IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

THE PEOPLE OF THE STATE OF ILLINOIS,	)	
	)	
Plaintiff,	)	
v.	)	**No. 05 CH 2474**
	)	
ABBOTT LABORATORIES, *et al.*,	)	
	)	
Defendants.	)	

MEMORANDUM ORDER AFTER TRIAL

In 2005, the State filed the present civil litigation against various manufacturers of brand and generic pharmaceuticals, alleging that the manufacturers reported false and inflated Average Wholesale Prices ("AWPs"), causing Medicaid to overpay for reimbursement of drugs and violating the Whistleblower Reward and Protection Act, 740 ILCS 175/1, *et seq.* ("WRPA") and the Illinois Consumer Fraud and Deceptive Business Practices Act, 815 ILCS 505/1, *et seq.* ("ICFA"). In 2013, after extensive motion practice and years of discovery, Teva, a manufacturer of both brand name and generic drugs, was the first defendant to go to trial. The trial was limited to the generic drugs manufactured by Teva. Following the trial, the parties filed voluminous post-trial briefs. The Court determined that the issue of causation should be addressed first. That issue, and the parties' briefs addressing it, are now before the Court.

Factual Background

Medicaid is a program jointly funded and managed by the states and the federal government. *Harris v. McRae*, 448 U.S. 297, 301 (1980). Pursuant to federal law, states participating in the Medicaid program must submit "state plans" to the Centers for Medicare and Medicaid Services ("CMS," formerly known as "HCFA") to receive federal funding. 42 U.S.C. §§ 1396a and 1396b(a). Federal regulations compel state Medicaid agencies to devise procedures for reimbursing pharmacists who dispense drugs to Medicaid recipients. 42 C.F.R. § 447.518. Under the federal guidelines, the reimbursements may not exceed the lesser of 1) the drug's estimated acquisition cost ("EAC") plus a reasonable dispensing fee, or 2) the "usual and customary" price the pharmacy charges to consumers paying for the drug without government assistance. 42 C.F.R. § 447.512(b). The regulations define EAC as "the agency's best estimate of the price generally and currently paid by providers for a drug." 42 C.F.R. § 447.502.

Under these federal regulations, Illinois Medicaid ("Medicaid" or the "Agency") is required to establish a formula to calculate the EAC for drugs, other than those for which the federal government has established a specific upper limit. 42 C.F.R. § 447.512; *see Id.,* § 447.514 (establishing specific upper limits). The Illinois Medicaid Act provides that the Agency must pay the "maximum price" for a drug, plus an established dispensing fee. 89 Ill. Admin.

Code 140.445. During the relevant time period at issue here (1991–2008), the "maximum price" of generic drugs was calculated as the lower of (1) the provider's estimated acquisition cost, defined as average wholesale price minus a percentage; (2) the federal upper limit; (3) any applicable state upper limit; (4) the pharmacy's prevailing charge to the public; or, after July 1, 2000, (5) the average wholesale price for drugs where that price is based upon the actual market wholesale price. *Id.*

The Illinois Medicaid program is run by the Illinois Department of Healthcare and Family Services ("DHFS"), previously the Illinois Department of Public Aid ("IDPA"). The process to establish this reimbursement formula involves extensive input from various lobbying interests, as well as from DHFS and other state officials.

Given the very large number of reimbursable drugs and the even larger volume of claims, Illinois Medicaid has always required a computerized system and broadly applicable formulas to calculate reimbursements. Like other States throughout the country, for a long period Illinois Medicaid utilized First DataBank ("FDB"), a company that supplied electronic drug pricing information to it through a computer file that was updated on a weekly basis. That format enabled Illinois Medicaid to input the weekly updated information wholesale, rather than being forced to enter hundreds of thousands of inputs manually. A primary element of the prices published by FDB was "average wholesale price" or "AWP." Teva and other pharmaceutical companies who chose to participate in the Medicaid program established an AWP for each of its drugs and submitted that information to FDB for publication. (FDB did not attempt to check or verify the information it received, but simply passed it along.) Illinois Medicaid then used that published information to set AWP-based reimbursement prices for drugs covered by Medicaid.

I. History of Average Wholesale Price or "AWPs"

1988: The State Abandons Actual Acquisition Cost or "AAC"

In 1988, Illinois Medicaid discontinued the "actual acquisition cost" ("AAC") approach that it had been using to calculate reimbursement formulas, which was based on invoices submitted by pharmacies. Though theoretically desirable (because based on actual invoices), the AAC approach was flawed in practice because pharmacies routinely failed to report discounts and rebates they received but did not pass on to consumers, resulting in inflated reimbursements. Marvin Hazelwood, head of Illinois Medicaid's prescription drug program from 1972 to 2002, testified that the flaws in the AAC approach cost the State "hundreds of thousands of dollars a year" in federal audit findings. *Trial Tr. Vol. V,* 831–833 (Hazelwood) (further explaining that the federal practice was to recoup a portion of the federal reimbursement to the State where audit findings showed that the State was not in compliance with its approved state Medicaid plan). In part, the State's decision to abandon the AAC approach was propelled by its efforts to reimburse pharmacies at the *average* acquisition cost, which in theory should be simpler to apply and which was consistent with the federal requirement that states reimburse at the "estimated" – as opposed to "actual" – acquisition cost, or EAC. *Trial Tr. Vol. V,* 836 (Hazelwood).

Average Wholesale Price or "AWP"

One element of, or a factor in, the State's pre-1988 "lesser of" reimbursement formula was AWPs without any discount. Over time, however, drug manufacturers began reporting, and FDB began publishing, AWPs that were inflated above the true average wholesale prices.[1] For that reason, which grew increasingly obvious over time, by the late 1980s the federal government made clear that it would no longer approve the use of undiscounted AWPs, which many States, including Illinois, had been using up until then. *See, e.g.*, DX-0903 (1989 memo warning that "nondiscounted or unmodified AWP is not acceptable").

Faced with inflated AWPs, but having found an AAC approach unworkable, Illinois Medicaid adopted the discounted-AWP approach in 1988. The State's new discounted-AWP policy purported to comply with the federal regulations and avoid unnecessary costs associated with federal audit findings. *Trial Tr. Vol. V*, 839–40 (Hazelwood). The discount percentage was applied in an attempt (albeit rough and inexact) to account and adjust for the inaccuracy of the published AWPs, which were known to be inflated; it sought to account for the difference between the published AWP and the estimated average price that a wholesaler *actually* charged retail pharmacies for the sale of the drug.

When deciding to adopt the discounted-AWP approach, and later when setting the discounts to AWPs, Illinois Medicaid considered input from various sources, including surveys at both the federal and state levels, pharmacy group interests, including the Illinois Pharmacy Association ("IPhA") and the Department's Drug Advisory Committee, and input from state officials. Hazelwood testified that it was generally Illinois Medicaid's practice to work with the interest groups directly affected before adopting a policy. *Trial Tr. Vol. V*, 851 (Hazelwood). According to Hazelwood, "the reality was that politically, that interest group could and did stop [Illinois Medicaid] if they had a strong opposition to a policy change." *Id.*

Thus, prior to adopting the discounted-AWP approach, Illinois Medicaid specifically conferred with the Illinois Pharmacy Association ("IPhA") and the Department's Drug Advisory Committee. The Drug Advisory Committee was an informal group of drug store owners and pharmacists with whom the Agency consulted, on occasion, regarding its pharmacy-related programs. *Trial Tr. Vol. V*, 846 (Hazelwood). Both the IPhA and the Drug Advisory Committee supported Illinois Medicaid's decision to abolish the AAC formula and adopt the discounted-AWP approach. But their support was conditional. For one thing, they wanted the Department's payment cycle reduced to 30 days. The Department's slow payment cycle was a consistent problem beginning in the mid-1980s, and it often took the Department 60 days or longer to pay back pharmacies. *Trial Tr. Vol. V*, 828–29 (Hazelwood). Support from pharmacy groups was also conditioned on allowing pharmacies to keep the difference between their acquisition cost and the reimbursement amount. *See* DX-0031 at 2; DX-0857 at 1 ("Mr. Sherman [of IPhA] stated that in return for [IPhA's] support on this issue, he wanted the Department to change

[1] Drawing on Voltaire's comment about the Holy Roman Empire, this Court observed on more than one occasion, during the extensive motion practice in this litigation, that eventually an AWP number became "neither average, nor wholesale, nor a price." Teva and the State do not really dispute that. But they disagree sharply about what consequences flow from it.

policy to allow the pharmacies to keep any difference between Department computer screens and pharmacies' actual acquisition costs.").[2]

Although the slow payment problem persisted, at the pharmacists' demand the discounted-AWP approach did permit pharmacies to keep the difference between their acquisition cost and the amount reimbursed by Medicaid. DX-0032 at 2. Seemingly making a virtue of this, Hazelwood testified that "[w]e were creating an environment that incentivized drug store owners to be prudent and aggressive in their negotiating with wholesalers regarding acquisition cost." *Trial Tr. Vol. V*, 840; *see also id.* at 835 ("the result of this change will be that if you're a prudent purchaser, you have the potential to make a profit"). Likewise, James Parker, Deputy Administrator of Illinois Medicaid's Division of Medical Programs since 2001, testified that one incentive of using estimated acquisition cost as compared to actual acquisition cost is that it incentivizes pharmacies to seek out the lowest price. *Trial Tr. Vol. II*, 288–89 (Parker). Parker testified that in a pure cost-based system, there is no incentive for pharmacies to be efficient. *Id.* Thus, effective July 1, 1988 "a pharmacy [would] be allowed to keep the difference between the Department's maximum allowable costs and the pharmacy's actual acquisition costs." DX-0032 at 2. That policy has remained in effect ever since.

The State set its initial discount at AWP-10%, which remained in place for generic drugs from 1989 to 1995. The discount for generics was increased to AWP-12% in 1995; AWP-20% in 2001; and AWP-25% in 2002, where it remained through 2008, the last year for which the State seeks damages. The State asserts that the discount rates were its "best guess," and that the discount rates were difficult to establish for several reasons. Parker, testifying on behalf of the State, stated that there was no consistent, predictable relationship between a drug's published AWP and the average price actually charged for the drug by wholesalers to retail pharmacies. *Trial Tr. Vol. II*, 257–59 (Parker). Parker testified that Illinois Medicaid was cautious about establishing a discount percentage that would cause pharmacies to lose money when dispensing particular drugs, fearing that pharmacies might choose not to stock or sell the drugs, or might sell more expensive brand products instead. *Id.* Further, though the AWP-based system benefited mechanically from using FDB's weekly computer file updates (which covered thousands of drugs and affected hundreds of thousands of transactions), the accuracy of the system was an ongoing problem because the difference between a drug's published AWP and the drug's actual market price (referred to as the "spread") changed over time. Likewise, the "average" wholesale price at which pharmacies purchased generics changed over significantly time. *Id.* at 264 (calling the estimates of the "average" discount from AWP a "moving target, let alone the fact that any one of those numbers doesn't represent the price on any particular drug").

Marketing the Spread

It was common knowledge, by the late 1980s, that drug manufacturers were reporting inflated AWPs. That problem persisted, in part "because higher [AWP] list prices from manufacturers result in greater profits to pharmacies when payment is set in relation to artificial

[2] This was in theory inconsistent with federal law. *See* pages 1-2 *supra*. But even under the AAC approach, as a practical matter it was impossible effectively to audit hundreds of thousands of transactions to try to recoup this difference. Arguably the AWP system not only continued, but enshrined, that problem. *See* "Marketing the Spread," pages 4-5 *infra.*

prices." PX-0184 (2005 memorandum from CMC to the U.S. Government Accountability Office). Since pharmacies pocketed the difference between the amount they paid for a drug and the amount reimbursed by Medicaid, the difference, known as the "spread," was important to Teva's customers. It was no secret that the spread could be a factor in a pharmacy's selection of which particular product to purchase, stock, and dispense to customers. *Bloom Dep.*, 80–81 (Teva representative acknowledging that the spread was a factor that pharmacies considered, that this was "no secret" and that "we were aware of it").

Because the spread mattered to customers, it mattered to Teva and other manufacturers. In 2004 an executive of Barr (which Teva acquired in 2008) told Congress: "If a generic manufacturer unilaterally reduces its AWP for a given product relative to the AWPs of other generic manufacturers for the same product, pharmacies would have an incentive to purchase another manufacturer's drug that did not reduce its AWP." PX-1187 (12/7/2004 Hearing Before the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee), at 44, 50. Therefore, Teva monitored its competitors' AWPs and made sure that it reported "competitive" AWPs. *Marth Dep.*, 219 (Teva's CEO testifying – in an ironic reversal of the usual pattern of competitive business pricing – that "we would raise price occasionally to meet competition."). Teva openly promoted the spread to its customers when selling its products. *See, e.g.*, PX-1038 (September 1998 letter from Robert Shanks to marketing firm, indicating that Ivax, which was later acquired by Teva, hired the firm to call pharmacies and point out that their generic drug offered a greater AWP-based reimbursement spread than its brand equivalent); PX-0826 (letter from Teva providing pharmacy with the AWP, in addition to actual selling price, to allow it to calculate the spread); PX-0561 (same). As used in this marketing context, "spread" is another word for inaccuracy. Thus, reliance on spread as a marketing tool obviously discouraged accurate Medicaid price reporting.

July 2000 Amendment: "True" and "False" AWPs

In early 2000, DOJ notified Illinois Medicaid that FDB would publish AWPs for 50 drugs, or 428 National Drug Codes ("NDCs"), based on "true" or "actual" wholesale prices (sometimes hereinafter referred to as "market AWPs" or "true AWPs"). The new true AWPs were in response to an investigation by the National Association of Medicaid Fraud Control Unit ("NAMFCU") of "a pattern of misrepresentation by some drug manufacturers of the average wholesale prices and wholesale acquisition costs of certain of their products." PX-0219. After reviewing over 400 NDCs with "true" market AWPs, Illinois Medicaid acknowledged that these numbers, which DOJ and NAMFCU said reflected "true" average wholesale prices, had to be factored into Illinois' discounted AWP methodology. Effective July 1, 2000, Illinois Medicaid amended 89 Ill. Admin. Code 140.445 to include in the Department's "lower of" formula a new metric: "the average wholesale price for drugs where that price is based on the actual market wholesale price plus the established dispensing fee."[3] PX-096; *Trial Tr. Vol. II*, 296–97 (Parker); *Trial Tr. Vol. V*, 985–86 (Hazelwood). We will call this the "July 2000 Amendment."

[3] At that time, the reimbursement for generic drugs was the lower of "(A) the pharmacy's prevailing charge to the general public; (B) the average wholesale price minus 12 percent plus the established dispensing fee; (C) the Federal Upper Limit . . . plus the established dispensing fee; (D) the State Upper Limit . . . plus the

According to the State, Illinois Medicaid intended to continue its efforts to obtain, and avail itself of, actual market prices for all drugs covered by Medicaid. This is evidenced, for example, in an e-mail from Hazelwood to a Minnesota counterpart, in which he wrote: "Next issue will be getting these same actual market AWPs for other NDCs and getting agreement that actual market AWPs will be updated as needed so they reflect the current avera[g]e wholesale amount. . . . We've got to . . . keep pushing for real average wholesale price information for all drugs." PX-0216. Further, in a letter to a state senator, Illinois Medicaid advised: "As the actual market average wholesale price becomes available for a product, our pricing of these prescriptions will use these amounts and will no longer apply the referenced discounts." PX-0211. Both Parker and Hazelwood testified that if the Department had received true AWPs from FDB, it would have used them. *Trial Tr. Vol. I*, 208–209 (Parker); *Trial Tr. Vol. V*, 986–87 (Hazelwood).

Despite Illinois Medicaid's "intent to continue its efforts to obtain actual market prices for all drugs covered by Medicaid," however, consistently reliable market AWPs were never established for NDCs other than the initial 428. The "actual market wholesale price" regulation stayed in effect though the end of the damages period, but by early 2001 Illinois Medicaid knew that the actual market AWPs published by FDB had already become inaccurate because they had not been updated to reflect the constantly changing actual market prices. *Trial Tr. Vol. V*, 985 (Hazelwood). The State blames the drug wholesalers, who failed to respond to FDB's surveys for updated price information on the NDCs in question, and the manufacturers, who denied NAMFCU's "repeated invitation . . . to certify the prices they report as representing something objective." PX-0137. Teva, on the other hand, blames the State, which never took any action on its own to obtain and/or update true AWPs. (Teva does not, however, clarify what meaningful action in that regard was open to the State as a practical matter.)

Alternatives to Discounted AWP

Additionally, Illinois Medicaid considered, but ultimately did not adopt, alternatives to the discounted AWP system. First, during the 1995 budget process, Illinois Medicaid proposed replacing discounted AWP with a component based on Wholesale Acquisition Cost ("WAC"). A "WAC-plus" component was considered; but Illinois Medicaid ultimately entered into an agreement with lobbyists for Illinois pharmacies that it would continue to use an AWP-minus formula, though with an increased discount for generic drugs (from 10 to 12 percent). DX-0086. In 2000, Illinois Medicaid added a WAC-plus component to its reimbursement formula for a brief six-month period as well; *see infra* Part II.

In 1995, Illinois Medicaid also considered a proposal referred to by pharmacy groups as Most Favored Nation ("MFN") pricing. The MFN approach would require pharmacies to bill the State at the lowest rate the pharmacy charged any third-party payer. DX-0079 at 2. The State felt it had sound reason for rejecting the MFN approach, since MFN would: revert to relying on pharmacies' self-reported costs, an approach that had proved unworkable with AAC; require the State to accept the rates negotiated by pharmacies and third-parties, without regard to the EAC requirement of federal law; and compel pharmacies to monitor frequently-changing payment

---

established dispensing fee; or (E) the average wholesale price for drugs where that price is based upon the actual market wholesale price plus the established dispensing fee. *Id.* § 140.445(b)(1).

rates to determine the lowest negotiated rate for each prescription. *Trial Tr. Vol. II*, 292–94 (Parker); *Trial Tr. Vol. V*, 990 (Hazelwood). Parker testified that MFN was not pursued because it was disliked by both pharmacies and the Agency. *Trial Tr. Vol. II*, 293 (Parker).

Additionally, in 2002 and 2004 the State considered and ultimately rejected the idea of hiring a Pharmacy Benefit Manager ("PBM") to negotiate prices with pharmacies and set reimbursement rates. The 2002 proposal would have significantly reduced reimbursement payments to pharmacies, saving the State an estimated $121 million. DX-0339. However, the proposal was controversial. Pharmacies complained that such a significant reduction – amounting to a reduction of approximately $6 per prescription – was "impossible . . . to live with" and that it would "limit access to Public Aid recipients throughout the state, but primarily in high [M]edicaid areas." DX-0363_0001. In the end, Medicaid rejected the 2002 PBM proposal, and instead increased the AWP-discount from 20% to 25%. Similarly, in 2004, Illinois Medicaid developed a plan to save an estimated $100 million using PBM rates. DX-0449_0002. That plan was rejected in exchange for pharmacy industry support for a discount card program for eligible senior citizens and disabled persons to purchase prescription drugs. The Agency concurrently eliminated co-payments on generic drugs in order to incentivize generic use, which added $8 million to the State budget. The State claims that it expected to recoup this amount and more in the long run by increasing generic use. *Trial Tr. Vol. II*, 432 (Parker). Teva contends that the senior discount card program was promoted by Governor Blagojevich, and that the Agency fell victim to a Blagojevich campaign promise by letting the Governor use significant savings that Illinois Medicaid had budgeted as a bargaining chip for a campaign promise unrelated to Medicaid.

II. Other Components of Illinois Medicaid's Reimbursement Formula

During the relevant time period, Illinois Medicaid's "lower of" reimbursement formula also included a Federal Upper Limit ("FUL"), a State Maximum Allowable Cost ("MAC"), and for about six months during 2000–2001, Wholesale Acquisition Cost ("WAC") plus a percentage, or "WAC-plus."

Wholesale Acquisition Cost ("WAC")

For about six months during 2000 – 2001, Illinois Medicaid's "lower of" methodology included a component based on published WAC, defined by FDB as the price charged by a manufacturer to a wholesaler. PX-0206 (Official Rulemaking Proposal). Initially, it was believed that the WAC was lower than retailer costs, and therefore Illinois Medicaid determined that the WAC figure would have to be marked up by a percentage, just as AWP was reduced by a percentage. A "WAC-plus" component had also been considered during the 1995 budget process, but Illinois Medicaid ultimately entered into an agreement with lobbyists for Illinois pharmacies that it would continue to use an AWP-minus formula, though with an increased discount for generic drugs (from 10 to 12 percent). DX-0086.[4]

[4] One would expect a generic drug to be cheaper than the same brand drug. But the evidence showed that generic AWPs were consistently more inflated than brand AWPs, leading to a greater AWP discount for generics.

Adding a WAC-plus component to the reimbursement methodology in 2000 was yet another attempt "to ensure that the Department uses the most accurate and appropriate information for identifying the most current price generally and currently paid by providers for a drug." PX-0206. Effective December 15, 2000 through June 30, 2001, Illinois Medicaid adopted, on an emergency basis, an amendment to § 140.445(b)(1), by including "AWP-12% or WAC+12%, whichever was lower" in the reimbursement methodology. However, the published WACs turned out to be just as inaccurate as AWPs; they did not include discounts and rebates that generic manufacturers offered to their customers, and thus were significantly inflated above actual market prices. PX-0184 (2005 memorandum from CMS advising the U.S. Government Accountability Office that WACs were greatly inflated). And although they were inflated, pharmacies complained that reimbursement calculated by the WAC-plus component did not sufficiently cover their acquisition costs. *Trial Tr. Vol. II*, 298–99 (Parker). Like the discounted-AWP component, the WAC-plus component was also problematic due to the lack of a consistent relationship between published WACs and a pharmacy's acquisition cost. *Hogan Dep.*, 126–27. Further, WACs were not available for all drugs in any event, since not all manufacturers sell through wholesalers. PX-1262; *Trial Tr. Vol. II*, 298 (Parker).

Federal Upper Limit ("FUL")

During the relevant time period, the federal regulations also established Federal Upper Limits ("FULs") for certain multiple source drugs. *See* 42 C.F.R. § 447.332. CMS did not establish a FUL for all generic drugs, but if one was available, Illinois Medicaid included the FUL price in its "lower of" reimbursement formula. According to the State, there were often delays in implementing a FUL once a generic drug entered the market. *See Trial Tr. Vol. II*, 299–300 (Parker). This delay was due to the requirement that three suppliers had to market the drug before CMS initiated action in setting a FUL. *Id.*

State Maximum Allowable Cost ("MAC")

The State equivalent of FULs, known as MACs, were essentially non-existent until late 2004. Prior to 2004, the task of setting MACs was assigned to a single Illinois Medicaid staff member, and, unsurprisingly, did not prove successful. *Trial Tr. Vol. II*, 302 (Parker: "we were doing it in house, but I mean, literally, we were practically doing it with one person trying to track down prices"). That changed in 2004 when Illinois Medicaid hired Myers & Stauffer – a company specializing in the development of pricing data for Medicaid programs – to obtain pharmacy invoices, collect and analyze actual cost information, and then set, update and manage MAC prices. The Department projected that "using a vendor to manage MAC pricing could result in savings of between 3 million and 5 million per month." PX-0187 (Procurement Decision Memorandum to issue RPF for MAC vendor). The State soon exceeded the estimated savings, however, and realized more than $75 million in annual savings. *Trial Tr. Vol. II*, 306 (Parker testifying that "we actually exceeded those [estimated savings] fairly quickly" and that it was his belief that "we saved about 75 million from MAC pricing"). Based on its invoice analysis, Myers & Stauffer determined an average acquisition cost for thousands of generic drugs. DX-0527 at 19–34.

To set MACs, Myers & Stauffer (or any other MAC vendor) had to collect a sufficient number of pharmacy invoices and obtain survey responses from both chain and independent pharmacies. PX-0236. Illinois Medicaid faced difficulties in doing this, which arose out of the lack of cooperation from small, independent pharmacies, which were reluctant to produce business records and respond to the vendor's surveys. *Trial Tr. Vol. II*, 313–19 (Parker). Because of this, and because the chain pharmacies had both a larger share of the market and the market power to negotiate lower supply prices, the average drug prices obtained from this effort were skewed towards the lower prices paid by large chain pharmacies.[5]

Illinois Medicaid applied a multiplier of 1.25 to the average invoice prices determined by Myers and Stauffer's surveys. *Trial Tr. Vol. II*, 322–23 (Parker). Parker testified that the 1.25 multiplier was applied to address the skewed data and to ensure that smaller, independent pharmacies (who typically pay higher drug costs) were not harmed. *Trial Tr. Vol. II*, 322–23 (Parker). The multiplier served other purposes as well. One purpose was to satisfy the MAC program's goal of "obtain[ing] savings on multi-source prescription drugs while, at the same time, allowing dispensing pharmacies to maintain an adequate profit margin on the products." DX-0467B (Request for Proposals), at 8. The multiplier was also applied for the purpose of achieving cost coverage objectives, allowing for and recognizing some variation in provider acquisition costs, and allowing for temporary marketplace price fluctuations without the need to adjust the MAC rate. DX-0468_0018 (2004 Bid Submission).

Current Reimbursement Methodology

For various reasons, FDB stopped publishing AWPs in 2012. That made continuing with an AWP-based system not just inherently inaccurate, but pragmatically impossible. In 2012, Illinois Medicaid again adopted WAC as part of its reimbursement methodology. Since July 2012, Illinois Medicaid's formula for the "maximum price" has been the lower of: (1) WAC (without a discount or markup); (b) FUL, if one exists; or (c) MAC, if one exists. *See* 89 Ill. Admin. Code 140.44. In part through evidence obtained in this litigation, the Agency has concluded that WAC is a reasonally good estimate of costs for brand drugs. *Trial Tr. Vol I*, 211–12 (Parker). The State contends, however, that WAC continues to be problematic as an estimate of generic drugs' acquisition costs. (For its part, Teva contends that the 2012 formula is another nod to pharmacies, arguing that even in the face of the State's budget crisis, pharmacies are still allowed to keep the difference between a drug's WAC price and the actual cost. It is perhaps ironic that Teva thus disavows the current form of the spread Teva itself marketed during the AWP years.)

III. The State's Argument

According to the State, Teva knew that the false AWPs it reported to FDB would be published and that Illinois Medicaid would use the published AWPs to determine the reimbursement amount for Teva's drugs. The State argues that increased reimbursement payments by Medicaid programs were in fact the intended consequence of Teva reporting

[5] This was potentially anticompetitive, because it had the potential to drive smaller pharmacies out of business. At various times, both pharmacy lobbyists and Illinois legislators expressed a desire to protect smaller pharmacies, especially in geographic areas not well served by the large chains.

inflated AWPs. This is evidenced, for example, by Teva's practice of using inflated AWPs to induce customers to purchase their products, in what is referred to as "marketing the spread." Further, according to the State, Teva had reliable information about the real prices that retailers paid because it was directly involved in the price negotiations between itself and the pharmacies for the sale of its drugs, and because it maintained internal databases through which it tracked the prices at which its drugs were sold.

The State also presented evidence that both federal and state government representatives warned Teva, starting in 2000, that its inflated AWPs were unacceptable, but Teva disregarded these warnings.[6] Further, in 2004, Congress for the first time devoted a hearing exclusively to the problems of AWP and Medicaid. PX-1187 (December 7, 2004 House Committee Hearing). The State asserts that Teva nevertheless continued to report and publish inflated AWPs through the end of the damages period, until FDB finally stopped publishing AWPs in 2012.

The State argues that Teva's arguments – which focus on the State's actions and inactions – are misdirections, and attempts to avoid the contribution of Teva's own misconduct to inflated reimbursements. According to the State, by reporting false AWPs, Teva and other manufacturers corrupted the reimbursement system, deprived the State of the information it needed, and put the State in the untenable position of being forced to guess at appropriate discounts off the false reported prices.

The State further argues that, contrary to Teva's assertions, Illinois Medicaid's intent was always to reimburse ingredient cost at its best estimate of actual market prices. It contends that during the damages period, Illinois Medicaid made various efforts to get more accurate and authoritative information about real acquisition costs for drugs; these efforts led to considerable success, albeit often less than the State sought. According to the State, Teva is attempting to inappropriately shift the burden to the State to accommodate Teva's misconduct by arguing that despite Teva's continuing publication of inaccurate AWPs, the State's own conscious decisions – such as the alleged failure to adopt alternatives to AWP – were the cause of overpayments. Likewise, the State argues that the impact of lobbyists and politics on Illinois Medicaid's reimbursement decisions does not defeat causation. The State argues that had Teva reported true AWPs, the State would have reimbursed pharmacies less for Teva drugs than it actually did during the damages period, and therefore the Court should find Teva liable for its conduct.

[6] According to the State, Teva received warnings by way of the following: a 2000 Civil Investigative Demand ("CID") from the Texas Attorney General's office; knowledge of the Texas Attorney General's office lawsuit against three generic manufacturers for reporting false AWPs, filed in 2000; a September 2000 letter introduced into the Congressional Record from U.S. Representative Fortney Pete Stark of California to the president of the Pharmaceutical Research and Manufacturers of America ("PhRMA") which laid out evidence that some manufacturers were knowingly reporting inflated AWPs and WACs; the OIG's Compliance Program Guidance for Pharmaceutical Manufacturers, initially released in draft form in October 2002, which observed that manufacturers have a legal duty to avoid submitting false AWPs; and a 2003 letter from Representative Greenwood and the House Energy and Commerce Committee Chairman, Rep. Tauzin, sent to 26 drug companies including Teva, addressing the discrepancies in AWP and requesting they provide certain records relating to AWP and WAC. (State Br. at 50–55.)

Teva's Argument

Teva contends that the State's own conscious choices, and not false AWPs, caused the overpayments that the State now seeks to recover as damages. According to Teva, Illinois Medicaid worked purposeful overpayments into its reimbursement program that would not have been prevented even if Teva had reported accurate AWPs. The State's "conscious decisions," Teva asserts, date back to 1988 when Illinois Medicaid ended AAC reimbursement and adopted the discounted-AWP approach, though even then the AWP methodology was widely discredited and controversial. According to Teva, Medicaid knew that even after discounting from AWP, its discounted-AWP formula would yield reimbursements greater than a drug's actual cost. Despite this knowledge, rather than adjust the formula to require pharmacies to remit the overpayments to the State, Illinois made a conscious decision to let the pharmacies keep the overpayments.

Moreover, Teva argues that it was pharmacy groups – and not manufacturers like Teva – which were the driving force behind the changes (or rejection of changes) Illinois Medicaid made to reimbursement, and that State leaders were unwilling to support initiatives that were against the pharmacists' interests. For example, prior to adopting the discounted AWP methodology, Illinois Medicaid conferred with IPhA and the Department's Drug Advisory Committee, which both recommended that Illinois Medicaid abolish the AAC formula and "instead, set a discount off of AWP and let the pharmacies keep the difference if they can find it." Their support was conditioned on allowing the pharmacies to keep the difference. Thus, Teva contends that although the State now claims that it always wanted to reimburse at actual acquisition cost, in reality it rejected that option and instead adopted the pharmacy-backed discounted-AWP approach.

Teva thus asserts that Illinois Medicaid knew early on that using discounted-AWP was unreliable, but decided to use that system anyway. Teva points out that throughout the damages period, Illinois Medicaid personnel, complaining of (and hence aware of) the inaccuracies of the discounted-AWP formula, proposed alternatives – but, Teva argues, each such proposal was rejected at the behest of pharmacies that would have lost profits from the proposals and lobbied against them. Therefore, Teva argues that the State would have overpaid even without AWPs because of the pharmacy industry's considerable political influence on the State's decisions. According to Teva, this is evidenced, first, by Illinois Medicaid's short-lived addition of the "WAC-plus" component into its reimbursement methodology in 2000 – 2001. The "WAC-plus" component had also been considered during the 1995 budget process, but in both 1995 and 2001, the Governor refused to support the proposals. As a result, Illinois Medicaid ultimately entered into agreements with lobbyists for Illinois pharmacies – who profited from discounted-AWP but not from WAC-plus – to continue to use the discounted-AWP formula, albeit with an increased discount for generic drugs. Teva further contends that the PBM proposals in 2002 and 2004, as well as the 1995 proposal to adopt the MFN approach, were viable alternatives to the unreliable AWPs, but – even though these proposals were projected to save the State hundreds of millions of dollars – the State refused to adopt these approaches in the face of pharmacy lobbyists.

By Teva's account, the discounted-AWP formula is itself evidence that the State knew that published AWPs were not actual prices. Teva argues that by adopting the discounted AWP formula, Illinois Medicaid assumed responsibility for deciding what the AWP discounts should

be, how frequently to update them, and on what basis; yet it failed to do so. Moreover, Teva repeatedly argues that the State intentionally agreed to set unduly small AWP discounts and intentionally worked purposeful overpayments into its discounted-AWP formula.

Teva argues that the State worked purposeful overpayments into its MAC program as well. The State chose not to commit adequate resources to its MAC program until 2004, and even then it instructed Myers & Stauffer to add a 25% mark-up to build a pharmacy profit into the reimbursement rate. Teva concludes: "There can be no false claim when the State's reimbursement system worked exactly as the State intended and pharmacies were reimbursed at amounts the State intended and agreed to pay." *Teva Br.* at 54.

Discussion

Following the trial, the parties submitted very lengthy post-trial briefs in lieu of closing arguments. Subsequently, per the Court's request, the parties submitted briefs limited to the issue of causation. By limiting the second round of briefing to causation, the Court anticipated that it could better assess the merits of Teva's arguments that (1) the State's knowledge that Teva's AWPs were false defeats causation; (2) the State would not have paid true AWPs if they were available; and (3) the actions of the State and the pharmacy lobby were the causes of overpayments such that Teva is not liable. These arguments are in essence attempts to fix the entire responsibility for any AWP-related losses on the State, exempting Teva from any responsibility. The legal framework of the Illinois Whistleblower Reward and Protection Act ("WRPA") is such that causation arguments like these, and indeed causation generally, affects several elements of liability under the Act. It is best to begin, then, with a brief overview.

1. The WRPA

The WRPA provides, in relevant part:

> Any person who . . . knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim . . . is liable to the State for a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages which the State sustains because of the act of that person. A person violating this subsection shall also be liable to the State for the costs of a civil action brought to recover any such penalty or damages.

740 ILCS § 175/3(a). The WRPA is modeled after the federal False Claims Act, ("FCA"), 31 U.S.C. § 3729, and therefore, the parties look to federal caselaw under the FCA in analyzing this claim. *See People ex rel. Levenstein v. Salafsky*, 338 Ill.App.3d 936, 946, 948 (2d Dist. 2003) (relying on federal FCA law and "see[ing] no reason to read the [WRPA] more narrowly" than the federal statute); *United States ex rel. Humphrey v. Franklin-Williamson Human Servs., Inc.*, 189 F.Supp.2d 862, 867 (S.D. Ill. 2002) (explaining that the WRPA is "virtually identical in all relevant aspects to the FCA," thereby allowing the court "to look to FCA case law for guidance").

To establish liability under the relevant provisions of the WRPA, the State must show that: (1) the defendant made, used, or caused to be made or used a record or statement to get the government to pay money; (2) the record or statement was false or fraudulent; (3) the defendant knew the record or statement was false or fraudulent. *United State ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1018 (7th Cir. 1999) (construing the comparable provision in the FCA). This Court has already held that, despite the State's knowledge that AWPs were not accurate, submitting false AWPs constitutes a "false claim" under the WRPA.

During the damages period, some courts judicially articulated a fourth requirement: that the false statement or record was "material." The requirement of materiality was perceived to be necessary, albeit (at the time) implicit, in order to avoid imposing liability under the FCA for falsehoods which actually made no discernible difference. The Seventh Circuit, for example, defined "material" as having a "natural tendency to influence, or being capable of influencing, the decision of the decision making body to which it was addressed." *United States v. Rogan*, 517 F.3d 449, 452 (7th Cir. 2008), citing *Neder v. United States*, 527 U.S. 1, 16 (1999). The consensus was that this made sense. Accordingly, a materiality requirement was explicitly included in the 2009 FCA amendments after DOJ recommended it, stating that it was consistent with a majority of courts interpreting materiality in the FCA context. *See* JOHN T. BOESE, CIVIL FALSE CLAIMS AND QUI TAM ACTIONS § 2.04 (4th ed.). In 2010, the materiality requirement was also codified in the WRPA. Both statutes define materiality as the Seventh Circuit did in *Rogan, supra*: "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C.A. § 3729(b)(4); 740 ILCS § 175/3(b)(4). The amendments were not retroactive, however, giving rise to some dispute as to whether materiality was a necessary element before it was codified in the FCA and WRPA. *Compare Rogan*, 517 F.3d at 452 (requiring materiality prior to FCA amendment) *with United States ex rel. Kennedy v. Aventis Pharms., Inc.*, 610 F. Supp. 2d 938, 944 (N.D. Ill. 2009) (prior to amendment, "it [was] not clear that a materiality requirement, as such, exist[ed] for all types of FCA claims").

The materiality test "focuses on the *potential* effect of the false statement when it is made, not on the actual effect of the false statement when it is discovered." *United States ex rel. A+ Homecare Inc. v. Medshares Mgmt. Group, Inc.*, 400 F.3d 428, 445 (6th Cir. 2005) (emphasis added). Causation, on the other hand, focuses on the actual effect, *i.e.*, whether the false statement actually caused the government's loss. Usually, though not always, causation implies some element of reliance.[7] The underlying idea is to "ensure that the government is actually harmed before attaching FCA liability." The distinction between materiality, reliance and causation is subtle, and they often overlap. *See* BOESE, § 2.04 ("The issues of materiality, reliance, and causation were obscured unnecessarily by the courts, but they became necessary elements of FCA liability in order to keep every violation of federal law or regulation from bankrupting those who deal with the government as contractors, grantees, or beneficiaries.").

[7] Which may not be concurrent with the particular loss. Here, for example, there was initial reliance on AWP, leading to the adoption of AWP-based reimbursement systems. When it became clear that AWP was not accurate, changing those systems was not easy, perhaps not even pragmatically possible. That led to losses even after it had become apparent that AWP was a problem rather than a solution. In somewhat the same vein, albeit a different context, consider a municipality which designs and builds its storm drainage system in compliance with the then-prevailing "hundred year flood" engineering standard – only to learn, years later and after considerable real estate development, that the standard was inaccurate and has been revised. Rebuilding the storm drainage system would cost much more than installing it to begin with, and may not be feasible at all.

Teva's proposed causation standard, however, analytically conflates these three issues. Teva contends that the causation question is: "had the State known that AWPs were false, would it have paid the pharmacy claims that it did under its discounted-AWP formula?" *Teva Resp.* at 38. That is breathtaking. It would effectively reward Teva (and other manufacturers) for their success in embedding AWP so deeply in reimbursement systems as to make it difficult to correct for inaccuracy. It should be obvious that applying this truncated approach to this case would leave out most of the analysis and most of the history. Teva relies on *United States v. Rogan*, 459 F. Supp. 2d 692 (N.D. Ill. 2006), *aff'd*, 517 F.3d 449 (7th Cir. 2008), for its proposition that "the government must prove that it would not have paid that claim for reimbursement had it known about the underlying violation of the law." *Id.* at 717. Teva's reliance on *Rogan* in this regard is misplaced, however, for three reasons. First, in the context of this case, that *Rogan* formulation, as thus framed by Teva, omits important considerations. Second, the *Rogan* discussion was really about *materiality*, not causation. Third, Teva's version of the *Rogan* materiality standard – though favorable to Teva – departs from accuracy. Though Teva quotes the *Rogan* District Court's wording, *see* 459 F.Supp.2d at 717, on appeal the Seventh Circuit preferred a different and broader formulation: a violation is material if it has "a natural tendency to influence, or [is] capable of influencing, the decision of the decision making body to which it was addressed." It is that materiality standard which is now codified in both the federal and State statutes. *United States v. Rogan*, 517 F.3d 449, 452 (7th Cir. 2008), citing *Neder v. United States*, 527 U.S. 1, 16 (1999). At the Seventh Circuit level, even *Rogan* disagrees with Teva's approach. *See* 517 F.3d at 452:

> ... [L]laws against fraud protect the gullible and the careless--perhaps *especially* the gullible and the careless--and could not serve that function if proof of materiality depended on establishing that the recipient of the statement would have protected his own interests. [Citation omitted.] The United States is entitled to guard the public fisc against schemes designed to take advantage of overworked, harried, or inattentive disbursing officers; the False Claims Act does this by insisting that persons who send bills to the Treasury tell the truth. As Justice Holmes put it, "[m]en must turn square corners when they deal with the Government." [Citation omitted.]

Therefore, the Court does not find Teva's formulation of a causation standard to be helpful. The statutes themselves are not entirely clear, however. The FCA does not provide a definition of its causation requirement, and therefore courts have developed their own causation standards, largely based on common law tort principles. Some courts have applied a "substantial factor" test to determine a defendant's responsibility under the FCA. *See United States ex rel. Schmidt v. Zimmer*, 386 F.3d 235, 245 (3d Dist. 2004); *United States ex rel. Franklin v. Parke-Davis*, 2003 U.S. Dist. LEXIS 15754, *12–*13 (D. Mass. Aug. 22, 2003). Courts applying this test ask whether the defendant's conduct was a substantial factor in bringing about the plaintiff's harm. *Id. See also* RESTATEMENT (2D) OF TORTS § 431 (1965). Applying this test here, we would ask whether Teva's false AWPs – or perhaps false AWPs overall, knowingly contributed to by Teva – were a substantial factor in causing the State to overpay for Teva's drugs.

Other courts use a "but for" test of causation in FCA cases, asking whether the harm would have occurred "but for" defendant's conduct. The Seventh Circuit generally uses this test.

See, e.g. United States v. First Nat'l Bank, 957 F.2d 1362, 1374 (7th Cir. 1992); *United States v. Rogan, supra*, 517 F.3d at 452. *But see United States v. King-Vassel*, 728 F.3d 707, 714 (7th Cir. 2013) (applying the substantial factor test of causation in FCA claim). The proper question under this test is whether the State would have overpaid on Teva's drugs but for Teva reporting false AWPs. As the State asserts in its post-trial brief, in this context, whatever subtle difference may exist between the "but for" test and "substantial factor" test is academic.

In addition, courts consider foreseeability: was it foreseeable that the defendants' conduct would result in the submission of the false claim and the government's loss? *United States v. King-Vassel*, 728 F.3d 707, 714 (7th Cir. 2013); *United States ex rel. Franklin v. Parke-Davis*, 2003 U.S. Dist. LEXIS 15754, *4 (D. Mass. Aug. 22, 2003). Generally, reasonably foreseeable intervening forces will not break the chain of causation. *King-Vassel*, 728 F.3d at 714 ("An action that breaks the chain of causation would relieve a defendant of liability. . . . [h]owever, reasonably foreseeable intervening forces will not break the chain of proximate causation."). In this regard, *King-Vassel*, quoting RESTATEMENT (2D) OF TORTS § 443 (1965), makes a further point of importance to this case:

> "The intervention of a force which is a normal consequence of a situation created by the actor's negligent conduct is not a superseding cause of harm which such conduct has been a substantial factor in bringing about."

A fortiori, that same principle applies if the actor's conduct in creating the situation was not just negligent, but intentional, or even knowing.

Though the issue presently before the Court is causation rather than damages, it is worth noting that the WRPA, mirroring the FCA, distinguishes between "penalties" and "actual damages" in a way which may bear somewhat on causation. Courts are divided as to the necessity of actual damages as an element of the FCA, but a majority, including the Seventh Circuit, have held actual damages are not necessary. *See Luckey v. Baxter Healthcare Corp.*, 2 F. Supp.2d 1034, 1044 (N.D. Ill. 1998), *aff'd*, 183 F.3d 730 (7th Cir. 1999) ("The Seventh Circuit appears not to require that the government suffer damage from the false claim."). *But see* BOESE, *supra*, at § 2.01[A] ("Expanding the scope of liability under [the FCA] to actions that have no impact on the Federal treasury would seem to divorce the Civil False Claims Act from its essential purpose – recovering monies wrongfully taken from the Federal treasury.").

The WRPA, however, seemingly ties penalties to actual damages. A person who violates the WRPA is liable to the State for civil penalties, "plus 3 times the amount of damages which the State sustains *because of* the act of that person." 740 ILCS 175/3(a)(1)(G) (emphasis added). As to damages, the "because of" language suggests a necessary causal link between the false claim and some actual injury suffered; the measure of actual damages, therefore, would be the difference between what the government actually paid and what it should have paid but for the falsity. But the Act covers penalties before addressing damages, implying that the former could be awarded even in the absence of the latter. Since it is not seriously disputed that the State paid more for Medicaid reimbursements under its AWP-driven system than would have occurred if the payments tracked actual cost, the point may be somewhat academic at this stage, however.

II. Causation

This brings us to the core of the parties' causation arguments. Causation is a necessary, but not alone sufficient, element of the State's damage claims – and even of Teva's arguments in opposition.

A. The State's Knowledge of the False AWPs

Government knowledge could conceivably be relevant to several elements of the FCA. The strength of the government knowledge defense "rests upon the depth of the government's knowledge of the facts underlying the allegedly false claims and the degree to which the government invites the claim." *United States ex rel. Burlbaw v. Orenduff*, 548 F.3d 931, 952 (10th Cir. 2008). This Court has already rejected Teva's argument that the State's knowledge of AWPs' inaccuracy, standing alone, outright negates a finding of "falsity," a requirement under the WPCA. *See* 4/2/13 Order (granting Plaintiff summary judgment pursuant to 735 ILCS 5/2-1005(d) on falsity requirement). This Court reasoned, in part, that under the circumstances of this case, in order to negate WPCA falsity the State must not only know that the claim is in some respect false (*i.e.*, that AWPs are not *per se* accurate), but must also possess knowledge of the actual true facts of the claim (*i.e.*, what the true cost is, for reimbursement purposes).

Courts have also discussed government knowledge as preventing the defendant from forming the requisite state of mind (*i.e.* knowing that the claim is false or fraudulent). That is perhaps possible. But it is not an easy argument to make. Applying the same reasoning as this Court did to its earlier falsity ruling, courts that have found that government knowledge can prevent the defendant from "knowingly" submitting a false claim have only done so where the government's knowledge as to the *true facts* is extensive. *See, e.g., Massachusetts v. Mylan Labs.*, 608 F. Supp. 2d 127, 149 (D. Mass. 2008); *Shaw v. AAA Eng'g & Drafting, Inc.*, 213 F.3d 519, 534 (10th Cir. 2000) (noting that where the government's knowledge or cooperation is "so extensive" it could prevent defendant from forming the requisite state of mind); *United States ex rel. Butler v. Hughes Helicopters, Inc.*, 71 F.3d 321, 327 (9th Cir. 1995) (where the defendant and the government "so completely cooperated and shared all information," claims could not be knowingly false); *United States ex rel. Becker v. Westinghouse Savannah River Co.*, 305 F.3d 284, 289 (4th Cir. 2002) (noting that government's "*full knowledge of the material facts* underlying [a defendant's representations] . . . negates any knowledge that [the defendant] had regarding the truth or falsity of those representations").

Teva contends that government knowledge here defeats causation as well. It is not so simple. In the circumstances of this case, Teva's approach has an uncomfortable resemblance to an argument that one who is known to lie often cannot commit fraud. That argument does not easily fit here. For one thing, the State's persistent efforts to bring its flawed AWP data into conformity with actual costs shows the opposite of "full knowledge" of those costs. As with falsity and the requisite intent, however, courts have also held that the strength of the government knowledge defense as to causation rests on the extent of the government's knowledge of the truth. In *Wisconsin v. Abbott Labs., Inc.*, 829 N.W.2d 753, 762 (Wis. Ct. App. 2013), for example, the court affirmed the jury's finding of liability against the defendant-drug manufacturer under Wisconsin's consumer protection and Medicaid fraud statutes, even though

the government knew that the published AWPs were inflated. With respect to causation, the court held that even though the government knew that the AWPs were inflated, "there [was] nothing unreasonable about the legislature's reliance on AWP," where there was sufficient evidence that the State did not know the extent of the inflation and that the State acted on its knowledge that the AWPs were inflated by discounting them by a certain percentage in the reimbursement formula. Similarly, in *In re Pharm. Average Wholesale Price Litig.*, 491 F. Supp. 2d 20, 96 n.70 (D. Mass. 2007), *aff'd* 582 F.3d 156 (1st Cir. 2009), the court rejected the argument that the government's decision to continue using AWPs while knowing they were false defeated causation. The court found that the defendant-manufacturers caused false AWPs to be published, "knowing that the government did not understand the extent of the mega-spreads between published prices and true average provider acquisition costs." *Id.* at 94. "If defendants had reported true AWPs, plaintiffs would have paid less," and accordingly, the court held that causation was satisfied. *Id.* at 96 n.70.

Here, too, the State knew the reported AWPs were false and inflated, and applied the discount percentage to account for that inflation. The evidence shows that the State knew the discount was not a complete cure – but also that it was, for much of the period at issue, the best the State could come up with as a practical matter. As IDPA Deputy Director Ann Patla explained, the discounts "are applied in an attempt to address the fact that the published average wholesale price information is known to be inflated by an *unverifiable* amount." PX-0220 (emphasis added). The State acknowledges that the discount rates were only its "best guess." *Trial Tr. Vol. II*, 257–59 (Parker). Parker testified on behalf of the State that various aspects contributed to the difficulties, including the lack of a consistent, predictable relationship between a drug's published AWP and the true market AWP (*i.e.* the spread). For example, some generic drugs could be acquired by pharmacies for as low as 80 or 90 percent below the published AWP, whereas other generic drugs could be acquired for only 20 or 25 percent less than the published AWP. *Id.* at 258–59. Adding to this difficulty is that the spreads changed over time, as did the "average" wholesale price of a drug over time. *Id.* at 259 ("[E]ven in the history of the single [generic] drug . . . that price changed . . . as competition comes in the market. So in the beginning, if there's only one generic on the market, the real price is going to be a lot closer to AWP than it is when there's six companies making the same drugs, and then it'll go way down, and so the spread is different. . . . in the course of one drug, that spread changes all the time."). In other words, the State's knowledge that the published AWPs were false does not show that the State knew – or, pragmatically, *could* know or apply – the truth; rather, the extent of inflation was in fact unverifiable, and thus the discount rates were difficult to establish.

Moreover, this was exacerbated both by the staggering number of drugs and transactions which had to be accounted for, and also (as even Teva officials conceded) by the fact that it was impossible to predict a provider's true AWP based on its published AWP. *DeNicola Dep.*, 186–87; *Bloom Dep.*, 156–57. Put differently, Teva knew that the government did not understand the extent of the spread between published AWPs and true AWPs, and Teva itself consciously capitalized on that by "marketing the spread" to its customers. As noted earlier, Teva monitored its competitors' AWPs to make sure its AWPs were "competitive" (a very different word, in this context, than "accurate"), and openly promoted the spread to its customers when selling its products. *Marth Dep.*, 219 (Teva's CEO testifying that "we would raise price occasionally to meet competition); *see* PX-1038 (September 1998 letter from Robert Shanks to marketing firm,

indicating that Ivax, which was later acquired by Teva, hired the firm to call pharmacies and point out that their generic drug offered a greater AWP-based reimbursement spread than its brand equivalent); PX-0826 (letter from Teva providing pharmacy with the AWP, in addition to actual selling price, to allow it to calculate the spread); PX-0561 (same).

The Court finds the cases relied on by Teva to be inapposite here. Neither *AstraZeneca LP v. Alabama*, 41 So. 3d 15 (Ala. 2009) nor *Sandoz, Inc. v. Alabama*, 100 So. 3d 517 (Ala. 2012) involved FCA claims, but rather involved common law fraud claims under which those courts held that the plaintiff must show it reasonably relied on the false misrepresentations. Where reasonable reliance was required, knowledge defeated causation because "the allegedly deceived party must have believed *[the statement] to be true*" and "if it appears that he was in fact *so skeptical as to its truth that he placed no confidence in it*, it cannot be viewed as a substantial cause of his conduct." *AstraZeneca, supra*, at 28. In *Sandoz Inc. v. Kentucky*, 405 S.W.3d 506 (Ky. Ct. App. 2012), also relied on by Teva, the Kentucky Court of Appeals reversed two jury verdicts finding drug manufacturers liable under the Kentucky Medicaid Fraud Statute and the Kentucky Consumer Protection Act for allegedly misreporting AWPs, on the ground that the state failed to show that it would have paid less if the defendants' AWPs had not been "false, fraudulent, misleading, or unfair." 405 S.W.3d at 510. The Kentucky court seemed to assume, without any explicit legal discussion, that a common-law reliance requirement applied under those statutes, in concluding that by knowing that the AWPs were inflated, the state "could not have *relied upon them as accurate figures*." *Id.* This Court has already declined to adopt that view. Here, the State was not required to show that it relied on the AWPs as "accurate figures." It didn't. Instead – having been led to an AWP-based regime years before AWP falsity became widely known – the State used ("relied upon," in a practical sense) AWPs as data inflated by an unverifiable amount, but nevertheless the best inputs realistically available at the time. Indeed, Teva's own AWP policy statement acknowledged that most Medicaid agencies and commercial payers used AWP "because there was no other publicly available price reference for retail sales." *See* PX-0834. In addition to the evidence showing the State did not know with any precision (or practical useability) the actual extent of inflation, the Court finds that it was not unreasonable for the State to rely on AWPs as a starting point where there was no other accurate metric pragmatically available. Although Teva contends that in fact there were other viable alternatives, discussed at greater length below, those arguments are unpersuasive insofar as they attempt to shift the burden to the State to find ways to neutralize Teva's wrongful conduct.

As such, the Court rejects Teva's argument that the State's knowledge that Teva's AWPs were false, in and of itself, defeats causation.

B. Whether the State Would Have Used Accurate AWPs

As discussed above, the pertinent causation question here is whether Teva's false AWPs were a substantial factor in causing the State to overpay for Teva's drugs, or, stated a different way, whether the State would have overpaid on Teva's drugs but for Teva reporting false AWPs. The State argues that it would have used accurate AWPs had Teva and other manufacturers reported them. There is much evidence that the State's Medicaid staff persistently complained about what they perceived as the forced inaccuracy of their reimbursement schedules, due to the inaccuracy (to a pragmatically unknowable degree) of the AWP data they got from FDB, and on

which their reimbursement system was built. The picture of complacent disregard Teva paints is not borne out by the evidence. The July 2000 Amendment, *see* pages 5-6 *supra*, is an example of the State's efforts to reimburse ingredient cost at actual market prices. After DOJ published the "true" AWPs of 50 drugs, Illinois Medicaid amended its regulation, effective July 1, 2000, to reimburse drugs at their true market AWP where available. PX-096.

Teva contends that the July 2000 Amendment does not support the State's claim, but instead is evidence that the State intended to pay more than true AWP, since the State continued to reimburse at discounted-AWP for drugs other than the 50 drugs with published true AWPs. Teva's assertion is unsupported by the evidence and borders on illogical. *When the State had true AWPs,* it used them. The DOJ data did not cover all AWPs. There was, then, no basis for the State to change its system with respect to AWPs not covered by the DOJ "true" data. The result was that regarding the DOJ data – that is, in the area where both true and inaccurate AWPs were available – the State clearly opted for the true data. There is no reason not to take the State's actions at face value.

Aside from the July 2000 Amendment, Teva contends that various other actions by the State evidence the State's intent to reimburse at inflated rates.[8] First, Teva argues that the State intentionally set low discounts to AWP. Teva asserts that the State's AWP-10% formula, which remained in place for generic drugs from 1989 to 1995, was well below the nearly 16% spread between AWP and actual acquisition cost that OIG had reported four years earlier. DX-0015 at 9. This drastically oversimplifies, and thus misapplies, the OIG data. Although the 1984 OIG study found that pharmacy drug purchases *averaged* AWP-16%, Teva ignores the OIG's findings that "[t]hese drug purchases ranged from as little as .23 percent below AWP to as much as 42 percent below AWP." DX-0015_0009. The State explains that given such variability, it would have substantially *under*paid on many drugs by using a reimbursement rate of AWP-16%, and accordingly, Illinois Medicaid set a lower discount percentage. This is consistent with Parker's testimony that Illinois Medicaid was cautious about establishing a discount percentage that would cause pharmacies to lose money when dispensing particular drugs, fearing that pharmacies might choose not to stock or sell the drugs, or might sell more expensive brand products instead. *Trial Tr. Vol. II*, 257–59 (Parker).

Teva also contends that the AWP-10% formula was below the federal government's alleged "minimally acceptable" discount of 10.5%. *Teva Br.* at 16. This contention, however, is also misleading. Although the HCFA attempted briefly to enforce a uniform requirement that AWP be reduced by 10.5% in 1985, HCFA quickly rescinded that requirement in response to opposition by the National Association of Chain Drug Stores, the National Association of Retail Druggists, and others. *Louisiana v. U.S. Dep't of Health & Human Servs.*, 905 F.2d 877, 880 (5th Cir. 1990). "The HCFA wrote to its regional offices stating that its policy was that the states were free to choose any pricing method that would result in the most accurate reflection of actual

[8] In the causation context, this – and several of Teva's other arguments regarding the State's supposed overpayments – may be a bit of a red herring. Even if the State "padded" reimbursements, that does not mean it did not overpay due to Teva's misstatement of AWPs. Begin with an AWP number. Then apply a 10% discount, resulting in AWP-10%. Suppose the State then "padded" the resulting number by, say, $10.00. But suppose the true AWP number should have been AWP-15%. Suppose further that the State would have added the same $10.00 to the true number. The State is still damaged by the difference between AWP-10% and AWP-15%. Thus, Teva's pointing to the $10.00 may affect the calculation of damages, but it does not affect causation.

cost, and that there was no specific federal requirement." *Id.* (discussing the HCFA's abandonment of a proposed uniform AWP-10.5% requirement). Indeed, Illinois' AWP-10% formula must have been acceptable to HCFA since it approved Illinois' reimbursement formula as well as numerous other states' reimbursement formulas in the range of AWP-10% during the 1990s. *See* PX-0107 (1991 report showing 29 states with reimbursement rates between AWP-9% and AWP-11%); PX-0485 (1995 report showing 30 states with reimbursement rates between AWP-9% and AWP-11%).

Finally, Teva argues that the pharmacy lobby repeatedly used its political clout to block or modify Illinois Medicaid's proposals to reduce reimbursement rates. In Teva's view, State officials were in thrall to the wishes of the pharmacy lobby as they were motivated by a desire to protect pharmacy revenue and would have rejected proposals to reimburse at a lower, more accurate cost. Teva therefore contends that even if it had reported accurate AWPs, the political and pharmacy opposition would have prevented Illinois Medicaid from using them.

The State does not deny that the pharmacy lobby had substantial political power in Illinois legislature during the damages period. From time to time, the pharmacy lobby was able to use that power to lessen proposed reductions in reimbursement. By definition, when a Governor rejected proposals to reduce pharmacy reimbursement, he was in some sense acting to "preserve pharmacy revenue." But as the State accurately asserts, a desire to protect pharmacy revenue is not synonymous with an intent to overpay on reimbursement costs. In 1995, for example, Governor Edgar rejected the WAC-plus proposal but ultimately increased the AWP discount rate from AWP-10% to AWP-12%. *See* DX-0086. The situation played out similarly in 2001. In late 2000, Governor Ryan proposed to cut $65 million over an 18-month period through several reimbursement initiatives that included WAC-plus. *See* DX-0210. However, when WACs turned out to be problematic, and pharmacies complained that the WAC-plus formula did not cover their acquisition costs, the Governor elected to discontinue using the WAC-plus formula after the six-month period expired. In its place, Illinois Medicaid nearly doubled its AWP discount for generics from AWP-12% to AWP-20%, and that discount was against increased to AWP-25% a year later. *See* DX-0305. Although the Governors rejected the proposed WAC-plus component in 1995 and 2001, both budget sessions ended in lowering the total pharmacy revenue. Thus, the Governors' desires to "protect pharmacy revenue" do not indicate a desire to overpay pharmacies, since the Governor was in fact cutting total pharmacy revenue (though by less than Illinois Medicaid would have liked), and are not indicative of how the State would have regulated reimbursement had true AWPs been available.

In any event, as previously noted (*see* page 19 n.8 *supra*), Teva's arguments about the pharmacy lobby, though not without some force, pertain more to damages than to causation. Even if we assume that the State would have made an effort to "protect pharmacy revenue," the inaccurate AWP data meant that the State did not really know what that "revenue" actually was. Had the State's efforts to "preserve pharmacy revenue" begun from an accurate base, the State's total cost would have been lower. Compounding that problem, as previously noted, the State's uncertainty about the accuracy of the "base" (*i.e.,* the AWP numbers with which its reimbursement system began) led the State to adopt lower AWP discounts than it would have preferred, in order not to impose a below-cost reimbursement formula on pharmacies. Had true AWP numbers been available across the board, that caution would not have been necessary.

The State argues that viewed in its totality, the causation evidence does not support Teva's conclusion that politics would have blocked the State from using true AWPs if they were readily available. The Court agrees. When the State did have access to actual market AWPs, Illinois amended its regulations to use those AWPs to reimburse pharmacies. That was the July 2000 Amendment. The July 2000 Amendment, and the other persistent efforts of Illinois Medicaid to arrive at a more accurate reimbursement system, is strong evidence that Illinois Medicaid would have used accurate AWPs had Teva and other manufacturers reported them. Moreover, Illinois Medicaid officials Parker and Hazelwood both testified credibly that if the Department had received true AWPs from FDB, it would have used them. *Trial Tr. Vol. I*, 208–209 (Parker); *Trial Tr. Vol. V*, 986–87 (Hazelwood). The State has shown that throughout the damages period, Illinois Medicaid made ongoing efforts to get more accurate and authoritative information about real acquisition costs for drugs. Those efforts led to considerable success, albeit often less than the State sought. Again: that the State may have built in some "padding" to protect pharmacies may warrant a close look at damages. But it does not mean that the "padding" was the *only* overpayment. The evidence shows that the false AWPs also resulted in overpayments, independent of any "padding."

These issues are further examined below.

C. Whether the Actions of the State and the Pharmacy Lobby Caused Overpayments

The crux of Teva's causation argument is that the State's own conscious choices, and not the false AWPs, caused the State's overpayments of reimbursement costs. Teva identifies various alternatives to AWP that the State failed to adopt, including: abandoning AAC and adopting discounted-AWP in 1988; failing to adopt a WAC-plus alternative in 1995 and 2000; failing to commit adequate resources to its MAC pricing until 2004; rejecting proposals to adopt Most Favored Nation ("MFN") pricing and to hire a Pharmacy Benefit Manager ("PBM").

The State contends that the evidence shows that it acted reasonably in making the decisions for which Teva criticizes it. The State also argues contends that in the context of a hugely complex State government, it is a dangerous oversimplification to say that the "State" made a "choice," because no matter what the outcome of a given State process is, it can always be described after-the-fact as a "choice." *State Resp.* at 14. The Court agrees that, in the real world, the outcome is the result of a complicated political process involving inputs from multiple State actors (*e.g.*, the governor, the governor's staff, legislators, Illinois Medicaid officials) who may have different views about what took place during, and what emerged from, that political process. One must keep this in mind when reviewing the evidence.

Abandoning AAC and Adopting Discounted-AWP

According to Teva, the State's "conscious decisions" date back to 1988 when Illinois Medicaid ended AAC reimbursement and adopted the discounted-AWP approach. Teva argues that AWPs were controversial from their inception because of widespread recognition that they were not actual averages and overstated the amounts pharmacies paid for prescription drugs. Teva points to various documents issued by the federal government in the 1970s and early 1980s warning states that AWPs were not accurate prices. *See, e.g.*, DX-0007 (warning that AWPs

should not be used as the basis for "actual acquisition cost" determinations); DX-0009 (letter from HCFA, warning Illinois Medicaid of the significant spread between AWP and AAC).

It is undisputed that by the late 1980s, the federal government no longer approved the use of *undiscounted* AWPs. DX-0903 (1989 memo warning that "nondiscounted or unmodified AWP is not acceptable"). The same cannot be said for the use of *discounted* AWPs, which were common practice in many States, and which, in Illinois, replaced reimbursement based on the flawed AAC approach. As this Court has noted, the AAC approach was unworkable without complete pharmacy cooperation, since the State could not police the vast number of transactions involved. *See 1/8/14 Hearing Tr.*, 47–48. Teva's own witness, Hazelwood, testified that the flaws in the AAC approach cost the State "hundreds of thousands of dollars a year" in federal audit findings. *Trial Tr. Vol. V*, 831–833 (Hazelwood). Hazelwood further testified that the State's decision to abandon the AAC approach was propelled by its efforts to reimburse pharmacies at the *average* acquisition cost, consistent with the federal requirement that states reimburse at the "estimated" – as opposed to "actual" – acquisition cost, or EAC. *Trial Tr. Vol. V*, 836 (Hazelwood). In light of these facts, Teva's criticism of the State's shifting from AAC to discounted AWP reimbursement rings hollow.

"Keep the Difference" as Part of Discounted AWP

In a recurring theme, Teva sharply criticizes the State for allowing pharmacies to keep the difference between the actual acquisition cost and the reimbursement cost, beginning when the State first adopted the discounted-AWP reimbursement formula and continuing (at least partly due to pharmacy pressure) thereafter. Teva contends that the Agency could have required pharmacies to remit the difference – which Teva treats as overpayments – to the State, but it instead chose to let the pharmacies keep them.[9]

The State, in response, asserts that the EAC approach of the federal regulations was designed to serve the overall goal of setting EAC at an average *real* acquisition cost, while not putting pharmacies out of business (hence the federally-supported addition of a "reasonable dispensing fee") and also – as an added goal a "dispensing fee" could not achieve – incentivizing pharmacies to find the best deals they could. That incentive would create pressure to lower average acquisition cost, which would ultimately save the State money. That this was the State's desire is supported by the Department's 1988 Decision Memorandum, which noted the result "would benefit both [pharmacies and the State]," since prudent pharmacies would "keep the difference if they can find it" and the State would achieve savings that it did not under the AAC approach, where pharmacies had no incentive to seek lower prices. DX-0031_0002. Further supporting the State's position, Hazelwood testified that "we were creating an environment that incentivized drug store owners to be prudent and aggressive in their negotiating with wholesalers regarding acquisition cost" and Parker testified that "an advantage of estimated acquisition cost"

[9] To implement Teva's approach in a discounted-AWP regime, one would need some way to calculate "actual" versus "estimated-via-discounted-AWP" cost (since that difference is what Teva calls an "overpayment"). This would have to be done for each completed transaction. That would seem to require continuing most of the mechanics of the former AAC system, *in addition to* using a discounted-AWP system. If the AAC system did not work well to begin with – as the State's evidence demonstrated – there is no reason to think it would work any better as a layer of an overall discounted-AWP system.

as opposed to actual acquisition cost "is that it incent[ivize]s pharmacies to seek out the lowest price." *Trial Tr. Vol. V*, 840 (Hazelwood); *Trial Tr. Vol. II*, 288–89 (Parker). Common sense, as well as evidence, supports the State's argument that requiring the pharmacies to forego the difference between actual and estimated acquisition cost (by remitting the overage back to the State) would have disincentivized pharmacies to make prudent purchases, thereby undercutting the goal of lowering overall average acquisition cost in the long run.

There is another difficulty with Teva's attack on the State's "keep the difference" approach. That approach only works (that is, it is only a useful incentive) if there is actually a meaningful "difference" to "keep" in a significant portion of the overall drug-purchasing transactions. The parties do not dispute that such a difference did exist. In significant part, it existed because of the market distortion created by Teva's, and other manufacturers', conscious and persistent use of their own AWP inaccuracies to "market the spread." In this light, the State's "keep the difference" can be viewed as the State's attempt to co-opt the same message which underlay "marketing the spread" – but using that dynamic to lower, rather than raise, overall average acquisition costs. Put another way, if there were no AWP inaccuracies (and hence no "spread" to "market"), there would be no "difference" to "keep."

This view is borne out by the pharmacy opposition to the State's attempts to reduce or eliminate what Teva terms "overpayments." Those overpayments – in other words, "spreads" between actual and estimated acquisition costs – were manifestly exacerbated, if not largely created, by Teva's and other manufacturers' own creation and stock in trade: "marketing the spread" by consciously using inaccurate AWPs as sales tools. That Teva's and others' "marketing the spread" campaigns succeeded in habituating pharmacies to such "overpayments," causing them to protest at the State's attempts to achieve greater accuracy, does not make those protests independent intervening causes. To the contrary, "the intervention of a force [pharmacy political protests] which is a normal consequence of a situation ["spreads"] created by the actor's ... conduct [inaccurate AWPs and "marketing the spread"] is not a superseding cause of harm which such conduct has been a substantial factor in bringing about." RESTATEMENT (2D) OF TORTS (1965), § 443; *United States v. King-Vassel*, 728 F.3d 707, 714 (7th Cir. 2013).

Not Adopting a WAC-Plus Alternative

Teva also contends that the overpayments to which it points were also caused by the State's failure, in 1995 and 2000, to end discounted-AWP based reimbursement by switching to WAC. According to Teva, WAC-plus was a viable alternative to discounted-AWP, and the State's failure to adopt a WAC regime was motivated by a desire to protect pharmacy revenue.

Teva's assertion that Illinois Medicaid considered *replacing* discounted-AWP with WAC-plus is somewhat overstated, however. Both the 1995 proposal and the December 2000 amendment opted to include a WAC-plus component *in addition to* the discounted-AWP components in its reimbursement formula. Although Illinois Medicaid did not consider eliminating discounted-AWP, however, it is true that, as Hazelwood testified, the WAC-plus component would "frequently" be lower than the discounted-AWP price; thus adding the WAC-plus component would have "nullified the AWP discount component" "for many products." *Trial Tr. Vol. V*, 923 (Hazelwood). The discounted-AWP component would not be eliminated

for *all* products, however, especially in light of the July 2000 Amendment differentiating between "true" and "false" AWPs, which was already in effect by the time the WAC-plus component was added in December 2000, and under which the true market AWP was the lowest value and would have been used where it was available.

Teva contends that WAC-plus was a viable alternative to discounted-AWP which would have saved the State millions of dollars, and that the State discontinued its use of WAC-plus only to please pharmacies. Underlying Teva's argument that the State's failure to replace discounted-AWP with WAC-plus "caused" its "overpayments" is the premise that WAC was a superior reimbursement alternative to AWP. The State contends that this was not the case and that the WAC-plus component turned out to be problematic for several reasons. For example, the State argues that, because the published WACs did not include discounts and rebates that generic manufacturers offered to their customers, the WACs themselves were significantly inflated above actual market prices, and there was not a consistent relationship between the published WACs and a pharmacy's actual acquisition cost. PX-0184 (2005 memorandum from CMS advising the U.S. Government Accountability Office that WACs were greatly inflated); *Hogan Dep.*, 69, 80–81, 126–27 (a published WAC for a drug was anywhere between 10 and 90 percent more than its true price). In addition, WACs were not available for all drugs, since not all manufacturers sell through wholesalers. PX-1262; *Trial Tr. Vol. II*, 298 (Parker). This would have made it difficult at best to replace discounted AWP across the board.

The evidence shows that Illinois Medicaid's decision to discontinue WAC-plus was driven by more than a desire to overpay pharmacies. In the Court's view, the State presented ample evidence to show that using a WAC-plus component was no less problematic than using the discounted-AWP, and that its decision to discontinue the WAC-plus component was reasonable under the circumstances. The WAC-plus component presented many of the same problems as the discounted-AWP component, and created an additional concern that pharmacies might be under-reimbursed. Parker testified that even when the State marked up the published WACs, pharmacies complained that the WAC-plus formula failed to cover their acquisition costs. *Trial Tr. Vol. II*, 298–99 (Parker); *see* DX-0207 (pharmacy representative complaining to Illinois Medicaid that the WAC-plus rates "will be the demise of the independent pharmacy"). The State could and should be legitimately concerned about using a reimbursement regime which might have such an effect.

Teva also argues that Illinois Medicaid's efforts to adopt a WAC-plus formula were rejected by Governors motivated by a desire to protect pharmacy revenue. As noted earlier, however, a desire to "protect pharmacy revenue" does not state or even imply a desire to overpay pharmacies, since the result was actually to cut total pharmacy revenue, albeit by less than Illinois Medicaid would have liked. Further, choosing not to adopt a policy on the ground that it lacked pharmacy support is not *per se* improper. Hazelwood testified that it was important to have pharmacy support before enacting a policy to "ensure that we could tell the governor and other elected officials that we weren't working in a vacuum, we were working with the interest groups directly affected." *Trial Tr. Vol. V*, 850–51. He further testified that "the reality was that politically, that interest group could and did stop us if they had strong opposition to a policy change we were proposing." *Id.* That is especially true where, as here, pharmacy opposition was only one of many reasons that the State did not adopt the WAC-plus formula.

MAC Program

Teva similarly criticizes the State for failing to commit adequate resources to its MAC pricing until 2004. After hiring vendor Myers & Stauffer in late 2004, the State set MACs on thousands of generics which resulted in millions of dollars in savings. *Trial Tr. Vol. II*, 306 (Parker). Teva contends that the State unjustifiably neglected to commit adequate resources to its MAC program until late 2004, and even then it added a 25% mark-up to build a pharmacy profit into the reimbursement rate.

To say that the State "chose" not to commit adequate resources to its MAC program is an over-simplified, if not incorrect, characterization of what happened. Teva paints a picture of a government with unlimited resources, when, in reality, the State was hampered by limited staffing and resources. Prior to hiring Myers & Stauffer, the task of setting MAC prices was assigned to a single Medicaid staff member. *Trial Tr. Vol. II*, 302 (Parker testifying that "we were doing it in house, but I mean, literally, we were practically doing it with one person trying to track down prices"). As this Court has noted, such a cumbersome approach would be unworkable and exactly what the AWP system was designed to avoid. *See 3/20/12 Tr.*, at 59–60. Indeed, that cumbersome approach could have been avoided had Teva and other manufacturers reliably reported accurate AWPs. The Court rejects Teva's assertion that the State should have committed resources to its MAC program to accommodate Teva's misconduct.

Further, the State presented ample evidence to show that adding the 1.25 multiplier to MACs was reasonable. The State presented evidence that the 1.25 multiplier was applied: to ensure that smaller, independent pharmacies (who typically pay higher drug costs) were not harmed (*Trial Tr. Vol. II*, 322–23 (Parker)); to satisfy the MAC program's goal of "obtain[ing] savings on multi-source prescription drugs while, at the same time, allowing dispensing pharmacies to maintain an adequate profit margin on the products (DX-0467B (Request for Proposals), at 8); to achieve cost coverage objectives; to allow for some variation in provider acquisition costs; and to allow for temporary marketplace price fluctuations without the need to adjust the MAC rate (DX-0468_0018 (2004 Bid Submission)).

Teva, on the one hand, accuses the State of causing its overpayments by not utilizing MACs sooner, and on the other hand criticizes the State for utilizing MACs in the manner it did. Neither argument suffices to negate Teva's own causation responsibility.

Most Favored Nation ("MFN") and Pharmacy Benefit Manager ("PBM")

Teva also criticizes the State for rejecting proposals to adopt MFN pricing and to hire a PBM. Again, however, the State had sound reasons to reject both approaches. Both Parker and Hazelwood – Teva's own witness – testified that the MFN approach was problematic, and Parker further testified that the approach was never pursued because it was disliked by pharmacies and the Agency. *Trial Tr. Vol. II*, 292–94 (Parker); *Trial Tr. Vol. V*, 990 (Hazelwood). Similarly, using PBM rates was controversial, since it would have amounted to a reduction of $6 per prescription – which pharmacies complained was "impossible . . . to live with" – and would "limit access to Public Aid recipients throughout the state, but primarily in high [M]edicaid areas." DX-0363_0001. Medicaid rejected the 2002 PBM proposal, and instead increased the

AWP-discount from 20% to 25%. Similarly, the 2004 PBM proposal was rejected, but in exchange Medicaid obtained pharmacy industry support for a discount card program for eligible senior citizens and disabled persons to purchase prescription drugs,[10] and concurrently eliminated co-payments on generic drugs in order to incentivize generic use. Although that program added $8 million dollars to the State budget, the State expected to recoup that amount and more in the long run by increasing generic use. *Trial Tr. Vol. II*, 432 (Parker).

A common thread links all of Teva's arguments just discussed: the starting assumption that the State's Medicaid program did, in fact, overpay for Teva's (and others') generic drugs. No one seriously contends otherwise. This leads to another common thread: Teva's consistent theme that, regardless of why those overpayments occurred, the State could somehow have avoided or stopped them if it had adopted a different reimbursement program. Viewed in context, that is a sort of "last clear chance" argument.[11] It diverts attention from the underlying cause of the overpayments by focusing on possible curative measures. In this Court's view, Teva's approach fails for two reasons. First, Teva has not shown that the curative measures to which it points would, in truth, have prevented Medicaid overpayments for Teva's drugs. At the most optimistic, those measures might have partly palliated – not solved – the problem. They cannot, then, sever the chain of causation which ineluctably points to Teva's (and others') inaccurate AWPs and their conscious use of those inaccuracies as sales tools. The State's failure to adopt those palliations in the way now urged by Teva might at most affect damages. It does not destroy causation. Second, in any event, the record does not show that the State's failure to adopt these palliative measures was unreasonable from a causation standpoint. On the contrary, in a world of false AWPs, limited budgets, and forceful pharmacy lobbyists, the State's decisions were reasonable under the circumstances. As earlier noted, even the political pressures of pharmacy lobbyists were themselves the foreseeable result of Teva's (and others') "marketing the spread." *See* page 23 *supra.* As the State notes, borrowing from Judge Saris' point in *In re Pharm. Average Wholesale Price Litig.*, 491 F.Supp.2d 20, 90 (D. Mass. 2007), *aff'd* 582 F.3d 156 (1st Cir. 2009), "shifting the payment paradigm from AWP to another approach is like turning the *RMS* Queen Elizabeth." The State explains (*Br.* at 46):

> A massive State government reimbursement system which depends on the integrity of prices submitted to the system, and which makes payouts of hundreds of millions of dollars every year, is not a jackrabbit that can reverse course and make corrections on a second's notice.... Such systems create their own constituency to preserve the gold mines they create. Changing them will be foreseeably difficult.

[10] Teva contends that the senior discount card program was promoted by Governor Blagojevich, and that the Agency fell victim to a Blagojevich campaign promise by allowing the Governor to use significant savings that Illinois Medicaid had budgeted as a bargaining chip for a campaign promise unrelated to Medicaid. Even if true (which is contested), this might affect damages, but does not really address causation. Teva provides no meaningful support for the assertion that the State could have entirely avoided its overpayments by adopting the MFN or PBM approach.

[11] "Last clear chance" was interred as a complete defense by *Alvis v. Ribar*, 85 Ill.2d 1, 10-11 (1981). But the analysis it represents remains available in determining levels of comparative negligence (and therefore damages). *See P.A.M. Transport, Inc. v. Builders Transport, Inc.*, 209 Ill.App.3d 889, 892-94 (5th Dist. 1991).

The Court agrees. While Teva critiques the State's efforts to adjust its reimbursement formula, it overlooks that those efforts were needed as a result of Teva's and others' creation and marketing use of an environment of false AWPs. In that regard, Teva's assertion that it "had nothing to do with [the State's] decisions" about reimbursement (*Teva Br.* at 17) is seriously inaccurate. Teva fails to acknowledge is that true AWPs were not available because Teva and other manufacturers did not report them – *consciously* did not report them, in order to take advantage of that flawed environment by "marketing the spread." The Court rejects Teva's attempt to blame the State for not properly fixing the broken system that Teva *et al.* created. *See In re Pharm. Average Wholesale Price Litig.*, *supra*, 491 F.Supp.2d at 95 ("Unscrupulously taking advantage of the flawed AWP system for Medicare reimbursement by establishing secret mega-spreads far beyond the standard industry markup was unethical and oppressive."). By reporting false AWPs and then using them as marketing tools, Teva and other manufacturers deprived the State of accurate information and put the State in the untenable position of having to guess at an appropriate reimbursement mechanism.

The Court concludes that the State has established causation. Taken together with the Court's prior rulings, the Court concludes that the State has accordingly established liability. To do so, the State must show: (1) that Teva made, used, or caused to be made or used a record or statement to get the government to pay money; (2) that the record or statement was false or fraudulent; and (3) that Teva knew the record or statement was false or fraudulent. *United States ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1018 (7th Cir. 1999) (construing the mirror provision in the FCA); *see* pages 12-15 *supra*. The Court has previously held that using false AWPs satisfies prong (2) (despite the State's awareness that the AWPs were inaccurate). It is not disputed that Teva knew the AWPs it used were inaccurate. That satisfies prong (3). Teva's repeated use of inaccurate AWPs in a deliberate "marketing the spread" program designed to cause pharmacies to use the "spread" to inflate State reimbursements satisfies prong (1). The final element of liability is proof that the false AWPs were "material," in that they had a "natural tendency to influence, or being capable of influencing, the decision of the decision making body to which it was addressed." *United States v. Rogan*, 517 F.3d 449, 452 (7th Cir. 2008), citing *Neder v. United States*, 527 U.S. 1, 16 (1999). There is no doubt of that. Ironically, Teva's own arguments here depend in part on Teva's recognition that the false AWPs *did* "influence" the State's reimbursement decisions, as an element in causing the State to "overpay."

This leaves the issue of damages. That will require further development and proof. Some of Teva's defenses, though not defeating causation, may well bear on damages. To the extent that the State consciously "padded" its reimbursement formula, that also may bear on damages. The State's awareness of the inaccuracy of AWPs, though not a complete defense, may also bear on the measure of actual damages. *See* Neal J. Wilson, *The Government Knowledge "Defense" to Civil False Claims Actions*, 24 Pub. Cont. L.J. 43, 60–61 (1994).

DATED: June 28, 2017 **ENTER:**

_____

Circuit Judge