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Prompt Payment Laws: Physician's New Weapon Against Managed Care Companies Creates Litigation

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I. Introduction

In the last issue of HMOs and Health Plans Newsletter, the article entitled "Prompt Payment Laws: A Brief Historical and Legal Analysis," by Neela Paykel, gave an overview of prompt payment laws. In particular, that first article in this two-part series described the origins of prompt payment laws, discussed specific examples of such laws and reviewed some of the administrative actions that have arisen in response to these laws.

This article, the second and final in the series, will address the legal actions that have sprung up regarding prompt payment laws and the current status of such lawsuits. Through a review of the courts' decisions, we will be able to determine the effectiveness, or lack thereof, of such laws, at finally helping providers receive payment from third party payors on a timely basis.

II. Enforcement of Prompt Payment Laws: In Re Managed Care Litigation

In February of 2000, the American Medical Association joined with Georgia physicians and the

Medical Association of Georgia in filing a class action lawsuit against Aetna U.S. HealthCare for failure to pay physician claims in a timely manner.¹ The suit claimed that Aetna U.S. Healthcare "routinely delays the payment of claims" which violates both Georgia's prompt payment law and "Aetna's contract with physicians and other providers."² Three months later, in May of 2000, the same group filed another lawsuit against three more insurers.³ This suit was practically identical to the suit against Aetna. In addition to claiming purposefully slow payment practices, the suit also contended that Prudential Healthcare Inc., United Healthcare of Georgia, Inc., and Coventry Healthcare of Georgia, Inc. were all unjustly enriched at the expense of physicians through such practices.⁴

Additional class action lawsuits alleging nearly the same thing were filed all across the country. In May of 2000, the California Medical Association filed a lawsuit against the state's three largest for-profit national health plans on several grounds including purposefully delaying payments.⁵

In New York, for example, a set of six class action lawsuits were filed by the Medical Society of the State of New York.⁶ The suits, which named the six largest health insurers—Aetna, CIGNA Healthcare, Empire Blue Cross and Blue Shield, Excellus, Oxford, and United

Healthcare—included allegations that these insurers violated, among other things, state prompt payment laws.⁷ Also in New York, 25 hospitals filed suit against Aetna U.S. Healthcare for violations of prompt payment laws, seeking \$45 million in compensatory damages and \$50 million in punitive damages.⁸

Similarly, the Connecticut Medical Society also filed six separate lawsuits against CIGNA, Aetna, PHS, Anthem, Connecticut, and Oxford health plans for failure to comply with Connecticut prompt payment laws.⁹ In California, Catholic Healthcare West sued Blue Cross of California for \$50 million, alleging unfair and fraudulent business practices related to delayed payments,¹⁰ and in Tennessee, West Tennessee Healthcare System sued Access MedPlus for \$3.5 million in unpaid bills.¹¹

A. In Re Managed Care Litigation

By January 2000, more than 16 class action suits had been filed across the country. As the number of lawsuits against the same insurers on essentially the same topics continued to grow, the Judicial Panel on Multidistrict Litigation finally intervened and, eventually consolidated over 50 of the pending complaints and transferred them to the U.S. District Court of the Southern District of Florida.¹² The consolidated cases, known simply as *In Re Managed Care Litigation*,¹³

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 —from a declaration of the American Bar Association

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were subsequently split into two categories: provider track and subscriber, or enrollee, track in order to be able to address the specific issues presented by both classes.

1. Pretrial Motions

In December of 2000, U.S. District Court Judge Federico Moreno began hearing pretrial motions in the *In Re Managed Care Litigation* case. Some of the first motions in the provider track cases were motions filed by the insurers arguing that instead of litigating these issues, the providers should be required to comply with the arbitration provisions contained in their contracts. As a way to limit damages paid to providers and negative publicity associated with lawsuits, a number of insurers had previously included arbitration language in their provider agreements and the insurers wanted to be sure that the court enforced these provisions instead of facing the possibility of a class action judgment.

The providers, of course, argued that since this was multi-district class action litigation, forcing those providers with arbitration clauses to arbitrate whereas other members of the class might not be required to arbitrate would not be fair or just. Judge Moreno disagreed with the providers and declared that the providers' contracts, including the arbitration provisions, were valid and that providers would have to arbitrate those issues which were capable of being arbitrated. As he noted, the potential for class certification did not permit the providers to escape the require-

ments of their contracts, nor did it require the court to help them meet the requirements for class certification by removing any difference among potential class members, such as the requirement to arbitrate.

The ruling was an important victory for the insurers. One of the largest hurdles facing both providers and enrollees is obtaining class certification. As discussed later in this article, although there are several criteria which must be met in order to obtain certification, the main requirement is that the plaintiffs must be able to represent the entire class of members without any conflict between the interests of the plaintiffs and the interests of the members. If the named plaintiffs are required to arbitrate, and the other class members are not, the court might not certify the cases as class actions due to the different requirements between the named plaintiffs and the members. Denial of class certification would impact all of the lawsuits since instead of multitudes of providers suing for multi-millions of dollars, it would simply be several individual providers suing and the damages would be insignificant. Thus, this ruling helped the insurers by sustaining a significant difference between the plaintiffs and providers which may have, ultimately, prevented the providers from obtaining certification.¹⁴

On March 14, 2003 the Eleventh Circuit upheld Judge Moreno's decision. The court affirmed that the claims between plaintiffs and defendants who are both signatories to contracts containing enforceable arbitration clauses must be arbitrated.¹⁵

2. Dismissal of Complaints

The second major development in *In Re Managed Care Litigation* came on March 2, 2001, when Judge Moreno issued an order dismissing certain elements of the providers' complaints. The providers' complaints included charges of: (1) violations of the federal Racketeer Influenced and Corrupt Organizations Act (RICO); (2) Employee Retirement Income Security Act of 1974 (ERISA) violations; (3) violations of federal and state prompt pay laws; and (4) breach of contract, unjust enrichment, and *quantum meruit* claims. In his ruling, Judge Moreno dismissed the charges of federal and state prompt payment law violations and RICO violations.

With respect to the providers' federal prompt payment law violations, the plaintiffs cited a provision of the Omnibus Budget Reconciliation Act of 1986,¹⁶ section 9312(d), which granted the Health Care Financing Administration (HCFA), the ability to impose sanctions on an HMO if it finds that the HMO failed to comply with section 1876(g)(6)(A) of the Act relating to the prompt payment of claims.¹⁷ Unfortunately, as the court noted, this section of the law regarding the prompt payment of claims was repealed. Moreover, even if it had not been repealed, it only gave HCFA, not providers, the right to sanction HMOs and therefore the providers would not have had the authority to invoke this law. Thus, Judge Moreno dismissed this part of the providers' complaints with prejudice, meaning that the providers are barred from raising these issues again.

With respect to the plaintiffs' charge that the defendants violated several state prompt pay laws, Judge Moreno made several findings. First, he noted that the plaintiffs only made this charge against Humana, Inc. Although this oversight could be easily fixed to include the other insurers, Judge Moreno determined that the plaintiffs also did not provide enough information as to how each of the insurers violated the laws or even exactly which laws they had violated. Judge Moreno therefore dismissed the claims without prejudice.

With respect to the alleged RICO violations, the federal RICO statute, though originally intended to help prosecute organized crime, has been expanded to prosecute a variety of other activities and industries. RICO prohibits, among other things, conducting or participating in the affairs of any enterprise which affects interstate commerce through a pattern of racketeering activity.¹⁸

In dismissing the providers' RICO claims, the court concluded that the plaintiffs failed to prove that the insurers participated in an "enterprise." An enterprise as defined by RICO is: (1) any corporation, association or other legal entity; or (2) any group of individuals associated in fact although not a legal entity, which are associated for a "common purpose of engaging in a course of conduct."¹⁹ The plaintiffs claimed that the enterprise in this case was: (1) the entire healthcare delivery system in the U.S.; (2) the healthcare systems within geographic regions; or (3) the third-party entities which promulgate health-

care reimbursement guidelines and/or which are subcontractors of the HMOs for the purpose of reviewing claims. The court determined that the plaintiffs' first two arguments, that the entire nationwide or regional healthcare industry was engaged in a conspiracy was too broad a category for the definition of an enterprise. As for the plaintiffs' third argument, Judge Moreno held that the providers did not sufficiently explain how the insurers could use a group of unrelated third-party entities who merely happened to contract with some or all of the defendants to conspire. In particular, the court noted that not only are the third-party payors unrelated to one another, the providers did not offer any evidence as to how or why the payors could have engaged in a conspiracy with the insurers. For this reason, Judge Moreno dismissed the providers' RICO claims without prejudice, and gave the plaintiffs a chance to amend their complaint to clarify where the enterprise for conspiracy arose from.

3. Provider Class Certification

On May 7, 2002, Judge Moreno heard oral arguments on the providers' motions for certification as a class. As discussed earlier, the ruling is perhaps the most important ruling in the case. If the providers fail to obtain certification as a class this litigation will simply be a collection of lawsuits filed by individual physicians and the potential for the large damages typically associated with class actions will be non-existent.²⁰

Section 23(a) and (b) of the Federal Rules of Civil Procedure set forth the requirements for certification of classes for the purpose

of bringing a class action lawsuit. The requirements are: (1) numerosity; (2) commonality; (3) typicality; (4) representational; (5) predominance; and (6) superiority.

The first requirement, numerosity generally means that the class must be so large that it would be impractical to try the cases individually. In other words, combining these cases is the most efficient way to dispose of the issue. Commonality generally requires that the questions of law and fact must be common to all class members. Somewhat relatedly, the requirement of typicality means that the claims of the named plaintiff must be typical of the entire class. Commonality and typicality, though somewhat similar, are different in that commonality focuses on whether the legal questions which arise are the same whereas typicality focuses on whether the remedies or damages required are the same. The next requirement, representational, requires that the named plaintiffs and their attorneys are capable of representing the interest of the class as a whole without any conflicts of interest. Predominance, the next requirement, means that the common issues of law and fact take precedence over any differences among the members of the class. Finally, the requirement of superiority means that the best way to resolve the issues is by certifying the members as a class and handling all of the cases in a similar manner.

The courts have generally required all of the requirements for certification to be present in order to certify a class, and in recent years courts have been especially critically and rigid

when reviewing potentially large class action lawsuits. The majority of legal experts seem to think that the likelihood that the providers will obtain class certification in this case is minimal, yet, the same comment was made about the tobacco litigation and the tobacco companies ended up paying billions in settlements.

In going through the requirements it looks like the first requirement, numerosity, is easily met because over 600,000 physicians are being represented in this case. The second and third requirements, commonality and typicality, require that the legal issues involved are common to all of the class members. The plaintiffs' attorneys are arguing, of course, that the legal issues are all the same in that the "doctors have experienced, almost uniformly, the exact same kinds of delays in care, denials of care and manipulation of claims . . . in ways that rise to the level of fraud and extortion and represent a systemic scheme that rises to the level of civil racketeering."²¹ On the other hand, the HMOs are arguing that the requirements are not met since each physician's contract, especially the provisions regarding payment, are different for each HMO.

The next requirement, representational, or whether the interest of all of the members of the class can be represented at the same time without a conflict of interest, is also contested. The fact that three states' medical societies have also joined in the litigation on behalf of the providers lends some credence to the argument that the providers' interests are all the same. Yet, whether the common

issues will predominate, the next requirement, over the differences between the providers' cases is hard to tell. Once again, the HMOs seem to be relying on the fact that not only is each provider's contract with an HMO different, but also that each of the HMOs have multiple contracts.

Lastly, the issue of superiority is also contested: the providers contend that efficiency and consistency of results require all of the cases to be tried together, whereas the HMOs counter that combining the cases will create a huge, unwieldy case that will take years to resolve, wasting time, energy, and money.

Finally, on September 26, 2003, Judge Moreno certified the provider track as a class action, including approximately 600,000 physicians, finding that the plaintiffs had demonstrated the existence of a common scheme among large managed care organizations to defraud physicians.²²

Obviously, this was a decisive victory for the providers, however, the health plans immediately appealed. In particular, they asked the Eleventh Circuit to hear an appeal of the class certification order. As discussed earlier, one of the health plan's first pre-trial petitions to the court was that class certification was not appropriate because some providers, based on their physician contracts, were required to arbitrate any claims. Judge Moreno had decided that the arbitration provisions should be upheld and the Eleventh Circuit previously affirmed. Thus, the health plans contended, since

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there are differences amongst the class members the class certification was inappropriate. On November 20, 2002 the court agreed to hear the appeal and in late December the parties submitted briefs in support of their positions.

In the meantime, although these issues have yet to be resolved, Judge Moreno has ordered the parties to commence discovery and proceedings are under way with respect to the providers' class action lawsuit. The providers hope that during the discovery they will find "the smoking gun" similar to the ones found in the tobacco cases that will prove beyond a reasonable doubt that the health plans have been deliberate in their payment practices.

B. Subscriber Class Certification

Similar to the provider track, the subscriber track had also sought class certification. Unlike the providers cases, however, Judge Moreno dismissed substantial portions of the subscriber track complaints and pointed out the fragility of some of the claims that survived. Although the subscribers had the ability to amend their complaints by March 20, 2002, which they did, on September 26, 2002 Judge Moreno issued an order denying class certification. Though the subscribers appealed the decision, Judge Moreno denied their appeal on November 25, 2002.

In dismissing the complaints the court noted that the subscriber class failed to meet the "uniformity" requirement. Specifically, Judge Moreno concluded that although the subscribers, all alleged 145 million of them,

meet the requirements of Rule 23(a), they did not meet the requirements of Rule 23(b)(2). Under this rule, the court must determine whether the defendants have acted on grounds "generally applicable to the class as a whole."²³ In other words, the defendants must have acted in a consistent manner toward members of the class so that their actions may be viewed as part of a pattern of activity, or to establish a regulatory scheme, to all class members.

The defendants pointed out that although there may have been typicality (i.e. similar factual issues under the same legal theory being advanced by all the plaintiffs), there was no uniform policy or scheme that they had engaged in. In particular, as the defendants argued, that the very nature of their health plans mean that decisions are made on individual or local level through subsidiaries and employers. Thus, there can be no united scheme. The court, agreeing with the plaintiffs, therefore denied class certification.

C. Kaiser v. CIGNA

Filed in a Madison County, Illinois state court in May of 2000, *Kaiser v. Cigna* was originally a class action contract dispute alleging that CIGNA was purposefully reducing its payments to in-network physicians in breach of its agreements.²⁴

The case was one of the few cases that was not consolidated with the others into the *In Re Managed Care Litigation* case. The reason was that the original complaint did not include the federal anti-racketeering and federal ERISA complaints that

were central to the consolidated class actions. It was only when these complaints were added and the case moved to the federal court in East St. Louis that this case became problematic with respect to the *In Re Managed Care Litigation* case.

The specific problem stems from the fact that in the *Kaiser* case the court certified the providers as a nationwide class on March 29, 2001, over a year and half before the provider track was certified as a class in the *In Re Managed Care Litigation* case.

As was the case in *In Re Managed Care Litigation*, in July of 2001 CIGNA moved to dismiss the certification contending that the arbitration provisions in its contracts with the physicians should be enforced. Given that arbitration was required, there was therefore no commonality between the physicians and class certification was not appropriate. As the issue was pending, fearful of the ramifications in favor of the physician as a class, CIGNA began settlement negotiations with the providers. The end result was that on November 25, 2002 the parties signed a settlement agreement, which, while subject to the court's approval, would have resolved all claims for over 400,000 physicians.²⁵

The settlement called for CIGNA to pay for wrongfully denied claims dating back to January 1, 1996 for these providers and to waive any arbitration requirements. Instead, providers simply had to provide documentation of their wrongfully denied claims.

Although CIGNA expected that

the claims would amount to approximately \$50 to \$65 million, the plaintiffs' attorneys estimated the number to be closer to \$200 million minimally.

The Illinois court conditionally approved the settlement on November 26, 2002 assuming that no more than 7.5% of the class members opted out of the settlement when finally proposed, and that the settlement pass a fairness hearing by the court. Yet, since the terms of this settlement would have applied to the physicians involved in the class action lawsuit against CIGNA in the *In Re Managed Care Litigation* case as well, the providers in both cases asked Judge Moreno to step in and enjoin the settlement even though technically the case was not within his jurisdiction. On December 12, 2002, Judge Moreno issued an order to CIGNA specifically enjoining them from entering into the settlement agreement without receiving the "express approval of the MDL court."²⁶ Judge Moreno also ordered that CIGNA not contact the members of the class certified by the MDL court.²⁷ In response to CIGNA's move to settle Judge Moreno noted that "the court cannot turn a blind eye to the underhanded maneuvers CIGNA took to obtain the settlement agreement in Kaiser."²⁸

Also in December 2002, pursuant to the rules on Multi-District Litigation the case as designated as a potential "tag-along" action in *In Re Managed Care Litigation*. Finally on February 23, 2003, it was transferred to Judge Moreno for consideration with the rest of the litigation. Thus, Judge

Moreno will decide whether the settlement is fair and should be implemented.

Given that the settlement has already been agreed to by at least some of the parties, it will be interesting to see whether or not Judge Moreno will support the proposal. More interesting, however, will be whether Judge Moreno looks to it as a basis for a possible settlement in the larger litigation case.

III. Impact of Proposed Legislation: Patient Bill of Rights and Others

Courts do not act in a vacuum. Although the court has begun to address the litigation that has arisen from physician's use of state prompt payment laws to force third party payors to pay claims in a timely manner, it is clear that the *In Re Managed Care Litigation* case still has a long time before it will be concluded and the outcome is also far from clear. In the meantime, new or proposed legislation may also have an impact on the court's final decision.

For a while it seemed very likely that Congress would enact a Patient's Bill of Rights. In particular, H.R. 2723, titled "The Bipartisan Consensus Managed Care Improvement Act of 1999," was the House patients' right bill sponsored by Rep. Charlie Norwood (R-GA). One provision of the bill would have required the prompt payment of claims. Specifically, it would have required that claims be paid in accordance with Medicare guidelines for prompt payment. Section 134 of the legislation, titled "Payment of Claims," provided that:

"A group health plan . . . shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary or enrollee . . . in a manner consistent with the provision of sections 1816(c)(2) and 1842(c)(2) of the Social Security Act [42 U.S.C. 1395h(c)(2) and 42 U.S.C. 1395u(c)(2)]."²⁹

The bill, which narrowly passed in the House on August 2, 2001, was finally agreed to when Rep. Norwood obtained consensus by amending the liability provisions of the existing bill. Among the provisions was one which would restrict class action litigation against health plans, including lawsuits that are already in the court system but had not been granted class action status by August 2, 2001 (the date the House bill passed). The provision stated that class action suits would only be allowed if the class or group of claimants that brings the case "is limited to the participants or beneficiaries of a group health plan established by only one plan sponsor."³⁰ If passed, the provision would have barred the plaintiffs' cases in *In Re Managed Care Litigation*. The suits had not yet received class-action certification by May of 2001. Thus, the case would have been in jeopardy if the provision had not been changed, since it is unlikely that the terms "participants" and "beneficiaries" would include providers. Even if providers were considered participants, they would have been prohibited from suing more than one health plan at a time. Thus, in essence the clause could have

cut off a physician's right to prosecute his case to be paid properly for services rendered.

Although Rep. Norwood, who developed this provision in a last minute effort to reach a compromise in order to get the bill passed, has since said that this was not the intent of this language and that if this was indeed the result he would have revised the language, the provision had not been changed when the bill was submitted to the Senate.

Due to other factors, the Patient's Bill of Rights did not ultimately pass in Congress. Nonetheless, discussion and proposals for a revised bill continue. Moreover, it is probable that there will be some provisions with respect to prompt payment and caps on liability and/or eligibility to bring suit. Thus, depending on what, if any, version of the patient's bill of rights statute is enacted and when it is enacted, it may impact the court's decision in the *In Re Managed Care Litigation* case.

IV. Conclusion

Although providers may have initially viewed prompt payment laws as their new weapon against managed care companies, it is apparent that this new weapon is still as of yet completely tested. By obtaining class certification the providers have gotten over one of the greatest challenges they faced. Yet, it is still uncertain how Judge Moreno will ultimately decide the issues. Additionally, depending on how long this case draws out it may be that other facts, such as new statutes, will impact on the court's decision. What is clear however, is that state

prompt payment statutes have provided at least the opportunity for the providers' claims to be heard if not paid.

Endnotes

¹ *Harrison v. Aetna U.S. Health-Care, Inc.*, Ga. Super. Ct., No. 2000-CV-194, complaint filed 2/16/00. This suit, though not the first of its kind, was the first time in which a state medical society and the AMA served as plaintiffs in litigation regarding prompt payment. *See also*, "Georgia Doctors, AMA File Class Action Under State Prompt Pay Statute," Vol. 4 No. 9 Mealey's Managed Care Liab. Rep. 5, 5/12/00; "Doctors Seek Legal Redress To Enforce Prompt Pay Laws," Carol Patton, Physicians Financial News, 18(6), s1,s5, 2000; and "Managed Care: Georgia Doctors Sue Aetna U.S. HealthCare, Alleging Slow Payment of Health Claims," BNA's Health Care Daily Report News Executive Briefing, 2/18/00 HCD dll.

² *Id.*

³ *Harrison v. Coventry Healthcare of Georgia, Inc.*, Ga. Super. Ct. Nos. 2000-CV-22194, 2000-CV-22196, 2000-CV-22204, complaint filed 4/18/00. *See also* "Managed Care: Georgia Doctors' Group Files More Prompt Pay Suits Against Three Health Plans," BNA's Health Care Daily Report News Executive Briefing, Monday 4/24/00 HDC d8; and "Three More Georgia Plans Sued Over Late Payments," Managed Care Week, No. 15, Vol. 10, Pg. 1, 4/24/00.

⁴ *Id.*

⁵ "Keeping the Fires Lit on Issue of Prompt Payment," AM News, Opinion of D. Ted Lewers, N.D.,

Continued from page 5

4/02/01.

6 *Medical Society of the State of New York v. Empire HealthChoice HMO, Inc.*, N.Y. Sup. Ct., Docket No. 604081/01, filed 8/15/01. *Nyack Hosp. v. Aetna U.S. Healthcare*, No. 2870/00, N.Y. Sup. Ct. filed 5/02/00. See also “New York Medical Society Lawsuits Accuse Health Insurers of Delaying Payments,” BNA’s Health Plan & Provider Report, Vol.7, No. 34, 8/22/01, pp. 1098-1099.

7 *Id.* See also “New York Medical Society Lawsuits Accuse Health Insurers of Delaying Payment,” BNA’s Health Plan & Provider Report, Vol. 7, No. 34, 8/22/01

8 “New York Metropolitan Hospitals Sue Aetna U.S. Healthcare for \$95 Million,” Roy W. Breitenbach, 7 No. 4 NY Health L. Update 1, May 2000, and “New York Hospitals Sue Aetna For Failure to Pay, Breach of Contract,” Mealey’s Litigation Report: Emerging Insurance Disputes, 7/5/00, Vol. 5, No. 13. This suit was eventually dropped by the doctors as Aetna reached individual settlements with each hospital, though the terms of these settlements were confidential. “Suburban New York Hospitals To Drop Lawsuit Against Aetna On Payment Delays,” BNA Reporter, Vol. 10, No. 34, pg. 1334, 8/23/01.

9 “Conn Doctors Sue 6 HMOs Citing Breach of Contract, Deceptive Trade Practices,” Vol. 5 No. 4 Mealey’s Managed Care Liab. Rep. 11, 2/23/01.

10 “Pending Law Seeks Fairer Medical Bills, Faster Payments,” Sacramento Business Journal, 9/8/00, pg. 7.

11 “Access Med Plus Claims Network Adequate,” Dave Flessner, Chattanooga Times/Chattanooga Free Press, 1/10/01, p. C2.

12 *In Re Managed Care Litigation*, J.P.M.L., No. 1334, 10/23/00. The main purpose for consolidating these suits was to have one judge, in this case, Federal District Court Judge Federico Moreno, review and decide these similar issues in a consistent manner. See also “Large Managed Care Class Actions Transferred to Federal Judge in Miami,” BNA’s Health Law Reporter, Vol. 9, No. 42, 10/26/00.

13 The MDL panel renamed the litigation *In Re Managed Care Litigation*. In addition to pending proposed class claims filed against Humana Inc. that were already pending before Judge Moreno, the transferred cases included *Mangier v. CIGNA Corp.*, *Klay v. Pacificare Health Systems, Inc.*, *California Medical Association v. Blue Cross of California*, *Harrison v. Aetna U.S. Healthcare Inc.*, *Harrison v. Coventry Healthcare of Georgia Inc.*, *Harrison v. Prudential Health Care Plan of Georgia, Inc.*, *Williamson v. Prudential Insurance Co. of America*, *McCarron v. Prudential Insurance Co. of America*, *Romero v. Prudential Insurance Co. of America*, *Shane v. Humana Health Plan*, *Curtright v. Aetna Inc.*, *O’Neill v. Aetna Inc.*, *Amorosi v. Aetna Inc.*, and *Conte v. Aetna U.S. Healthcare Inc.*

14 Note again that this ruling only affects the provider track of the litigation. The subscriber track is discussed separately.

15 *In re Humana Inc. Managed Care Litigation*, 285 F.3d. 971.

16 18 U.S.C.A. § 9312(d).

17 42 C.F.R. § 417.500(a)(6).

18 18 U.S.C.A. § 1964

19 Order Granting In Part Without Prejudice Motions to Dismiss Provider Track Complaint, March 2, 2001, at pg. 10 citing *United States v. Turkette*, 452 U.S. 576, 583 (1981).

20 One of the problems providers have always had with trying to obtain late payments is that often the claim is for a small amount and not necessarily significant enough for the cost of instituting proceedings. Providers must instead wait until the number and amount of claims have accumulated. Thus, one of the benefits of a class action lawsuit is that even those providers who are only owed small amounts are also able to collect.

21 “Managed Care: Doctors Plan Class Action Suit Against HMO,” American Health Line, 5/7/01.

22 MDL No. 1334, Master File No. 00-1334-MD Moreno, 9/26/02.

23 MDL No. 1334, Master File No. 00-1334-MD-Moreno, 9/26/02, at pg. 13.

24 *Timothy N. Kaiser, M.D. et. al. v. Leonard J. Klay, M.D. et. al.*, No. 02-16965-C, Eleventh Circuit.

25 “CIGNA Settles Massive Managed Care Lawsuit,” Tanya Albert, AMNews, 12/16/02.

26 MDL No. 1334, No. 02-1179-GPM, S.D. Ill.

27 *Id.*

28 “Kaiser Plaintiffs Seek Stay Of MDL Injunction Pending Appeal,” Mealey’s Managed Care Liab. Rep. Vol. 7, No. 3, 2/14/03.

29 “Ask the Editors,” Health Care Fraud and Abuse Newsletter, July 2000. Generally, under the provisions of 42 U.S.C. §§ 1395h(c)(2) and 1395u(c)(2), payment must be issued for not less than 95% of all clean claims submitted for which payment is not made on a periodic interim payment basis, within 30 calendar days; otherwise interest is also owed. *Id.* It is interesting to note that of the state prompt payment laws that do define a clean claim, many follow these provisions of the Medicare statute.

30 “Patients’ Rights Bill Could Run Doctors’ HMO Lawsuits,” Amy Snow Landa, American Medical News, 9/3/01, pgs. 5 and 8.

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- Task Force Leader: Listserve Discussion Series with Guest Moderator, and
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Last year Congress enacted the Sarbanes-Oxley Act of 2002 (Act), which requires companies whose securities are publicly traded to comply with various corporate responsibility, disclosure, and audit rules. The Act was Congress's response to corporate scandals such as the ones at Enron and WorldCom, in which allegedly shady accounting practices, skewed financial reporting, and head-in-the-sand board supervision resulted in investors losing millions of dollars. In the months since the Act was passed, the Securities and Exchange Commission (SEC) has been promulgating regulations to implement the requirements of the Act. Several states also have proposed or enacted legislation to impose similar requirements.

Although the Act applies only to public companies, its effects are being felt directly or indirectly throughout the corporate world, including by managed care companies. The Act and its implementing regulations set forth new obligations for publicly traded managed care organizations. These new requirements may not unduly burden publicly traded health plans, which already are subject to significant regulation of their financial activities under state licensing laws. Non-publicly traded managed care organizations are similarly subject to state licensure laws and, in some cases, to state law analogues to the Act. The impact of the Act, however, may be most keenly felt indirectly by all managed care organizations, regardless of size or corporate status, and by their directors or trustees, because it has raised public awareness of the need for corporate responsibility.

This article will provide a brief overview of the requirements of the Sarbanes-Oxley Act as they apply to publicly traded managed care organizations. It also will highlight briefly how several states and the Internal Revenue Service (IRS) have responded to the Act. Finally, this article will discuss the effect the Act may be expected to have upon the activities of managed care organizations of all types.

I. An Overview of Sarbanes-Oxley

The Act's requirements for public companies can be roughly divided into three parts—corporate responsibility and governance, auditor independence, and enhanced disclosure. The Act also provides for additional federal oversight of public companies and penalties for noncompliance.

A. Corporate Responsibility Provisions

The corporate responsibility provisions of the Act impose new requirements upon public companies' principal executive and financial officers. They also require companies to disclose to the public

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the codes of conduct applicable to senior management. In addition, they require corporate counsel to report evidence of misconduct. Rules proposed by the New York Stock Exchange go even farther than the Act and would require independent representatives on a company's board and key committees.

A public company's CEO and CFO now are held directly accountable for assuring the company's financial performance is accurately disclosed to the public. Under the Act, a public company's CEO and CFO must personally certify the accuracy of each of the company's annual and quarterly reports. The certification must indicate that the CEO and CFO have reviewed the report and that, to his or her knowledge, the report is true and fairly presents the company's financial condition. The CEO and CFO also must certify that they have evaluated and reported to the company's auditors and audit committee any deficiencies in the company's internal financial controls. CEOs and CFOs who knowingly certify false company financial reports face prison terms of up to twenty years and fines of up to \$5 million. CEOs and CFOs also are required to reimburse the company for any bonus or incentive compensation or profits from the sale of company stock in certain cases of misconduct that result in material noncompliance with securities law reporting requirements.¹

The Act prohibits any director or executive officer of a public company to engage in any transaction in the company's equity securities during pension fund

blackout periods. Public companies also are prohibited from extending credit or making loans to directors or officers.²

Public companies must disclose in annual reports whether they have adopted a code of ethics for executive and financial officers, and if they have not, why not. The code of ethics must contain written standards reasonably necessary to deter wrongdoing and promote ethical conduct, full and accurate disclosure in financial reports, compliance with applicable law, and prompt internal reporting of code violations. Companies must make their codes of ethics available to the public and also must disclose any changes to or waivers of the code.³

To further compliance efforts, the Act requires corporate counsel to report to a company's CEO or chief legal counsel evidence of any material securities law violation or breach of fiduciary duty by the company or an employee. If the CEO or chief legal counsel fails to respond, the corporate counsel must report to the audit committee or the board of directors. The SEC may bar a person it finds "unfit" from serving on the board of a public company.⁴

The New York Stock Exchange (NYSE) has proposed rules that would apply to most listed securities issuers. The rules would require that a majority of the company's directors be independent, meaning that the board has affirmatively determined that the person has no material relationship with the listed company. Certain persons having an employment relationship with the company, its auditors, or persons on the compa-

ny's compensation committee are presumed not to be independent. Nominating and compensation committees must be composed entirely of independent directors. The NYSE rules would require non-management directors of a listed company to meet at regularly scheduled executive sessions without management's presence.⁵

B. Independence of Audit Committee and Advisors

The Act imposes requirements to assure the independence and competence of a public company's audit committee and external auditing firm. National securities exchanges and associations must prohibit listing companies that do not comply with audit committee standards.

The Act requires public companies to have audit committees that are composed solely of independent company directors. To be "independent" under the Act, a director may not accept any consulting, advisory, or compensatory fee from the company (other than for service in his capacity as a director), and may not be an affiliated person of the company or any of its subsidiaries. The SEC may grant discretionary exemptions from these requirements.⁶

An audit committee must be vested with the authority and resources to engage independent counsel and advisers. The Act also explicitly charges the audit committee with responsibility for engaging, compensating, and overseeing the work of the company's outside auditor and responding to accounting-related complaints received by the company.⁷

Each public company must have at least one "audit committee financial expert" on its audit committee or disclose why it does not have one. An "audit committee financial expert" is someone who has the education and experience to understand financial statements, generally accepted accounting principles (GAAP), internal controls, financial reporting, and the function of an audit committee.⁸

Directors and officers are prohibited from taking or directing others to take action to influence, coerce, manipulate, or mislead an independent accountant engaged in auditing the company's financial statements. In addition, a public company's auditor must report to the audit committee information regarding critical accounting policies and practices to be used, alternative treatments of financial information within GAAP relevant to the company's audit, and material written communications between the auditor and management of the company.⁹

The Act also impacts the composition of the team performing an audit by requiring accounting firms to rotate the lead audit partner and the reviewing audit partner on an audit for a public company every five years. Further, an accounting firm will be disqualified from auditing a public company for a year after an employee of the firm leaves to become the company's CEO, CFO, chief accounting officer, controller, or other financial officer.¹⁰

The Act prohibits accounting firms from providing certain non-audit related services, such as bookkeeping, valuation, invest-

ment banking, and actuarial services, to a company to which it provides audit services. Further, the audit committee must approve in advance an accounting firm's provision of all audit-related services and any permissible non-audit services.¹¹

C. Enhanced Disclosure Provisions

The Act raises the bar for public companies' disclosure of financial information, requiring more fulsome, rapid and detailed publication of such information. The Act requires that companies augment their financial statement reporting by reflecting all material correcting adjustments that have been identified by their auditors in accordance with GAAP. Companies also must disclose in each quarterly and annual report to the SEC all material off-balance sheet transactions, arrangements, obligations (including contingent obligations), and other relationships that may have a material effect on their financial condition. Companies may not make any public statements, including in press releases or pro forma financial information that are untrue or misleading.¹²

The Act also accelerates to two business days the deadline for reporting transactions in a public company's equity securities by directors, officers, and certain shareholders. No later than this summer, statements disclosing these transactions must be filed electronically with the SEC and posted on the company's Web site. Public companies also must disclose on a rapid and current basis material changes in operations or financial condition.¹³

D. Federal Oversight and Penalties

The Act provides for the establishment of a five member Public Company Accounting Oversight Board, charged with the duties of registering and inspecting public accounting firms, enforcing compliance with the Act, and establishing standards regarding the preparation of audit reports for companies, including auditing, quality control, and ethics standards. Only those accounting firms that have registered with the Oversight Board within six months of its creation will be permitted to audit public companies.¹⁴

The Act creates new crimes and new penalties for corporate fraud and, notably, provides for imprisonment for up to twenty years for knowingly concealing, destroying, or altering documents sought in certain federal investigations. The Act also increases sentences for mail and wire fraud and permits temporary freezes on payments to employees of companies being investigated by the SEC. In addition, the Act extends the statute of limitations for private securities fraud claims under Rule 10b-5, which applies to non-profit corporations that issue tax-exempt debt as well as public companies. Finally, the Act gives federal protection to employees of public companies who act as whistleblowers.¹⁵

II. Several States and the IRS Respond

Several states either have enacted, proposed, or are considering legislation in response to the Sarbanes-Oxley Act of 2002. Some of the statutes would impose requirements

similar to the Act. Others increase penalties for violations of existing corporate fraud laws or focus on encouraging whistleblowers to report misconduct of which they become aware.

- In California, lawmakers have enacted comprehensive legislation requiring public companies doing business in the state to report all executive stock options, loans to directors, bankruptcies, fraud convictions, or violations of securities or banking laws.¹⁶
- Connecticut legislation would establish a corporate whistleblower hotline at the Attorney General's office.¹⁷
- A Kentucky bill would make it a felony for businesses with \$1 million or more in assets to falsify or deliberately omit financial information from financial records.¹⁸
- Massachusetts legislators have proposed a new law that would prohibit employers from retaliating against employees who disclose illegal acts of the employer.¹⁹
- The New York Attorney General has sought sponsorship for legislation that would impose requirements similar to those of Sarbanes-Oxley upon all corporations, including non-profits. Provisions for non-profit corporations would include requiring CFOs and treasurers to certify the accuracy of annual reports, requiring certain corporations to establish independent audit committees, tightening conflicts of interest rules, and providing specific rules for approving director and officer compensation.²⁰

- A Texas bill would establish a corporate integrity unit within the state attorney general's office to assist in investigating alleged misconduct and enforcing corporate fraud laws already on the books.²¹

Also in direct response to the Act, the IRS recently sought public comment on possible changes to Form 990 that would expand certain reporting requirements for tax-exempt organizations in order to increase public confidence in the integrity of exempt organizations' disclosures. The proposals under IRS consideration include requiring exempt organizations to disclose: (1) whether they have conflicts of interest policies or independent audit committees; and (2) additional information about transactions with substantial contributors, officers, directors, and trustees. The IRS also requested suggestions for other information exempt organizations might be required to disclose in order to raise public confidence.²²

As public companies begin to comply with the requirements of the Sarbanes-Oxley Act and federal and state regulators begin to see the practical effects and limitations of such compliance, managed care organizations and other corporate entities may expect to see more federal and state regulation of corporate responsibility.

III. The Effect of Sarbanes-Oxley on Managed Care Organizations

The Sarbanes-Oxley Act of 2002 made headlines when it was passed last year. Since its

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enactment, the Act has been the subject of much discussion. But what will it really mean for the managed care organizations to which it directly applies? What will it mean for non-publicly traded for-profit and non-profit corporations?

Managed care companies, whether or not publicly traded, already are heavily regulated at the state level. Thus, public managed care companies may not feel the burden of the Act's disclosure and corporate responsibility provisions to the same extent as other companies, and non-public companies may already be subject to analogous requirements. For example, the SEC now has the power under the Act to bar unfit directors. Many state managed care licensing laws already require that regulators approve the character and competency of a managed care organization's proposed directors and officers prior to issuing a certificate of authority. Under some state laws, managed care organizations also must disclose to the public their directors, stakeholders, and ultimate owners.

Many states already regulate and audit the finances of managed care organizations and require annual disclosure of the organization's financial condition, reserves, and ability to pay claims. In some instances, the Act's new CEO and CFO certification requirements are similar to, although harsher than, those under existing state HMO licensing laws. For example, under Pennsylvania law, at least two principal officers of a licensed HMO must verify the

statement of financial activities filed annually with the state's Department of Insurance.²³

Similarly, many managed care organizations already are required to have a certain number of directors who are independent. The Sarbanes-Oxley Act and proposed NYSE rules would require that majority of the board and all of the members of certain committees of public companies be composed of persons who are not otherwise affiliated with the company. Under the HMO licensing laws of some states, such as New York, subscribers must comprise a certain proportion of the governing board.²⁴ Presumably one of the purposes of such requirements is to assure that the board includes persons with no financial interest in the HMO's performance.

For non-profit managed care organizations, the Act's requirements similarly parallel existing obligations. Managed care organizations organized as tax-exempt charitable entities are subject to IRS oversight at the federal level and attorney general or court oversight at the state level to assure the proper use of charitable assets. For example, proposed conversions of managed care organizations from non-profit to for-profit status frequently are subject to close regulatory scrutiny. In some cases, an attorney general is empowered to review and approve non-profits' fundamental corporate transactions and order disgorgement of funds improperly paid to charitable organizations' directors and officers. Many states' non-profit corporation statutes already bar loans to directors and officers. IRS regulations set forth a proce-

dures for independent review of executive compensation and impose high penalty taxes upon executives who receive and directors who approve excessive compensation.

However, the largest impact of the Act may be felt in less direct ways—through the public's closer focus on corporate responsibility. In the wake of Sarbanes-Oxley, managed care enrollees, or board members who also serve on the boards of other public companies, may be more likely to request financial information or seek assurance that the managed care organization is run by independent directors and advisors. The additional disclosures that publicly traded managed care organizations must make may become "best practices" for non-publicly traded organizations by virtue of public and board member expectation. Audit firms that are directly subject to the requirements of the Sarbanes-Oxley Act will likely change how they interact with all of their clients, regardless of whether those clients are themselves subject to the Act. These may, in turn, increase the likelihood that the Act's requirements will "migrate" toward organizations that are not directly subject to it.

In all, managed care organizations, regardless of corporate status, and their board members would be well advised to pay close attention to corporate responsibility. Corporations already are subject to fiduciary responsibilities under state corporate law, and some might argue that the Act simply makes more explicit what is otherwise already required. Because cor-

porate responsibility has become a higher priority for both federal and state regulators as well as the subject of greater public attention, managed care organizations that are not directly subject to the Act should consider implementing some of its principles. For example, adopting a robust conflicts of interest policy, assuring the independence of nominating, compensation and audit committees, or reviewing and, if necessary, adjusting board composition might be a good start.

Endnotes

¹ Sarbanes-Oxley Act of 2002 §§ 302-04, 1106, Pub. L. No. 107-204, 116 Stat. 745 [hereinafter Sarbanes-Oxley].

² *Id.* §§ 306, 402.

³ *Id.* § 406; 17 C.F.R. § 229.406 (2003).

⁴ Sarbanes-Oxley, §§ 305, 307.

⁵ April 4, 2003: Corporate Governance Rule Filing (SR-NYSE-2002-33), available at www.nyse.com.

⁶ Sarbanes-Oxley, § 301.

⁷ *Id.*

⁸ *Id.* § 407; 17 C.F.R. § 229.401.

⁹ Sarbanes-Oxley, §§ 204, 303.

¹⁰ *Id.* §§ 203, 206.

¹¹ *Id.* §§ 201, 202.

¹² *Id.* §§ 401, 403.

¹³ *Id.* §§ 403, 409.

¹⁴ *Id.* §§ 101, 102.

¹⁵ *Id.* §§ 802, 804, 806.

¹⁶ 2002 Cal. Stat. 1015.

¹⁷ S. 230, 2003 Gen. Assem., Reg. Sess. (Conn. 2003), available at <http://www.cga.state.ct.us>.

¹⁸ S. 10, 2003 Gen. Assem., Reg. Sess. (Ken. 2003), available at www.lrc.state.ky.us/legislat/legislat.htm.

¹⁹ S. 59, 2003 183d Gen. Ct., Reg. Sess. (Mass. 2003), available at www.state.ma.us/legis/bills.

²⁰ Press Release, New York Attorney General's Office, Spitzer's Corporate Accountability Reforms Include Proposals Covering Not-for-Profits (Jan. 23, 2003), available at www.oag.state.ny.us/press/2003/jan/jan23a_03.html.

²¹ H. 2039, 2003 78th Legis., Reg. Sess. (Tex. 2003), available at www.capitol.state.tx.us.

²² I.R.S. Announcement 2002-87 (undated), available at www.irs.gov/charities.

²³ 40 PA. CONS. STAT. § 1561(a) (2000).

²⁴ N.Y. COMP. CODES R. & REGS. tit. 10, § 98-1.11(f) (requiring at least 20% of an HMO's governing board to be composed of non-employee, non-provider subscribers within one year of the HMO's receipt of a certificate of authority).



June 30 - July 2, 2003

Annual Meeting 2003

HMOs and Health Plans Luncheon *July 2, 2003 12:00 noon - 1:20 pm*

Presenters:

Kevin D. Gordon, Esq., Crowe & Dunlevy PC, Oklahoma City, OK and

Gregory N. Pimstone, Esq., Manatt Phelps & Phillips LLP, Los Angeles, CA

Health maintenance organizations (HMOs) and health plans currently operate in a highly litigious environment that has been recently distinguished by new strategies employed by plaintiff's counsel to attempt to hold health plans liable for delays in medical care which may have been caused by providers or provider networks. As a result, traditional medical malpractice liability cases have been used as an entry to raise attacks on managed care and/or utilization review cases in an effort to broaden the liability base from providers to HMOs and health plans. Guest speakers will present a luncheon discussion for Practice Group members which will examine the various litigation strategies being used by the plaintiffs and the health plan defenses to these attacks. As will be discussed, recent cases highlight the increasing difficulty that exists in distinguishing between the practice of medicine and insurance utilization review. This ambiguity spills into other areas such as whether plan medical directors are engaging in the practice of medicine when they make eligibility and/or other utilization review decisions. Among the cases and issues that are likely to be reviewed and discussed are practical effects of the Kentucky Association of Health Plans case, including its impact upon credentialing and other areas.

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Join Us in San Antonio, Texas!

Antitrust Primer with Practical Application

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With increased attention to healthcare antitrust issues, Health Plans and Providers should be aware of not only the fundamental antitrust laws that govern their business, but how these laws apply to specific activities. This document provides an overview of antitrust laws and issues as they relate to Health Plans and Providers. This document also: (i) provides an overview of current healthcare antitrust activity; (ii) points out areas of antitrust risk; and (iii) presents practical tips to identify and avoid risk.

I. Current Antitrust Activity and Enforcement in Healthcare

Notwithstanding the fact that during the last decade the Federal Trade Commission (FTC) has not been particularly successful in stopping hospital and other healthcare related merger activity, it is fair to say that both the FTC and the Antitrust Division of the Department of Justice (DOJ) are very interested in promoting and protecting competition in the healthcare industry. In fact, the FTC and DOJ are jointly sponsoring a number of hearings this year addressing a wide range of topics impacting healthcare and competition. These hearings will culminate in the preparation of a public report. The goals of the hearings include fact gathering, discussion, and policy development. Health Plans and Providers should pay close attention to developments that may arise out of the following agenda items: (1) defining product and geographic markets for hospitals; (2) contracting practices of hospitals; (3) post-merger conduct of hospitals; (4) health insurer market definition; (5) health insurer monopsony issues; (6) health insurer/Provider countervailing market power; (7) most favored nations clauses; (8) physician-hospital organizations; (9) physician product and geographic market definition; (10) IPA patterns and benefits of integration; and (11) the messenger model.

At the first such hearing, the acting assistant attorney general for antitrust advised that the DOJ is considering convening a grand jury to investigate possible collusion by a group of Health Plans to set provider fees. Similarly, physicians in Ohio and Kentucky have recently brought private civil antitrust suits against Health Plans for alleged collusion on provider fees. Further, the FTC recently issued an advisory opinion permitting a physician group to retain an advocacy group to undertake a public education campaign critical of Health Plans for allegedly under compensating physicians in the Dayton area and allegedly hampering physician recruitment and retention¹. Given the rising cost of healthcare services, more governmental antitrust scrutiny of Providers and Health Plans can be expected. It is therefore very important for Health Plans as well as Providers to have a basic understanding of antitrust policy and laws.

II. Antitrust Policy and Laws

The purpose of the federal antitrust laws is to promote and protect free enterprise and competition for the benefit of consumers. The key to understanding these laws is understanding that they are designed to protect competition, *not competitors*. The public policy behind the antitrust laws is that competition is a good thing for consumers. The antitrust laws reflect the fundamental concept that a marketplace characterized by fair competition will cause the most innovative and efficient companies to thrive and consumers to benefit by the availability of higher quality goods and services offered at lower prices.

The antitrust laws attempt to prevent companies from unfairly obtaining market power. The concern with excess market power is that it can cause a misallocation of resources and an inequitable distribution of wealth. However, market power that is obtained fairly on a company's competitive merits is lawful and is protected by the antitrust laws.

It is not uncommon for business people to confuse the purpose of the antitrust laws, equating them to business torts. However, unlike tort law, where a plaintiff need only show harm caused by the defendant, in order to prevail in an antitrust action, a governmental enforcement agency or a private plaintiff must prove that competition or the competitive nature of a particular market is harmed. In other words, antitrust injury exists where competition is lessened in a market—not simply where a competitor is disadvantaged in a market. In order for a private plaintiff to prevail in an antitrust suit against a competitor, the plaintiff must show that its harm is caused by a wrongful action by the defendant that also caused harm to competition (i.e., increased prices or decreased output).

There are four principle antitrust laws. They are the Sherman Act,² the Clayton Act,³ the Robinson-Patman Act,⁴ and the Federal Trade Commission Act.⁵ These laws apply only to conduct or activity in or affecting interstate or foreign commerce (i.e., virtually all activity in modern commerce). In addition to the four basic antitrust laws that proscribe certain conduct, the National Cooperative Research and Production Act (NCRPA)⁶ provides certain relief from antitrust laws for high tech joint ventures.

The *Sherman Act* prohibits agreements or understandings between two or more persons or companies to restrain trade in any product or service (§ 1). The broad language of the statute has been held to encompass a variety of anticompetitive practices such as price-fixing, allocation of a market or its customers within a market, group boycotts and/or concerted refusals to deal, tying arrangements, and exclusive dealing agreements.

Section 2 of the Act prohibits any single firm, either acting alone or with another, from illegally monopolizing or attempting to monopolize a particular product or service in a market. In addition to monopolization, this section of the act prohibits various practices by a company with monopoly power such as: (1) leveraging one prod-

uct or service to sell another product or service; (2) denying competitive access to an “essential facility” (a firm in the market that competitors must have access to in order to compete, e.g., the only physician group in a market); and (3) predatory pricing (pricing below marginal cost to eliminate competition).

The *Clayton Act* prohibits specific acts or practices that may have anticompetitive results. Section 3 of the Clayton Act prohibits exclusive dealing arrangements, tying sales, and output and requirements contracts in the sale of goods (as opposed to services) where the effect of those three arrangements may result in a substantial lessening of competition. Sections 7 and 7A deal with mergers, acquisitions, consolidations, and joint ventures. The former prohibits mergers and acquisitions that may substantially lessen competition or create a monopoly, whereas the latter requires certain large transactions to give pre-merger notification to the federal antitrust agencies so that a merger can be challenged if the agencies believe that it will create a monopoly.

The *Robinson-Patman Act* addresses price discrimination in the sale of goods (as opposed to services). It prohibits a seller, under certain circumstances, from discriminating in the price of a product of like quality and grade between two competing customers or favoring one competing customer over another in the granting of promotional services, facilities or allowances. It also applies to buyers who knowingly receive illegally discriminatory prices.

The *Federal Trade Commission Act* at § 5 (a catch-all provision) broadly prohibits any “unfair methods of competition” and any “unfair or deceptive acts or practices” including those prohibited by the Sherman and Clayton Acts. The broad language of this statute has been held to extend beyond the prohibitions of the other antitrust laws but for the most part has been construed similarly to the Sherman and Clayton Acts.

The *National Cooperative Research and Production Act*, passed in 1984 and amended in 1993, has as its purpose to provide antitrust relief for joint ventures involving high tech research, development, and production. The policy behind the law was to encourage cooperative arrangements among unaffiliated businesses in the private sector for technological innovation. The law allows proper parties to escape the more onerous *per se* scrutiny (as explained below) and provides for a reduction in damages for prevailing plaintiffs.

III. “Per Se,” “Rule of Reason,” and “Quick Look” Standards of Antitrust Review

Not all restraints of trade violate the Sherman Act. Rather, only *unreasonable* restraints present antitrust concern. In determining whether a restraint is unreasonable, there are two basic standards of review and one hybrid standard.

The “*Per Se*” standard of review is reserved for those certain trade restraints that have been identified by the courts as so restrictive of competition and so lacking in justification that they are condemned as illegal and unreasonable *per se* regardless of their business pur-

pose and regardless of whether any injury to competition has in fact taken place. *Per se* violations essentially have no redeeming value. Examples of *per se* violations include agreements between competitors: (1) to fix prices; (2) to allocate or divide a market; (3) to conduct a group boycott or refuse to deal; and (4) to condition the sale of one product or service on the purchase of another product or service (tying). *Per se* violations are often prosecuted as crimes with no need legally to prove actual anticompetitive harm. Rather, such harm will be presumed due to the insidious nature of the practice.

The “*Rule of Reason*” standard of review applies to all other violations. The *rule of reason* standard permits a court to determine whether the restraint at issue actually promotes or suppresses competition. This analysis involves an extensive and detailed inquiry into an activity’s reasonableness in light of surrounding circumstances. Essentially this analysis involves a balancing of the anticompetitive effects and the pro-competitive efficiencies of a particular restraint of trade in a particular arrangement. A *rule of reason* analysis will involve determining the relevant geographic and product markets as well as the market share of the company engaged in the challenged conduct. Cases involving the rule of reason standard are typically very expensive and time consuming.

The “*Quick Look*” standard is somewhat of a hybrid of the two basic standards and is also referred to as the truncated *rule of reason*. Under certain circumstances, this approach allows the court to condemn particular restraints without resorting to a full blown rule of reason market analysis and balancing of competitive effects.

IV. Penalties/Enforcement

Federal antitrust laws are enforced by the FTC, the DOJ, and by private plaintiffs. Only the DOJ has authority to enforce the criminal provisions of the antitrust laws. Only the FTC has the authority to enforce the Federal Trade Commission Act.

The FTC and DOJ have divided up healthcare antitrust enforcement such that the DOJ handles cases involving health insurers and the FTC handles cases involving Providers, e.g., physician price-fixing and boycott cases. However, since the FTC has limited jurisdiction over conduct involving non-profit corporations, (except for mergers of non-profit hospitals), the DOJ will continue to handle most matters involving the majority of hospitals. Further, since the FTC has no criminal authority, the DOJ handles criminal cases. However, the FTC does have the authority to seek injunctions for violations of the Clayton Act and the Federal Trade Commission Act.

A criminal violation of the Sherman Act is a felony. The statute of limitations for such a violation is five years. The maximum penalty for individuals for each violation is three years imprisonment and a fine equal to the greater of twice the gain or loss or \$350,000. The maximum fine for a corporation is \$10 million or twice the gain or loss resulting from the violation. A private plaintiff who is injured

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by reason of a violation of the antitrust laws may recover treble damages plus costs and attorneys' fees.

V. Antitrust Risk for Providers—Price-fixing, Exclusive Dealing, and Other Illegal Conduct

A. Price Fixing

One of the most prevalent antitrust concerns today for Health Plans is potential price fixing among Providers. Numerous cases involving physician price fixing have been prosecuted by the enforcement agencies. What frequently happens in a price fixing case is that a group of independent physicians join a Provider network such as an independent practice association or a physician-hospital organization (hereinafter collectively referred to as an IPA) and they then allow the IPA to negotiate on their behalf with Health Plans. What these physicians often do not realize is that they may in fact be engaged in illegal price-fixing (depending on the nature of the IPA, its market share, and the type of agreement that is being negotiated).

In general, illegal price-fixing occurs if two or more competitors come together and agree upon the price that they will charge buyers. Price-fixing is a *per se* violation of the Sherman Act and the type of conduct that the DOJ typically prosecutes criminally. Examples of illegal price-fixing by competing Providers include agreements regarding: (1) use of fee schedules to set fees; (2) the maximum prices to be charged; (3) the range of prices to be charged; (4) the amount of co-payment; (5) whether or not to grant discounts; (6) whether or not to participate in a Health Plan if it fails to increase prices; and (7) coercing a Health Plan to increase reimbursement.

If an IPA is neither economically nor clinically integrated, group negotiations with Health Plans is considered “naked” price-fixing and therefore illegal. “Naked” price-fixing means that the agreement on price is unrelated to an economically integrated business function designed to achieve various efficiencies. The DOJ and FTC have published policy statements for the healthcare industry with specific “safety zones”⁷ of protection. One such statement describes the type of integration that will be deemed acceptable for joint price negotiations with Health Plans. Essentially an IPA will be deemed economically integrated if it involves the sharing of substantial financial risk among its physician members.

Consequently, safety zone protection is accorded to negotiations by an IPA regarding capitation payments with a Health Plan. Safety zone protection is also accorded to negotiations that involve discounted fee-for-service agreements with substantial withholds, e.g., discounts in the 75th percentile and withholds of 15-20% paid out based on group performance. However an IPA that can legally negotiate jointly with respect to arrangements involving capitation or discounted fee-for-service with substantial withholds payments may not negotiate jointly for fee-for-service or other agreements that do not involve

the sharing of financial risk. In other words, joint negotiations by an IPA may be legal in some circumstances and illegal in others.

Safety zone protection may also be accorded a Provider organization that is not economically integrated so long as it has a sufficient level of *clinical integration* creating a high degree of interdependence and cooperation among its physician members to control costs and ensure quality. Because the concept of *clinical integration* is relatively untested (other than a recent FTC advisory opinion that provides limited guidance),⁸ a Health Plan that wishes to negotiate with individual physicians rather than groups of physicians may consider advising the IPA that it will deal with its physician members only through use of a “messenger model” of communication (whereby offers and acceptances are communicated individually by and through a messenger and not shared by and among network members).

Even though a Provider network may have substantial economic integration, a Health Plan may still challenge its legal ability to negotiate on behalf of Providers if the network has monopoly power, i.e., the power to raise and maintain prices above competitive levels for a period of time. Exclusive Provider networks have safety zone protection if their market share consists of 20% or less of the physicians within a specialty and within the geographic market. The safety zone market percentage is raised to 30% for nonexclusive Provider networks.

B. Exclusive Dealing Among Providers

In general, exclusive arrangements have a greater probability of restricting competition than do non-exclusive arrangements because they restrict the excluded party's ability to compete outside of the exclusive arrangement. As a result, exclusive arrangements have the potential to foreclose competition in a market. If the foreclosure is substantial, the arrangement may raise antitrust concerns. An IPA with substantial market share that limits its members from contracting with Health Plans outside of the IPA can be challenged by enforcement agencies or private plaintiffs as foreclosing competition.

C. Other Illegal Conduct

In addition to price-fixing, other illegal conduct by Providers includes group boycott, and/or tying. An example of a group boycott is when physicians in an IPA agree among themselves to refuse to deal with a particular Health Plan. An example of unlawful tying is when a hospital ties the sale of its hospital services to a Health Plan's purchase of affiliated physician services.

VI. Antitrust Risk for Health Plans—Monopoly, Most Favored Nations, Exclusive Dealing, and Other Restraints

A. Monopoly and Monopsony Power

Monopoly and Monopsony Power represent mirror opposite antitrust concerns. Monopoly power is when a seller is able to raise prices above competitive levels and maintain them above competitive levels for a period of time. The economic impact of monopoly

and the harm it causes consumers is that output decreases and prices increase. Monopsony power, on the other hand, is the power of a *buyer* to decrease and maintain prices below competitive levels for a period of time. The economic impact of monopsony and the harm it can cause competition is a misallocation of resources such that wealth is transferred from the producer to the buyer. The terms monopoly and monopsony, although technically different, are often used interchangeably.

Often, large Health Plans are criticized by Providers as monopsonistic and/or having uneven bargaining power and unfair buying power. However, just because a Health Plan is large and powerful and just because that Health Plan is able to extract low rates from Providers does not mean that such Health Plan has exercised illegal monopsony power. In general, in order for a Health Plan to have monopsony power the Health Plan must have substantial market share and there must be substantial barriers preventing other Health Plans from entering the market and buying the Providers' services.

Moreover, just as the antitrust laws permit a seller with legitimately earned monopoly power to use its power to get the highest price that the market will bear, similarly a buyer with legitimately earned monopsony power may pay as little as it can (other than predatory payments) to purchase the products or services that it wants. Thus monopoly or monopsony power alone are not illegal. However, if Health Plans agree among themselves as to what they will pay Providers, they risk a challenge of monopsonistic price-fixing.

Enforcement actions against large Health Plans acting alone are relatively rare. The fact that the playing field between Providers and Health Plans may not be even is of little concern to the antitrust laws and their enforcement agencies. Regardless, Providers, have filed several suits against large Health Plans under § 2 of the Sherman Act prohibiting unlawful monopoly. These cases are generally not successful.

B. Most Favored Nations Clause

A Most Favored Nations Clause (MFN) is an agreement between a Health Plan and a Provider whereby the Provider agrees that it will not accept a lower rate from any other Health Plan. In other words, the Provider will always give the best deal to the Health Plan with whom it has a MFN. Thus, if the Provider does accept a lower rate, it must lower its rate to the Health Plan who has the benefit of the MFN. MFNs can cause antitrust harm when the Health Plan places this restriction on numerous Providers in the market and the amount of reimbursement that each such Provider receives from the Health Plan accounts for a substantial amount of that Provider's revenues. When this occurs, the Providers will be unlikely to offer rate discounts to other Health Plans and this may impair the ability of other Health Plans to conduct business in the market (barrier to entry) or may cause these other Health Plans to have to pay higher rates than they might otherwise have to pay. Although MFNs may harm competitors, whether or not they actually harm competition

ultimately depends largely upon the market power of the parties. It is fair to say that DOJ is quite concerned about the potential adverse impact of MFNs and has opposed MFNs in several cases—all resulting in consent decrees that eliminate MFNs. However, thus far no court has ruled that MFNs are illegal. If challenged, the MFN would be analyzed using the *rule of reason* standard. Factors the court would take into account include market share of the parties to the MFN and barrier to entry by other competitors.

C. Exclusive Dealing Between IPAs and Health Plans

Exclusivity between IPAs and Health Plans can take two basic forms. Under the first scenario, a Health Plan agrees to contract exclusively with a particular IPA within a particular market. Under the second scenario, an IPA agrees to contract exclusively with a particular Health Plan in a particular market. Additionally, the Provider/Health Plan relationship can provide for mutual exclusivity. Because Health Plans and Providers are generally not competitors (unless the Health Plan is Provider controlled), the agreement is considered a *vertical* rather than *horizontal* restraint of trade. As such, if challenged, the effect of the arrangement will be analyzed under a *rule of reason* standard. The ultimate antitrust question is whether the exclusive relationship causes competition to be substantially foreclosed from the relevant market and whether such foreclosure will probably cause immediate and future anticompetitive effects. For example, if a particular geographic market has only one physician group with the necessary capacity and expertise to provide services, an exclusive contract with a Health Plan may prove unlawful. Further, the duration of an exclusive dealing contract is an important factor in assessing anticompetitive effects. Obviously, shorter term contracts and/or those with easy out provisions present less antitrust risk.

D. Other Restraints on Providers by Health Plan

Examples of other attempts by Health Plans to impede competition include: (1) a refusal to contract with a hospital that operates its own Health Plan; (2) paying a higher rate to Providers in exchange for their agreement not to contract with other Health Plans; and (3) agreeing to terminate a hospital's contract in exchange for receipt of lower rates from a competitor hospital. These types of restraints may or may not violate the antitrust laws depending on their effects on competition. If challenged, these types of restraints would most likely be analyzed under a *rule of reason* analysis weighing the procompetitive and anticompetitive effects. If the conduct essentially forecloses competition for a period of time resulting in higher prices or lower quality to consumers (due to market power) the restraints will most likely be held unlawful.

Health Plans should also be aware of the potential antitrust risk arising from certain agreements between Health Plans and employers. Health Plans and employers that self-insure employee health benefits can be considered competitors with respect to the purchas-

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ing of healthcare services. To the extent that a Health Plan and an employer agree to exclude certain Providers from their respective Health Plans, this activity may constitute an illegal group boycott. Similarly, if a Health Plan and an employer agree on Provider reimbursement, the agreement may constitute unlawful price-fixing. Either type of activity holds significant potential antitrust risk and likely will be analyzed under the *per se* standard of review.

VII. A Limited Exemption from Antitrust Laws for Insurers

The McCarran-Ferguson Act⁹ is a federal law that provides a limited exemption from antitrust challenge for the *business of insurance* so long as the *business of insurance* is regulated by the particular state where the insurer conducts its business and so long as the challenged conduct does not involve an agreement to boycott, coerce, or intimidate. The *business of insurance* has been held to be those acts of an insurer that have to do with the spreading of risk and with the relationship between the insurer and the insured.¹⁰ Matters that involve the *business of insurance* include: (1) actions regarding the type of policies to offer; (2) to whom to sell the various insurance products; and (3) the amount of premiums to be charged. Matters that do not involve the *business of insurance* include: (1) Provider participation agreements; (2) levels of Provider reimbursement; (3) peer review programs (Providers reviewing the fees charged by other Providers); and (4) decisions regarding who may and who may not be a participating Provider. The term “boycott” has been held to mean “group boycott” and therefore must involve concerted activity. Further, such a group boycott can apply to conduct aimed at policyholders as well as competitors. The exemption is not limited to insurance companies but to any company involved in the *business of insurance*. Overall, the exemption has limited application and cannot be used to shield an insurer from its acts with respect to its competitors and with respect to Providers.

VIII. Noteworthy Antitrust Cases Involving Health Plans

A. *Westchester Radiological Associates P.C., et al. v. Empire Blue Cross and Blue Shield, Inc.*¹¹

The plaintiffs in this case were a group of hospital-based radiologists who worked in seventeen counties in and around New York City. The defendant was Empire Blue Cross and Blue Shield. Empire, in its contracts with hospitals, required the hospital to offer radiology services as part of the hospital package of services. The radiologists claimed unlawful restraint of trade, monopolization, and price-fixing. The court ruled in favor of Empire, holding: (1) the restraint was not anticompetitive on its face therefore the *rule of reason* analysis applies; (2) the restraint did not cause anticompetitive harm—in fact, the restraint saved consumers money; (3) even though Empire had market power there was no evidence of predatory pricing; and (4) even though there was evidence that Empire

intended to impede competition, and that Empire may have monopoly power, there was no antitrust violation because there was no harm to competition.

B. *Ocean State Physicians Health Plan, Inc., et al. v. Blue Cross & Blue Shield of Rhode Island*¹²

Plaintiffs were a health plan and a group of physicians who alleged BCBS of Rhode Island acted unlawfully to exclude the health plan from the market place. BCBS of Rhode Island had been the largest health insurance company in Rhode Island for many years. Ocean State, an HMO, moved into the market and provided more coverage for lower premiums. As a result, many subscribers switched from BCBS of Rhode Island to Ocean State. In response, BCBS of Rhode Island instigated a three prong strategy: (1) it launched its own HMO; (2) it instituted an “adverse selection” policy of pricing; and (3) it initiated a “prudent buyer” (or most favored nations) policy of paying for physician services. Under the adverse selection pricing policy, BCBS of Rhode Island priced its traditional indemnity plan three ways—the lowest price going to employers that offer the BCBS of Rhode Island indemnity plan only, a middle price for employers that offer two or more HMOs including the BCBS of Rhode Island HMO, and a higher price for employers that only offer a competitor’s HMO. The court ruled in favor of BCBS of Rhode Island holding that the McCarran-Ferguson Act exemption applied to the first two prongs of the BCBS of Rhode Island strategy and that the third prong (the MFN) was not an unlawful monopoly because there was no evidence of predatory pricing.

C. *U.S. Healthcare v. Healthsource*¹³

In this case one HMO sued another HMO for alleged antitrust violations for entering into contracts with physician providers offering higher compensation in exchange for exclusivity. The physicians were offered 14% more reimbursement for exclusivity with the defendant HMO. The physicians were able to contract with other Payors for other insurance products and the exclusive arrangement had a short term without-cause termination provision. The court ruled in favor of the defendant, holding: (1) the restraint was vertical rather than horizontal so the *rule of reason* standard applied; and (2) an exclusivity provision will only be considered an unlawful restraint of trade if it forecloses competition, which was not apparent here, because foreclosure depends on the market share of each party to the contract and the foreclosure must be substantial with a probability of immediate and future effects.

D. *Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*¹⁴

The plaintiffs in this case were a physician and a hospital (owned by a company that also owned an insurance company) in a three-hospital town. Plaintiffs’ theory was that BCBS of Kansas, alarmed by its perceived competitive threat from hospital plaintiff, determined to “hurt” it and thereby send a message to other hospitals not to do business with entities BCBS of Kansas believed

were competitors. It did this by agreeing with plaintiff hospital's competitors to terminate plaintiff hospital's provider agreement with BCBS of Kansas and to reduce the maximum allowable payments it would make to hospitals that also offered health plans, thereby causing a shift of BCBS of Kansas patients from plaintiff hospital to competitor hospitals. The termination of plaintiff hospital's provider agreement because of its affiliation with a BCBS of Kansas competitor, made other hospitals less willing to affiliate with, or enter into relationships with, BCBS of Kansas competitors. As a result, healthcare consumers in the market were restricted in their access to and benefits from healthcare financing arrangements involving entities other than BCBS of Kansas, and were deprived of the benefits of competition in that area. The jury agreed with plaintiffs and found multiple antitrust violations by BCBS of Kansas.

On appeal, the court upheld the jury's verdict because it found sufficient evidence of antitrust abuse. In reaching its conclusion, the court held: (1) plaintiff hospital had standing to assert its antitrust claims and proved an antitrust injury; (2) BCBS of Kansas entered into an agreement with the competitor hospitals that restrained trade in the market of healthcare financing; and (3) BCBS of Kansas had market and monopoly power and it willfully and unlawfully maintained its monopoly power.

*E. Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*¹⁵

BCBS of Wisconsin and its subsidiary HMO brought suit against the Marshfield Clinic (a large physician group in northern Wisconsin) and its HMO alleging that the defendants had improperly monopolized the "HMO market" in the area. BCBS of Wisconsin further alleged that the defendants had engaged in improper price-fixing and division of markets. On appeal, the court held that there is no separate HMO market because the same physicians provided services under both HMO and fee-for-service plans and there was nothing restricting the physicians from switching from one type of plan to another. In keeping with its finding that the HMO market does not constitute a separate market, the court found that the defendants, with only 50% of the physicians in the market, did not have monopoly power. However, the court did rule in favor of BCBS of Wisconsin's claim that the defendants unlawfully divided the market.

IX. Practical Tips for Health Plans

A. Red Flags Regarding Providers

- *Beware* of an IPA that attempts to negotiate fee-for-service or discounted preferred provider agreements on behalf of a group of independent practitioners. This activity may constitute illegal price-fixing.
- *Beware* of an IPA with substantial market share (generally over 30% of a particular medical specialty within the geographic market) that seeks to extract payment rates above competitive

levels. Even if the IPA is economically integrated, and even if the negotiations involve capitation payments or substantial withhold, this activity may constitute an illegal monopoly.

- *Beware* of an IPA whose members agree not to participate in a Health Plan or whose members agree to terminate participation in a Health Plan if the Health Plan fails to meet their demands. This activity may constitute an illegal group boycott.
- *Beware* of a Provider group or medical specialty society that submits collective input on fees to a Health Plan and who thereby attempts to extract agreement on such fees. This activity may constitute illegal price-fixing.
- *Beware* of a Provider-owned health plan that sets a fee schedule for its Providers. This activity may constitute illegal price-fixing.
- *Beware* of a hospital that threatens to terminate its hospital agreement if the Health Plan refuses to offer rate increases to its affiliated (non-employed) physicians. This activity may constitute illegal tying as well as illegal price-fixing.
- *Beware* of an IPA representing a large percentage of physicians in the market (over 20% if an exclusive network and over 30% if a non-exclusive network) that attempts to use its market power to extract higher than competitive rates from a Health Plan. This activity may constitute an illegal monopoly.

B. Red Flags Regarding Health Plans

- *Beware* of entering into an agreement with a Provider to exclude that Provider's competitor(s) in exchange for a larger price discount—particularly where the Health Plan has a substantial market share. This activity may constitute an illegal restraint of trade and/or monopoly.
- *Beware* of entering into an agreement with a Provider restricting that Provider's ability to contract with competitive Health Plans—particularly where the Health Plan has a substantial market share. This activity may constitute an illegal restraint of trade and/or illegal monopoly.
- *Beware* of refusing to deal with a Provider who competes with Health Plans in the insurance business—particularly where the Health Plan has substantial market power. This activity may constitute an illegal restraint of trade and/or illegal monopoly.
- *Beware* of entering into agreements with competitors as to rates to pay Providers. This activity may constitute illegal price-fixing.
- *Beware* of entering into agreements with competitors to divide markets. This activity may constitute illegal market allocation.
- *Beware* of entering into agreements with competitors regarding which party will sell which product or service. This activity may constitute illegal market allocation.

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- *Beware* of entering into agreements with competitors to exclude certain Providers. This activity may constitute illegal group boycott.
- *Beware* of requiring Providers to agree to MFNs, particularly if the Provider group is large and the Health Plan's payments equal a substantial portion of the Provider's revenues.
- *Beware* of creating evidence of unlawful motive to harm competition. Anticompetitive expressions may constitute evidence of intent to monopolize or intent to restrain trade.

C. Red Flags Regarding Problem Evidence

Words alone do not violate the antitrust laws. However, words can be used against a party to an antitrust challenge if those words create evidence of unlawful intent to restrain competition or create evidence of a market share that is larger than actual market. As a general rule, a party should not put anything in writing that he or she would not want to say in a court of law to a judge or a jury.

However it is not uncommon for business people to occasionally flex their muscles in internal as well as external communications. Internal memos and e-mail are generally not privileged and therefore can and will be subpoenaed in the event of a challenge. Both internal and external communications should avoid overstating market share or criticizing competition. A statement such as "*We are the market leader for the entire metropolitan area and no one else comes close*" may be used as evidence of an unlawful monopoly. Similarly a statement such as "*If we can get an exclusive deal with the only physician group in town, we can drive the competition out of the market*" may be used as evidence of unlawful intent.

X. Conclusion

With the increased focus of the FTC and DOJ on healthcare issues, it is fair to say that antitrust concerns in healthcare are alive and will continue to develop. This is particularly true as the cost of healthcare continues to rise and as various healthcare models of delivery continue to evolve. Health Plans and Providers alike should understand the fundamental concepts of antitrust laws and adhere to such laws to avoid potential liability.

Endnotes

¹ FTC Staff Advisory Opinion to Gregory Binford, Esq. (PriMed Physicians) (February 6, 2003).

² 15 U.S.C. §§ 1-7.

³ 15 U.S.C. §§ 12-27.

⁴ 15 U.S.C. § 13.

⁵ 15 U.S.C. § 45.

⁶ 15 U.S.C. § 4301 et seq.

⁷ Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Healthcare (1996).

⁸ FTC Staff Advisory Opinion to John J. Miles, Esq. (MedSouth, Inc.) (February 19, 2002).

⁹ 15 U.S.C. §§ 1011-1015.

¹⁰ *Group Life Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

¹¹ *Westchester Radiological Assoc., et al. v. Empire Blue Cross and Blue Shield, Inc.*, 884 F.2d 707 (2nd Cir. 1989).

¹² *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101 (1st Cir. 1989).

¹³ *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589 (1st Cir. 1993).

¹⁴ *Walter L. Reazin, M.D., et al. v. Blue Cross and Blue Shield of Kansas, Inc. v. Hospital Corp. of America*, 899 F.2d 951 (10th Cir. 1990).

¹⁵ *Blue Cross and Blue Shield United of Wisconsin and Compcare Health Servs. Ins. Corp. v. Marshfield Clinic and Security Health Plan of Wisconsin, Inc.*, 65 F.3d 1406 (7th Cir. 1995).

HMOs and Health Plans

Sponsored Breakfast at Managed Care Law Conference 2003

The HMOs and Health Plans Practice Group sponsored a breakfast meeting on Friday, May 16, 2003 at the Managed Care Law Conference in Colorado Springs. Approximately 40 people attended. Margit Nahra opened the meeting with an overview of the Practice Group's activities over the past year, followed by a presentation by Lisa Hathaway on the Practice Group's new affinity group initiative. Linda Tiano, Vice President and General Counsel of Well-Choice, then led the group in a spirited discussion of the impact of recent ERISA cases on health plan operations, the direction of health plan liability, and health care reform. Those interested in joining or leading an affinity group addressing HIPAA, Contracting, Regulatory or Litigation for HMOs and health plans should contact Lisa Hathaway at lhathaway@HCR-ManorCare.com.

The Medicaid Provider Tax Law—How to Maintain the Financial Viability of State-Sponsored Medicaid Managed Care Programs

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I. The State Budget Crunch

States throughout the country are currently in an economic free fall with deficits in excess of \$50 billion that are at their largest since the 1940s. Rainy day funds and the use of tobacco settlement money no longer exist to prevent significant cuts in government programs, particularly healthcare.² States are exploring numerous options to meet the growing demand for Medicaid coverage despite limited fiscal resources. The latest foray into anchoring depleted Medicaid programs is the imposition of a premium tax on managed care plans.

II. The Medicaid Provider Tax Law

Several states, including Michigan, Oklahoma, Nebraska, Arizona, Wisconsin, and Maryland, have either enacted or proposed legislation to assess a tax on HMOs. The laws are designed to add revenue to faltering Medicaid programs.

A decade ago, Congress became concerned that states were using provider taxes improperly to increase the federal contributions to Medicaid programs. In response, Congress enacted a law in 1993 that placed limitations on provider assessment programs (Provider Tax Law).³ The Provider Tax

Law establishes basic rules and procedures for how a provider tax can be applied. A state may receive, without a reduction in federal financial participation, healthcare-related taxes if all of the following requirements are met: (1) the taxes are broad-based; (2) the taxes are uniformly imposed; and (3) the tax program does not violate the hold harmless provision specified under the law.⁴ Prior to the enactment of the Balanced Budget Act of 1997,⁵ the Provider Tax Law defined the term “health maintenance organization” to include all managed care plans regardless of whether they were authorized to provide benefits to Medicaid recipients. In 1997, Congress limited the scope of the term to managed care organizations that provide services to Medicaid-eligible enrollees.⁶ The change in the Provider Tax Law was a critical development because states like Michigan that were initially inclined to propose a tax on all HMOs met stiff resistance from plans that did not participate in the Medicaid managed care program. The non-Medicaid Managed Care Organizations (MMCOs) in Michigan viewed the proposal as a significant financial liability without any positive return. Once Michigan became aware of the possibility that non-Medicaid HMOs could be removed from the burden of the levy, Michigan’s initiative received the support necessary to win legislative approval.

III. The Tax Must Be Broad-Based

Under the rules pertaining to permissible healthcare-related taxes, the term “broad-based” is defined as a tax that is

“imposed on at least all healthcare items or services in the class of providers of such items or services furnished by all non-federal, non-public providers in the state, and is imposed uniformly.”⁷ A broad-based tax, for example, must include an entire class of providers within a definable group such as hospitals or nursing homes.

IV. The Tax Must Be Uniform

Uniformity is another requirement that must be satisfied.⁸ The uniformity requirement obligates states to tax providers at the same rate for all providers within the class.

V. The Tax Cannot Guarantee a Return of Revenue

The third requirement that states must satisfy is the assurance that the levy does not include a hold harmless provision guaranteeing a return of the revenue to providers.⁹ The Centers for Medicare and Medicaid Services (CMS) recently reviewed Nebraska’s managed care tax law and determined that the law violated the hold-harmless provision.¹⁰ The legislation imposes a five percent assessment on the state’s only Medicaid managed care organization, United Health Care.¹¹ The law also contains a provision that required the tax to be implemented upon approval by CMS. In CMS’ letter to the Medicaid Division of the Nebraska Department of Health and Human Services, Thomas Lenz, a CMS Associate Regional Director, wrote:

CMS has neither the authority nor a process to review State laws prospectively for the impact on

State Medicaid claims. If CMS prospective “approval” is required as a precondition to the bill becoming effective such a precondition can never be met. CMS authority is limited to review of State claims that are submitted for federal financial participation under the Medicaid statute.

According to CMS, the Nebraska statute directly links the rate increase as an offset to the five percent tax. CMS concluded that the law represents a hold harmless arrangement because it guarantees to hold the provider class (the Medicaid health plan) unaccountable for the tax. CMS explained that “[a]lthough taxes are considered allowable administrative costs in determining capitation rates because Nebraska plans to impose a 5% revenue tax on its MCO and then increase taxes by 5% to offset the tax, sufficient evidence exists to demonstrate a direct hold harmless arrangement.” Based on Nebraska’s experience, states need to be careful to steer clear from either legislating or making other special arrangements with health plans to minimize the risk of CMS refusing to authorize federal financial participation revenue.

VI. Actuarial Soundness

One of the quandaries that state Medicaid managed care programs face is not only the issue of declining state revenues, but also the obligation to maintain such programs in an actuarially sound manner. Federal law requires states that elect to participate in the Medicaid program to set rates on

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an actuarially sound basis.¹² In the federal regulations pertaining to MMCOs, states can only enter into risk contracts if the payments are actuarially sound.¹³ The issue of actuarial soundness has become significant lately particularly since a Colorado Court of Appeals found that the Colorado Department of Health Care Policy and Financing breached its contract with the Rocky Mountain Health Maintenance Organization. The court determined that Colorado failed to establish capitation rates in an actuarially sound manner and upheld the plan's \$15 million damage award.¹⁴ The case has sent shockwaves throughout the Medicaid managed care state program community and explains in part why states are scrambling to shore up the economic effectiveness of their Section 1915(b) waivers.¹⁵

VII. State Health Plan Tax Legislation

States that seek to impose a premium tax on health plans must first enact legislation that establishes the tax and provides distribution of the revenue. If the legislation is consistent with the intent of the provider tax law, then CMS, the agency that enforces the provider tax law, will not question the initiative as long as the basic requirements of the law are met. As part of the legislation, however, states can impose no more than a six percent tax on provider revenue and the law must be limited to statutorily recognized healthcare items or services.¹⁶ MMCOs are specifically identified as a class that can be the subject of state tax legislation.¹⁷

VIII. The Michigan Legislation

Michigan was one of the first states to move toward imposing a tax on revenue generated by MMCOs. On May 10, 2002, the Medicaid Quality Assurance Assessment Fee law was enacted.¹⁸ The law was subsequently amended on December 23, 2003 to address hold harmless issues raised by CMS.¹⁹ The assessment applies to Michigan HMOs that have a Medicaid managed care contract awarded by the Michigan Department of Community Health (MDCH).

For HMOs that maintain a Medicaid managed care contract, the MDCH is authorized to impose a fee that equals no more than six percent of a plan's total non-Medicare premiums.²⁰ Health plans that fail to pay the fee may be subjected to a penalty of five percent of the assessment for each month that the assessment and penalty were not paid, up to a maximum of fifty percent of the assessment.²¹

Michigan's MMCO tax law specifically refers to the Provider Tax Law by providing:

The department of community health shall implement this section in a manner that complies with federal requirements. If the department of community health is unable to comply with the federal requirements for federal matching funds under this section or is unable to use the fiscal year 2001-2002 level of support for federal matching dollars other than for a change in covered benefits or covered population required under the state's

Medicaid contract with health maintenance organizations, the quality assurance assessment fee under this section shall no longer be assessed or collected.²²

Michigan's health plan tax is different from Nebraska's in that its enforceability is not conditioned on CMS' prior approval. Michigan's explicit reference to "federal requirements" is intended to guard against federal preemption. More importantly, Michigan's legislation satisfied all federal requirements.²³

CMS made it clear when it reviewed Nebraska's law that the following elements need to be satisfied to avoid a reduction in federal Medicaid funding:

- (1) The tax is broad-based. All Medicaid managed care organizations are taxed.
- (2) The tax is uniform. The tax rate must be applied equally to Medicaid MCOs.
- (3) There is no hold harmless arrangement with respect to the tax (either directly or indirectly). The State cannot vary all or any portion of the Medicaid payments to the taxpayer based only on the amount of the total tax payment, or guarantee to return the tax through a Medicaid or any other type of provider payment.²⁴

"If a State," said CMS, "increased the Medicaid managed care rate to offset the cost of the provider's tax it would be a hold harmless provision."²⁵

Michigan's law easily passes the first two requirements because it applies to all MMCOs and the tax rate is applied equally

to the class. Finally, the assessment is not a hold harmless arrangement because it does not guarantee to return the tax through a Medicaid payment, and the overall calculation of the tax was used as part of an adjustment in capitation rates. CMS made it clear that such approaches are appropriate by explaining:

While Medicaid managed care rate setting regulations may allow Nebraska to consider tax costs in adjusting capitation rates, the State must maintain documentation justifying any such adjustment. Specifically the rate setting checklist says that a State must document the policy assumptions, size, and effect of these adjustments and demonstrate that they are not double counting the effects of each adjustment. . . .²⁶

The startling aspect of CMS' opinion in its letter to Nebraska Medicaid is the recognition that actuarial soundness can be achieved in part through a provider tax mechanism.²⁷

IX. The Oklahoma MMCO Tax Law

Michigan's MMCO tax law was duplicated most recently by Oklahoma.²⁸ One of the interesting differences, however, is that Oklahoma MMCOs were allowed thirty days from the effective date of the law to terminate their contracts with the Oklahoma Health Care Authority (OHCA) to presumably allow each plan to consider whether the tax would create a significantly adverse cost impact. Another dimension of the statute not addressed in the

Michigan law is the ability of plans to “create a stand alone Medicaid managed care organization” in lieu of terminating a contract with the OHCA.²⁹ The intent of this provision is to induce all health plans, particularly HMOs with a commercial “book of business,” to maintain a Medicaid managed care contract and maximize the state’s federal financial participation revenue.³⁰

X. The New Mexico, Arizona, Wisconsin, and Maryland Initiatives

New Mexico also recently enacted a health plan tax law.³¹ The law, which took effect on March 20, 2003, eliminates an insurance premium exemption provided for state payments to MMCOs. Prior to the amendment, only New Mexico indemnity plans were taxed. However, by expanding the scope of the tax to include MMCOs, the state expects to receive an influx of about \$21 million in federal matching money that it does not currently receive.³²

On May 1, 2003, the State of Arizona enacted a law that removed the exemption from the State’s insurance premium tax for MMCOs participating in the Arizona Health Care Cost Containment System (AHCCS).³³ Each Arizona MMCO will incur a two-percent tax on their monthly Medicaid capitation payments beginning October 1, 2003. The MMCOs will be required to make estimated tax payments every quarter to the Arizona Director of the Department of Insurance. Arizona expects to generate approximately \$70.9 million each fiscal year as a result of the MMCO tax, which will result in a federal match of

approximately \$47 million.³⁴ At least two other states, Wisconsin and Maryland, are seriously considering similar laws. In Wisconsin, the proposed assessment would be limited to HMOs only and based on gross revenues.³⁵ The proposed legislation would authorize the Wisconsin Department of Health and Family Services (DHFS) to assess each HMO a one percent tax on annual gross revenue based on the HMO’s annual financial statement as submitted to the Office of the Commissioner of Insurance. The bill would also allow the DHFS to distribute the revenue collected to supplement Medicaid payments to HMOs that provide services to Medicaid and Wisconsin’s BadgerCare recipients.

The Maryland legislation would impose a two percent premium tax on HMOs as part of comprehensive tax legislation.³⁶ The tax would be assigned to the general fund and would not necessarily be used to bolster the state’s MMCO program. Maryland’s indemnity plans are already subject to the tax.³⁷

XI. Provider Tax Hurdles

Although the Medicaid health plan tax laws address short-term revenue problems, the tax collection scheme can result in revenue losses if a plan’s participation in Medicaid is limited. As is evident in Oklahoma, HMOs with limited participation in the Medicaid managed care program will likely terminate their involvement in such programs or create a subsidiary to avoid being forced to pay taxes on revenue derived almost entirely from their commercial customers.

XII. Equal Protection and Pre-Emption Issues

One of the challenges that can be asserted when a provider tax law is enacted is its unconstitutionality under the Equal Protection Clause of the United States and state constitutions. This question was addressed by the Kentucky Supreme Court in *Yeoman v. Commonwealth of Kentucky Health Policy Board*.³⁸ The Kentucky Legislature enacted House Bill 250 in 1994 for the purpose of levying a two percent provider tax. The legislation imposed the tax against eight classes of healthcare items and services. The court concluded that the test for evaluating the constitutionality of the legislation was whether the law was rationally related to a legitimate state objective.³⁹ As long as provider tax legislation is intended to promote any state interest, the Kentucky Supreme Court wrote, it will likely pass the rational review test.⁴⁰

Another argument that is raised is whether the legislation violates the Supremacy Clause of the United State Constitution.⁴¹ This issue was recently addressed in *United States v West Virginia*⁴² due to a conflict between the West Virginia Provider Tax Act and the Federal Employee Health Benefits Act (FEHBA).⁴³ Under the West Virginia law, the gross receipts of almost all of the state’s healthcare providers were taxed to increase federal financial participation revenue under the Provider Tax Law. West Virginia’s defense was that its tax law was permitted pursuant to the Provider Tax Law, and that the FEHBA was superceded.

The United States District Court ruled in favor of the United States. First, the court concluded that, pursuant to the Supremacy Clause, Congress has the authority to set aside the laws of a state when enacting federal statutes. Congress’ enactment of FEHBA was intended to pre-empt state laws such as the West Virginia Provider Tax Act because FEHBA provides for the pre-emption of a state tax that is imposed, either directly or indirectly, on a carrier with respect to any payment made from the federal Employee Health Benefits Fund (Fund).⁴⁴ A state provider tax, the court reasoned, is inconsistent with the intent of the FEHBA because it “was enacted to reduce expenditures from the Fund by preventing states from charging taxes on health care reimbursements drawn by carriers from the Fund.”⁴⁵ The district court also ruled that the FEHBA and the Provider Tax Law were intended to be read and enforced harmoniously, and therefore, the Provider Tax Law does not supercede the FEHBA pre-emption provision.⁴⁶

XIII. Conclusion

The economic crisis that states are currently enduring is forcing government-mandated Medicaid managed care programs to not only maintain funding in a creative way, but to ensure that such programs are actuarially sound. As Michigan, Oklahoma, and New Mexico have recently demonstrated, one way to assist in this effort is to tax Medicaid HMOs. However, CMS is scrutinizing each state’s proposal very carefully. States that can success-

Continued on page 22

Continued from page 21

fully establish the tax as part of a comprehensive rate setting methodology will be in a much better position to satisfy federal requirements and enhance their federal financial participation revenue.

Endnotes

¹ Mr. Wexler is the General Counsel at Great Lakes Health Plan—a Michigan Medicaid Managed Care Organization. He oversees the plan’s legal affairs, human resources, and provider contracting departments. He is a member of the State Bar of Michigan Health Care Law Section and serves as Vice Chair of the Legislative Committee for the Michigan Association of Health Plans. He was responsible for identifying Michigan’s Medicaid Managed Care Organizations as a separate provider class to enable Michigan to propose and enact the first comprehensive Medicaid Managed Care provider tax law in the country. Portions of this article originally appeared in *The Michigan Health Law Reporter*—Spring 2002.

² “State Budget Constraints: The Impact on Medicaid,” Kaiser Commission on Medicaid Facts—Medicaid and The Uninsured (Jan. 2003).

³ 42 U.S.C. § 1396b(w).

⁴ 42 C.F.R. § 433.68(b)(1-3).

⁵ Pub. L. No. 105-33.

⁶ 42 U.S.C. § 1396b(w)(7)(A)(viii).

⁷ 42 C.F.R. § 433.68(c).

⁸ 42 C.F.R. § 433.68(d)(2).

⁹ 42 C.F.R. § 433.68(b)(3).

¹⁰ See CMS letter to Nebraska Medicaid (2/28/03).

¹¹ Laws 2002, Second Spec. Sess., LB9, § 2 (Nebraska Statutes).

¹² 42 U.S.C. § 1396b(m).

¹³ See 42 C.F.R. § 438.6(c)(2-5).

¹⁴ See *Rocky Mountain Health Maintenance Org. v. Colorado Dep’t of Health Care*, 54 P.3d 913 (Colo. Ct. App. 2001). Three other Colorado MMCOs—Community Health Plan of the Rockies (CHPR), Colorado Access, and Kaiser Permanente—are suing the Colorado Department of Health Care Policy and Financing for allegedly underpaying them for up to five years. CHPR’s lawsuit is scheduled for trial in August—Brand, Rachel, “Health Plan’s Lawsuit Could Bring Big Payoff,” *Rocky Mountain News* (4/23/03).

¹⁵ See 42 U.S.C. § 1396n(b).

¹⁶ 42 C.F.R. § 433.68 (i).

¹⁷ In addition to Medicaid managed care organizations, other healthcare items or services that can be subject to a tax include inpatient hospital facilities; outpatient hospital facilities; nursing homes; intermediate care facilities for the mentally retarded; physician services; home health services; outpatient prescription drugs; and such other classification of healthcare items and services as the Secretary for Health and Human Services may establish by regulation. 42 U.S.C. § 1396(b)(w)(7)(A)(i-ix).

¹⁸ Office of the Governor Press Release, “Governor Announces Support for Medicaid Quality Assurance Assessment,” (4/9/02); H.B. 4057; S.B. 748.

¹⁹ MCL § 500.224b.

²⁰ MCL § 500.224b(1).

²¹ *Id.* at § 224b(2)(f).

²² *Id.* at § 224b(2)(e).

²³ On April 22, 2003, CMS determined that Michigan’s MMCO provider tax law was consistent with federal law as part of the state’s application to renew its 1915(b) Medicaid Managed Care

waiver in a letter from CMS to the State’s Medicaid Director.

²⁴ See CMS letter to Nebraska Medicaid (2/28/03).

²⁵ *Id.*

²⁶ *Id.*

²⁷ See 42 C.F.R. § 438.6(c).

²⁸ Enrolled House Bill 1017 of 2003 (Oklahoma Law-3/18/03).

²⁹ *Id.*

³⁰ *Id.*

³¹ Senate Bill 331 (New Mexico Laws—3/20/03).

³² “Governor Signs Bill to Aid State in Meeting Rising Medicaid Costs,” *BNA’s Health Law Reporter*, Vol. 12, No. 15 (4/10/03).

³³ House Bill 2391 (Arizona Laws – 5/1/03)

³⁴ See Arizona State Senate Fact Sheet Revised for H.B.2391 (4/30/03); and “Governor Signs Measure Removing Health Insurance Premium Tax Exemption,” *BNA’s Health Law Reporter*, Vol. 12, No. 19, p. 751 (5/8/03).

³⁵ Senate Bill 44 (Wisconsin Laws).

³⁶ House Bill 753 (Maryland Laws).

³⁷ Governor Robert L. Ehrlich pledged to veto the legislation. See “Ehrolich Signs More Health Bills, But Stalls on HMO Tax, CareFirst,” *BNA’s Health Law Reporter*, Vol. 12, No. 20 p. 768 (5/15/03).

³⁸ 983 S.W.2d 459 (1998).

³⁹ *Id.* at 470-71; *Waggoner v. Waggoner*, Ky., 846 S.W.2d 704, 708, *cert. denied*, 510 U.S. 932, 114 S.Ct. 346, 126 L.Ed.2d 310 (1993) (*citing McGowan v. Maryland*, 366 U.S. 420, 425-26, 81 S.Ct. 1101, 1104-05, 6 L.Ed.2d 393 (1961)).

⁴⁰ In *Yeoman*, the court opined that “[a]ppellants have not even begun

to satisfy their burden in terms of showing that the tax in question was arbitrary or irrational. As was noted in *Regan v. Taxation with Representation of Washington*, 461 U.S. 540, 546, 103 S.Ct. 1997, 2002, 76 L.Ed.2d 129 (1983), ‘Legislatures have especially broad latitude in creating classifications and distinctions in tax statutes.’” *Lehnhausen v. Lake Shore Auto Parts Co.*, 410 U.S. 356, 359, 93 S.Ct. 1001, 1003, 35 L.Ed.2d 351 (1973); *Allied Stores of Ohio v. Bowers*, 358 U.S. 522, 526-527, 79 S.Ct. 437, 440, 3 L.Ed.2d 480 (1959); *Madden v. Kentucky*, 309 U.S. 83, 60 S.Ct. 406, 84 L.Ed. 590 (1940); *Heritage Cablevision v. Board of Supervisors*, 436 N.W.2d 37, 38 (Iowa 1989); *Revenue Cabinet v. Estate of Marshall*, 746 S.W.2d 408, 411 (Ky. Ct. App. 1988).

⁴¹ Federal law “shall be the supreme Law of the Land” and all state laws must operate in concert with federal law or be struck as invalid. *U.S. Const. Art. VI (2)*.

⁴² 238 F.Supp. 2d 751 (S.D. W.Va. 2002).

⁴³ See W.VA. CODE §11-27et seq. and 5 U.S.C. § 8909(f).

⁴⁴ 238 F.Supp. 2d at 756 (S.D. W.Va. 2002).

⁴⁵ *Id.* at 758.

⁴⁶ *Id.* at 760.

Upcoming Practice Group Teleconferences

May 2003

Danger! Erosion of the Peer Review Privilege Can Be Dangerous to Organizational and Professional Health!

Co-Sponsored by Credentialing and Peer Review (CPR), Labor and Employment (Labor), and Physician Organizations (Physicians) Practice Groups and American Society for Healthcare Risk Management (ASHRM)

Thursday, May 29, 2003

1:00 to 2:30 pm Eastern

June 2003

Financial Support Arrangements Between Academic Medical Centers and Faculty Practice Plans

Sponsored by Teaching Hospitals and Academic Medical Centers (TH/AMC) Practice Group

Thursday, June 4, 2003

1:00 to 2:30 pm Eastern

Bracing for an Industry Wreck in October: Financial Disruptions in the Transition to HIPAA Standard Transactions

Sponsored by Health Information and Technology (HIT) Practice Group

Date: Monday, June 9, 2003

Time: 1:00 to 2:30 pm Eastern

Forced Labor and Liability-The Effect of EMTALA on Physicians

Co-Sponsored by Credentialing and Peer Review (CPR) and Physician Organizations (Physicians) Practice Groups

Thursday, June 12, 2003

1:00 to 2:30 pm Eastern

Health Lawyers' Publications

AMA Press Publications

AMA Press Publications: Health Lawyers is pleased to offer a select group of publications from the American Medical Association (AMA) Press designed to assist you in providing your clients with the best advice. Titles cover HIPAA implementation, physician recruitment, medical practice divorce, and health care fraud and abuse. To find out more about the AMA Press Publications, go to

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Physician Employment and Financial Issues

By American Health Lawyers Association

This collection, culled from the presentations at 2002 Health Lawyers Education Programs, provides an annual review of physician employment and financial issues.

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By Michael Cassidy

In this new monograph, the author defines the current process for credentialing and peer review, identifies and analyzes the legal issues associated with the process, reviews the impact of the HCQIA, and more.

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Annual Meeting & In-House Counsel Program

June 29–July 2, 2003

San Antonio Marriott Rivercenter Hotel

In-House Counsel Program

June 29, 2003

Designed to address the unique issues faced by in-house counsel, this year's program will include sessions on:

- Preparing for Audits
- Settling Disputes
- Legal Ethics—Representing the Healthcare Organization in a Post-Sarbanes-Oxley World
- Workplace Violence: New Theories for Liability and How to Avoid It
- Operating the Small In-House Law Department
- Operating the Larger In-House Law Department
- Attorney-Client Privilege
- Managing an Outsourcing Negotiation

The In-House Counsel Practice Group will hold a business meeting and the Golden Ferret Award will be presented during lunch. The lunch is included in the registration fee and all attendees are welcome to attend.

Annual Meeting

June 30–July 2, 2003

As the culmination of Health Lawyers' educational year, the Annual Meeting provides a forum for networking and interaction with colleagues, friends and families as well as an outstanding educational event. Speakers will address the most important health law issues, including:

- Privacy and Security
- Stark II
- EMTALA
- CMS Payment Initiatives
- Hospital/Physician Joint Ventures
- Emerging Issues in Peer Review
- Intermediate Sanctions
- Legal, Financial and Political Implications of Medicaid Budget and Rate Shortfalls
- Legal Issues in Health System Governance
- Trends in Fraud and Abuse Enforcement
- Provider/Payor Disputes

In addition to the educational sessions, the Annual Meeting includes a variety of networking and social events: each of the Practice Groups will hold a luncheon meeting with presentation; attendees and their registered guests are invited to attend the Welcome Reception on Sunday, a reception at the Institute of Texan Cultures on Monday, and the annual Dinner Dance on Tuesday; and table topic discussions will take place each morning during breakfast.

To make hotel reservations, please call the San Antonio Marriott Rivercenter Hotel at (210) 223-1000. Indicate you are attending the Health Lawyers program in order to be eligible for the group rate. Rooms at the group rate are limited and are accepted on a space-available basis until Friday, June 6, 2003.

Practice Group Annual Meeting Luncheons

Sunday, June 29, 2003: 12:00 noon-1:30 pm

In-House Counsel

For something completely different, attend the In-House Counsel Practice Group luncheon. You'll be entertained by real-life, too-weird-to-be-true stories told by fellow health law attorneys competing for the Fourth Annual Golden Ferret Award. Listen to your colleagues as they recount their strangest work-related escapades. Past winners include "Death of the Gypsy King," "The Derriere-Pinching ER Resident," and "The Ferret Rescue".

Monday, June 30, 2003: 12:15-1:35 pm

Credentialing and Peer Review

"Credentialing and Peer Review—or Crime and Punishment?"

Presenters:

Glenn Martin, Esq., Assistant US Attorney, US Department of Justice/Western District of Michigan, Lansing, MI

Barbara C. Tanase, Esq., Assistant US Attorney, US Department of Justice/Western District of Michigan, Lansing, MI

Labor and Employment

"Open Forum on Hot Topics in Employment and Labor Law"

Among the topics to be discussed, are the following

- Employment Issues related to Telemedicine
- Employment Issues related to an Aging Workforce
- Update from the Supreme Court on Labor and Employment Issues
- E-Mail and Electronic Recordkeeping as it relates to Employees
- Significant Labor Cases
- Significant Disability Cases
- NLRB decisions by the new Bush appointed Board

Facilitators:

Katherine Benesch, Esq., Duane Morris LLP, Princeton, NJ

Barry Guryan, Esq., Epstein Becker & Green, Boston, MA

Michael Jordan, Esq., Walter & Haverfield LLP, Cleveland, OH

John Lyncheski, Esq., Cohen & Grigsby PC, Pittsburgh, PA

Regulation, Accreditation, and Payment and Hospitals and Health Systems

"CDC's Outreach Efforts to Involve Members of the Legal Community in Public Health Legal Matters"

Presenters:

Gene W. Matthews, Esq., Legal Advisor to CDC, Atlanta, GA

Lori Spencer, Esq., Sutherland Asbill & Brennan LLP, Atlanta, GA

Teaching Hospitals and Academic Medical Centers

"FDA's Growing Focus on Hospitals: The Reprocessing Story"

Ms. Furman will address FDA's regulation of medical device reprocessing, which is an important example of the trend toward increasing FDA regulation of hospitals. Among other things, Ms. Furman's presentation will cover the forces that led to FDA regulation of in-hospital reprocessing, the current FDA regulatory requirements for reprocessing, and the implications of the reprocessing-related provisions contained in the Medical Device User Fee and Modernization Act of 2002.

Presenter:

Pam Furman, Esq., Olsson Frank and Weeda PC, Washington, DC

Tuesday, July 1, 2003: 12:15-1:35 pm

Antitrust

Information on this luncheon will be available on the Health Lawyers Web site when it becomes available.

Fraud and Abuse, Self-Referrals, and False Claims

"Current Developments in Qui Tam Litigation"

This point-counterpoint discussion will address current qui tam litigation, focusing on pharma issues and the recent Pfizer settlement.

Moderator:

Robert G. Homchick, Esq., Davis Wright Tremaine LLP, Seattle, WA

Presenters:

John T. Boese, Esq., Fried Frank Harris Shriver & Jacobson, Washington, DC—*prominent qui tam defense attorney* and

Joel Androphy, Esq., Berg & Androphy, Houston, TX—*represented the relator in the recent Pfizer \$49 million settlement; claims were based on Medicaid Best Price violations for the drug Lipitor*

Healthcare Liability and Litigation

"An interactive, roundtable discussion on Alternative Risk Financing and Risk Management Issues"

- What's new in Alternative Risk Financing?
- Where are the excess markets heading?
- How to move to Mandatory Physician Risk Management
- Retirement Community excess insurance crisis . . . what now?

Facilitators:

Robert Feinberg, Esq., Snell & Wilmer LLP, Phoenix, AZ

Continued on page 26

Tax and Finance

An interactive discussion of hot topics in the areas of tax exemption, non-profit law and finance, focusing on items of interest not only to tax practitioners, but also to other health lawyers who need to keep informed of emerging trends in these areas.

To encourage a lively exchange on these issues, attendees will be provided before the meeting with hypotheticals designed to elicit a sharing of approaches and best practices on a variety of tax-related issues, including:

- What advice is being given regarding the structuring of ancillary joint ventures?
- What approaches (if any) are nonprofits taking in response to Sarbanes-Oxley?
- What steps (if any) should nonprofits be taking in light of the Attorney General's actions in HealthPartners and Allina?
- Are more organizations opening a dialogue with the state Attorneys General before completing major and minor transactions?
- How do organizations deal with executive compensation decisions differently after Enron and the CareFirst conversion?
- What types of physician compensation programs are being used in the field?
- What approaches are being taken to deal with that influential physician group that wants a long-term contract to run a department of the hospital, before and after the bond issue?
- Based on recent cases, are health care institutions changing their practices regarding treating physicians as employees, rather than independent contractors?
- Have recent rulings and decisions (e.g., Caracci) increased industry attentiveness to obtaining the rebuttable presumption against intermediate sanctions?"

Facilitators:

Lisa Gilden VP, General Counsel, Catholic Health Association, Washington, DC;

Gerry Griffith, Esq., Honigman Miller Schwartz & Cohn LLP, Detroit, MI;

Doug Anning, Esq., Seigfreid Bingham Levy Selzer & Gee, Kansas City, MO

Wednesday, July 2: 12 noon-1:20 pm

Health Information and Technology

"Practical Issues in Security Risk Assessments"

Presenter:

Connie Emery, Privacy/Security Officer, Tenet HealthSystems, Dallas, TX

HMOs and Health Plans

Health maintenance organizations (HMOs) and health plans currently operate in a highly litigious environment that has been recently distinguished by new strategies employed by plaintiff's counsel to

attempt to hold health plans liable for delays in medical care that may have been caused by providers or provider networks. As a result, traditional medical malpractice liability cases have been used as an entry to raise attacks on managed care and/or utilization review cases in an effort to broaden the liability base from providers to HMOs and health plans. Guest speakers will present a luncheon discussion for Practice Group members which will examine the various litigation strategies being used by the plaintiffs and the health plan defenses to these attacks. As will be discussed, recent cases highlight the increasing difficulty that exists in distinguishing between the practice of medicine and insurance utilization review. This ambiguity spills into other areas such as whether plan medical directors are engaging in the practice of medicine when they make eligibility and/or other utilization review decisions. Among the cases and issues that are likely to be reviewed and discussed are practical effects of the Kentucky Association of Health Plans case, including its impact upon credentialing and other areas.

Presenters:

Kevin D. Gordon, Esq., Crowe & Dunlevy PC, Oklahoma City, Oklahoma

Gregory N. Pimstone, Esq., Manatt Phelps & Phillips LLP, Los Angeles, CA

Long Term Care

"Dialogue with Department of Justice"

Facilitator:

Mr. Sheehan, an Assistant US Attorney, will identify topics that are getting the attention of the Department of Justice. He will discuss the Department's enforcement efforts and initiatives and then open the floor for questions from and discussion with attendees. Come prepared to interact with Mr. Sheehan and your colleagues.

James G. Sheehan, Esq., Assistant US Attorney, US Attorney's Office, Philadelphia, PA

Physician Organizations Annual Luncheon Meeting

A roundtable discussion of "hot" topics, including:

- The impact of hospital on-call requirements on physicians
- Patient requests for pharmaceutical prescriptions
- Non-competes- are courts enforcing provisions requiring resignation of hospital privileges?
- Asset protection-offshore, Delaware and Alaska trusts

Facilitators:

Charlene McGinty, Esq., Powell Goldstein Frazer & Murphy LLP, Atlanta, GA;

Cynthia Reisz, Esq., Bass Berry & Sims PLC, Nashville, TN;

Michael Schaff, Esq., Wilentz Goldman & Spitzer PA, Woodbridge, NJ;

Lisa Taylor, Esq., St John & Wayne LLC, Newark, NJ

PROGRAM REGISTRATION FORM

In-House Counsel Program and Annual Meeting

June 29 - July 2, 2003

To register: Remit payment and completed registration form by mail to the American Health Lawyers Association PO Box 79340 · Baltimore, MD 21279-0340 or fax with credit card information to (202)833-1105 (Phone: (202)833-0766). In order to avoid duplicate charges, please do not mail this form if you have already faxed it to us.

Name: _____ Member ID#: _____

First Name for Badge (if different from above): _____

Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Fax: (_____) _____

E-Mail: _____

In-House Counsel Program

Members: \$295

Non-Members: \$470

Annual Meeting

Early Registration (postmarked and paid by June 6, 2003):

Members: \$910

\$835 each additional member registering from the same organization or firm at the same time.

Non-Members: \$1,085

If you are not a member, but join when you register for the program you will be eligible for the member registration fee! If you are interested in getting more information about Membership and the fees, please contact the Health Lawyers Member Services Center at (202)833-0766.

PAYMENT INFORMATION

Please fill in applicable amount: (Registrations cannot be processed unless accompanied by payment.)

Registration Fee: \$ _____ EF

Membership Dues: \$ _____

Total Enclosed: \$ _____

Check enclosed (Make checks payable to American Health Lawyers Association)

Bill my credit card: VISA MasterCard American Express

Card Number _____ Exp. Date: _____

Name of Cardholder _____

Signature of Cardholder _____

Zip code of Cardholder _____ - _____

Please note: AHLA will charge your credit card for the correct amount if your total is incorrect.

To receive a refund of the registration fee paid minus \$125, cancellation notice must be received in writing by June 18, 2003.

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www.healthlawyers.org

HMOs and Health Plans Luncheon

Wednesday, July 2, 2003

Annual Meeting 2003 • San Antonio, Texas

June 30–July 2, 2003

For more information on the luncheon, go to page 11 and for more information on the program go to page 24.

HMOs
& Health Plans
Spring 2003 Volume 6 Issue 1