92-SWD-1, 1994 SOL Sec Labor LEXIS 18 at *7-8 (Sec’y Dec., June 25, 1994) (holding that even though the complainant was concerned about the disposal of oil and antifreeze, two substances not covered under the Solid Waste Disposal Act, given the “complexity and opacity” of the statute it was reasonable for an average lay person to believe these substances were covered).

However, in whistleblower complaints under SOX, the ARB has held that to qualify as protected activity, a complainant must have a reasonable belief in a violation of *one of the enumerated laws* under SOX.²⁶ For example, in *Micallef v. Harrah’s Rincon Casino & Resort*, ALJ No. 2015-SOX-025, ARB No. 16-095 (ARB Jul. 5, 2018), the ARB affirmed the ALJ’s dismissal of a complaint based on the complainant’s failure to allege specific facts or present evidence to show her objectively reasonable belief that her disclosures related to the protected categories of law enumerated in SOX. The ALJ noted that the complainant’s concerns about Harrah’s tip policy might have “some relevance” to its financial state, but concluded that SOX does not protect an employee for reporting illegal activities of any kind. Slip op. at 5. The ARB agreed, concluding that while the complainant “asserted repeatedly that her actions were related to fraud and therefore SOX-protected,” the complainant did not provide “any suggestion of any objectively reasonable belief that supports her theory.” *Id.* See also *Fredrickson v. The Home Depot U.S.A., Inc.*, ARB No. 07-100, ALJ No. 2007-SOX-13, slip op. at 6 (ARB May 27, 2010) (complaints about corporate expenditures that do not directly implicate the categories of fraud listed in the statute or securities violations are not protected activity because the “mere possibility that a challenged practice could adversely affect the financial condition of a corporation, and that the effect on the financial condition could in turn be intentionally withheld from investors, is not enough.”) (citing *Smith v. Hewlett Packard*, ARB No. 06-064, ALJ Nos. 2005-SOX-088, -092, slip op. at 9 (ARB Apr. 29, 2008); *Harvey v. Home Depot U.S.A., Inc.*, ARB Nos. 04-114, -115, ALJ Nos. 2004-SOX-020, -36, slip op. at 14-15 (ARB June 2, 2006).

Discussion

Respondent relied on the ALJ’s decision on remand in *Gallas* to argue that the same reasoning should be applied here: that because Complainant’s alleged concerns related to a *provider’s* quality of care, not a health *insurer*, her claims fall outside the scope of Title I of the ACA as a matter of law. R. Mot. at 12-14. Complainant’s response is only that “*Gallas* believed she was being asked to act illegally and jeopardize her license. She could have found a better way to approach her concerns. You will also note that the ALJ decision was reversed by the ARB.”²⁷ R. Resp. & Mot. at 21.

²⁶ Under SOX, an employee must reasonably believe that the information he or she provides relates to a “violation of section 1341 [mail fraud], 1343 [wire, radio, TV fraud], 1344 [bank fraud], or 1348 [securities fraud], any rule or regulation of the Securities and Exchange Commission, or any provision of Federal law relating to fraud against shareholders” 18 U.S.C. § 1514A(a)(1).

²⁷ The ARB vacated and remanded the ALJ’s granting of the motion to dismiss; however, the ARB has not yet weighed in on the ALJ’s Decision and Order following the hearing.

Respondent also cited to whistleblower decisions under SOX in support of its argument that Complainant did not show a reasonable belief that she complained about a violation of Title I of the ACA. Respondent argues that analogizing from SOX whistleblower jurisprudence, Complainant's burden is to prove that she has an objectively reasonable belief that Respondent's conduct violated Title I of the ACA, comparing Title I of the ACA to SOX's enumerated laws. In her Response and Motion, Complainant did not directly address the objective reasonableness of her concerns or her refusal to participate in certain activity such as the alleged over prescription of opioids or antibiotics.

As explained by the ALJ in *Gallas* on remand, the realm addressed by Title I of the ACA is health insurance and health insurance reforms. In order to engage in protected activity under the ACA's whistleblower protection, Complainant must have had a reasonable belief in the violation of the *pertinent* statute. See Final Rule, 81 Fed. Reg. at 70611-12; *Sylvester*, slip op. at 16 (must have a reasonable belief in a violation of *relevant* law). I find that given that the general subject of Title I of the ACA concerns the obligations of health insurers and group health plans, Complainant has failed to show that her complaints and refusals to participate in certain activity related to the relevant statute in order to be protected under the ACA whistleblower provision. The inclusion of the "reasonableness" language in Section 18c still refers to a reasonable belief of "any provision of this title," not a reasonable belief in any provision of the ACA or any provision relating to quality of care. Similar to how a complainant must establish a reasonable belief in a violation of one of the enumerated categories of protected activity under SOX, a complaint under the ACA must allege a reasonable belief in a violation of Title I of the ACA. Citing to a *provider's* alleged quality of care issues is analogous to citing to a violation of a different statute; she simply did not allege a violation of the *pertinent* statute (i.e., Title I). Congress could have included a whistleblower provision that protected a reasonable belief in violations relating to the entire ACA, but instead it restricted the whistleblower protections to Title I.

After reviewing the submissions of both parties, and viewing the evidence in the light most favorable to Complainant, I find that there is no dispute that Complainant's alleged concerns did not concern the requirements imposed on health insurers and group health plans by Title I of the ACA. Instead, her concerns addressed what she perceived to be quality of care issues, as practiced by the Clinic as a health care provider, not as practiced by health insurance issuers or a group plan. Complainant maintains that her refusal to unnecessarily prescribe opioids, antibiotics, and her other complaints should qualify under Title I because Title I includes a section with the heading "Ensuring Quality of Care." Title I provides that certain health insurance reforms are attained, in part, through ensuring that health insurance issuers and group health plans embrace standards relating to quality of care. But this does not mean that concerns about quality of care in general are related to the type of quality of care provisions in Title I of the ACA. Complainant has not alleged, and points to no evidence that would support, that she believed she was concerned about violations related to the failure of a health care insurer or group health plan to ensure quality of care.

I acknowledge that the ARB in *Gallas* held that the complainant's concerns, which related to a provider's quality of care, were "sufficiently related to matters contained in ACA to invoke protection under the ACA's whistleblower provisions and to satisfy the threshold requirements to survive a motion to dismiss under the *Evans* standard." However, in making its determination in *Gallas*, the ARB cited to 42 U.S.C. § 2717, "Ensuring the Quality of Care," see slip op. at 11, n.27, but did not discuss the fact that this provision, and the others in Title I to which it cited, refer to requirements placed on health insurers and group health plans. The ALJ did not draw this

distinction in her order dismissing the claim, and the ARB's focus was the ALJ's error in indicating "that a complainant must cite to a specific section of the ACA to support her claim and that before there can be a valid whistleblower complaint under ACA, there must first be an ACA violation." Slip op. at 10. Further, the ARB's decision was in the context of a motion to dismiss and the liberal pleading standard allowed for whistleblower complainants in this forum. I also note that in another case before the ARB, it held that referencing violations of the Comprehensive Omnibus Budget Reconciliation Act of 1985 ("COBRA") "are not sufficient to raise a claim under the ACA as it is a separate and independent statute." *Stroud v. Mobergan Tribal Gaming Auth.*, ARB No. 13-079, ALJ Nos. 2013-ACA-00003, 2013-CFP-00003 (ARB Nov. 26, 2014); see also *Blake v. Mast Drug Co., Inc.*, 2012-ACA-2, slip op. at 2-3 (Oct. 5, 2012) (dismissing claim because the respondent was a pharmacy not governed by Section 3310 of the ACA); *De Wolfe v. Hair Club for Men*, 2012-ACA-3, slip op. at 13 (Apr. 1, 2014) (dismissing claim based on reporting of improper disposal of medical records because "a report of improperly disposed patient medical records is not a protected activity under the ACA").

Alternatively, Complainant has also not shown that a reasonable person could have believed that her alleged concerns amounted to a violation of a health insurer's or group plan's obligations under Title I of the ACA. She conceded that she never complained about insurance violations, and that her complaints did not have anything to do with insurance or health insurers. Her concern related to the general quality of care provided by the Clinic, as well as various requirements imposed on the Clinic as a health provider. Complainant cited to the Clinic's alleged receipt of increased reimbursement of funds as a link to the "market-based incentives" under Title I of the ACA. However, her quarrel is with the actions of the Clinic as a health provider; it is a too far of a stretch to believe that (alleged) malfeasance by a Clinic that is receiving funds would result in the violation of a statute that requires health plans seeking certification under the ACA to establish a quality improvement strategy through market-based incentives.²⁸ See 42 U.S.C. § 18031(c), (g).²⁹ Similarly, while Complainant referenced "quality of care," a phrase also used in Title I of the ACA, this does not suggest that she had a reasonable belief that a health insurer or group health plan was violating its obligations under Title I because the Clinic, as a provider, was allegedly engaging in sub-par practices.

Respondent maintains that neither it, nor the Clinic, are health insurance companies, health insurers, or sellers of health insurance. R. Mot. at 3, citing Oberg Dep. at 41-42. Complainant disputes this fact, asserting that Respondent "is self-insured through Berkley Administrators as well as managing the Community Health Plan (CHS)," which is a "fund that maintains and pays for tribal members that receive services off tribal lands and have no insurance." C. Resp. & Mot. at 7, citing Oberg Dep. at 41, 42. Complainant cites no evidence relating to "Berkley Administrators" or how such insurance may relate to the Clinic. In her deposition, Complainant conceded that Respondent is not an insurance company, but noted that the Clinic has a "CHS budget" which it can use to "take an Indian from another tribe and pay their bills out of that funding." Oberg Dep. at 42. However,

²⁸ Further, Complainant cited to no supporting documentation that the Clinic was receiving such funds. The assertion is only referenced in her declaration. I also note she does not make this argument directly in her Response and Motion, but I discuss it as part of my duty to construe the evidence in the light most favorable to her as the non-moving party.

²⁹ Complainant did not cite to portions of Title I of the ACA apart from Section 2717. However, she quoted "market-based incentives" in her declaration, and, drawing all inferences in her favor, I assume this is the portion of Title I she refers to.

Complainant has not linked any of her asserted protected activity to the Community Health Plan, and has not provided any evidence that she believed she was reporting a complaint related to the Community Health Plan.³⁰ Merely asserting that the Community Health Plan exists is not sufficient to establish a genuine dispute regarding the nature of her complaints.

Accordingly, I find as a matter of law that Complainant did not engage in protected activity because she did not raise concerns about or refuse to participate in an activity related to the health insurance reforms found in Title I of the ACA. Alternatively, after considering all of the evidence before me, I find that the record is undisputed that Complainant did not have a reasonable belief that the conduct she complained about and the activity she refused to participate in related to the health insurance reforms found in Title I of the ACA.

Respondent's Motion for Summary Decision is granted. Complainant's Cross Motion for Summary Decision is denied. All dates are vacated. The matter is dismissed.

SO ORDERED.

RICHARD M. CLARK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: To appeal, you must file a Petition for Review ("Petition") with the Administrative Review Board ("Board") within fourteen (14) days of the date of issuance of the administrative law judge's decision. The Board's address is: Administrative Review Board, U.S. Department of Labor, Suite S-5220, 200 Constitution Avenue, NW, Washington DC 20210, for traditional paper filing. Alternatively, the Board offers an Electronic File and Service Request (EFSR) system. The EFSR for electronic filing (eFile) permits the submission of forms and documents to the Board through the Internet instead of using postal mail and fax. The EFSR portal allows parties to file new appeals electronically, receive electronic service of Board issuances, file briefs and motions electronically, and check the status of existing appeals via a web-based interface accessible 24 hours every day. No paper copies need be filed.

An e-Filer must register as a user, by filing an online registration form. To register, the e-Filer must have a valid e-mail address. The Board must validate the e-Filer before he or she may file any e-Filed document. After the Board has accepted an e-Filing, it is handled just as it would be had it been filed in a more traditional manner. e-Filers will also have access to electronic service (eService), which is simply a way to receive documents, issued by the Board, through the Internet instead of mailing paper notices/documents.

³⁰ She did not argue in her Response and Motion that any of her complaints related to the Community Health Plan; she only stated that "[t]his raises a genuine issue of material fact under 56(c)." *See* C. Resp. & Mot. at 7.

Information regarding registration for access to the EFSR system, as well as a step by step user guide and FAQs can be found at: <https://dol-appeals.entellitrak.com>. If you have any questions or comments, please contact: Boards-EFSR-Help@dol.gov

Your Petition is considered filed on the date of its postmark, facsimile transmittal, or e-filing; but if you file it in person, by hand-delivery or other means, it is filed when the Board receives it. *See* 29 C.F.R. § 1984.110(a). Your Petition must specifically identify the findings, conclusions or orders to which you object. You may be found to have waived any objections you do not raise specifically. *See* 29 C.F.R. § 1984.110(a).

At the time you file the Petition with the Board, you must serve it on all parties as well as the Chief Administrative Law Judge, U.S. Department of Labor, Office of Administrative Law Judges, 800 K Street, NW, Suite 400-N, Washington, DC 20001-8002. You must also serve the Assistant Secretary, Occupational Safety and Health Administration and, in cases in which the Assistant Secretary is a party, on the Associate Solicitor, Division of Fair Labor Standards. *See* 29 C.F.R. § 1984.110(a).

You must file an original and four copies of the petition for review with the Board, together with one copy of this decision. In addition, within 30 calendar days of filing the petition for review you must file with the Board an original and four copies of a supporting legal brief of points and authorities, not to exceed thirty double-spaced typed pages, and you may file an appendix (one copy only) consisting of relevant excerpts of the record of the proceedings from which the appeal is taken, upon which you rely in support of your petition for review. If you e-File your petition and opening brief, only one copy need be uploaded.

Any response in opposition to a petition for review must be filed with the Board within 30 calendar days from the date of filing of the petitioning party's supporting legal brief of points and authorities. The response in opposition to the petition for review must include: (1) an original and four copies of the responding party's legal brief of points and authorities in opposition to the petition, not to exceed thirty double-spaced typed pages, and (2) an appendix (one copy only) consisting of relevant excerpts of the record of the proceedings from which appeal has been taken, upon which the responding party relies, unless the responding party expressly stipulates in writing to the adequacy of the appendix submitted by the petitioning party. If you e-File your responsive brief, only one copy need be uploaded.

Upon receipt of a legal brief filed in opposition to a petition for review, the petitioning party may file a reply brief (original and four copies), not to exceed ten double-spaced typed pages, within such time period as may be ordered by the Board. If you e-File your reply brief, only one copy need be uploaded.

If no Petition is timely filed, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 29 C.F.R. §§ 1984.109(e) and 1984.110(b). Even if a Petition is timely filed, the administrative law judge's decision becomes the final order of the Secretary of Labor unless the Board issues an order within thirty (30) days of the date the Petition is filed notifying the parties that it has accepted the case for review. *See* 29 C.F.R. § 1984.110(b).