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A Message from the Section Chair

The Blizzard

Last issue, I directed my remarks to law students and new lawyers, and wrote of the many rewards of being a health lawyer. This time, I hope they skip my column: I intend to rant.

On a daily basis, health lawyers are inundated with reams of new, complicated information. No, that's too tame: we're besieged, assaulted, avalanched with information. It's a blizzard; arriving by mail, e-mail, fax, phone, video and voice. My desk is embarrassingly cluttered with stacks of recent federal regulations, just-enacted state laws, new court decisions, CCH updates, new advisory opinions, newsletters, faxed alerts and more.

As professionals, we're committed to staying current in our field. But our field doesn't make it easy for us. It refuses to sit still, even for a moment, so we can try to catch up.

For example, many of us now need to get up to speed on the new HIPAA regulations governing the electronic transmission and storage of individually identifiable health data. Those regulations and commentary are thick, dense and technical. But we need to know about them because we need to be able to advise our clients on how those regulations affect their rights and responsibilities. So for the past two weeks, I've carted them home at night, and back to the office in the morning—although I still haven't finished plowing through all of them. As for New York's new similarly thick, dense and technical Health Care Reform Act (HCRA), well, it's a similar story.

So what's a responsible health lawyer to do? First, don't drive yourself crazy (If I knew how to say that in Latin, I would propose that as the health lawyer's motto—our answer to the physician's *primum non nocere*) Of course we need to stay abreast of new health law developments—but we all have other responsibilities too, including responsibilities to ourselves. I'll get to HIPAA tomorrow night. Tonight after dinner I'm going to play a board game with my wife and son, and then practice a Joe Pass tune I'm trying to learn on the guitar.

Life is a balancing act, and the need to stay current on professional developments doesn't trump all other obligations. But it is an obligation. That means that we need to find effective, preferably pleasant ways to learn the latest complex information.

Happily, the Health Law Section can help in that area. For example, this issue of the *Journal* carries an excellent summary of the new HCRA legislation by Gene Laks of Albany and Sean Nataro of NYC. (Incidentally, Gene was a principal drafter of the first HCRA bill, and the NYPHRM law that preceded it.)

Health Law Section professional education programs are also an excellent, efficient way to get the information we need on legal developments in our field. In fact our upcoming Spring conference on medical information, organized by Anne Maltz of NYC and Gary Fields of Long Island, will give practitioners a solid understanding of the new medical privacy rules under HIPAA—a far better understanding than the uninitiated lawyer can get from just wading unescorted through the regulations.

And next fall, the Section will again offer its well-regarded Health Care Primer and Update—another great way to acquire information quickly and relatively painlessly. (By the way, I looked it up and the preferred pronunciation of "primer" rhymes with "swimmer," not with, well, "rhymer.") Phil Rosenberg of Albany and Sally True of Ithaca are organizing that program.

Of course, one of the best ways to get to understand new health law initiatives is by discussing them with your colleagues. The Health Law Section and its committees furnish the occasion for that kind of invaluable interaction.

At the same time, I think we need to attack the regulatory blizzard at the supply side. Federal and state legislators and regulators needs to recognize the aggregate impact of the requirements they impose on the health care field. Each new rule, in isolation, may have a strong rationale. But when a regulation like the 1998 proposed Stark rule goes on and on describing intricate requirements to satisfy the group practice exception to the prohibition on physician self-referrals—one loses sight of the policy rationale, and is left with just stunned weariness. Worse, our clients become more cynical and disrespectful of the law. (To add insult to injury, some of them regard such laws as HIPAA to be, well, the Health Initiatives to Profit Attorneys Act.)

I believe in proactive, progressive government. Government has been and continues to be an enormous force for good in the health care field. The forward-thinking legislators who enacted Medicare and Medicaid have advanced the public health of our state and nation more than anyone else I can think of. More

recently, the N.Y.S. Legislature, in taking the surprising step of enacting Family Health Plus, made a great stride toward securing health care for the uninsured (although, as several prominent experts note in a significant article in this issue, there is still more to be done). I am proud to have worked in support of initiatives like the Health Care Proxy Law and the Community Mental Health Reinvestment Act. And I support vigorous governmental oversight of quality of care.

But I do feel strongly that policymakers, in addressing a particular health system issue that crosses their line of vision, whether it is physician self-referrals or the electronic transmission of medical information or human subject research on vulnerable populations, must remain cognizant of the current regulatory strain on the health care system, and the extent they would add to it. And the closer their regulations come to touching actual physician-patient interactions (as opposed to business, billing or record-keeping issues), the more cautious they need to be. I raise this issue not to spare me from having to read lengthy regulations, but to keep my doctor and our health system focused on restoring and preserving health, and not further hampered by or anxious about intrusive, hypertechnical, often counterintuitive requirements.

But that's just my opinion.

Incidentally, this is my last message to you as Chair. It was a pleasure and honor—and great fun—to have access to this forum, and it is also a pleasure and honor to pass it along to my friend and colleague, Tracy Miller, who becomes Chair of the Section in June.

Robert N. Swidler

From the Editors

As our new format goes into its third issue, we want to take this opportunity to thank our regular outside contributors—Len Rosenberg, Frank Serbaroli, and James Lytle—for their columns on activity in the New York courts, agencies, and legislature, respectively. Also, Claudia Torrey, Margaret Moreland and students from the Pace University School of Law Health Law Society, particularly Joe DaBronzo, for their regular features.

In addition to our recurring columns and Section reports and news, this issue contains a comprehensive overview on the new HCRA 2000 legislation, authored by Eugene Laks and Sean Nataro; an article by Edward McArdle on limiting patient responsibility for the cost of out-of-network care; and a forum on issues concerning health care for the uninsured.

Last, but by no means least, we want to pay our special thanks and praise to our out-going Section Chair, Robert Swidler. He was the motivating force behind the *Journal*'s new content and format, and has been a pleasure to work with.

Barbara Atwell and Audrey Rogers

In the New York State Courts

Deaf Patient's Disability Discrimination Claim Dismissed Without Trial for Lack of Standing and Failure to Demonstrate Intentional Conduct

Freydel v. New York Hospital, Civ. No. 97-7925 (S.D.N.Y. Jan. 3, 2000). The plaintiff in this case is a 76-year-old deaf woman whose primary language is Russian. Plaintiff claimed that New York Hospital failed to provide her with Russian sign language interpreting services during the first week of a two-week hospital stay, in violation of Title III of the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973. She sought injunctive relief under the ADA, and compensatory damages under the Rehabilitation Act.

After discovery, the Court granted the Hospital's summary judgment motion and dismissed the action in its entirety. First, the Court dismissed the injunctive relief claims for lack of standing. To meet the constitutional standing requirement, plaintiff had to show a likelihood that she would return to New York Hospital, and that the Hospital was likely to violate her rights. The Court concluded that plaintiff did not meet this requirement because she failed to provide any evidence of a likely return to New York Hospital. The Court also found that changes in the Hospital's policy for obtaining and providing sign language interpreting services made it unlikely that plaintiff would be deprived of her rights if she returned.

The Court also dismissed plaintiff's claim for compensatory damages under the Rehabilitation Act because she failed to offer evidence that the Hospital intentionally discriminated against her. To meet the intentional discrimination requirement, plaintiff had to present facts demonstrating that the Hospital was deliberately indifferent to her rights. The Court concluded that the Hospital made legitimate, good-faith attempts to obtain interpreting services, and that any failure to provide services resulted from negligence or mistake, not deliberate indifference. [Garfunkel, Wild & Travis, P.C. represented New York Hospital in the *Freydel* case].

Psychiatric Hospital Incident Reports Exempt From Disclosure

Katherine F. v. State of New York, 1999 WL 1073791 (Court of Appeals, Nov. 30, 1999). Plaintiff, a patient in a psychiatric hospital, filed a personal injury suit based on allegations of sexual abuse by a hospital staff member. Plaintiff sought pretrial discovery of the hospital's investigation files (including incident reports, an investigative report, and a safety department report). The Court of Claims directed production of the files for *in camera* inspection.

As reported in this column in the Summer/Fall issue of the NYSBA *Health Law Journal*, the Appellate Division reversed, ruling that Education Law § 6527(3) and Mental Hygiene Law § 29.29 protect from disclosure not only records relating to performance of a medical or quality assurance review function, but also "reports required by the Department of Health pursuant to Public Health Law § 2805-1 . . . including the investigation of an incident pursuant to § 29.29 of the Mental Hygiene Law. 684 N.Y.S.2d 243 (1st Dep't 1999).

The Court of Appeals affirmed, holding that the documents created by the hospital in its investigation of alleged patient abuse by a hospital staff member are exempt from disclosure. The Court held that nothing in the plain language or legislative history of § 6527(3) indicates that quality of care should be read to exclude reports of patient abuse. Because the overall purpose of Ed. Law § 6527(3) is to promote quality of care through self-review without fear of legal reprisal, applying its confidentiality to incident reports will enable psychiatric hospitals to reduce untoward incidents through unfettered investigations.

Court Denies Hospital's Petition to Sell Substantially All of Its Assets

Manhattan Eye, Ear and Throat Hospital v. Spitzer, (Sup. Ct., New York Co., December 8, 1999). As a result of financial difficulties, Manhattan Eye, Ear & Throat Hospital (MEETH) sought judicial approval under § 511 of the Not-For-Profit Corporation Law to sell substantially all of its assets to Memorial Sloan-Kettering Cancer Center ("Memorial"). MEETH's Board of Trustees voted to sell the hospital's facilities and entered into a non-binding letter of intent to sell MEETH's real estate to Memorial and to a real estate developer for $41 million.

Section 511 of New York's Not-for-Profit Corporation Law prohibits a not-for-profit corporation from selling all or substantially all of its assets without first obtaining court approval on notice to the State Attorney General's office. The Attorney General reviews such transactions to "ensure that the interests of the ultimate beneficiaries of the corporation, the public, are adequately represented and protected from improvident transactions." In this case, based in part on complaints that MEETH did not negotiate in good faith with other potential bidders, the Attorney

General's office opposed MEETH's petition.

To receive Court approval, MEETH needed to demonstrate that the terms of the sale were "fair and reasonable" and that the purposes of the corporation would be promoted by the sale. The Court ruled against MEETH on both counts.

First, although the Court did not dispute that $41 million may be a "fair and reasonable" price for MEETH's tangible assets, the Court determined that the transaction was not "fair and reasonable" as a whole because it did not consider the value of MEETH's intangible assets, such as its name.

Second, the Court ruled that the sale would not promote the purposes of the corporation. Although a not-for-profit corporation's Board may respond to financial distress by selling assets and eliminating the corporation's mission, it must first seek to preserve the original mission. Here, the Court ruled that MEETH's Board did not consider or make any efforts to preserve the corporation's mission.

Court Affirms Decertification of Class Actions by Cigarette Smokers

Small v. Lorillard Tobacco Co., Inc., 1999 WL 976090 (Court of Appeals, October 26, 1999). This case involved five proposed class action suits against tobacco companies. Plaintiffs alleged that as a result of defendants' deceptions about the addictive properties of cigarettes, they were fraudulently induced to purchase cigarettes, thereby becoming addicted to nicotine. Plaintiffs sought recovery under New York's consumer fraud statute, General Business Law (GBL) § 349.

The trial court certified the cases as class actions under CPLR 901, by eliminating addiction as an issue, and focusing instead on whether plaintiffs could recover as damages the money they spent on cigarettes. The Appellate Division reversed, decertified the classes, and held that plaintiffs failed to state a claim under GBL § 349.

The Court of Appeals affirmed all aspects of the Appellate Division's ruling. First, it ruled that simply purchasing a product was insufficient to demonstrate injury under GBL § 349. Each plaintiff would have to come forward with individual proof of addiction, and those individual issues would predominate over common issues. Second, publicity about the dangers of smoking precluded a presumption of reliance, again requiring individual proof in each case. Third, the Court held that because the plaintiffs limited their damage claims to the purchase price of cigarettes, excluding personal injury claims, they were not adequate representatives of the proposed class.

Patient May Obtain His Own Medical Records from the Department of Health under FOIL

Mantica v. N.Y.S. Department of Health, 1999 WL 976084 (Court of Appeals, October 26, 1999). In connection with a medical malpractice claim, plaintiff made a request under the Freedom of Information Law (FOIL) for the Department of Health's (DOH) investigation file concerning the underlying incident. DOH produced some of the requested documents but withheld others, including the patient's medical records. DOH contended that (i) under Public Health Law § 18(6), it was prohibited from redisclosing patient information obtained during an investigation; and (ii) the patient could obtain his medical records directly from the hospital under PHL § 18. Both the motion court and the Appellate Division ruled that DOH must turn over the patient's medical records.

The Court of Appeals affirmed, noting that documents in the possession of public agencies are presumptively disclosable under FOIL, absent a statutory exemption. The Court rejected the argument that PHL § 18(6) provided such an exemption. Instead, PHL § 18 was intended to provide patients with access to their own records; and § 18(6) was intended to prevent disclosure of confidential medical records to third parties. The Court also ruled that a patient's right to obtain his medical records directly from the hospital did not diminish the patient's right to obtain those records from DOH under FOIL.

Restrictive Covenant Against Licensed Professional Not Enforceable by Physician Practice Management Company

Martone v. Healthsouth Holdings, Inc., N.Y.L.J., December 24, 1999. In this case, a licensed physical therapist sold her practice to a physician practice management company. The sale agreement required the therapist to continue to provide services to her patients as an employee of the management company. The agreement also contained a restrictive covenant prohibiting the therapist from competing with the company within a 15-mile radius of her old practice for a period of five years after the date of sale.

After the sale, the State Education Department issued an opinion prohibiting business corporations from providing physical therapy services through employed physical therapists. This resulted in termination of the therapist's employment, and she sued successfully for a declaration that the non-compete agreement was unenforceable. The Court ruled that because the man-

agement company could not legally provide physical therapy services, the therapist could not be found to be in "competition" with it.

Medical License Revocation Based on Out-of-State Conviction Annulled for Failure to Identify Specifics of Guilty Plea

Jacobs v. De Buono, 699 N.Y.S.2d 842 (3d Dep't, 1999). The State Board for Professional Medical Conduct (the "Board") revoked petitioner's license based upon his plea of guilty under Louisiana's Medicaid fraud statute. The Board's contended that the conviction would also constitute a crime if committed in New York. However, in a rare annulment of a Board determination, the Appellate Division, Third Department, noted (i) that the Louisiana statute contained three subsections—one of which would not constitute a crime in New York, and (ii) that the petitioner had not pleaded guilty to any particular subsection. Based on these facts, the Court held that the Board's finding that petitioner's plea would have constituted a crime in New York was "necessarily founded upon speculation and must be annulled as unsupported by substantial evidence."

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a partner at Garfunkel, Wild & Travis, P.C., a full service health care firm representing hospitals, health care systems, physician group practices, individual practitioners, nursing homes and other health-related businesses and organizations. Mr. Rosenberg's practice is devoted primarily to litigation, including medical staff and peer review issues, employment law, disability discrimination, defamation and directors' and officers' liability claims.

In the New York State Legislature

The N.Y.S. Legislature went into session briefly in December 1999, principally to renew New York's Health Care Reform Act (HCRA), which governs the reimbursement of hospitals and other health care financing matters. Among other things, HCRA 2000 (Ch.1, L.2000) gives DOH the authority to set Medicaid rates, renews the authority of hospitals to negotiate rates with other payors, funds charity care and graduate medical education through a revised system of surcharges, and provides grants for a variety of purposes. Significantly, HCRA 2000 also establishes Family Health Plus, a program for subsidizing health care insurance for low-income families who are above the Medicaid eligibility level.

This issue of the *Journal* carries an article by Eugene M. Laks and Sean Nataro that describes HCRA 2000 and Family Health Plus in more detail. See page 23.

Apart from HCRA, the N.Y.S. Legislature has not enacted any significant health-related measures since the last issue of the *Journal*. With respect to the Legislature's current year 2000 session, the principal bills the Legislature is expected to consider include:

- Reform of managed care payment practices; e.g., S.5445 (would require health care payors to accept electronic claims and would shorten prompt payment time frames); S.5224 (would require an HMO that consistently violates payment obligations to make weekly interim payments to providers); S.5348 and A.8368 (would create a health insurance guarantee fund to reimburse providers and enrollees for the cost of unpaid claims in the event a payor becomes insolvent);
- Continuation of the Medicaid managed care law;
- Coverage of infertility treatment (e.g., S.3131-B; A.7303);
- The Family Health Care Decisions Act (A. 4114).

Submitted by James W. Lytle, resident partner, and Ami Schnauber, Legislative Coordinator, from the Albany offices of Kalkines Arky Zall & Bernstein, LLP. The firm devotes a substantial part of its practice to health care and government relations.

In the New York State Agencies

The New York State Department of Health has recently promulgated these regulations of note:

Blood Bank Record Requirements

These new regulations amend §§ 58-2.11(a), 58-2.16(a)(1)(iv), and 58-2.27 (h) of Title 10. They clarify the requirement that blood banks maintain a record of every container of blood or blood component prepared at the facility. Blood banks are also required to report serious unexpected reactions or incidents involving transfusions on a form approved by the Health Department. The new regulations also permit a licensed practical nurse, who has satisfactorily completed a transfusion training program, to transfuse blood and blood components provided a registered nurse, or physician or other person permitted by law to manage transfusion reactions is present. *See* NYS Register, January 26, 2000.

External Appeals Program

A series of Emergency Regulations have been adopted by the New York State Insurance Department. These regulations have been promulgated pursuant to the implementation of an external appeals program mandated by the legislature (L. 1998, ch. 586). The legislature has provided that individuals have a right to request an external appeal of a final adverse determination made by an insurer on the grounds that a service is not medically necessary, experimental, or investigational. The Department of Insurance anticipates the permanent adoption of these regulations. Effective date: December 13, 1999. *See* NYS Register, December 29, 1999.

The emergency regulations include:

- **§ 410.1:** Defines an insured's rights to an external appeal and the appeal process applies to health care plans defined as insurers subject to Article 32 or 43 of the Insurance Law and external appeals agents.
- **§ 410.2:** Includes definition of "attending physician," "commissioner," "confidential HIV information," and "final adverse determination."
- **§ 410.3:** Specifies the type of information to be included in the standard description of the external appeals process which must be provided to all insured. The standard description must include: a statement of the insured's right to an external appeal; the eligibility requirements for an appeal; notification of the timeframes in which an external appeal agent must make a determination; and instructions on how to complete and file the appeal request with the Department of Insurance.
- **§ 410.4:** Outlines the standards which need to be met in order to qualify for certification as an external appeals agent. The agent must demonstrate access to a sufficient pool of clinical peer reviewers and an ability to comply with the applicable laws and rules.
- **§ 410.5:** Outlines the information required in the application for certification as an appeals agent. The applicant must provide information regarding affiliations with health care plans, health care providers, health care facilities and/or developers or manufacturers of health services; a description of the clinical peer reviewer network; a description of the applicant's external appeal process; and the fees to be charged.
- **§ 410.6:** Provides standards for evaluating conflicts of interest between the external appeals agent and clinical peer reviewers. A description of the disqualifying criteria as well as a sworn statement by applicants attesting to the absence of material affiliations which may constitute a conflict must be provided to the Department of Insurance. An applicant must also provide a description of the written policies and procedures for ensuring that no conflict exists.
- **§ 410.7:** Outlines the process and standards for determining the eligibility of requests by insured for an external appeal. Health care services covered by Medicare are not subject to external appeal. The insured is required to attach all the documentation necessary to evidence his/her eligibility for appeal. The State is required to notify the insured and the insured's health care plan when a request for appeal is determined eligible.
- **§ 410.9:** Provides that health care plans provide information regarding the appeals process to the insured.
- **§ 410.10:** It is the responsibility of the certified external appeal agent to notify the insured, the insured's physician, and the health plan upon receiving an appeal. The agent must also provide a timeframe for making a determination. The medical director of the certified external appeal agent must certify that the clinical peer reviewers followed the appropriate procedures and that each reviewer provided a sworn statement that no prohibited material affiliation existed with respect to the appeal.
- **§ 410.11:** The insured must file complete requests for an appeal within the statutory timeframes

and is responsible for paying the fee as proscribed by the insured's health plan.

- **§ 410.12:** Gives a description of the confidentiality requirements which must be followed by health care plans, certified appeal agents, and clinical peer reviewers regarding the insured's medical treatment.
- **§ 410.13:** Describes the record-keeping requirements for health care plans, certified appeal agents, and clinical peer reviewers.

Department of Health Public Notice Regarding Medicaid State Plan

The Department of Health has proposed amendments to Title XIX for hospice-operated nursing homes. The amendment, pursuant to 42 CFR § 447.205, implements a limited pilot reimbursement program with a hospice-operated nursing home in order for the Department of Health to study and analyze alternative methods for reimbursement, delivery of medical services or eligibility of medical assistance in such facilities. *See* NYS Register, December 29, 1999.

Department of Health, Office of Mental Retardation and Developmental Disabilities Public Notice Regarding Reimbursement

Pursuant to 42 CFR 447.205, The NYS Office of Mental Retardation and Developmental Disabilities (OMRDD), intends to amend the Medicaid State Plan for the reimbursement formula for Day Treatment Facilities serving persons with disabilities. The amendment will provide an annual adjustment account for anticipated increases in the operational costs of these facilities. Proposed Effective Date: January 1, 2000. *See* NYS Register, December 29, 1999.

HIV Reporting

Regulations §§ 63.1-63.11. Proposed amendments affecting 10 N.Y.C.R.R. Part 63 regarding HIV reporting. These regulations authorize HIV reporting and contact notification. These regulations are not retroactive. Physicians and other diagnostic providers must provide laboratories with the names and addresses of the sources of specimen. Informed consent to an HIV test must include information concerning the mandated reporting of HIV tests and also inform the patient that if the test is positive, they will be asked to cooperate in the contact notification process. Physicians and other diagnostic providers must report cases of HIV infection, AIDS, or HIV-related illness as soon as possible after post-test counseling but no later than 21 days after receiving the positive test result. Three mechanisms are also set forth for contact notification: (1) for contacts identified through Article 21 reporting; (2) for contacts identified by physicians and other diagnostic providers in the course of their practice; and (3) when an exposure incident occurs to staff in the performance of their professional duties. The regulations also set forth the requirement of initial employee education and annual in-service education. *See* NYS Register, December 15, 1999.

Insurance Department Proposed Regulation on Standards for Financial Risk Transfer Between Insurer and Health Care Providers

The Insurance Department proposed a new Part 101 to Insurance Regulations (N.Y.C.R.R. Title 11), which provide that the Superintendent will not approve any agreement to share financial risk entered into between an insurer and a health care provider (including an IPA) unless such insurer has demonstrated that the provider is "financially responsible." To meet that requirement, the provider must post a financial security deposit that is at least 12.5% of the estimated annual capitation to be received from the insurer, but where the provider is a health care facility or an IPA, not less than $100,000. The deposit may consist of either securities or a letter of credit or a combination of securities, a letter of credit and a provider stop loss insurance policy. The proposal also specifies provisions which must be included in health care provider contracts which transfer financial risk. *See* NYS Register, March 1, 2000.

Compiled by Francis J. Serbaroli, Esq. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft's 20-attorney health law department. He is the Vice Chairman of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and serves on the Executive Committee of the New York State Bar Association's Health Law Committee. He is the author of "The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care" published by BNA as part of its Business and Health Portfolio Series.

The assistance of Mr. David Quirolo, a second year law student at the New York University School of Law, in compiling this summary is gratefully acknowledged.

In the Law Journals

1. Jill Schlick, Symposium, *Administrative Law – The Fourth Circuit Strikes Down the FDA's Tobacco Regulations,* Brown & Williamson Tobacco Corp. v. FDA, 25 Wm. Mitchell L. Rev. 741 (1999).
2. Andrew P. Czajkowski, Symposium, *The Making of a Lawsuit: A Health Plan Perspective,* 25 Wm. Mitchell L. Rev. 379 (1999).
3. Patricia Carter, *Health Information Privacy: Can Congress Protect Confidential Medical Information in the Information Age?* 25 Wm. Mitchell L. Rev. 223 (1999).
4. David J. Mack, *Cleansing the System: A Fresh Approach to Liability for the Negligent or Fraudulent Transmission of Sexually Transmitted Diseases,* 30 U. Tol. L. Rev. 647 (1999).
5. George W. Conk, Symposium, *Compared to What? Instructing the Jury on Product Defect Under the Products Liability Act and the Restatement (Third) of Torts: Products Liability,* 30 Seton Hall L. Rev. 273 (1999).
6. The Hon. William A. Dreier, Symposium, *Manufacturers' Liability for Drugs and Medical Devices Under the Restatement (Third) of Torts: Products Liability,* 30 Seton Hall L. Rev. 258 (1999).
7. Richard L. Cupp, Jr., Symposium, *The Continuing Search for Proper Perspective: Whose Reasonableness Should be at Issue in a Prescription Product Design Defect Analysis?* 30 Seton Hall L. Rev. 233 (1999).
8. Twila Keim, *Physicians for Professional Sports Teams: Health Care Under the Pressure of Economic and Commercial Interests,* 9 Seton Hall J. Sport L. 196 (1999).
9. Alan D. Lieberson, Symposium, *Issues of Concern When Drafting a Physician-Assisted Suicide Statute,* 2 Quinnipiac Health L.J. 267 (1999).
10. David P. Twomey, Symposium, *Employee Privacy Law and the Developing Law Relating to Employee Medical Information and "Other" Private Matters,* 2 Quinnipiac Health L.J. 135 (1999).
11. Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation,* 14 Ohio St. J. on Disp. Resol. 907 (1999).
12. Deborah Garner, *Up In Smoke: The Medical Marijuana Debate*, 75 N.D. L. Rev. 555 (1999).
13. Becky M. Brooks, *Local Health Care Districts Can Now Play Ball: Chapter 18 Levels the Playing Field for Asset Transfers to Non-Profit and For-Profit Corporations,* 30 McGeorge L. Rev. 769 (1999).
14. Melissa M. Perry, *Fragmented Bodies, Legal Privilege, and Commodification in Science and Medicine,* 51 Me. L. Rev. 169 (1999).
15. Robert Pitofsky, *Prepared Statement of the Federal Trade Commission Before the Committee on the Judiciary, United States House of Representatives, Concerning H.R. 1304, the "Quality Health-Care Coalition Act of 1999"* 12 Loy. Consumer L. Rev. (1999).
16. Eric M. Eusanio, *Control, Quality, and Cost: The Need for Federal Legislation Amending ERISA's Failure to Protect Consumers from Liability-Free MCOS,* 7 J.L. & Pol'y 627 (1999).
17. Lawrence Martin, *Pitfalls in Diagnosis of Occupational Lung Disease for Purposes of Compensation – One Physician's Perspective,* 13 J.L. & Health 49 (1998-1999).
18. Susan Stefan, Symposium, *The Americans with Disabilities Act and Mental Health Law: Issues for the Twenty-First Century,* 10 J. Contemp. Legal Issues 131 (1999).
19. Natalie R. Azinger, Symposium, *Too Healthy to Sue Under the ADA? The Controversy Over Pre-Offer Medical Inquiries and Tests,* 25 J. Corp. L. 193 (1999).
20. Barry S. Levy, M.D. M.P.H., *Twenty-First Century Challenges for Law and Public Health,* 32 Ind. L. Rev. 1149 (1999).
21. John C. Render, James B. Hogan, *Health Care Law: A Survey of Significant 1998 Developments,* 32 Ind. L. Rev. 841 (1999).
22. Oliver Pancheri, *Is There Light at the End of the Carpal Tunnel? Compensation for Workers with Cumulative Trauma Disorders Under Theories of Accident and Occupational Disease,* 35 Idaho L. Rev. 377 (1999).
23. Timothy Stewart Bland, *The Determination of Disability Under the ADA: Should Mitigating Factors Such as Medications be Considered?* 35 Idaho L. Rev. 265 (1999).

24. James M. Wood, *The Judicial Coordination of Drug and Device Litigation: A Review and Critique*, 54 Food & Drug L.J. 255 (1999).

25. Senator Charles Grassley, *The Resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality of Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987*, 7 Elder L.J. 267 (1999).

26. Bethany J. Spielman, *Managed Care Regulation and the Physician Advocate*, 47 Drake L. Rev. 713 (1999).

27. Mia M. McFarlane, *Mandatory Reporting of Domestic Violence: An Inappropriate Response for New York Health Care Professionals*, 17 Buff. Pub. Interest L.J. (1998-1999).

28. Ellen L. Luepke, *White Coat, Blue Collar: Physician Unionization and Managed Care*, 8 Annals Health L. 275 (1999).

29. Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 Annals Health L. 201 (1999).

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Compiled by Joe DaBronzo, who is a second year law student at Pace University School of Law. Mr. DaBronzo completed a residency in Clinical Pharmacy at the National Institutes of Health and served in the position of Clinical Coordinator for Neurology in the National Institute of Neurological Disorders and Stroke of the National Institutes of Health. Joe also has 11 years experience in the pharmaceutical industry. He was Assistant Director in the International Medical Department for American Cyanamid's International Pharmaceutical Division Lederle International and with Merck Pharmaceuticals serving in the positions of Director of Clinical Policy and Director of Health Utilization Management in Merck's managed care division Merck-Medco Managed Care L.L.C.

'Net Worth

By Margaret R. Moreland

Merriam-Webster's Dictionary of Law on the Internet defines "regulation" as "an authoritative rule, *specif* a rule or order issued by a government agency and often having the force of law." I define regulations as the rules that make the laws work. In the past it has often been difficult to find regulations on the Internet in an easily usable format. Happily, that situation is changing even on the state level.

National

Code of Federal Regulations http://www.access.gpo.gov/nara/cfr/index.html

The CFR online database is the codification, under 50 titles, of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government. It is a joint project of the National Archives and Records Administration's Office of the Federal Register and the Government Printing Office under a mandate to provide the public with enhanced access to government information. Revised titles are added to the online service concurrent with the release of the paper editions. Each volume of the CFR is revised once each calendar year and the revisions are issued on a quarterly basis (Titles 1-16 in January, Titles 17-27 in April, Titles 28-41 In July and Titles 42-50 in October). Prior editions will remain in the database as a historical set. CFR online is exceptionally easy to use. The user can search all 50 titles of the current set by keyword. If the keyword search is limited to one or more titles/volumes, the user can choose the current or historical versions. Specific citations (title and section) can be retrieved from both the current and historical volumes.

Federal Register http://www.access.gpo.gov/su_docs/aces/aces140.html

The Federal Register online uploads the contents of each issue on the day it is published. Back issues to 1994 are also available (1994 issues have no fields or section identifiers). Keyword searches can be performed against the volume for a specific year, and may be limited by section or date. The individual sections that can be searched are: Contents and Preliminary Pages, Final Rules and Regulations, Proposed Rules, Notices, Presidential Documents, Sunshine Act Meetings, Reader Aids, and Corrections. A particular feature, "In the News," currently includes collections of Federal Register documents on the following topics: (1) Health Plans, Health Care Clearinghouses, and Health Care Providers, and (2) Physician Fee Schedule (2000 CY); Payment Policies. Prior collections are archived. Some include: (a) Lists of Designated Primary Medical Care, Mental Health, and Dental Health Professional Shortage Areas, (b) Health Insurance Reform: Standards for Electronic Transactions, (c) FDA rule on Quality Mammography

Also, check out state agency sites to find current activity. Note: the quality varies greatly!

Commission on Quality of Care	**http://www.cqc.state.ny.us/**
Community Health Care Association of NYS	**http://www.chcanys.org/**
Department of Education	**http://www.nysed.gov/**
Department of Family Assistance (formerly Social Services)	**http://www.dfa.state.ny.us/**
Department of Health	**http://www.health.state.ny.us/**
Office for the Aging	**http://aging.state.ny.us/nysofa/**
Office of Advocate for Persons with Disabilities	**http://www.state.ny.us/disabledadvocate/**
Office of Mental Health	**http://www.omh.state.ny.us/**
Office of Mental Retardation and Developmental Disabilities	**http://www.omr.state.ny.us/**
Workers' Compensation Board	**http://www.wcb.state.ny.us/**

Standards, (b) Executive Order on Protecting Federal Employees and the Public From Exposure to Tobacco Smoke in the Federal Workplace, (d) Procedures for Ambulatory Surgical Centers, and (e) many on Medicare programs.

List of CFR Sections Affected (LSA)
http://www.access.gpo.gov/nara/lsa/aboutlsa.html

This new addition to the Internet assists in the process of bringing your CFR research up to date. First you will search the most recent LSA to find any changes since the last revision date of the volume you are using. (The online LSA will give you access to all four annual issues.) Then you will look at the "Current List" for changes made after the last ones included in LSA. The List of CFR Parts Affected Today will allow you to monitor changes on a daily basis.

New York State

NYCRR Title 10: Public Health
http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm

NYCRR Title 18: Social Services
http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm

The Department of Health has made it possible to browse these two sections of the NYCRR or to perform a full-text keyword search. The entire NYCRR is not yet available in its entirety anywhere on the Internet.

Margaret R. Moreland is Lawyer/Librarian for Research Services at Pace University School of Law. Her e-mail address is mmoreland@law.pace.edu.

For Your Information

By Claudia O. Torrey

On August 2, 1999, a *new* Patients' Rights Condition of Participation (CP) became effective for all Medicare and Medicaid participating hospitals and health care entities,[1] including short-term, psychiatric, rehabilitation, long-term, children's and alcohol-drug facilities.[2] The CP, issued by the Health Care Financing Administration (HCFA), delineates six standards that are intended to protect patient health and safety. The six standards are entitled: notice of rights, exercise of rights, privacy and safety, confidentiality of patient records, restraint for acute medical and surgical care, and seclusion and restraint for behavior management.

For background knowledge purposes, the CP is a mandatory requirement that health care facilities and hospitals must meet in order to participate in the Medicare and Medicaid program. State survey agencies (SSA; usually the State Health Department), under contract with HCFA, survey these entities to assess compliance with the CP. Accordingly, the SSA submit their recommendations to HCFA regarding the hospital's participation/certification status.

To be sure, entities accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO; or the American Osteopathic Association) are not routinely surveyed for compliance by SSA, but are *deemed* to meet CP requirements based upon their accreditation. However, even JCAHO is not immune to governmental reproof. In response to criticism about its inspection reports by the Office of Inspector General of the Health and Human Services Department, the JCAHO Board of Commissioners decided that as of January 1, 2000, hospitals will be subject to unannounced, random accreditation survey visits. This policy will do away with the 24-hour advance notice that is usually given regarding an on-site survey. The JCAHO Commissioners believe this new policy will go a long way toward ensuring that their accreditation process is much more meaningful.

The CP Standards seek to enhance hospital care quality. Indeed, quality of care issues may start to emerge as a salient predicate for such things as discrimination cases and/or fraud and abuse liability.[3] Whether this new CP will create an undue financial burden on hospitals and health care entities is yet to be determined. Given the fact that patients' concerns such as an expanded right to sue health plans, health information privacy issues, quality of care and managed care are likely to be on Congress' health care agenda this year, hospitals and health care entities would do well to become familiar with these new CP Standards.

Endnotes

1. *See* 42 CFR Part 482, Subpart B, § 482.13.
2. *See* 64 Fed. Reg. 36070 (1999).
3. Milo Geyelin, *Unhealthy Bias?—A Disabled Attorney Puts Civil-Rights Spin on HMO Litigation,* Wall St. J., January 26, 2000, at A1.

Claudia O. Torrey, Esq. can be reached at Post Office Box 150234, Nashville, Tennessee 37215.

Securing Health Care for the Uninsured: What Still Needs to be Done

By Hon. F. Richard Gottfried, Anne Erickson, Gary J. Fitzgerald, Craig Duncan, Karen Schimke and Elliott A. Shaw, Jr.

Hon. F. Richard Gottfried

Chair, Health Committee, NYS Assembly

Passing the Health Care Reform Act (HCRA 2000) was an extraordinary victory for New Yorkers. The most exciting element is Family Health Plus—publicly sponsored and publicly-funded health coverage for low-income adults, following the highly successful Child Health Plus model. Other important new elements include a new program to subsidize coverage for people who purchase individual insurance, and funding for community-based outreach to enroll people in Family Health Plus or Medicaid.

"The only effective solution to the problem of the uninsured—as well as a lot of the problems with current coverage—is a universal health plan with broad-based public funding."

HCRA 2000 also creates a program to subsidize health coverage offered by small businesses that have not provided coverage to their workers for at least the preceding 12 months. Like almost all incremental approaches, this means that small business owners who have been "doing the right thing" by providing coverage will get no benefit, while a competitor may get the subsidy. But I doubt that this limited subsidy will attract enough employers to significantly reduce the number of uninsured.

While these programs are valuable steps forward in providing health coverage for New Yorkers, they are still small steps. And the economy and labor market will continue to generate uninsured New Yorkers faster than we are expanding and creating health care programs to cover them.

Even when Family Health Plus is fully implemented, there will almost certainly be more uninsured New Yorkers than there are today—though not as many as there would have been without Family Health Plus.

Today, Medicaid is always under downward pressure, because politicians see it as a program for the poor. Most private health coverage is controlled by employers, and is therefore also under downward pressure. And about a quarter of the non-elderly population has no coverage at all.

I believe hospitals, doctors and other health care providers are coming to understand that this is not a set up they can survive in. The only effective solution to the problem of the uninsured—as well as a lot of the problems with current coverage—is a universal health plan with broad-based public funding.

Medicare and Child Health Plus are highly successful demonstrations that publicly sponsored and publicly funded coverage works. Family Health Plus will be one more demonstration.

We should build on that concept. The more who are eligible, the better the quality of the plan will be. Politics tends to work that way. My "New York Health" bill, A.3571, sponsored by a majority of members of the Assembly, would set up a state health plan, similar to Medicare and Child Health Plus, but for everyone.

Anne Erickson

President and CEO, Greater Upstate Law Project

Shortly after Family Health Plus was enacted, I found myself in the meeting room of a church in Binghamton. Braving the winter snow, people had come to hear about this incredible expansion of health coverage; an expansion, they were told, that would cover one million uninsured New Yorkers. Some came to listen; others came hoping to be one of those million.[1]

As I walked through the income eligibility levels of Family Health Plus and the phase-in periods and the

disparity between households with children and those without, a woman in her early 50s, sitting up front, shook her head in sad disbelief. "You've done nothing for me," she said, "my kids are grown and gone and I'd be over income." She will be ineligible for the core component of Family Health Plus—an expansion of coverage to the uninsured based on need.

There are two other components, Healthy New York for Small Businesses and Healthy New York for Individuals, but unless this woman's employer meets the definition of and decides to participate in the small business program (and she can afford the premium), or unless she can navigate into, pay the premiums, afford the co-pays and be secure with the limited benefit package offered under the individual program, she will not be one of the lucky million.

That's not to say the creation of Family Health Plus is anything but an incredible step forward in our efforts to cover the uninsured. It is simply to say there is much more to be done. First and foremost, we need to ensure that FHP is implemented as quickly and effectively as possible. The Department of Health must move quickly and aggressively to secure the federal waivers required to implement Family Health Plus. The state legislature should revisit and repeal if necessary the "poison pill" included in FHP that eliminates the expanded coverage for childless households unless the federal government agrees to share in the cost of that coverage.[2] Finally, the legislature should expand Family Health Plus to include our immigrant populations.

As we work to make Family Health Plus a reality, we also need to clean up our current Medicaid program and rebuild it as a health care program capable of financing and coordinating comprehensive health care for all who are eligible. We need to build on the work the state is undertaking in Child Health Plus and Medicaid and ensure seamless movement between Medicaid and Family Health Plus as a family's income changes. We need simplify our application process and make it user friendly. We need to move health care out of the welfare arena and make sure that it reaches all who are eligible.

This is critically important when we note the precipitous drop in Medicaid enrollment as a result of welfare reform and the diversion from assistance that takes place at the local level. Rather than help families package health care and child care and potentially child support and a job as a way of avoiding the need for cash assistance, many districts, New York City, in particular, are simply diverting families from all assistance, often illegally.

Congress allowed the state broad latitude in the design of cash assistance programs when it enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("welfare reform"). However, Congress deliberately maintained the federal rights and protections Medicaid and prohibited states from imposing new or more stringent eligibility requirements on participation.

"Clearly, if we are committed to making Family Health Plus work as comprehensively as possible, we need to tear down the Medicaid barriers to participation, streamline the application process, and make enrollment in either Medicaid or Family Health Plus as painless and as customer-friendly as possible."

Despite these legal protections, almost 3 million New Yorkers have lost health coverage under Medicaid since March 1995 as welfare reforms have been aggressively pursued. Even more troubling, has been the decline in children's enrollment in Medicaid. At the very time we are seeing enrollment in Child Health Plus grow at a robust rate (up by more than 281,800 children since 1995), we are seeing an almost parallel decline in children covered by Medicaid (down by 182,857 children).

Clearly, if we are committed to making Family Health Plus work as comprehensively as possible, we need to tear down the Medicaid barriers to participation, streamline the application process, and make enrollment in either Medicaid or Family Health Plus as painless and as customer-friendly as possible.

Finally, we need to continue our efforts to expand access to health care. Remember, even when fully operational, and if the programs are fully enrolled, two million uninsured New Yorkers will remain ineligible for coverage under these newly created programs.

Note: Greater Upstate Law Project is the support center for legal services throughout upstate New York, and advocates for the legal rights and entitlements of poor and low income New Yorkers.

Endnotes

1. It is estimated that one million individuals will be eligible for one of the three expansion efforts, but it is unclear how many will actually participate. For instance, an estimated 600,000 adults will be eligible for Family Health Plus when it is fully implemented, but it is estimated that less than 300,000 will actually enroll.
2. The Federal Medicaid program primarily remains "child-based," available to households in which there is a dependent child. New York moves beyond this to provide coverage to single adults and couples without children or whose children are over 21, as long as they meet the financial eligibility standards set by the state.

Gary J. Fitzgerald

President, Iroquois Healthcare Alliance

Many people believe that health care is a right. To that end, hospitals in New York State, almost exclusively not-for-profit entities, have a long tradition of providing care to all who seek treatment. More significantly, hospitals and their affiliated physicians in many upstate New York counties are the primary, if not sole source of health care delivery in the communities they serve.

Numerous state and federal programs—e.g., Medicaid, Child Health Plus, bad debt and charity care pools, etc.—and the recently enacted programs under HCRA 2000 have been designed to ensure that all members of our communities, regardless of their ability to pay, will have access to health care. Despite these efforts, there remain more than 3 million uninsured New York residents who last year received more than $1.4 billion in hospital services for which they could not pay.

"Our region's hospitals have placed a priority on expanding enrollment efforts to break down the barriers that keep the working uninsured from accessing public and private health insurance programs."

During a period of unprecedented economic expansion, many of the uninsured have jobs, but their employers do not provide insurance and they do not earn enough to pay for individual or family health insurance. Each region of our state has unique characteristics which contribute to the problem of the uninsured. Upstate's poor economy, agricultural employment base, and large percentage of seasonal/part-time workers make employer-based health insurance programs less accessible. In addition, particularly in upstate communities, many residents associate a stigma with receiving public support in any form that often keeps people from enrolling for the various benefits they may be entitled to receive. Although the growing numbers of uninsured is a national problem, effective solutions are best implemented locally. Local health care providers, businesses, schools, and social organizations must work together to identify and educate families and individuals about the availability of the many new health insurance programs. As community leaders involved in New York State's health care environment, health lawyers could provide much-needed leadership in establishing local/regional coalitions to address this problem.

Our region's hospitals have placed a priority on expanding enrollment efforts to break down the barriers that keep the working uninsured from accessing public and private health insurance programs. Iroquois Healthcare is working with the Blue Cross and Blue Shield Plans across Upstate to develop a demonstration program targeting enrollment of the working uninsured. At the same time, both state and federal efforts to decrease the number of uninsured should focus on marketing and monitoring Child Health Plus, Family Health Plus, and other innovative employer-based insurance programs.

The growing numbers of uninsured negatively impact all New York State citizens. Hospitals annually update their charity care policies to ensure the needs of the community will be met and hospital operating budgets can absorb the impact from an increasing amount of charity care services provided. This means that each year, all services must be evaluated to determine which ones can be continued so that unreimbursed care can be provided to the uninsured. Without improving the uninsured's access to health insurance, hospitals' ability to offer the entire community access to a full range of health care services will ultimately be compromised.

Note: The Iroquois Healthcare Alliance is a regional trade association representing 58 hospitals and health systems in 31 upstate counties in New York.

Craig Duncan

CEO, Northeast Health, Troy, NY

I work for Northeast Health, a health care system that includes two hospitals, primary care centers, and "The Eddy," a network of residential, home care and day care services for the elderly. From my standpoint, the value of Family Health Plus is clear. Today, a low-income woman will show up in the emergency room of Albany Memorial Hospital without health insurance. We will provide her with expensive, high quality care, and receive only token reimbursement from the state bad debt and charity care

pool. Family Health Plus will help that woman buy health insurance. As a result, she will be more likely to get primary care that could head off her need to come to an emergency room. And if she does need our emergency care, we will be able to secure reimbursement for it.

That last point is important. To a large extent, our society has, by default, relied on hospitals to subsidize the health care of the uninsured. We've been able to meet that obligation, in part, because government has provided sufficient reimbursement under Medicare and Medicaid to allow for some cross-subsidization. But in recent years—and particularly as a result of the 1996 federal Balanced Budget Act—government has significantly cut reimbursement to hospitals, hampering our ability to meet our obligations to our communities. At the same time, government has continuously demanded more from us, in terms of standards and regulatory compliance. Hospitals are also facing other severe pressures, from labor shortages to an explosion in pharmaceutical costs.

"[F]ederal and state policymakers . . . must recognize that access to care—for all of us, irrespective of income—depends on adequate provider reimbursement rates and a reasonable regulatory environment."

It is enormously important to secure health coverage for the uninsured. But federal and state policymakers need be equally intent on preserving the health care infrastructure. They must recognize that access to care—for all of us, irrespective of income—depends on adequate provider reimbursement rates and a reasonable regulatory environment.

"[W]e need to provide the type of comprehensive case management that we know helps families receive the health services that improve their lives."

As a result of Family Health Plus, the woman I mentioned earlier will be insured if she needs emergency care. That is a great step forward, and the Legislature and Governor are to be congratulated. But further steps need to be taken to ensure that the emergency room will be there when she arrives.

Karen Schimke

President, State Communities Aid Association

The State Communities Aid Association is a 127-year-old organization dedicated to improving health and human services for all the citizens of New York State. Through our years as a leader in public policy and advocacy we have been particularly active in seeking compassionate and cost-effective solutions to the problems that confront this state's poorest and most vulnerable citizens. We believe that New York has reached a crossroad in its delivery of health services through the current configuration of public programs.

By its own legislative predilections and bureaucratic excesses, the State of New York has contrived a health care system for the poor that is exceedingly complicated for recipients as well as administrators. The federal government has also been a culprit in the evolution of this hopelessly fragmented system. We have created a series of discreet programs with labyrinthine rules and regulations that have the effect of keeping out the very people who qualify for the services.

In the simplest terms, this means that state and local governments are forced to squander scarce resources administering multiple programs. Instead, we need to provide the type of comprehensive case management that we know helps families receive the health services that improve their lives. All the good intentions that led to the establishment of these programs are wasted if the people they are designed to help do not receive health services either because they do not understand the rules or because they are wary or afraid of government programs.

New York needs to create a single health program—let's call it Our New York: Our Health—that would include a single point of entry as well as a single standard of eligibility. By combining the existing programs and their different payment streams, financing health care would be a "back-office" operation. Recipients could be presented with one health care program that looks more like private insurance than a government program while administrators would be relieved of the burden of competing bureaucracies. This is not a new idea, but at this point in time—with the right political leadership and will—it could be one in an interlocking series of strategies that are the key to improving New York's commitment to providing health care to the poor.

Elliott A. Shaw Jr.

Director of Government Affairs, The Business Council of New York State, Inc.

At a time when individuals and employers are increasingly worried about paying growing health care bills, why do policymakers so easily overlook the fact that making health care more costly will also make it less affordable? Perhaps for the same reason that politicians prefer to cut ribbons at ceremonies for new bridges, not old ones made safer by repairs. New bridges, like new health programs, get headlines. Repairs get little notice.

For example, New York's Health Care Reform Act 2000 got banner headlines because it expands New York's already highest-in-the-nation level of taxpayer-funded health care. But less ink has been expended on one of the most important problems facing our health care system: the eroding base of the privately insured.

Consider Census Bureau data on employment-based coverage rates for those under age 65. New York shows the steepest decline in coverage among 48 states between 1988 and 1998. In 1988, 67.5 percent of New Yorkers under age 65 reported having health coverage as an employment benefit. A decade later, the rate was 61.7 percent. Nationally, employment-based coverage rate was 66 percent in 1988 and only slightly lower, 65.8 percent, in 1998. Only Arizona and Connecticut had steeper rates in the decline than New York.

Health care premiums reflect costs charged by the hospitals, doctors and outpatient facilities, as well as how often consumers use health care services. Clearly addressing New York's uninsured problem will require a closer examination of costs. For example, New Yorkers pay $1.4 billion annually in additional taxes to help subsidize the training of doctors here. But New York already has a surplus of physicians. In fact, more than half of the new doctors we train eventually leave the state.

And New York's hospitals have the worst record in the country when it comes to average length of stay for patients. More than a third of our hospital beds aren't used. This excess-capacity problem will only worsen while we continue to pay for it. And per-capita Medicaid spending in New York is more than three times the national rate.

HCRA 2000 could have addressed these issues and eased the burden borne by those who pay for private health coverage. But the opportunity was missed. And this year, lawmakers are considering new bills that would drive costs even higher. Proposals to mandate infertility coverage are at the top of the list.

"New bridges, like new health programs, get headlines. Repairs get little notice."

Studies show that most employers cannot absorb the full share of cost increases created by such actions. Increasingly, the expense is being shared with workers. Some workers are even declining offers of coverage as an employment benefit because they say they cannot afford their share of the premium.

With our shrinking base of privately insured, HCRA 2000 was a classic example of the ribbon-cutting ceremony for the new bridge. The sad irony is that this new program is being financed by increasing tolls collected on an existing bridge that sorely needs repair.

The New York Health Care Reform Act of 2000

By Eugene M. Laks and Sean M. Nataro

The New York Health Care Reform Act of 2000 (HCRA 2000) was signed into law on December 30, 1999.[1] This bill establishes, for the period January 1, 2000 through June 30, 2003, the parameters for Medicaid reimbursement to hospitals and other health care providers; the financing of "public goods" through various pooling mechanisms, allocation of a portion of New York State's share of national tobacco litigation settlement funds, and anticipated tax revenues from an increase in the cigarette tax; and new and expanded health insurance initiatives for low-income families and children. In this article we will provide a brief summary of significant aspects of this complex, comprehensive legislation.

"A degree of uncertainty, however, rests over the HCRA 2000 reimbursement and pooling systems because of a drafting issue that may be corrected in this legislative session."

HCRA 2000 builds upon the initiatives of the New York Health Care Reform Act of 1996 (HCRA),[2] which deregulated as of January 1, 1997 inpatient and outpatient hospital reimbursement rates for private insurers. HCRA also established various state assessments which require Medicaid, private insurance plans, health maintenance organizations, self-insured funds and hospitals to contribute to various pools to support the costs of "public goods," including initiatives to provide funds for provider costs of care for the uninsured, graduate medical education, the Child Health Plus insurance subsidy and other programs.

A degree of uncertainty, however, rests over the HCRA 2000 reimbursement and pooling systems because of a drafting issue that may be corrected in this legislative session. HCRA, the predecessor to some of the key provisions of HCRA 2000, contains a repeal provision in its effective date language[3] which provides that "sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law . . . shall expire and be deemed to be repealed on December 31, 1999." That provision was not repealed in HCRA 2000. Therefore, technically, the amendments in HCRA 2000 to provisions of those sections of the Public Health Law, which establish the Medicaid hospital inpatient reimbursement methodology and establish the surcharges and assessments to fund the "public goods" pools, are amendments to repealed provisions of law.

The caption of a bill recites each of the consolidated laws and unconsolidated laws to be amended in the body of the bill. The caption of HCRA 2000 lists an amendment to HCRA, Chapter 639 of the Laws of 1996, but no such amendment is included in the body. We can surmise that it may have been intended to include in HCRA 2000 a repeal of that earlier sunset date. That type of omission would usually be noted and corrected by the Legislative Bill Drafting Commission.

If the effect of that repeal provision is litigated, the courts may defer to legislative intent that may be gleaned from HCRA 2000 as a whole, that those sections of the Public Health Law would continue in effect, over strict application of the repeal provision.[4] However, that outcome is not guaranteed. If corrective action is taken by the Legislature, both a repeal of the earlier HCRA sunset provision and an affirmative provision deeming sections 2807-c, 2807-j, 2807-s and 2807-t of the Public Health Law to have been in full force and effect on and after January 1, 2000 should be enacted, as the General Construction Law provides that repeal of a repealer provision after it has taken effect does not revive the underlying law.[5]

The following is a description of the provisions of HCRA 2000.

Hospital Reimbursement

The current inpatient hospital reimbursement system under PHL § 2807-c for Medicaid and certain other payors[6] is continued. This is a system of case-based payments per discharge for most patients and *per diem* payments for certain specialized services.[7] Each patient is assigned to one of over 800 diagnosis-related groups (DRGs) upon discharge, based on diagnosis, whether surgery was performed and whether any complications were present. Each DRG has a relative weight which is used as a multiplier of the per discharge historical reimbursable costs of care of a hospital for its patients. The weighting factor is based on the average costs of care of all patients within that particular DRG. This forms the basis for the operating cost component of the Medicaid reimbursement rate paid to the hospital. A hospital's reimbursable historical costs continue to be related to base year 1981 costs of the hospital and of similar hospitals in a peer group trended forward to reflect inflation, plus approved hospital rate appeals, plus various rate enhancements added over the years, and less various Medicaid reimbursement formula cost containment initiatives enacted over the years. To the operating cost component, factors are added for hospital capital costs.

HCRA 2000 continues this reimbursement system with no new rate enhancements and no new cost containment provisions. Existing cost containment changes to the reimbursement formula are continued through March 31, 2003. The calculation of the trend factor to project for inflation is simplified by linking it to the federally determined change in the consumer price index—urban.

Extension of prior cost containment provisions through March 31, 2003, rather than on an annual basis, resolves many of the contentious budget negotiations between the Governor and the Legislature over Medicaid expenditures that typically arise each year. This may result in more timely state budgets in the future. For example, budget negotiations in 1999 were not concluded until after July 1. Federal regulations require[8] that a state must notify the federal government by the end of the quarter of any changes in its Medicaid reimbursement methodology. Since continuation of prior Medicaid cost containment provisions after April 1, 1999 had not been agreed upon prior to July 1, 1999, those provisions lapsed for the quarter April 1, 1999 through June 30, 1999 and could not be retroactively reinstated. The hospitals, therefore, received higher Medicaid rates for patients discharged during that quarter.

It must be noted that this statutory Medicaid reimbursement methodology applies to patients in the fee-for-service system. As the state continues over the next few years to phase into Medicaid managed care, negotiated rates between managed care organizations and hospitals will control reimbursement for a greater number of Medicaid patients. The bill also continues the discreet reimbursement rates paid directly to teaching hospitals by Medicaid for graduate medical education costs, in addition to reimbursement paid by HMOs for Medicaid managed care patients.

Other Provider Medicaid Reimbursement

Similar to continuation of hospital cost containment adjustments to the Medicaid reimbursement methodology, various cost containment adjustments to the Medicaid reimbursement methodologies and social services district cost savings targets are continued through March 31, 2003 for: nursing homes, diagnostic and treatment centers, adult day care programs, certified home health agencies, long-term home health care programs, and personal care programs. The determination of the trend factors to project base year costs for the effects of inflation is linked to the hospital trend factor methodology.

The programs for payment of additional Medicaid funds to public hospitals for uncompensated care and additional funds to public nursing homes up to federal maximums are continued. These programs bring in additional federal funds, based on a federal match of local funds, which are shared between the state and local governments.

Pool Funding Sources

The annual "public goods" pools which provide funds for hospital uncompensated care to uninsured patients, graduate medical education costs of teaching hospitals, health insurance subsidy programs, and other health care initiatives are derived from an amalgam of sources. The pools are established for 2000, 2001, 2002 and for the period January 1, 2003 through June 30, 2003. An independent audit of all state pools retroactive to 1983 is required.

HCRA 2000 continues under PHL § 2807-c(18) the 1% assessment on hospital inpatient revenue, to be paid by hospitals to a state pool.

HCRA 2000 continues the 8.18% surcharge under PHL § 2807-j on bills for hospital inpatient and outpatient services, comprehensive diagnostic and treatment center services, freestanding ambulatory surgical center services, and freestanding clinical laboratory services. Medicaid and Medicaid HMOs continue to pay a reduced surcharge of 5.98%. Insurers, health maintenance organizations, and self-insured funds that do not elect to pay the surcharges directly to the state pool, rather than to the health care providers, continue to be assessed an additional 24% surcharge.

Effective October 1, 2000, the surcharges on freestanding clinical laboratories, and on referred ambulatory clinical laboratory services provided by hospitals and by diagnostic and treatment centers are eliminated. However, these surcharges would pop up again retroactively for all providers if the federal Department of Health and Human Services determines that the exclusion of clinical laboratory revenue from the surcharges results in a surcharge being an impermissible provider-specific tax under federal law and regulations. Federal law[9] and regulations[10] require that any tax by a state on health care items or services either be uniform in its application to all provider revenue within a provider class, or that the state qualify for a waiver under a complex statistical regression analysis which measures the impact of the tax on Medicaid providers. If a tax is not permissible under the federal definitions, a state would loose a like amount of federal Medicaid funds.

Additional flexibility is provided to payors as they may now revoke a surcharge direct pay election prior to any quarter, and payors whose surcharge payment obligations do not exceed $10,000 based on the prior year's experience may elect to make annual payments. The Commissioner of Health is authorized to impose a civil penalty of up to $10,000 if a payor or provider does not

provide records for audit upon request or does not file required reports.

HCRA 2000 also continues the surcharges under PHL § 2807-s and covered lives assessments under PHL § 2807-t on insurers, health maintenance organizations, and self-insured funds. These provisions raise funds primarily for the pool to fund hospital graduate medical education costs. The amount to be raised from the covered lives assessments is reduced by $60 million over three years to provide some relief to the payors. Similar payor flexibility provisions as added to PHL § 2807-j, and Commissioner of Health authority to impose civil penalties is also added here.

$1.3 billion dollars over 3½ years is allocated from funds to be received by the state from the national tobacco litigation settlement and all revenue from a 55 cents per pack increase in the state cigarette tax is allocated to a tobacco control and insurance initiatives pool.

Hospital Indigent Care Pool

The hospital indigent care pool,[11] previously known as the bad debt and charity care pool, provides funds to hospitals to meet a percentage of the costs of providing services to the uninsured. Pool funds are distributed based on a scaled formula which measures the relative "need" of each hospital based on consideration of the amount of uncompensated care provided as a percentage of hospital revenue. The pool will receive a guaranteed $738 million per year during HCRA 2000. The infusion of funds from the national tobacco litigation settlement assures that there will be no pool shortfalls. During HCRA, indigent care pool shortfalls now amounting to over $100 million per year compared to anticipated funding levels were of great concern to hospitals.

Hospitals previously classified as financially distressed hospitals continue to transition to the HCRA need determination methodology.

Each year $27 million will be reserved for an additional indigent care allocation among teaching hospitals to compensate for a reduction in funds those hospitals will receive from the graduate medical education pool.

High Need Indigent Care Adjustment Pool

An additional $82 million per year is allocated for distribution from a new high need indigent care adjustment pool.[12] Funds will be allocated among rural hospitals ($20 million), urban safety net hospitals ($36 million), and all other hospitals ($26 million). Each rural hospital will receive $140,000 plus a scaled payment based on relative need.

Professional Education Pool

This pool,[13] also known as the graduate medical education pool, will be funded at $494 million per year under HCRA 2000. This is a $50 million reduction from HCRA funding levels. However, through a reduction of $23 million in the amount annually to be set aside within the pool for hospitals that achieve certain public policy goals related to graduate medical education, a reduction from $54 million per year under HCRA to $31 million per year under HCRA 2000, and an addition of $27 million in indigent care pool allocations, teaching hospitals will receive the same general level of funds as under HCRA to support graduate medical education. Funding is eliminated for former teaching hospitals which have closed their residency programs.

$1 million in 2000 and $1.6 million per year thereafter will be allocated for distributions to the New York State Area Health Education Center Program for the purpose of expanding community-based training of medical students.

"Pool funds are distributed based on a scaled formula which measures the relative 'need' of each hospital based on consideration of the amount of uncompensated care provided as a percentage of hospital revenue."

Health Care Initiatives Pool

A multiplicity of programs are funded under the health care initiatives pool.[14] A complex hierarchy of funding is established in the event there is a shortfall in the pool. A complete description of the programs and funding amounts is beyond the scope of this article. Briefly, HCRA programs funded for some or all of the HCRA 2000 period include: increased funding for enrollment of additional children in the child health insurance program; phasing-out of the small business health insurance subsidy program, the individual health insurance subsidy pilot program, and the individual health insurance voucher program, to be replaced with new and expanded health insurance programs; the catastrophic health care cost relief program; health system transition priorities pools of the Commissioner of Health, the New York State Assembly and the New York State Senate; various public health programs, including hospital-based grants, the emergency medical services program, regional poison control centers subsidies, and the HIV program for infants and pregnant women; the health facility capital restructuring pool; a revised health workforce retraining program; state gen-

eral fund relief; rural health care delivery grants; comprehensive diagnostic and treatment center uncompensated care payments for uninsured patients; the AIDS drug assistance program; and cancer-related services grants.

Several programs funded under HCRA were not continued, including: primary care education and training act grants; primary care initiative grants for expansion of capacity, which reportedly were not awarded during HCRA; health information and health care quality improvement program grants; and indigent care grants to freestanding clinical laboratories and ambulatory surgical centers. The Task Force on Quality Improvement and Information Systems has been repealed.

Tobacco Control and Insurance Initiatives Pool and Cigarette Tax Increase

A new tobacco control and insurance initiatives pool is established,[15] funded with $276 million for 2000, $305 million for 2001, $383 million for 2002, and $360 million for January 1, 2003 through June 30, 2003 from New York's share of the national tobacco litigation settlement. In addition, a 55 cents per pack increase in New York's cigarette tax is enacted and funds from this tax increase are allocated to this pool. This pool will fund several new HCRA 2000 health care initiatives, which are described below.

New Health Insurance Initiatives

HCRA 2000 contains three major health insurance initiatives designed to expand access to health care for the uninsured. First, Medicaid will be expanded by adding the Family Health Plus program. This program will provide coverage to low-income adults between the ages of 19 and 65 beginning in January 2001. Second, a new standardized health benefit package, referred to in the Governor's memorandum as the "Healthy New York Program" will also be made available to certain small employers who do not offer health insurance to their employees. This coverage will also be available to qualified low-income individuals. Third, the State will provide new stop-loss coverage to HMOs to cover excess losses in the State-mandated direct pay contracts that HMOs must offer. This stop-loss program is intended to stabilized premiums which have made this coverage too expensive for many New Yorkers.

Family Health Plus

The Family Health Plus program, codified at § 369-ee of the Social Services Law, will provide insurance coverage to low-income adults. While similar in name and structure to the State's current Child Health Plus,[16] Family Health Plus will in fact be part of the State's Medicaid program in order to secure federal funding. Under federal law Medicaid programs such as this receive a portion of their funding, 50% in New York State, from the federal government and the remainder from the State and local governments. New York's Child Health Plus program has its own source of funding under the federal S-CHP legislation,[17] there is no comparable source of funding for a program for low-income adults outside of Medicaid. The program will not take effect until all required federal waivers and approvals are obtained.[18]

While the placement of the program within Medicaid secured federal funds, it also raised issues regarding local funding. Counties around the state are concerned regarding their ability to finance their share of the costs. The New York State Association of Counties has called the program "the largest unfunded mandate to be passed to local government in over a decade,"[19] while the Governor's office has pointed, as potential sources of funds for the counties, both to county savings under HCRA 2000 by continuing Medicaid payment cost containment provisions and to counties receiving a portion of the state's share of the national tobacco litigation settlement. Whether the counties will ultimately be made to foot the bill is unclear and the Senate and Assembly have introduced bills for the State to pick up the tab.

To be eligible to enroll in Family Health Plus an individual must be 1) a New York resident aged 19 to 64, 2) not otherwise eligible for Medicaid (or eligible only by "spending down" excess income), and 3) without equivalent health insurance as defined by the Department of Health (DOH) and Department of Insurance. In addition, the individual must be without other coverage through an employer plan for at least six months (subject to various exclusions for employer termination, death of family member, expiration of COBRA benefits, etc.).[20]

In addition to those criteria above, individuals must also meet financial need criteria. In the case of a parent or stepparent of a child under 21, the family must have net income at or below 100% of the federal poverty level (FPL) in 2001 when the program begins. By 2002 eligibility rises to 125% of the FPL. In the case of an individual not living with child under 21, net family income must be no more than 84% of FPL.[21] Individuals may establish their financial need with paystubs, written documentation from employers, proof of identity and residence and other documentation as determined by DOH.[22] Individuals who qualify are guaranteed eligibility for six months.[23]

Each insurer will be required to provide a standard benefit package.[24] The benefit package is similar to that provided through the Child Health Plus program. The specific health care services to be provided include physician services, inpatient hospital services, inpatient and outpatient mental health and alcohol abuse, lab

and diagnostic x-ray, prescription drugs, emergency room services, emergency, routine and preventive dental care (but not orthodontia and cosmetic dental services) and emergency, preventive and routine vision care.

Entities that may contract with the State to participate in the program include insurers licensed under Articles 32, 43 and 44 of the Insurance Law and organizations licensed under Article 44 of the Public Health Law.[25] As with the Child Health Plus program, insurers will apply to and contract with DOH to write the coverage. HCRA 2000 explicitly states that existing Child Health Plus and Medicaid managed care plans do not need to engage in a competitive bidding process, implying that other plans must do so. The statute also allows DOH to award contracts to Child Health Plus plans that do not participate in Medicaid managed care in areas of the state where there are few Medicaid plans. DOH has previously taken the position that Child Health Plus plans also participate in the State's Medicaid managed care program and it remains to be seen how the statute's language will impact that position. DOH's position may be moot however since commercial carriers may find little incentive to participate in a second Medicaid program following the drop in Medicaid managed care premiums over the last several years.

While DOH has regulatory responsibility for the program, it is not clear which office in the Department will take the lead, the Office of Managed Care or the Office of Medicaid Administration. Regardless, insurers will be required to meet various operational standards which are similar to those currently required of Medicaid managed care and Child Health Plus plans. These include DOH approval of marketing materials, adequate means to communicate with non-English speakers, compliance with the ADA, limitations on basis for disenrollment by plan and approval by "local district" prior to disenrollment by plan. The term "local district" is not defined but presumably refers to the Local Social Services Districts.[26] Participants are free to choose among eligible plans in their county.[27]

DOH will develop education, outreach and enrollment programs.[28] This will include locally tailored education, outreach and facilitated enrollment strategies. DOH will enter into contracts with community based organizations to perform facilitated enrollment, education and outreach.

Healthy New York Program

The Healthy New York Program will provide standardized health insurance coverage to qualifying small businesses and certain eligible individuals. Healthy New York is intended to provide coverage to small business and individuals who previously have been unable to purchase insurance in the commercial market. The coverage is intended to be affordable in part by providing a relatively modest benefit package and in part by stabilizing premiums through a State-funded stop-loss program. However given the limited financial resource of the target population, even modest premiums may be unaffordable, particularly to individuals who are required to pay the entire premium.

To be eligible, a small employer must fit one of two classes. First, the employer may be a sole proprietor who has not had health insurance in the last year and whose household income is less than 208% of the federal poverty level. Alternatively, the employer may have 50 or fewer employees without employer sponsored health insurance for the past year and at least 30% percent of whom have annual wages less than $30,000.

"Healthy New York is intended to provide coverage to small business and individuals who previously have been unable to purchase insurance in the commercial market."

Individuals are also eligible for coverage if they have 1) been uninsured for at least one year, 2) their employer has not provided health insurance during that period, 3) they are not eligible for Medicare and 4) their household income is at or below 208% of the federal poverty level.

Each insurer will offer a standardized benefit package consisting of inpatient and outpatient hospital services, physician services, outpatient surgical services, radiology and lab services, certain preventive health services (including Pap smears, immunizations and mammography), and prescription drug coverage. Not included in the coverage are mental health and substance abuse treatment. The benefit package is also not subject to the State-mandated benefits contained in the Insurance Law. However, the statute does require coverage for certain similar benefits such as breast reconstruction after surgery and second opinions for cancer.

Plan subscribers will be required to pay for certain co-payments and deductibles. These include, among others, a $500 co-payment for inpatient services, $50 for emergency services and a $100 calendar year deductible for prescription drugs. There is also a $3,000 annual cap on benefits.

Every HMO in New York will be required to offer coverage under Healthy New York beginning in January 2001. Other health insurers in the state may elect to offer the coverage. The statute does not specifically address the issue, but it appears that other entities

licensed under Article 44 of the Public Health Law, such as provider sponsored health plans ("PHSPs") are not required to offer the coverage.

Similar to the stop-loss funding described below as part of the direct pay market, the State will offer stop-loss coverage to participating plans. Plans will be able to recover 90% of losses between $30,000 and $100,000 in a calendar year. The addition of the stop-loss coverage is intended to stabilize premium levels and allow the program to be accessible to the qualifying small employers and individuals.

Direct Pay Market Subsidies

HCRA 2000 also implements a stop-loss insurance program to subsidize losses experienced in the mandated individual enrollee direct pay HMO market. Section 4321 of the Insurance Law requires all HMOs to offer a direct pay option with a standard benefit package. The claims experience for these contracts has not been good because of adverse selection and resulting premium increases have placed the insurance out of the reach of many New Yorkers. HCRA 2000's stop-loss coverage is an attempt to stabilize losses in this market and make premiums more affordable.

Under the stop-loss program, HMOs may recover up to 90% of the losses for claims paid between $20,000 and $100,000 in a calendar year for subscribers under a direct pay contract. There is no recovery for losses above $100,000. The program will be administered by the Department of Insurance which may contract with an outside entity for such administration. There will actually be two funds: one covering losses in the direct pay market with an out of plan feature[29] (i.e., the subscriber may go out of network to receive services) and a second fund covering losses in the direct pay market with only an in-plan feature.[30]

The stop-loss program will be funded by allocations from the new Tobacco Control and Insurance Initiatives Pool.

Home Care Worker Insurance Demonstration Program

In addition to the programs above, HCRA 2000 authorizes the DOH to implement a demonstration project under which Medicaid will underwrite the cost of health insurance premiums for personal and home health workers. Under a new § 367-0 of the Social Services law, DOH will evaluate this possibility in New York City and counties with at least a million population. Eligible applicants include employers who provide at least half of their services to Medicaid recipients, provide health insurance to their employees, and whose employees work is irregular or episodic. The subsidy to the employer may be made either through an enhanced Medicaid payment for personal care or home health services or through a lump sum payment. The funding source for the demonstration program is the tobacco control and insurance initiatives pool.

Limits on Medical Resident Working Hours

Amid evidence of violations by hospitals of the limitations on medical resident working hours, Part 405 Regulations,[31] established by the DOH following the Libby Zion case and the Bell Commission report, HCRA 2000 now requires hospitals to develop compliance plans which must be submitted to the DOH by April 1, 2000. In addition to annual audits by DOH of hospital compliance with Part 405, hospitals are subject to fines of $6,000 per violation found on an audit and up to $50,000 for repeated failure to adhere to a corrective action plan. Finally, hospitals must supply data to DOH as part of a DOH audit and failure to do so can result in a $10,000 fine.

Other HCRA 2000-Funded Initiatives

- Worker retraining to address changes in the health care delivery system continue to be funded. Funding, which ranges from $30 to $50 million annually through 2003, will be available through grants administered by DOH. Health worker unions, hospitals, long-term care facilities, and other organizations are eligible to apply.
- A toll-free hotline is established in the Department of Health to receive reports of alleged fraud and abuse in the Medicaid program.
- A tobacco use prevention and control program is established in the DOH to prevent and reduce tobacco use among minors and adults.
- Funding is provided for audit expenses to determine payor and provider compliance with pool payment requirements.
- Funding is provided for various community mental health services programs, public health programs, the Elderly Pharmaceutical Insurance Coverage (EPIC) Program, a subsidy for the Roswell Park Cancer Institute Corporation, school-based health centers, and the State's Medicaid costs for dual-eligible Medicare recipients.

Councils and Commissions

The oversight role of the Council on Health Care Financing is continued through HCRA 2000 and a new Commission on Financially Distressed Residential Health Care Facilities is established which shall report to the Governor and the Legislature by December 31, 2001.

Other Provisions

The authority for hospitals to elect to receive payments on admission of Medicaid patients to improve hospital cash flow is continued.

The authority for DOH to conduct ambulatory care pilot reimbursement programs is continued.

In allocating funds from the hospital restructuring pool, consideration shall be given to the extent to which a hospital has alternative sources of funds, including through affiliation with other hospitals.

Funding is provided to the DOH for costs of administering HCRA 2000 and health care reimbursement-related programs.

"[W]e can expect continuing debate on the scope and financing of the State's Medicaid program and HCRA 2000 initiatives."

Sunset Date

The bill provides that "the provisions of sections 2807-c, 2807-j, 2807-s, 2807-t, 2807-v and 2807-w of the public health law, as added or amended by this act, shall expire and be deemed to be repealed on June 30, 2003. . . ."[32]

Conclusion

This is a comprehensive bill that was designed to establish the scope of the Medicaid program for the next 3½ years. However, county governments have been greatly dissatisfied with the imposition of 25% of the cost of the new Medicaid expansion under the Family Health Plus program. As stated above, bills have been introduced in both the Assembly and the Senate to make the State completely responsible for the 50% non-federal share of the program. This has led to a well-publicized rift between Governor Pataki and Senator Bruno, the Senate Majority Leader. Thus, we can expect continuing debate on the scope and financing of the State's Medicaid program and HCRA 2000 initiatives. Further, the State's Medicaid managed care program[33] expires this year and reauthorization is expected to be addressed in this legislative session.

Endnotes

1. Chapter 1 of the Laws of 1999.
2. Chapter 639 of the Laws of 1996.
3. Chapter 639 of the Laws of 1996, § 168(5).
4. *See, e.g., Bank of Metropolis v. Faber*, 150 N.Y. 200.
5. General Construction Law § 90.
6. Workers' Compensation, automobile no-fault insurance, volunteer firefighters, volunteer ambulance workers, state correctional services and local correction services.
7. *E.g.,* psychiatric units, rehabilitation units, children's hospitals, cancer hospitals, AIDS centers.
8. 42 CFR § 447.256.
9. Social Security Law § 1903(w), 42 U.S.C. § 1396b(w).
10. 42 CFR Part 433.
11. PHL § 2807-k.
12. PHL § 2807-w.
13. PHL § 2807-m.
14. PHL § 2807-l.
15. PHL § 2807-v.
16. Sections 2510 and 2511 of the Public Health Law.
17. Social Security Act § 2101; 42 U.S.C. § 1397aa.
18. Social Services Law § 369-ee(7).
19. Summary of County Impact of the New York Health Care Reform Act 2000, New York State Associations of Counties, December 30, 1999 at page 3.
20. Social Services Law § 369-ee(2)(a).
21. Social Services Law § 369-ee(4)(2)(v)(B).
22. Social Services Law § 369-ee(2)(b).
23. Social Services Law § 369-ee(2)(c)(d).
24. Social Services Law § 369-ee(1)(d).
25. Social Services Law § 369-ee(1)(b).
26. Social Services Law § 369-ee(3)(d).
27. Social Services Law § 369-ee(2)(b).
28. Social Services Law § 369-ee(4).
29. Section 4321 of the Insurance Law.
30. Section 4322 of the Insurance Law.
31. 10 NYCRR 405.
32. Chapter 1 of the Laws of 1999, § 138(1).
33. Social Services Law § 364-j.

Mr. Laks is Of Counsel with Hiscock & Barclay, LLP and is located in their Albany office. Prior to 1997, Mr. Laks was with the New York State Department of Health where he was the principal draftsman of HCRA of 1996.

When the Doctor Charges More than the Plan Determines Is Usual, Reasonable and Customary: Strategies for Limiting Patient Responsibility for the Cost of Out-of-Network Care Under the Point of Service Health Care Benefits Option

By Edward McArdle

> Emily Marino was insured when she discovered that she had breast cancer, so the bills were the least of her problems. Or so she thought. Though she was covered by Oxford, Marino ended up with some $25,000 in out-of-pocket expenses after undergoing a lumpectomy, mastectomy, and the countless hospitalizations, tests, and appointments that can come with breast cancer. Even now, almost a year and a half after diagnosis, Marino's follow-up bills are still piling up. Much of this mounting debt can be traced to the sometime giant discrepancies between what her out-of-network providers at Memorial Sloan-Kettering billed and the mysterious, ever-shifting charges known as "usual and customary rates" (or UCRs in HMO-speak).[1]

The issue raised by Emily Marino and other consumers who are seriously ill is an all too common and compelling one—a patient recently diagnosed with cancer who requires extensive and immediate medical treatment and resolves to receive this treatment under her Point of Service (POS) option from the "best" providers, who by dint of reputation charge the highest rates of any providers.[2] Because they have not signed a participating contract with the patient's Managed Care Organization (MCO), the patient's doctors and other providers are not limited by contract in how much they can charge for their services or from balance billing the patient for amounts not paid by the MCO.[3] The only limitation is the common law requirement that the provider's charges be reasonable.[4]

The patient, expecting that her responsibility will be limited to the patient copayments set forth in her policy, commonly 20%,[5] does not determine what her medical and hospital charges will be or attempt to negotiate these charges in advance. Only after services are provided does the patient learn that her Plan will not pay 80% of the provider's charges, but rather bases its payment of benefits on what it determines is a "usual, customary, and reasonable" (UCR) fee.[6] The patient can end up owing 50% or more of the provider's bills when she had expected that she would owe no more than 20%.

This is a growing issue for many consumers, as MCOs respond to market demand and government mandates[7] to provide consumers with increased provider choice, and providers respond to MCO reimbursement discounting by refusing to join provider networks.[8] As patients exercise POS rights, they find themselves unwittingly caught in the crossfire of increasingly restrictive MCO payment of UCR fees and pace-setting charges by providers with brand-name reputations who attract consumers because of their reputation, but who also charge significantly more than less well-known providers.

As discussed below, patients who find themselves stuck with unexpected bills have several limited strategies available. As discussed in Part I, consumers can challenge the Plan based on its methodology for determining a UCR fee, or, more successfully, on its failure to unambiguously define its terms. Further, although the bar is higher, challenges can be made to determinations made by Plans organized under the Employee Retirement Income Security Act (ERISA)[9] through various arguments designed to reduce the deference ordinarily accorded to Plan determinations and to persuade the court to apply common law principles of contract construction that favor insureds.

Alternatively, the consumer's best argument may be to challenge the reasonableness of the provider's actual charges. As set forth in Part II, the charges of providers who agree to steep discounts in managed care contracting, but charge individual patients far higher amounts, may be subject to attack as unreasonable and violative of state consumer protection laws.

I. Challenging Plan Payment Based on Its Methodology for Determining UCR or on Inadequate Disclosure to Insureds

With rare exception, an MCO's method for determining a UCR charge will likely pass court muster if it

is statistically based and consistently applied (See Part I.A). Less clear is whether a Court will determine that the Plan adequately disclosed its payment method to insureds and will apply common law principles of contract construction that favor the insured's interpretation of benefits (See Part I.B). Further, although the threshold for overturning MCO benefit determination is higher if the plan is organized under the Employee Retirement Income Security Act (ERISA), under evolving ERISA jurisprudence, courts are increasingly willing to accord less deference or no deference to Plan decisions, to find contract ambiguities, and to apply common law principles that favor the insured's interpretation (See Part I.C.).

A. In Most Cases, an MCO Method for Determining Payment of UCR Fees which Is Statistically Based Will Not Be Overturned By a Court

Consumers seeking to challenge the standard methods used by MCOs to determine payment of UCR fees face a difficult road, even though the MCO payment may be substantially less than the provider's actual charges and leave the patient owing more than the POS copayments she or he had bargained for.

In most cases, the Plan will have reserved the right in its subscriber contract to make payment based on an amount it determines to be a UCR fee. In virtually all cases, this is based on a fixed schedule determined by the MCO, not on the provider's actual charges. If the provider's actual charges are lower than the MCO's UCR fee, Plans commonly reserve the right to make payment based on the provider's actual charges.[10]

Some MCOs base POS payments on an internal statistical analysis of processed claims to determine the average charge for a particular procedure.[11] This statistical analysis has been reviewed in several reported cases.[12] Commonly, under this method UCR fees are determined using statistical methods based on internal provider charge data for each procedure in each geographic location.[13]

Other Plans rely on rates established statistically by the Health Insurance Association of America (HIAA).[14] HIAA has described its "Prevailing Healthcare Charges System" as "the nation's largest, most comprehensive, up-to-date database of provider charges for private sector health care services."[15] These rates are described as based on millions of actual provider charges, are subjected to statistical testing, and are published every six months.

Subscribers to HIAA rates can choose from eight different percentile levels, which allow Plans to pay at rates that are somewhat higher or somewhat lower than the statistically average actual provider charge.[16] The most frequently used HIAA percentile level is the 80th percentile rate.[17] As described by one Plan, by paying at the 80th percentile, "it is expected that, for a given service, the amount charged by 80% of all providers in the region will be less than the maximum allowable reasonable and customary charge."[18]

Under any standard of court review, even no deference review, it is likely that a statistically based process used for determining a UCR fee which is consistently applied will pass court muster. MCO methods based on internal statistical data and analyses have withstood challenge in several reported court decisions.[19] Further, MCO payment based on HIAA rates have additional credibility because they are outside the control of the insurer and are often used by providers as a benchmark for determining actual charges.[20] There is no requirement that Plans base UCR payments on a provider's actual charges, although that is in fact how many consumers interpret their POS benefits. MCOs ordinarily will pay based on a provider's actual charges only if they amount to less than the UCR fee schedule.[21]

This is not to say that some Plans, in particular self-insured and self-administered Plans, may be paying claims using a non-statistical and whimsical approach designed to pay out as little as possible. A payment process which is not statistically based or consistently applied would be subject to challenge under any standard of court review.[22]

Further, this does not foreclose challenge based on the MCO's failure to adequately disclose its payment method for UCR fees to insureds.

B. Even If an MCO's Method for Determining a UCR Charge Passes Court Scrutiny, It May Fail If It Is Inadequately Disclosed to Insureds

Even if the process and analysis used by the MCO is reasonable, it can be challenged if it was not fully disclosed in the Plan member handbook or subscriber contract given to members, who reasonably believed that payment would be based on actual provider charges.[23] The consumer could also argue that she or he would not have obtained services under the POS option if she or he had known in advance the amount the MCO would pay, or that she or he would have attempted to negotiate a lower price from the provider.

The following are two arguments for finding ambiguity in ERISA-based and other Plan definitions and disclosure of UCR payment methods.

1. UCR Definition in Subscriber Contract Is Not Tied to a Fixed Standard

If the consumer's subscriber contract does not explain the method used by the MCO to determine UCR payment or if it is not fixed to a disclosed stan-

dard, the insured could argue that the term is ambiguous.[24] In both New York and other states, courts have found ambiguity in health insurance contracts which do not explain how a UCR fee is determined, and have applied common law principles of contract construction that require that terms be interpreted under an average-man standard.[25] Courts are most likely to find ambiguities and to interpret them against an MCO when the Plan is organized under state law, making it subject to review under state common-law principles of contract interpretation, or when the Plan is an ERISA plan reviewed under less deferential *de novo* court review.[26] This argument is least likely to prevail in an action against an ERISA plan reviewed based on an "arbitrary and capricious" standard of review, under which a court provides Plan decisions with a high degree of deference and is primarily focused on the reasonableness of the Plan's actions.[27]

MCOs have responded by defining contract terms using fixed, outside standards, making it more difficult to find ambiguity.[28] In defining UCR, many Plans have expressly tied the definition in member handbooks/contracts to a fixed percentile of HIAA,[29] or have added qualifying language that payment is based on the average charges by similarly qualified physicians and not on a provider's actual charge.[30]

2. The Plan Pays UCR Differently Based on Different Agreements Negotiated With Employers, Which Is Not Disclosed in Its Member Handbook or Subscriber Contract

Plan payment under the POS option often varies depending on the MCO's agreement with the employer who is ultimately footing the bill.[31] For example, an MCO's agreement with one employer may be to pay POS benefits based on 40% of HIAA, and with another at the substantially higher 80% of HIAA.[32] Some member handbooks and contracts do not state the HIAA percentage under which payment is made.[33] Some physicians have alleged that the benchmark for UCR payment by MCOs is 80% of HIAA; however, there appears to be no legal bar to Plans paying at a lesser percentage of HIAA or using some other process that is reasonable and adequately disclosed to members. There is some anecdotal evidence that UCR calculations are increasingly being based on a lower percentage of HIAA which, if true, would increase the amount owed by patients when obtaining out-of-network benefits.[34]

If the Plan's payment differs depending on its agreement with the employer that is not disclosed to insured employees, this could be the basis for arguing that the Plan's definition is ambiguous, thereby triggering a reasonable layperson's interpretation of contract benefits, even under the least searching arbitrary and capricious court review.[35]

C. ERISA Creates Additional Hurdles Because of a More Deferential Court Review That Does Not Apply Consumer-Friendly Common Law Principles of Contract Construction, But an Evolving Jurisprudence Is Making It Easier to Overcome These Obstacles

The Employee Retirement Income Security Act (ERISA), which governs the provision of health care and other benefits by most private employers, is the setting for most disputes over the proper payment of UCR benefits.[36] Approximately 65% of Americans receive their health insurance through an ERISA plan.[37]

Although ERISA expressly authorizes patients to bring civil actions to overturn Plan decisions denying payment of benefits,[38] it has traditionally been difficult for patients to prevail because court review has generally been under deferential "arbitrary and capricious" review, and because federal courts have been less likely to apply common law principles of contract construction that favor the insured's interpretation of ambiguous terms.

When reviewing the decisions of an ERISA plan, the Court's review will be limited, based either on the deferential "arbitrary and capricious" standard or the more searching *de novo* standard of review.[39]

The Court will apply the "arbitrary and capricious" or abuse of discretion standard when the Plan gives the administrator or fiduciary discretion to determine eligibility for benefits or to construe the terms of the plan.[40] A Court, however, will review under a *de novo* standard when the Plan administrator was not given such discretionary authority to make decisions.[41] *De novo* review means not only that the Court provides less deference to the Plan's decisions, but that it may also substitute its own judgment and makes it more likely that it will base its decision on the consumer's reasonable interpretation of contract provisions.[42]

Courts have also begun to weigh into their review of ERISA and other plans the inherent conflict for an MCO between its decision-making role in determining whether to pay benefits and its profit-making role.[43] In some federal circuits, the court will apply a "continuum of deference" if the Plan is operating under a conflict of interest in making benefit interpretations.[44] In the Second Circuit, the standard is somewhat higher, requiring the patient to establish that "the conflict affected the reasonableness of the [Plan's] decision," and, if established, applying *de novo* review.[45]

Further, state statutes and common law, including principles of contract interpretation that apply the insured's reasonable expectations and resolve ambiguities in favor of the insured, are preempted by ERISA.[46] Courts have recognized that a federal common law

applies under ERISA.[47] However, they have not uniformly incorporated state common law principles of contract interpretation into its creation, especially when Plan decisions are reviewed under the more deferential arbitrary and capricious standard.[48]

Needless to say, a key consumer strategy has been to argue for a less deferential court review of ERISA plan decisions. As more Courts review Plan decisions, an evolving ERISA jurisprudence has developed which accords less deference to Plan determinations and applies common law principles of contract interpretation that favor insureds.[49]

Primarily, consumers can argue that the Court should review Plan decisions *de novo*, with no deference, because the Plan did not provide its administrator or fiduciary with sufficient discretion to trigger the less searching arbitrary and capricious review. As a fallback position, the consumer can argue that the Court should employ a heightened scrutiny under the arbitrary and capricious standard based on a Plan's conflict of interest between its decision-making and profit-making roles.[50] Under a low deference or no deference review, a Court is more likely to substitute its own judgment for that of the Plan or to apply common law principles of contract construction that construe ambiguities in favor of the insured or apply the reasonable expectations of the consumer.[51]

II. Challenging Reasonableness of Actual Charges of Providers Who Agree to Steeply Discounted Rates in MCO Contracting

In some cases, the patient's best argument is to challenge the reasonableness of the provider's bills rather than the payment by the MCO. Commonly, and perhaps nearly universally, patients and physicians do not discuss the price to be charged before services are provided.[52] Although this is not important when the patient is receiving in-network benefits, because the contract between the provider and the MCO shields the patient from balance billing, it is crucial for the patient when receiving services from a non-participating provider.[53]

When the provider does not have a direct contract with the patient's insurer or third-party payer, or the patient is uninsured, the law implies a promise that the patient will pay the physician the reasonable worth of the services.[54] A number of elements are weighed by a court in determining reasonableness, including the qualifications and experience of the provider, and the amount that similarly qualified providers charge for the same services.[55] There is no bar, however, to this amount being more than the Plan considers to be UCR, which leaves the patient open to owing more, sometimes substantially more, than the copayments and deductibles for POS set forth in the subscriber contract.[56]

Although determining what is a reasonable charge is fact-intensive and subject to differing interpretation even if the facts are undisputed,[57] at least one commentator argues that the bill of a provider which is substantially more than the amount it accepts in direct contracting with MCOs is not reasonable.[58] Given the substantial discounting by providers in managed care contracts with MCOs, a patient's self-pay bill could be twice the amount paid by an MCO to the same provider for the same procedure.[59] The patient could argue that the provider's charges do not constitute a reasonable fee because the provider steeply discounts charges in contracts with MCOs, only charging the full rate to patients who are not shielded from personal liability by a direct contract between the MCO and the provider.[60]

Further, the provider practice of charging consumers, who have neither discussed nor agreed on a price for the medical services, double or more what they agree to in arms-length contracting with MCOs, is questionable. In addition to the defense that the charge is unreasonable, the patient could also argue that it constitutes a violation of New York's General Business Law § 349, which prohibits "deceptive acts or practices in the . . . furnishing of any service in this state." This statute provides a basis for action by the New York Attorney General to protect consumers, but it also authorizes a private cause of action for "any person who has been injured by reason of any violation of this section . . . to enjoin such unlawful act or practice."[61] Alternatively, the class action has been proposed as means for individual consumers to challenge health care issues that affect the public generally,[62] but has met with mixed results.[63]

Conclusion

There are several arguments, depending on the circumstances, that patients could make to reduce the amount they owe for POS services when the difference between Plan payment and provider charge is more than the patient's policy copayment. If the subscriber contract is silent or ambiguously defines UCR payment fees, the consumer could argue that the Plan is required to pay benefits based on the amount actually billed by the provider and not on a schedule created by the MCO that is unrelated to the provider's actual charges. This argument is less persuasive if the Plan pays at 80% or higher of rates established by HIAA, commonly considered to be the benchmark for out-of-network payments, or if the provider's charges are far higher than other providers.

A more persuasive argument could be made, in many cases, that the provider's charges are unreasonable if the provider charges the self-pay patient significantly more than she or he has agreed to accept from MCOs. This argument is less persuasive if the provider charges more than other providers but does not contract with MCOs, as is apparently the case with many nationally known hospitals and physicians who charge premium prices, but do not discount rates in MCO contracting.

In all cases, consumers could benefit from a better explanation by MCOs of POS benefits, including the pitfalls of obtaining services from providers who have not contracted with the MCO. With a better understanding of POS benefits, consumers would know in advance what their MCO will pay and could attempt to negotiate the cost of services from the POS provider or decide to obtain services within the network. At the very least, if consumers knew what they were getting into when using POS benefits, they could make a reasoned determination whether going out-of-network for benefits that could be provided in-network was worth the financial cost and uncertainty.[64]

Endnotes

1. *Out-of-Network Costs Leave the Insured In a Hole*, Village Voice, March 17, 1999.
2. Point of Service is the term commonly used to describe the benefit some MCOs provide to members to obtain insurance payment for services provided outside the Plan's network of providers (*see, e.g., Consumer's Guide For Standard Individual HMO and Point of Service Coverage*, New York State Department Of Insurance, 1998).
3. *See, e.g., Patel v. Healthplus, Inc.*, 684 A.2d 904 (Court of Special Appeals of Maryland, 1996), holding that physician who had signed a participating provider contract with an MCO was prohibited under a Maryland law from balance billing the patient. In other states, the patient is protected from balance billing by a standard patient "hold harmless" clause in MCO contracts with participating physicians limiting patient responsibility to copayments set forth in the Plan.
4. *See, e.g., Lange v. Kearney*, 4 N.Y.S. 14, *aff'd,* 127 N.Y. 676 (1891); *Husik v. Lever*, 95 Pa. Super. 258 (Pennsylvania, 1928).
5. *See, e.g.,* New York Insurance Law § 4322, which requires that HMOs licensed in New York provide an individual direct payment contract with out-of-plan benefits, and sets HMO payment at 80% of "usual, customary and reasonable charges," with annual deductibles of $1,000 for an individual and $2,000 for a family.
6. See note 5.
7. *Id*.
8. *See, e.g., Rebellion in White: Doctors Pulling Out of HMO Systems,* N.Y. Times, January 10, 1999; *For the Right Price, These Doctors Treat Patients as Precious: Practicing HMO-Avoidance*, Wall St. J., August 12, 1998; Appleby, *Sick and Tired of HMOs: Leaving Managed Care Behind a Good Remedy for Some Docs*, USA Today, May 18, 1999.
9. 29 U.S.C. §§ 1001 *et seq*.
10. *See, e.g.,* General Information Book and Empire Plan Certificate for New York State Employees, p. 63 (NYS Department of Civil Service, Employee Benefits Division, 1996) ("the determination of 'reasonable and customary' is made by [the Plan]," and is defined as the lesser of actual charges or "usual charge of other doctors or other providers of similar training or experience in the same or similar geographic area for the same or similar service"); Individual Service Agreement (New York), United Healthcare of Upstate New York, Inc., p.7 (1998) (similar definition to that contained in Empire Plan).
11. *See, e.g.,* Empire Plan Certificate, note 10 ("reasonable and customary" determined by the lower of actual charges, "the usual charge by the doctor or other provider for the same or similar service or supply," or "the usual charge of other doctors or other providers of similar training or experience in the same or similar geographic area for the same or similar service"); Individual Service Agreement (New York), United Healthcare of Upstate New York, Inc., p.7 (1998), note 10; (similar definition to that contained in Empire Plan); Individual POS Member Handbook for BlueChoice (New York), Empire Blue Cross Blue Shield, p. 5 (1998*)* (out-of-network reimbursement of usual and customary charges "based on our experience in a given area.").
12. *See, e.g., Maushardt v. Harris Corporation*, 855 F. Supp. 1240 (MD Fla., 1994); *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588 (2nd Cir., 1993); *Florence Nightingale Nursing Service v. Blue Cross and Blue Shield of Alabama*, 832 F. Supp. 1456 (ND Ala., 1993); *Eidler v. Blue Cross Blue Shield United of Wisconsin*, 671 F. Supp. 1213 (E.D., Wis., 1987).
13. *See, e.g., Maushardt,* note 12 at 1245 (In reviewing UCR determinations by MetLife, Court found that

    > MetLife determines the R & C (reasonable and customary) values by utilizing its database of charges that have been processed through the claims system. Using statistical methods, MetLife's actuarial department compiles this data to determine a standard R & C amount for each procedure in each geographic area. If there is not enough data to establish a standard R & C value (at least 25 charges), MetLife sets a fee using other methods which take into account the level of specialized knowledge and training required to perform the procedure as well as the geographic location where the procedure was conducted. For purposes of R & C values, MetLife has divided the United States into 282 geographic areas. Each area consists of a contiguous region of 3-digit zip code groupings with a similar health care charge history.

14. *See, e.g.,* Individual Subscriber Contract (New York), PHP Plan, Health Services Medical Corporation of Central New York, Inc., pp. 13-14 (1998); Individual Point of Service Contract (New York), Choice Plus Direct Contract, 4 (1998), HIP, Health Insurance Plan of Greater New York, p. 25 (1998); Blue Choice Plan, Blue Cross Blue Shield of the Rochester Area, p. 4 (1998); Point-of -Service Individual Membership Contract (New York), Magnahealth of New York, Inc., p. 4 (1997); Individual Agreement (New York), Managed Healthcare Systems of New York, Inc., d/b/a MHSNY Health Plan, p. 7 (1998).
15. *See, e.g.,* description of the HIAA "Prevailing Healthcare Charges System" (PHCS) (www.hiaa.org*)* (checked 3/23/99). PHCS "collects, compiles and publishes data for professional services associated with surgery, anesthesia, radiology, pathology and laboratory, medicine and dental, as well as facility charges for hospital services." Its data is based on millions of claims of actual charges by health care providers reported by "commercial insurance companies, third party administrators, Blue Cross and Blue Shield plans . . . and self-insured groups." Submitted data is "subjected to rigorous statistical tests and sophisticated edits which verify completeness, reasonableness and accuracy." Every 6 months, it publishes its data to subscribers at "eight different percentile levels."

16. See note 15.

17. *See, e.g.,* note 14, contracts of PHP Plan, pp. 13-14; Choice Plus Direct Contract, p. 4; Health Insurance Plan of Greater New York, p. 25; Blue Choice Plan, p. 4; Magnahealth of New York, Inc., p. 4; Managed Healthcare Systems of New York, Inc., p. 7.

18. *See, e.g.,* PHP contract, note 14, pp. 13-14.

19. See cases cited under note 12.

20. Based on numerous discussions with physicians.

21. See note 10.

22. *See, e.g., Juliano v. HMO of New Jersey d/b/a U.S. Healthcare*, 1997 WL 83405, p. 8 (SD NY, 1997) (Court awarded patient home care benefits denied by HMO providing benefits under ERISA plan based on de novo review, finding that HMO's medical necessity review "was not conducted prudently but, rather, almost whimsically based on U.S. Healthcare's unfounded belief that alternative sites for care would be more cost-effective"); *Florence Nightingale Nursing Services, Inc., v. Blue Cross and Blue Shield of Alabama*, 832 F. Supp. 1456 (ND, Ala., 1993*)* (Court found that insurer's determination of a reasonable fee for home care nursing services to be without logical basis); *Russ v. Group Health Incorporated*, 78 Misc. 2d 637, 640, 356 N.Y.S.2d 193, 197 (Civil Ct., Queens Co., 1974*)* (Court upheld GHI's interpretation of "reasonable, necessary and customary," but noted that New York State law requires that benefits under "group health insurance contracts must be made in a uniform, non-discriminatory manner consistent with the purpose of maintaining medical coverage at a low rate," at 197); *Mount Sinai Hospital v. Zorek*, 50 Misc. 2d 1037, 271 N.Y.S.2d 1012 (Civil Ct., NYC, 1966*)* (Court found insurer's decision to pay only one of two good claims as determined by treating physician to be arbitrary).

23. *See, e.g., Anonymous v. Monarch Life Insurance Co.*, 42 Misc. 2d 308, 309, 247 N.Y.S.2d 894, 896 (1964*)* (Court found that "phrase 'usual and customary' without further qualification is ambiguous" and "must be construed favorable to the insured and against the insurance company"; *Little v. Blue Cross of Western New York, Inc.*, 72 A.D.2d 200, 424 N.Y.S.2d 553 (4th Dep't, 1980*)* (Court found ambiguity in rider providing for private duty nursing because did not expressly note that Blue Cross makes decision, not treating physician); *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield of Alabama*, 832 F. Supp. 1456 (ND Ala., 1993*)* (Court found ambiguity in Plan's definition of UCR fee to be paid providers because Plan retained discretion to determine reasonableness of provider fees).

24. *See, e.g.,* Individual Pay Contract of Aetna/U.S. Healthcare (New York*)* (1998*)* (states that payment is made based on "the usual, customary and reasonable rate (UCR) for Covered Expenses set forth in the Schedule of Benefits"); Individual Pay Contract of Partners Health Plan (New York*)* (1998*)* (defines its payment obligation using the terms "usual, customary and reasonable rate"); Empire Blue Cross Blue Shield, p. 5 (1998*)* (out-of-network reimbursement of usual and customary charges "based on our experience in a given area."); GHI Comprehensive Benefits Plan for City of New York employees (1998*)* (refers members to GHI office and the State Insurance Department to determine rates (§ 2(1) and (9); § 4).

25. *See, e.g., Anonymous v. Monarch Life Insurance Co.*, 42 Misc. 2d 308, 247 N.Y.S.2d 894 (1964), note 23; *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield of Alabama*, 832 F. Supp. 1456 (ND Ala., 1993), note 23 (Court found Plan's definition of UCR fee to be ambiguous because Plan retained discretion to determine reasonableness of provider fees).

26. *See, e.g.,* Gallinari, *Insurance Coverage for State-of-the-Art Medical Treatments*, N.Y. Law J., January 12, 1996, 215:9; *Masella v. Blue Cross & Blue Shield of Connecticut*, 936 F.2d 98 (2nd Cir., 1991*)* (Court found ambiguity in ERISA policy's medical definition of a covered condition, temporomandibular joint syndrome (TMJ), under less deferential conflicted arbitrary and capricious court review); *Zuckerbrod v. Phoenix Mutual Life Insurance Company*, 78 F.3d 46, 50 (2nd Cir., 1996*)* (in reviewing ERISA plan under arbitrary and capricious, Court found ambiguity against Plan based on its "policy of resolving doubts in claims determinations in favor of the claimant"); *Kekis v. Blue Cross and Blue Shield of Utica-Watertown, Inc.*, 815 F. Supp. 571, 583 (USDC, NDNY, 1993*)* (under conflicted arbitrary and capricious, Court ordered insurer to pay cost of high dose chemotherapy with autologous bone marrow transplant (HDC-ABMT), finding term "proven medical value" in contract "susceptible to multiple interpretations"; *Scalamandre v. Oxford Health Plans, Inc.*, 823 F. Supp. 1050 (USDC, EDNY, 1993*)* (under *de novo* review, Court ordered insurer to pay for HDC-ABMT because denial had been based on policies which limited access to HDC-ABMT which were not disclosed in subscriber contract); *Heasley v. Belden & Blake Corporation*, 2 F.3d 1249 (3rd Cir., 1993*)* (in reviewing decision of ERISA plan under de novo court review, adopted state common rule that ambiguities are to construed in favor of the insured); *Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382 (9th Cir., 1994*)* (adopted doctrine of reasonable expectations of layperson in interpreting ERISA-governed insurance contract).

27. See cases at note 22; *see also Donnelly v. Union Trustees of Local 32B-J Health Fund*, 126 Misc. 2d 914, 487 N.Y.S.2d 254 (Sup. Court, App. Term, First Dep't, 1984); *Jones v. Laborers Health & Welfare Trust Fund*, 906 F.2d 480 (9th Cir., 1990); *Johnson v. District 2 Marine Engineers Beneficial Association*, 857 F.2d 514 (9th Cir., 1988); *Nazay v. Miller,* 949 F.2d 1323 (3rd Cir., 1991); *Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, 951 F.2d 771 (7th Cir., 1991); *Saah v. Contel Corporation*, 780 F. Supp. 311, *aff'd,* 978 F.2d 1256 (4th Cir., 1992); *Klebe v. Mitre Group Health Care Plan*, 894 F. Supp. 989 (USDC, D MD, 1995).

28. *See*, Gallinari, *Insurance Coverage for State-of-the-Art Medical Treatments*, N.Y. Law J., January 12, 1996, Vol. 215:9; Densberger, *Medical Necessity in Benefit Determinations* (unpublished, National Health Lawyers Association, Managed Care Law Institute, December 11-13, 1996); Hall, *Health Insurers' Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637 (1992); Furrow, Health Law, at p. 505 (1 vol., 1995).

29. See note 18.

30. *See, e.g.,* note 11; *Maushardt v. Harris Corporation,* 855 F. Supp. 1240 (M.D. Fla., 1994), note 12 (defining "reasonable and customary" to mean that "benefits will be paid on the basis of an average charge made by similarly qualified physicians for comparable services. The term is not intended to relate to the charge agreed upon between patient and doctor.")

31. *See, e.g., Out-of-Network Costs Leave the Insured In a Hole*, Village Voice, March 17, 1999, note 1; discussions with counsel for an MCO plan.

32. As discussed with counsel for national health insurer (October, 1998); see also HIAA web site (www.hiaa.org), which states that its data is reported to subscribers at 8 different percentile levels, *supra*, note 15.

33. Note that the New York state law requiring that HMOs licensed in New York offer individual HMO and POS policies requires only that payment of out-of-plan benefits be at "80% of the usual, customary and reasonable charges" or "80% of the amounts listed on a fee schedule filed and approved by the superintendent which provides a comparable level of reimbursement," but does not define the term (Insurance Law § 4322(d)).

34. Based on discussion with a consumer whose Plans cut UCR payment from 80% to 70% of HIAA.

35. See cases cited at notes 23 and 27.

36. 29 U.S.C. §§ 1001 *et seq*.

37. *Jacobson, Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 Houston L. Rev. 985, 988 (1998).

38. "A civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." (29 U.S.C. § 1132(a*) (1) (*B)).

39. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989).

40. *Firestone Tire & Rubber Co. v. Bruch*, note 39; *Zuckerbrod v. Phoenix Mutual Life Insurance Company*, 78 F.3d 46, 49 (2nd Cir., 1996); *Brown v. Blue Cross & Blue Shield of Alabama, Inc*., 898 F.2d 1556, 1559 (11th Cir., 1990), *cert. den.*, 498 U.S. 1040; *Kunin v. Benefit Trust Life Insurance Company*, 910 F.2d 534, 536-537 (9th Cir., 1990).

41. *See, e.g., Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98 (2nd Cir., 1991); *Heasley v. Belden Blake Corp*., 2 F.3d 1249 (3rd Cir., 1993); *Scalamandre v. Oxford Health Plans, Inc.*, 823 F. Supp. 1050 (EDNY, 1993); *Juliano v. HMO of New Jersey, Inc*., 1997 WL 83405 (SDNY, 1997).

42. See notes 23 and 27.

43. *See, e.g., Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d at 1562-1563, *cert. den.* 498 U.S. 1040; *Whitney v. Empire Blue Cross And Blue Shield*, 106 F.3d 475, 476-477 (2nd Cir., 1997).

44. *See, e.g., Brown*, note 43.

45. *Whitney v. Empire Blue Cross And Blue Shield*, note 43.

46. *See, e.g., Nealy v. US Healthcare HMO*, ___ N.Y.2d ___, 1999 WL 161533, 1999 N.Y. Slip. Op. 02630 (New York Court of Appeals, 3/25/99).

47. *See, e.g., Saltarelli v. Bob Baker Group Medical Trust*, 35 F.3d 382, 386 (9th Cir., 1994*) (*incorporated into federal common law "the strong modern trend in insurance contract interpretation—the 'reasonable expectations' doctrine); *Glass v. United of Omaha of Life Ins. Co*., 33 F.3d 1341, 1347 (11th Cir., 1994).

48. *See, e.g.,* Gallinari, *Insurance Coverage for State-of-the-Art Medical Treatments*, note 28; *Loyola University of Chicago v. Human Insurance Company*, 996 F.2d 895 (7th Cir., 1993*) (*Court under arbitrary and capricious analysis considered only whether Plan's interpretation was reasonable and did not reach policyholder's interpretation).

49. *See, e.g.,* Trueman, *As Managed Care Plans Increase, How Can Patients Hold HMOs Liable for Their Actions?*, New York State Bar Journal 6 (February, 1999).

50. Trueman, note 49, at 14.

51. See note 23.

52. *See, e.g., Eagle v. Snyder*, 604 A.2d 253, 259 (Pa., 1992); *Husik v. Lever*, 95 Pa.Super. 258 (1928); Law, Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society?* (A Case Study in Federalism), 61 NYU L. Rev. 1, 28 *et seq*., 1986).

53. *See, e.g., Patel v. Healthplus, Inc.*, 684 A.2d 904 (Maryland, 1996), note 3 (provides background on provider/MCO contracting and state laws, including discussion of standard "hold harmless" clauses which prohibit providers from balance billing patients for more than reimbursement rate negotiated with Plan; see, also, Kadzielski, *Managed Care Contracting: Pitfalls and Promises*, 20 Whittier L. Rev. 385, 406 (1998*) (*discusses limitations on billing by providers under participating provider/MCO contracts).

54. *Husik v. Lever*, 95 Pa. Super. at 260, note 4 ("In the absence of an express agreement as to amount, the law implies a promise to pay for a physician's services as much as they are reasonably worth," at 260).

55. *See, e.g., Schoenberg v. Rose,* 145 N.Y.S. 831 (elements to be considered include "the experience of the physician as such, and the nature and difficulty or easiness of the case, and what is considered by him and by other physicians an ordinary or reasonable charge for the services," at 833); *Husik v. Lever*, note 4; see also New York Pattern Jury Instructions - Civil (The Lawyers Cooperative Publishing Company, 1968), § 4.30; "Necessity and Sufficiency, in Personal Injury or Death Action, of Evidence as to Reasonableness of Amount Charged or Paid For Accrued Medical, Nursing or Hospital Expenses," 12 ALR3d 1347.

56. *See, e.g., Maushardt v. Harris Corporation*, 855 F. Supp. 1240, note 12; *Eagle v. Snyder,* 604 A.2d 253 (Superior Court of Pennsylvania, 1992*) (*cases in which patients ended up being responsible for more than copayments set forth in subscriber contract).

57. *See, e.g., Eagle v. Snyder,* 604 A.2d 253, note 52; *Curnow v. Sloan*, 625 S.W.2d 605 (Supreme Court of Missouri, 1981*) (*Appellate court decisions with strong dissents on reasonableness of physician's fees and proving reasonableness even though facts were undisputed).

58. Beard, *The Impact of Changes in Health Care Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses in Personal Injury Suits*, 21 Am. J. Trial Advocacy 453, 483 (Spring, 1998*) (*In the context of defending plaintiff's claims in personal injury actions for a physician's full charges, the author notes that "the defendant should be allowed to contest the reasonableness of that charge on the basis that market competition has resulted in lower charges being routinely accepted by providers in general and the specific provider in question.").

59. Beard, note 58, at 454 (providers are routinely discounting their standard fees in contracts with MCOs by as much as 50%).

60. Beard, note 58, at 489-90 (quoting Crane, "Getting Peanuts," Medical Economics, at 145, 146 (9/22/97*) (*"If your stated fee for a procedure is $5,000, but no insurer is paying more than $2,500, what will you charge an out-of-network patient or someone with a medical savings account? . . . If you're willing to take $2,500, then that's your fee.").

61. General Business Law § 349(g); *Karlin v. IVF America, Inc.*, ___ N.Y.2d ___, 1999 WL 262448 (May, 1999*) (*Court of Appeals affirmed application of state's consumer protection laws contained in General Business Law §§ 349 and 350 to medical providers in case involving claim of deceptive advertising and misrepresentation of fertility rates by an in vitro fertilization program).

62. *See, e.g.,* Cerminara, *The Class Action Suit As a Method of Patient Empowerment in the Managed Care Setting*, 24 Am. J. Law & Med 1 (1998).

63. *See, e.g., Karlin v. IVF America, Inc*., 239 A.D.2d 562 (2d Dep't, 1997*) (*under New York's class action law, court refused to certify class action based on fertility clinic misrepresentation of success rates, finding that individual issues predominate over questions of law or fact common to the class); but see *Marocek v. Bellsouth Telecommunications, Inc*., 49 F.3d 702 (11th Cir., 1995*) (*under federal class action law, court certified class of employees in claim by employee that defendant had incorrectly determined that she was not totally disabled).

64. *See, e.g., Russ v. Group Health Incorporated*, 78 Misc. 2d 637, 642, 356 N.Y.S.2d 193, 199 (Civil Ct., Queens Co., 1974), note 22 (in case in which patient was charged more by a physician than the insurer determined was "reasonable, necessary and customary," Court recommended specific steps be taken by the insurer and by the employer to explain to members how payment is determined and to provide average charge information.)

Edward McArdle is an assistant attorney general in the Office of the Attorney General, State of New York, Health Care Bureau.

LEGISLATION REPORT

Health Law Section

REPORT NO.		March 15, 2000
A. 4114	By:	Assemblyman Gottfried
	Assembly Committee:	Health
	Effective Date:	The 1st day of June next succeeding the year in which it becomes law.

AN ACT to amend the public health law, in relation to establishing procedures for making medical treatment decisions on behalf of persons who lack the capacity to decide about treatment for themselves and to repeal certain provisions of such law relating thereto

LAW AND SECTION REFERRED TO: Public Health Law, Article 29-C

REPORT PREPARED BY THE HEALTH LAW SECTION

THE BILL IS APPROVED

The Health Law Section hereby restates its support for the Family Health Care Decisions Act. We previously wrote in support of this proposal in 1995 and 1997. As we stated in 1997:

> Existing law imposes needless suffering on dying patients and their families by requiring the provision of treatment that runs contrary to the patient's wishes and best interests. New York is among a handful of states in the nation that continues to deny family members and others close to the patient the authority to forgo life-sustaining measures for incapacitated patients in accord with appropriate safeguards. Our laws on this matter are unreasonable and unsound.

Much has changed in health care in recent years, but New York's rule on end-of-life care, unfortunately has remained in place. We urge the Legislature to finally recognize the harshness of that rule, and to replace it with the more reasonable, more humane and more respectful principles set forth in the Family Health Care Decisions Act.

For the foregoing reasons, this bill is APPROVED

Chair of the Section: Robert N. Swidler, Esq.

Statement in Support of S.4449 and A.7288 on Telemedicine

The practice of telemedicine, the use of electronic communications to deliver health care services at a distance from the health care provider, is widely relied upon in New York and other states to provide medical care that would not otherwise be available to patients. For this reason, it is increasingly important to amend New York law to provide guidance to practitioners and regulators about the practice of telemedicine and to promote the interests of patients. The Health Law Section supports two pending bills that address telemedicine, S.4449 and A.7288, with the amendments as proposed below. Both bills take the right approach to this critical issue, but require amendment to clarify the scope of the bills and extend the protections accorded patients.

The burgeoning practice of telemedicine offers important benefits for patients, including increased access to specialty care for patients who live in rural areas, are homebound, or reside in confined settings such as prison. Telemedicine may also improve emergency treatment by providing needed access to specialty care. At the same time, telemedicine presents certain risks that should be addressed by public policy, including the need to protect patient confidentiality and continued access to face-to-face consultation when feasible and desired by the patient. A separate statement prepared by the Health Law Section on the legal, ethical, and policy issues posed by telemedicine is attached.

Comments on S.4449

Health care professionals licensed in other states that practice telemedicine in New York State face uncertainty about their exposure to civil and criminal liability for practicing without a New York license. This uncertainty urgently requires resolution. Senate Bill 4449 would amend the New York Public Health and Insurance Laws to: (1) establish a separate licensure system for telemedicine; (2) provide that New York has authority to enforce professional standards of practice and protect the well-being of patients in New York State; (3) require insurance coverage for telemedicine when such services would be covered if provided in a traditional face-to-face consultation; and (4) mandate informed consent for use of telemedicine; and (5) give patients access to telemedicine records. These legal changes are essential at the present time.

The general approach taken by S.4449 would create sound public policy and a needed legal framework for the practice of telemedicine in New York State. However, the legislation must be amended to clarify its scope and expand the protections for patients.

Definition of Telemedicine; Scope of the Bill. The definition of telemedicine set forth in § 3920 is overbroad, and would encompass numerous activities that should not fall under the scope of this legislation. Section 3920 defines telemedicine to mean " . . . the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using synchronous and asynchronous interactive audio, video or data communications." This definition would cover activities that should not require licensure, including email or phone calls in an established patient- physician relationship or the transmission of information or data solely for purposes of medical education or research, as well as activities that should not be licensed without further deliberation and review, including the practice of medicine on the Internet in the absence of a pre-existing patient-physician relationship.

The Health Law Section proposes that § 3920 should be amended to define telemedicine as follows: "diagnosing, treating, operating, or prescribing for any human disease, pain, injury, deformity or physical condition via electronic communication for a patient located in New York State, except that the following practices shall not be included in this definition: (i) consultation between a physician responsible for the patient's care in New York State and a physician outside the state in the absence of direct contact, communication, or examination of the patient via teleradiology or other electronic communication; (ii) the provision of diagnostic or treatment services to a patient in New York State as follow up to medical care initially provided to the patient outside the state; (iii) and the provision of medical services or information on the Internet or by telephone." In addition, the definition of the practice of telemedicine for licensure purposes set forth in proposed § 6525-A should exclude diagnosis, treatment, operation, or prescribing that is infrequent and not part of a regular, ongoing practice by the physician. This proposed definition tracks the definition of medical practice and the consultation exemption for licensure set forth in existing law. (N.Y. Education Law §§ 6521, 6526)

Safeguarding Patients' Interests. The Health Law Section recommends that the patient protections in S.4449 be extended to address other key patient interests. First, the bill should clarify that the consulting physician or other health care professional in New York State has the obligation to obtain informed consent. Second, S.4449 in a substantive provision or in a statement of legislative intent should state that telemedicine should not be used as a substitute for traditional face-to-face consultation if such consultation is medically appropriate, feasible, and preferred by the patient.

The bill contains important protections for informed consent in light of the fact that telemedicine is an entirely new way to deliver treatment and it is likely that neither providers nor patients have considered the implications of the technology for patients. The requirements

for informed consent under the proposed new § 3921(B) should be expanded by adding the following language to the statement that the potential risks, consequences, and benefits of telemedicine must be disclosed: "including but not limited to the risk that third parties such as technicians may be present but not visible to the patient during the provision of services, and that the telemedicine encounter may result in a record of all statements by the patient and others during the clinical examination or visit." Other provisions, in particular, proposed §§ 3921(A), 3921 (2), (3) (4) and (6) should be deleted. Several of these provisions would apply as a matter of course without specific statement. A separate statement in addition to informed consent indicating the patient has understood the information should not be required. That statement is the essence of informed consent; it is unduly onerous and confusing to require two statements. Section 3921(5) should also be amended, deleting reference to consent by a "parent or legal representative" for an incapacitated patient, and referring instead to "the person authorized to consent to treatment."

Significantly, S.4449 has key provisions for professional oversight. It would subject out-of-state practitioners to New York State professional standards by defining the practice of telemedicine as the practice of medicine in New York State, and by subjecting practitioners to the oversight of the Department of Education (§ 11). Currently, the bill requires that the applicant for a telemedicine license be licensed as a physician in another state. The requirements for licensure should be tightened in several respects. First, the bill should require licensure in a state that the Commissioner of Education has determined has standards of licensure commensurate to New York standards. Second, the Commissioner should be required to determine as part of the application review that the license in not subject to any limitation or suspension in another state. Finally, the Health Law Section proposes that practitioners who apply for a telemedicine license be required to subject themselves to civil jurisdiction. This would allow New York State residents to bring an action in this State where the injury occurs rather than a remote location.

Reimbursement. Section 6 of the bill proposes that a new § 4406-e be added to the Public Health Law stating that "no organization certified pursuant to this article shall require face-to-face contact between a health care provider and an enrollee for services provided through telemedicine." This provision seems designed to bar the requirement of face-to-face contact as a condition for reimbursement for services that would otherwise be covered, and should state this purpose more clearly.

Comments on A.7288

Assembly Bill 7288 provides for the study of telemedicine and report of the findings by the Commissioner of Health to the Governor and the Legislature. Given the rapid proliferation of telemedicine and its impact on the delivery of health care, the Health Law Section supports this legislation and recommends that the mandate to examine issues presented by telemedicine be extended to include certain critical questions relative to patient access, confidentiality and care. Specifically, the Health Law Section proposes that § 1 of the bill be expanded to list the following issues for examination: (1) improved access to care offered by telemedicine, including access by vulnerable populations such as the elderly homebound, rural low income communities, and prisoners, and public policies that could expand access to telemedicine for these populations; (2) the extent to which telemedicine is being used to substitute for face-to-face consultation for the convenience or financial interests of providers rather than the needs of patients; (3) the impact of telemedicine on the patient-physician relationship, including review of state or national studies and studies of patient satisfaction; (4) the effectiveness of telemedicine compared to traditional face-to-face consultation; (5) the security of information transmitted via telemedicine and the need for specific policies regarding storage and confidentiality of that information; and (6) the role of nurses, psychologists and other health care professions in providing telemedicine.

Ordinarily, telemedicine is practiced in the context of an ongoing patient-provider relationship. In general, a physician or other health care professional initiates contact with the physician providing services at long distance using telemedicine technology. At the present time, a growing number of services are being provided on the Internet in the absence of a pre-existing or ongoing relationship between patient and physician. These practices include services traditionally considered the practice of medicine, such as consultation and prescribing, as well as the provision of information tailored to respond to the patient's particular medical condition and circumstances. These practices, often referred to as "cybermedicine," should not be licensed under the umbrella of S.4449. Instead, such practices should be the subject of extensive study under A.7288, with appropriate attention given to the ethical, legal, and regulatory issues raised by such activities. Among other issues, it will be important to examine activities that might constitute the practice of medicine over the Internet and develop a clear framework for public policy for medicine online.

Conclusion

In conclusion, the Health Law Section would strongly support passage of S.4449 and A.7288 with the amendments proposed to clarify and strengthen these two important pieces of legislation.

This Statement was drafted by Tracy E. Miller.

News from the Health Law Section

Section Annual Meeting a Success

On January 26, 2000, the Health Law Section held its Annual Meeting at the Marriott Marquis Hotel in Times Square, NYC. The meeting was part of the five-day Annual Meeting of the New York State Bar Association (NYSBA).

The Section events were very well attended—both educational programs sold out—and were quite successful.

In the morning, several committees held their meetings, including the Committee on Biotechnology and the Law, the Fraud, Abuse and Compliance Committee, the Professional Discipline Committee, and the Special Committee on Medical Information.

Later that morning, there was a professional education program on employment law issues that health lawyers might face, including disputes under the Family Medical Leave Act, the Americans with Disabilities Act and ERISA. The program, "Disability, Discrimination and Benefits Claims in the Year 2000," included some lively interaction among the speakers, who brought sharply different perspectives to the issues.

At the luncheon business meeting, Section Chair Robert Swidler contended that the Section was now well-positioned to be a force for good. He urged the members to act through the committees "to add our voice, our perspective, to the great issues of health law and policy."

The Section then conducted its business meeting, at which the members elected new officers, and adopted amendments to the Section bylaws (See related stories, below).

The featured luncheon speaker was Hank Greenberg, General Counsel to the NYS Department of Health. He spoke first of the importance of the Section's work. He then discussed the recently re-enacted NY Health Care Reform Act, and focused on the significance of a part of that statute, Family Health Plus. That initiative makes health care coverage available to low-income families who do not qualify for Medicaid.

"The Section events were very well attended—both educational programs sold out—and were quite successful."

The afternoon educational program concerned the liability of managed care organizations and their medical directors. The program featured prominent speakers who offered clashing viewpoints on the issue of empowering patients to sue HMOs or their medical directors for the adverse results of their claims decisions.

Upcoming MCLE Program on Medical Information

During the past year, the federal government has moved toward implementing major, complex regulations to protect the privacy of medical information and to facilitate uniform protocols for the secure electronic transmission of such information. To help health lawyers familiarize themselves with these initiatives and the underlying policy issues, NYSBA and the Section are cosponsoring a professional education program entitled "Protecting Health Information and Technology: New Requirements and Risks."

The program will be held at three locations:

Long Island	May 4
Rochester	May 4
New York City	May 11

The program chairs are Anne Maltz and Gary Fields. Further information is available from the Section's website.

New Section Officers Elected

At its January 26 Annual Meeting, the Section elected its officers for 2000-2001. They are as follows:

Chair:	Tracy Miller
1st Vice Chair:	Robert Abrams
2nd Vice Chair:	Salvatore Russo
Secretary:	Linda Nenni
Treasurer:	Robert Corcoran

Tracy Miller, the incoming chair, is a Clinical Associate Professor of Health Policy at Mt. Sinai Medical School, and recently served as Project Director for the Quality Forum Planning Committee, convened by Vice President Al Gore to build an organization to advance quality measurement improvement. Ms. Miller, a graduate of Harvard Law School and author of numerous articles on health law policy issues, was previously the Executive Director of the NYS Task Force on Life and the Law.

The new officers take office in June 2000.

Inhouse Counsel Committee Sponsors Educational Session

In January, the In-House Counsel Committee held the first of an expected series of educational programs for inhouse counsels. The program included two segments: a presentation by attorneys on negotiating managed care contracts, and a presentation by attorneys on labor organizing at health care facilities.

Committee Chair Patrick Taylor, who is General Counsel to Albany Medical Center, organized the event, which was held at the NYC offices of Nixon Peabody. He plans to hold similar programs on other topics in the near future.

The Inhouse Counsel Committee is open to attorneys who hold in-house positions with health care providers, health insurers, and other health care organizations. For more information, contact the Health Law Section's NYSBA Liaison, Lisa Bataille, at 518-487-5680.

Over 100 Join Section List-Serve

The Health Law Section's list-serve now has over 100 subscribers.

The list-serve—basically an Internet bulletin board—focuses on the interests of New York State health lawyers. Subscribers submit inquiries, comments and other messages, which are instantly e-mailed to all other list-serve subscribers. Health lawyers use the list-serve to obtain advice from their colleagues, and to share information.

"The list-serve—basically an Internet bulletin board—focuses on the interests of New York State health lawyers."

It is easy to subscribe. Instructions are found on the Section's website—http://www. nysba.org/sections/health. If you encounter difficulties, contact Gary Sawtelle at NYSBA for help—gsawtell@nysba.org.

Incidentally, subscribers to this and other list-serves should not use e-mail services that automatically reply to e-mail by announcing that they are on vacation or out of the office: it could announce your vacation repeatedly to all list-serve subscribers.

Medical Information Committee Comments on Proposed Regs

In January, the Special Committee on Medical Information submitted written comments on behalf of the Health Law Section to HHS regarding the proposed Standards for Privacy of Individually Identifiable Health Information (45 CFR 160-164). The Committee, chaired by Anne Maltz, focused on premption, disclosure with authorization and specific instances of disclosure without authorization. Special thanks to the participants on this project: James Fouassier, Frank Grad, James Horan, Philip Rosenberg, Claudia Torrey and Anne Maltz.

Bylaws Revisions Adopted

On January 26, the Section members voted to adopt various amendments to the Section's bylaws. For example, the proposed amendments would limit the Section Chair to a one-year term, and generally would limit committee chairs to two one-year terms. The proposed amendments would also reduce the size of the nominating committee, and formalize the nomination process. They would also require candidates for elected offices to have been Section members for at least three years.

The Bylaw amendments, which become effective in January 2001, are set forth on the Health Law Section's website: http:/www.nysba.org/sections/health.

Health Lawyers Needed for Pro Bono Work

Attorneys with working knowledge of Medicare or Medicaid law are urgently needed to provide pro bono assistance to low-income clients.

Anne Erickson, President and CEO of Greater Upstate Law Project, urged health lawyers to devote their skills to help one or more pro bono clients with these and other health-care-related legal concerns.

Providing pro bono services can be enormously helpful to a needy client. But it can also be professionally and personally rewarding for the attorney.

Greater Upstate Law Project is the support center for legal services throughout upstate New York. But the need for services is statewide.

For more information about offering your services, the Section's Web site now carries a list of organizations that would welcome your offer and coordinate your health law-related pro bono activities. If you'd like to add an organization to that list, send an e-mail to the Section's Web site Director Sean Nataro at snataro@yahoo.com.

For those who seek even greater involvement, the 5th New York Legal Assistance Partnership Conference will be held in Albany, NY Monday, June 12 - Wednesday, June 14. The conference will offer nearly 50 workshops, covering areas such as housing, family law, HIV/AIDS issues, disability law, economic development, consumer issues, bankruptcy and pro bono. The NYSBA will be providing CLE credit for many of the workshops. For more information about the conference and how to register, please contact Eva Valentin-Espinal at 518-487-5641 or probono@nysba.org.

"Providing pro bono services can be enormously helpful to a needy client. But it can also be professionally and personally rewarding for the attorney."

High Marks for Health Law and the Internet Program

The program on Health Law and the Internet, cosponsored by NYSBA and the Section, was highly regarded by those who attended, according to participant surveys. Indeed, some noted that it was among the most valuable programs they had ever attended.

The program was offered by the Section for the first time in November and December at four locations throughout the state. It covered, among other topics, finding general legal resources on the Internet, health-law-specific websites, and research strategies. Speakers also addressed legal, policy and ethical issues relating to health-related internet activities.

Robert Abrams was program chair. Educational materials from the program are available from NYSBA.

REQUEST FOR ARTICLES

If you have written an article and would like to have it published in the *Health Law Journal* please submit to:

Professor Barbara L. Atwell or
Professor Audrey Rogers
Pace University School of Law
78 North Broadway
White Plains, NY 10603

Articles should be submitted on a 3 1/2" floppy disk, preferably in WordPerfect 5.1 or 6.1 or Microsoft Word, along with a printed original and biographical information, and should be spell checked and grammar checked.

Newsflash offers Section members a way to keep up on the comings and goings of their colleagues and upcoming events of interest. Has there been a change in your practice? Any recent or forthcoming articles or lecture presentations? Won any awards recently? Please send submissions to Professor Barbara Atwell or Professor Audrey Rogers, Pace University School of Law, 78 North Broadway, White Plains, NY 10603.

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Michael Brett Weinstein
Susan Beth Weisenfeld
Marc P. Zylberberg

Section Committees and Chairs

The Health Law Section encourages members to participate in its programs and to volunteer to serve on the Committees listed below. Please contact the Section Officers (listed on the back page) or Committee Chairs for further information about these Committees.

Biotechnology and the Law
James W. Lytle (Chair)
Kalkines Arky, et al.
121 State Street, 3rd Floor
Albany, NY 12207
(518) 432-5990
Fax (518) 432-5996
e-mail: jlytle@kazb.com

Consumer/Patient Rights
Jeffrey S. Gold (Co-Chair)
Health Care Bureau
332 Miller Road
East Greenbush, NY 12061
(518) 474-8376
Fax (518) 402-2163
e-mail: nuggett477@aol.com

L. Susan S. Slavin (Co-Chair)
Slavin Law Firm, PC
350 Jericho Turnpike, Suite 301
Jericho, NY 11753
(516) 942-9300
Fax (516) 942-4411
e-mail: ssesqs1@ix.netcom.com

Ethical Issues in the Provision of Health Care
Larry I. Palmer (Chair)
Cornell Law School
120 Myron Taylor Hall
Ithaca, NY 14853
(607) 255-3383
Fax (607) 255-7193
e-mail: lip1@cornell.edu

Fraud, Abuse and Compliance
James D. Horwitz (Chair)
Glens Falls Hospital
100 Park Street
Glens Falls, NY 12801
(518) 761-5208
Fax (518) 761-5273
e-mail: jhorwitz@glensfallshosp.org

Health Care Providers
Francis J. Serbaroli (Chair)
Cadwalader Wickersham & Taft
100 Maiden Lane, Room 703
New York, NY 10038
(212) 504-6001
Fax (212) 504-6666
e-mail: fserbaro@cwt.com

Health Care Delivery Systems
Robert A. Wild (Chair)
Garfunkel Wild & Travis, PC
111 Great Neck Road, Suite 503
Great Neck, NY 11021
(516) 393-2222
Fax (516) 466-5964
e-mail: rwild@gwtlaw.com

Inhouse Counsel
Patrick L. Taylor (Chair)
Albany Medical Center
27 Dumbarton Drive
Delmar, NY 12054
(518) 262-3828
Fax (518) 262-4184
e-mail: taylorp@mail.amc.edu

Managed Care
Frederic L. Bodner (Chair)
Hinman, Straub, Pigors & Manning, P.C.
10 Fox Run
Latham, NY 12110
(518) 436-0751
Fax (518) 436-4751
e-mail: fredb@hspm.com

Membership
Robert W. Corcoran (Chair)
57 Wilton Road
Cold Spring Harbor, NY 11724
(516) 367-3336
Fax (516) 367-2626

Payment Issues
Ross P. Lanzafame (Chair)
Harter, Secrest & Emery
700 Midtown Tower
Rochester, NY 14604
(716) 232-6500
Fax (716) 232-2152
e-mail: rlanzafame@hselaw.com

Professional Discipline
Joseph K. Gormley (Chair)
225 Broadway, Suite 1201
New York, NY 10007
(212) 349-7100
Fax (212) 349-2764

Public Health
Salvatore J. Russo (Chair)
NYC Health and Hospital Corporation
125 Worth Street, Room 527
New York, NY 10013
(212) 788-3300
Fax (212) 267-6905
e-mail: russos@nychhc.org

Securing Health Care for the Uninsured
Peter J. Millock (Chair)
Nixon Peabody, LLP
1 Keycorp Plaza
Albany, NY 12207
(518) 427-2650
e-mail:
pmillock@nixonpeabody.com

Special Committee on Medical Information
Anne Maltz (Chair)
Herrick Feinstein, LLP
2 Park Avenue
New York, NY 10016
(212) 592-1400
Fax (212) 592-1500
e-mail: amalt@herrick.com

Health Law Section

Committee Assignment Request

Please designate the Committee in which you are interested.

____ Biotechnology and the Law (HLS1100)

____ Consumer/Patient Rights (HLS1200)

____ Ethical Issues in the Provision of Health Care (HLS1300)

____ Fraud, Abuse and Compliance (HLS2400)

____ Health Care Providers (HLS1400)

____ Health Care Delivery Systems (HLS1500)

____ Inhouse Counsel (HLS2300)

____ Managed Care (HLS1800)

____ Membership (HLS1040)

____ Payment Issues (HLS1900)

____ Professional Discipline (HLS2200)

____ Public Health (HLS2100)

____ Securing Health Care for the Uninsured (HLS2500)

____ Special Committee on Medical Information (HLS2600)

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NYSBA

Please return to:
Theresa Knickerbocker
New York State Bar Association
One Elk Street
Albany, New York 12207

Publication and Editorial Policy

Persons interested in writing for this *Journal* are welcomed and encouraged to submit their articles for consideration. Your ideas and comments about the *Journal* are appreciated.

Publication Policy: All articles should be submitted to:

Professor Barbara L. Atwell
Pace University School of Law
78 North Broadway
White Plains, NY 10603
(914) 422-4257
batwell@law.pace.edu

or

Professor Audrey Rogers
Pace University School of Law
78 North Broadway
White Plains, NY 10603
(914) 422-4068
arogers@law.pace.edu

Submitted articles must include a cover letter giving permission for publication in this *Journal.* We will assume your submission is for the exclusive use of this *Journal* unless you advise to the contrary in your letter. Authors will be notified only if articles are rejected. Authors are encouraged to include a brief biography with their submissions.

For ease of publication, articles should be submitted on a 3 1/2" floppy disk. Please also submit one hard copy on 8 1/2" x 11" paper, double spaced.

Editorial Policy: The articles in this *Journal* represent the authors' viewpoints and research and not that of the *Journal* Editorial Staff or Section Officers. The accuracy of the sources used and the cases cited in submissions is the responsibility of the author.

HEALTH LAW JOURNAL

Co-Editors
Professor Barbara L. Atwell
Pace University School of Law
78 North Broadway
White Plains, NY 10603
(914) 422-4257
Fax (914) 422-4229
e-mail: batwell@law.pace.edu

Professor Audrey Rogers
Pace University School of Law
78 North Broadway
White Plains, NY 10603
(914) 422-4068
Fax (914) 422-4229
e-mail:arogers@law.pace.edu

Section Officers

Chair
Robert N. Swidler
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
(518) 271-5027
Fax (518) 273-3307
e-mail: swidlerr@nehealth.com

First Vice-Chair/Committees
Tracy E. Miller
Mount Sinai School of Medicine
Department of Health Policy
Box 1077
New York, NY 10029
(212) 659-9567
Fax (212) 423-2998
e-mail: tracy_miller@smtplink.mssm.edu

Second Vice-Chair/Professional Education
Robert Abrams
Abrams Fensterman et al.
5 Dakota Drive
Lake Success, NY 11042
(516) 328-2300
Fax (516) 328-6638
e-mail: rabrams@abramslaw.com

Secretary
Linda J. Nenni
Kaleida Health
901 Washington Street
Buffalo, New York 14203
(716) 843-7502
Fax (716) 843-7595
e-mail: lnenni@kaleidahealth.org

Treasurer
Salvatore J. Russo
NYC Health & Hospital Corporation
125 Worth Street, Room 527
New York, NY 10013
(212) 788-3300
Fax (212) 267-6905
e-mail: russos@nychhc.org

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Health Law Section
New York State Bar Association
One Elk Street
Albany, NY 12207