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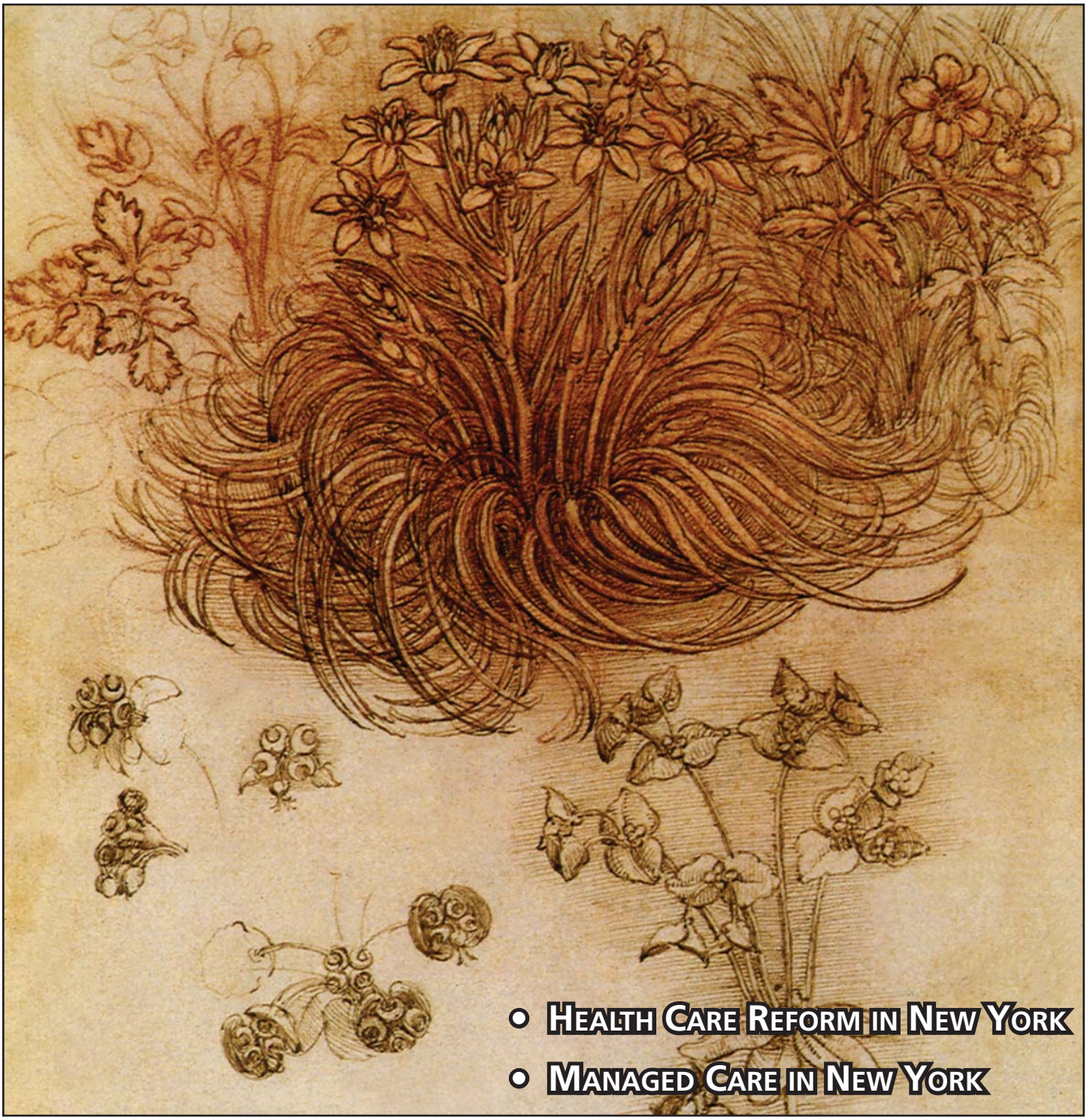

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THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

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Cover artwork: *Star-of-Bethlehem and Leaves of Crowfoot* by Leonardo da Vinci (1500)

The *Journal* expresses its appreciation to Harold Iselin, Esq., of Greenberg Traurig in Albany, N.Y., for his help and guidance in creating this Edition.

A Message from the Chair

Our Section has now concluded its Annual Meeting, held on January 24, 2007 in conjunction with the Annual Meeting of the New York State Bar Association. Our topic this year was the continued financial crisis in New York State of its many public and private health care facilities. We were fortunate at our meeting to be addressed on this topic by, among others, executives of the Berger Commission, the Hospital Association of New York, and by the Hon. Richard Gottfried, Chair of the State Assembly Committee on Health. The hospitals and nursing homes that many in our Section represent are now puzzling over the Berger Commission recommendations, which include closing some facilities and revising the service delivery plans and capacities of many others. We have yet to see all the ways—political and legal—by which the Berger Commission recommendations will be challenged, but we can be sure, as we heard at our Annual Meeting, that challenged they will be.

At our annual lunch, we heard a remarkable talk from the outgoing General Counsel of the State Department of Health, Donald Berens, who gave us an "inside look" at how his office perceives and works with outside counsel. It is no surprise to those of us who have worked in New York State and local government that, as Donald related, courtesy and succinctness tend to get better attention from our state regulators than bluster and bluff. We are all proud of Donald, and of his many predecessors as general counsel of NYSDOH (but especially Peter Millock, our current Section Vice-Chair), for what they have been able to do in Albany, and they remind us of the many incredible ways that members of our Section have served, and continue to serve, the people of New York State.

This Spring we are looking forward to a series of "health care law 101" courses, chaired by our stalwart Sal Russo, held at various locations around the state to introduce new lawyers to the vast and complicated area of law in which we practice. Unfortunately, most of us who practice in this area had no formal training in health care law and "learned by doing." This course, which our Section has conducted several times, is an attempt to remedy this gap and to give young lawyers an introduction and practical overview that we wish we had had.

Also this Spring, our Section's Mental Health Committee is holding a crisis intervention training for courts, law enforcement staff, mental health advocates and providers, and attorneys, in which the methods of crisis intervention of persons with mental illness, and the appropriate uses of crisis intervention in civil and criminal processes, will be addressed. The training has been organized by Henry Dlugacz, Carolyn Reinach Wolf, and David Seay, and we are very grateful to them and their Committee for continuing to be a resource for our entire Association on essential issues that tend not to be addressed by other Sections.

Best regards for the Spring and Summer of 2007.

Mark Barnes

Request for Articles

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

Robert N. Swidler, Esq.
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
e-mail: swidlerr@nehealth.com

Articles should be submitted in Microsoft Word or WordPerfect, along with a printed original and biographical information.

In the New York State Courts

By Leonard M. Rosenberg

Court of Appeals Affirms Dismissal of Suit Challenging Constitutionality of Women's Health and Wellness Act

Catholic Charities of the Diocese of Albany v. Serio, 7 N.Y.3d 510, 825 N.Y.S.2d 653 (2006). The Women's Health and Wellness Act of 2002 ("WHWA") expanded health insurance coverage for certain services needed by women. One provision mandates that any employer health insurance contract that provides coverage for prescription drugs must also include coverage for the cost of contraceptive drugs or devices. A narrow exception to this provision is granted for "religious employers." The plaintiffs, faith-based social service organizations that do not fit under the exception, sought a declaration that these provisions of the WHWA are unconstitutional under the State and Federal Constitutions. The plaintiffs argued that the provisions compel the plaintiffs to violate their beliefs by funding contraception. The Supreme Court, Albany County, granted summary judgment for the defendant. The Appellate Division affirmed, with two justices dissenting.

The Court of Appeals affirmed. It first held that the WHWA did not violate the Free Exercise Clause of the United States Constitution. The WHWA is a neutral law of general applicability. It does not target religious beliefs, or attempt to interfere with the exercise of religion. The Court also rejected the plaintiffs' argument for a "hybrid rights" exception, as the WHWA does not restrict religion in conjunction with any other constitutional protection. The plaintiffs' argument for church autonomy also failed, as the Legislature has not empowered one side over the other in questions of religious authority or dogma.

The Court applied a different test when analyzing the State free exercise

claim, weighing the burden on religious freedom against the interest advanced by the legislation. It rejected a strict scrutiny approach, and held that a "compelling" State interest is not required. Therefore the burden of proof of unreasonable interference with freedom of religion lies on the party claiming an exemption from the statute, with substantial deference granted to the Legislature. The Court held that the plaintiffs failed to meet their burden. The WHWA does not compel the organizations to purchase contraceptive coverage, as they are not required by law to provide prescription drug coverage at all. Moreover, many of the plaintiffs' employees do not share the plaintiffs' beliefs, and their rights must be protected. Finally, weighing the interests, the State showed a legitimate interest, supported by substantial evidence, in enhancing women's health coverage through these provisions. To grant a broader exemption would exclude too many women from the protections the statute seeks to create. Therefore the interests involved weighed in favor of the State.

Finally, the Court quickly discarded the claim made under the Establishment Clause of the Federal Constitution. The WHWA does not favor or disfavor one religion over any other. Its choice to distinguish the types of religious organizations entitled to the exemption is not the kind of differentiation prohibited under the Establishment Clause.

Court Dismisses Hospital's Article 78 Suit That Alleged Berger Commission Violated Open Meetings Law

St. Joseph's Hospital v. Commission on Health Care Facilities in the Twenty-First Century, No. 2006-2915 (Sup. Ct. Chemung Co. 2007). In 2006, the Commission on Health Care Facilities in the Twenty-First Century (the "Berger Commission"), in accordance with its legislative mandate to review and make recommendations regarding the structure of New York health care facilities, recommended that St. Joseph's Hospital seek affiliation with Arnot Ogden Medical Center, and if it failed to do so, St. Joseph's should close. Upon the Governor's submission of the recommendations to the Legislature, and the Legislature's failure to reject them by December 31, 2006, the Commission's recommendation became law on January 1, 2007.

The petitioner, St. Joseph's Hospital, sought a judgment pursuant to Article 78 that the Berger Commission violated the Open Meetings Law (Public Officers Law, Article 7) by transacting business relating to the petitioner in closed-door, non-public sessions; declaring such actions and the following recommendation null and void; and awarding attorneys fees. The petitioner was in ongoing negotiations with another health care facility for purposes of affiliation or merger, and contended that forced negotiations with a third party would impede these negotiations.

The Court found that the petitioner did not demonstrate that it was injured by any acts or omissions of the Berger Commission. The Court reasoned that the Berger Commission's recommendations did not carry the force of law when they were made, and therefore they could not have affected any rights or caused injury in fact. Moreover, the petitioner was continuing its negotiations with another facility, and was in

the process of drafting an agreement with that facility. There was therefore, according to the Court, no evidence that the claimed interference with such negotiations actually occurred. Without an "aggrieved" status, the Court held that it had no power to make a declaration under Article 7 of Public Officers Law.

Court Dismisses Hospital's Constitutional Challenge to Law That Created the Berger Commission

St. Joseph Hosp. of Cheektowaga v. Novello, __ N.Y.S.2d __, 2007 WL 308201 (Sup. Ct. Erie Co. 2007). The New York State Legislature created the Commission on Health Care Facilities in the Twenty-First Century (the "Berger Commission") in 2005, charged with examining the hospital system in the State and making recommendations for facility closure and restructuring. Plaintiffs St. Joseph Hospital of Cheektowaga and Catholic Health System, Inc. sought declaratory and injunctive relief from the Commission's recommendation that St. Joseph Hospital should close. On January 1, 2007, this recommendation gained the force of law.

The Supreme Court, Erie County, dismissed the complaint on Defendants' cross-motion for summary judgment. First, the Court held that the challenge to the legislative veto in the Berger Commission's enabling legislation under the State Presentment Clause and separation of powers was moot. Per the legislation, the Berger Commission's recommendations become law, once approved by the Governor, unless the Legislature rejects them through a concurrent resolution. The Court held that this veto provision was severable, both because there is a severability clause in the legislation, and because severance of the veto power would not grant unreasonable and overly broad power to the Berger Commission. Moreover, Plaintiffs were not in fact injured by exercise of the legislative veto—the injury they claimed would not exist had the veto been utilized. Therefore Plaintiffs' veto claims were deemed moot.

Second, the Court held that, although Plaintiffs held a protected property interest in their operating certificate, and the Commission's actions were adjudicative in nature, due process was not violated, even though Plaintiffs were not given a formal hearing. Substantive due process was not violated because the enabling legislation was enacted within the State's police power to promote the public good, enhancing the efficiency of the State's health care system. The regulation of the property interest was thus rationally related to a legitimate state interest.

The Court also ruled that procedural due process was not violated because a full, trial-type hearing was impractical, Plaintiffs were given as much notice as any other facility, and the opportunity to submit written materials for consideration. The Court held that more extensive notice, once the Commission was more narrowly considering St. Joseph for closure, was not warranted. The Court held that what process is due depends on the circumstances at hand, and in the Court's view, individual hearings would have precluded the Berger Commission from fulfilling its legislative mandate, and were not necessary.

Third, the Court dismissed Plaintiffs' claims under the State and Federal Free Exercise Clause. Plaintiffs argued that they were given less time to meet with the Commission during the evaluation process than another, non-religious hospital system. The Court rejected this argument, as there was no requirement that the Commission meet with any hospital at all. Any impact that the legislation may have had on religious freedom was incidental, and therefore did not violate the federal Constitution. Plaintiffs also failed to satisfy the balancing test applied under the New York Constitution. Substantial deference is afforded the Legislature, and there was no evidence that Plaintiffs were in any way precluded from carrying out their religious mission.

Finally, the Court dismissed Plaintiffs' claims under the Contract Clause on the ground that Plaintiffs failed to show that the legislation was not in furtherance of a legitimate interest. The Court held that interference with contracts was a necessary aspect of the Commission's mandate, and it could not have performed this duty without making recommendations that would in some way affect contractual relationships.

Court Holds That Labor Management Relations Act Provides No Jurisdiction for Suit by SUNY Physician Faculty Members Who Claim That the Clinical Portion of Their Compensation Was Set Too Low

Baumgart, et al. v. Stony Brook Children's Service, P.C., et al., 03 CV 5526, 2006 WL 1877145 (E.D.N.Y. July 6, 2006). In a case of first impression, the District Court for the Eastern District of New York (J. Hurley) found that Section 301(a) of the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 185, did not confer federal jurisdiction over an action brought by physician faculty at SUNY Stony Brook School of Medicine ("Stony Brook"), in which they claimed that the clinical portion of their compensation was unreasonably set too low. Plaintiffs are physicians employed as faculty members of Stony Brook, and provide clinical services for Stony Brook University Hospital. They receive separate compensation for each aspect of their employment.

The clinical aspect of Plaintiffs' compensation is governed by New York State Regulations at 8 N.Y.C.R.R. § 340, which codify the Policies of the Board of Trustees of the State University of New York (the "Policies"). Pursuant to those regulations, defendant Stony Brook Clinical Practice Management Plan ("CPMP") was created to manage the clinical income of the Stony Brook physicians. CPMP, its Governing Board, and the professional service corporation with which Plaintiffs were associated with

respect to their clinical duties were all named as defendants (the "CPMP Defendants").

Section 301(a) of the LMRA provides in pertinent part that "[s]uits for violation of contracts between an employer and a labor organization . . . may be brought in any district court of United States having jurisdiction of the parties, without respect to the amount in controversy or without regard to the citizenship of the parties." A Section 301(a) claim requires allegations of both a breach of a collectively bargained-for agreement and a breach of a union's duty of fair representation. Plaintiffs claimed that the collective bargaining agreement ("CBA") reached between their union (the "Union") and the State of New York was breached because their clinical income was unreasonably set in violation of the Policies, which were incorporated into the CBA. Plaintiffs further claimed that the Union breached its duty of fair representation by failing to pursue their grievance.

The Defendants moved to dismiss the Complaint for lack of jurisdiction. That motion was granted, and Plaintiffs made a motion for reconsideration. The Court denied the motion for reconsideration as well. The Court pointed out that none of the CPMP Defendants were signatories to the CBA, which was only between the Union and the State. Moreover, the Court noted that the State (and political subdivisions thereof, like Stony Brook) does not fit the definition of "employer" under the LMRA, and the Union, which represents Plaintiffs in their public capacity, does not meet the definition of "union" under the LMRA. The Court found determinative the fact that the only signatories to the CBA were specifically exempt from LMRA jurisdiction, and that there is no contractual relationship between Plaintiffs and the CPMP Defendants.

[Ed. Note: Garfunkel, Wild & Travis, P.C. represented the CPMP defendants in this suit.]

Cardiologist's Antitrust Action Survives Motion to Dismiss

Reddy v. Puma, 06 CV 1283, 2006 WL 2711535 (E.D.N.Y. Sept. 21, 2006). This action involved a dispute between cardiologists associated with New York Methodist Hospital (the "Hospital"). Plaintiff was the former Chief of Cardiology for the Hospital, and in conjunction with another physician, allegedly handled 35 to 40% of all volume in the Hospital's cardiology division prior to being removed as Chief.

Plaintiff alleged that the new Chief of Cardiology, along with the new Director of Cardiac Catheterization, conspired to exclude him from receiving cases at the Hospital. The alleged conspiratorial actions included: (i) discouraging physicians from referring patients to Plaintiff; (ii) ordering that Plaintiff be removed from his regular cardiology rounds; (iii) instructing physician assistants not to provide post-operative care for Plaintiff; and (iv) giving presentations to the Hospital's administration in which Plaintiff's rate of complications was misrepresented.

Plaintiff claimed that this conspiracy to exclude him violated Section 1 of the Sherman Act, and Section 4 of the Clayton Act because it harmed his own practice and because it "reduce[ed] the availability and number of providers of interventional cardiac services."

The Court noted that the pleading standard in an antitrust case is not a heightened one. The Court then determined that Plaintiff had standing to bring an antitrust claim. The Court applied a two-pronged test to determine standing: "(1) has the plaintiff asserted an antitrust injury, and (2) is the plaintiff the proper plaintiff to assert the antitrust laws?" The Court found that the injury asserted by Plaintiff was "a type of injury that the antitrust laws were designed to prevent," in that Plaintiff alleged that his exclusion led to a decline in the overall quality of services provided to consumers. The Court also found that Plaintiff was an "efficient enforcer of the antitrust laws," in that Plaintiff is a practicing cardiologist in the relevant market, and "is likely the only potential plaintiff with enough knowledge and incentive to bring suit."

The Court then addressed the allegations of a conspiracy. The Court noted that, "[i]n recognition of the unique aspects of employment in the medical field, courts have recognized that an antitrust conspiracy can exist among doctors who serve on the same medical staff, as those doctors remain sufficiently independent economic actors." The Court rejected Defendants' argument that they could not commit a conspiracy because they are both employees of the Hospital, and denied Defendants' motion to dismiss the Complaint.

Court Vacates Temporary Restraining Order and Denies Injunctive Relief in Physician's Suit Challenging Nonrenewal of Participating Provider Agreement

Dhillon v. Healthnow New York, Inc., et al., 32 A.D.3d 1197, 821 N.Y.S.2d 703 (4th Dep't 2006). Plaintiff physician sued a health care plan, seeking damages for the alleged wrongful nonrenewal of his participating provider agreement ("PPA"). Plaintiff alleged that the nonrenewal was in retaliation for his complaints to government agencies, his patient advocacy, and his request for a hearing.

The Court granted defendant's motion to stay the action while the parties pursued mediation and/or arbitration, as provided for in the PPA. However, the Court preliminarily enjoined defendant from not renewing the PPA pending completion of the dispute resolution process.

The Appellate Division vacated the injunction on the ground that plaintiff's "loss of employment" did not constitute irreparable harm that could not be compensated by money damages.

Court Denies Hospital's Motion for a Protective Order and Grants Plaintiff's Motion to Compel Disclosure of Medical and Hospital Records

Kivlehan v. Waltner, __ N.Y.S.2d __, 2007 WL 60187 (2d Dep't 2007). In a medical malpractice action, plaintiff patient appealed from an order of the Supreme Court, Orange County, denying her motion to compel the disclosure of medical and hospital records, and granting defendant, Good Samaritan Hospital of Suffern, N.Y. (the "Hospital") a protective order precluding the depositions of two of its officers.

In this action, plaintiff alleged that after giving birth to her daughter in the Hospital, she incurred a nearly fatal strep infection from her obstetrician. The patient's physician admitted at her deposition that she did have a strep infection during the time period in question. Thereafter, plaintiff moved to compel the disclosure of both of the physicians' medical records and the Hospital's records. The Hospital opposed discovery of its records under the physician-patient privilege, as well as the quality assurance privilege afforded to hospitals under Education Law § 6527(3) and Public Health Law §§ 2805-j, 2805-k and 2805-m. Based on those grounds, the Court denied plaintiff's motion to compel discovery and granted the Hospital's protective order to preclude the depositions of two of its officers.

The Appellate Division noted that while the New York Education Law shields the disclosure of certain records, including those relating to quality assurance review, the party seeking to invoke the quality assurance privilege bears the burden of demonstrating that the documents were prepared in accordance with the relevant statutes. Records that are merely duplicated by a quality assurance committee are not necessarily privileged. A hospital is required, at a minimum, to demonstrate that (1) it has a review procedure; and (2) the information for which the exemption is claimed was obtained or maintained in accordance with that review procedure.

Here, the Hospital did not meet its burden under the statute to show that the documents maintained by its Department of Infection Control regarding the physician's condition were actually generated at the request of the Hospital, and thus, denial of the plaintiff's motion to compel the discovery of these documents was improper.

Additionally, disclosure of the names and addresses of the physicians and health care providers who were involved in taking and obtaining cultures from the physician were not subject to the physician-patient privilege. Once a plaintiff demonstrates that a defendant's medical condition is "in controversy" within the meaning of CPLR 3121(a), the burden then shifts to the defendant to demonstrate that the information sought by the plaintiff is protected by the privilege. In this case, the names and addresses were not privileged. Rather, they related to "the mere facts and incidents of [the physician's] medical history." Therefore, plaintiff's motion to compel this disclosure was improperly denied. Given the circumstances, the Court held that the Hospital's motion for a protective order precluding the depositions of two of its officers was improperly granted.

Court Upholds Surrogate's Court Procedure Act 1750 Against Attack Based on Constitutional Grounds of Equal Protection, Due Process and Vagueness

In re Guardianship of Chantel Nicole R., 34 A.D.3d 99, 821 N.Y.S.2d 194 (1st Dep't 2006). Mental Hygiene Legal Service ("MHLS"), on behalf of respondent Chantel R., challenged the constitutionality of the Surrogate's Court Proceedings Act ("SCPA"), 1750, on equal protection, due process, and vagueness grounds. In the underlying guardianship proceeding, Chantel R. was described as "moderately retarded" with the academic functioning of a first- to second-grade level. Although Chantel R. expressed anxiety when questioned about death, the Surrogate's Court determined that she was incapable of making any significant health care determinations. Thus, pursuant to the SCPA, the appointment of Chantel R.'s mother as guardian with the power to withhold life-sustaining medical care was deemed appropriate.

On appeal, MHLS asserted that the SCPA violated respondent's rights to equal protection because it treated her differently, without any rational basis, from persons who were once competent. In particular, MHLS contended that SCPA violated the Equal Protection Clause because it afforded less weight to a mentally retarded person's expressions to live than the expressions of those with average functional ability.

The Appellate Division disagreed. Upholding the Surrogate's Court, it concluded that "[t]he Equal Protection Clause only prohibits the government from treating persons differently from others who are similarly situated, and mentally retarded persons are not similarly situated to those who were once competent." The Court explained that "a mentally retarded person's expression of a desire to continue life-sustaining measures is categorically distinguishable from the same desire expressed by a mentally competent individual because only the latter has the capacity to appreciate the consequences of the decision and thus the ability to make the choice to pursue an uninformed or irrational alternative." In comparison, it would be impossible to determine whether a mentally retarded person such as Chantel R. would ever elect to receive life-prolonging treatment "because such an individual has never been competent to make a decision concerning medical." Thus, the disparity in treatment of retarded persons need only be rationally related to a legitimate government interest to pass constitutional muster. Here, for example, the state

had a legitimate interest in advancing the right of mentally retarded persons to be free from prolonged suffering.

Respondent also argued that SCPA violated due process because the appointment of a guardian with the consent of both parents does not require the Court to hold a hearing. However, having sought and obtained a hearing, the Court dismissed such claims, pursuant to CPLR 5511, as respondent was not aggrieved by the order. Lastly, respondent argued that SCPA was unconstitutionally vague because it permits a guardian to terminate life-support when an attending physician determines that the life-sustaining treatment would impose an "extraordinary burden" on the mentally retarded patient. The Court did not consider the vagueness issue on the grounds that respondent might never require life-sustaining treatment. Thus, there was no justiciable controversy for the Court's determination.

Court Allows DOH to Recover Actual Costs of Clinical Lab Inspection Program, Pursuant to Public Health Law § 576, Despite Non-Compliance With Record-Keeping and Improper Inclusion of Unrelated Costs

Am. Ass'n of Bioanalysts v. N.Y.S. Dep't of Health, 33 A.D.3d 1138, 823 N.Y.S.2d 552 (3d Dep't 2006). Plaintiffs' trade association and its clinical laboratory members, which provide laboratory testing services in New York, brought an action seeking a full refund of fees paid to the Department of Health ("DOH"). Pursuant to Public Health Law ("PHL") § 576, to assure quality and accuracy of the laboratory testing services, the DOH operates an inspection program (the "Program"). The program monitors, among other things, the staff, facilities, and procedures of the laboratories. Section 576 requires laboratories, such as plaintiffs', to pay annual fees to the DOH as a reimbursement for the "total actual costs" of operating the Program.

The Appellate Division affirmed that the computation of "actual" costs should include both direct costs and indirect costs necessarily incurred in support of the Program, such as overhead costs. In addition, the motion court properly deferred to the DOH's interpretative expertise when it held that the cooperative research and method validation components were components of the Program entitled to reimbursement.

Regarding the mandatory record-keeping and annual computation of actual costs, as required by Section 576, the Court specifically found that the DOH's lack of compliance constituted arbitrary and capricious conduct. However, the Court did not void the Program fees and grant full refunds, as sought by the plaintiffs. Rather, since the fees collected would be improper only to the extent that they exceeded actual costs, the Court remanded the case for a determination as to what costs should have been included as "actual costs." Consequently, the plaintiffs would only be refunded any excess of the "actual costs."

Physician's False Entry in Medical Record That Complete Patient Examination Had Been Performed Constitutes Fraudulent Practice of Medicine, Suspension of License Upheld

Sookhu v. Comm'r of Health of the State of N.Y., 31 A.D.3d 1012, 820 N.Y.S.2d 146 (3d Dep't 2006). In an Article 78 proceeding, a physician sought to annul a determination of the Hearing Committee of State Board for Professional Medical Conduct (the "Hearing Committee") that suspended the physician's license to practice medicine for one year. Charges were brought by the Office of Professional Medical Conduct ("OPMC") for the physician's alleged failure to maintain records, the filing of a false report and the fraudulent practice of medicine. After an evidentiary hearing, the Hearing Committee made a finding that the physician had intentionally documented a complete examination of a patient in the patient's medical records when, in fact, he had not performed the complete examination.

In seeking appellate review, the physician alleged that hearsay evidence improperly admitted at the hearing, the Hearing Committee's failure to call the patient to testify, and his limited ability to cross-examination the OPMC's witnesses prejudiced his right to a fair hearing. The Appellate Division confirmed the Hearing Committee's determinations.

The Court found the physician's first complaint regarding the admission of hearsay evidence—statements of the physician's admissions of wrongdoing—unpersuasive. Citing to Public Health Law § 230(10)(f), the Court stated that the "Hearing Committee is not bound by the rules of evidence." Further, the Court noted that so long as the evidence is "sufficiently believable, relevant and probative," it may be considered in assessing misconduct. Additionally, the hearsay statements brought into question in this matter were "not so inherently unreliable as to preclude its admissibility."

The physician's argument of prejudice based upon lack of testimony from the patient, was rejected. First, the physician had the right to subpoena the patient [Public Health Law § 230(10)(c)(4)], but failed to do so. Second, the physician continually brought to the Hearing Committee's attention the fact that the OPMC failed to call the patient to testify, thereby mitigating any possible prejudice. The Court also held that the physician had a "wide latitude" in cross-examining witnesses and he was not "impermissibly curtailed."

In assessing the penalty imposed on the physician, the Court looked to whether the punishment was "so disproportionate to the offense that it shocks one's sense of fairness." Based upon the fraudulent conduct of the physician, the Court found the one-year suspension of the physician's license, three years of probation and three years of practicing in a supervised setting, as well as a review of the physician's medical records and

a requirement to attend continuing medical education courses was warranted.

Allegedly Defamatory Statements Made in Independent Medical Exam Report Protected by Absolute Immunity

Kaisman v. Carter, New York County Supreme Court Index No. 115999/2005, N.Y.L.J., September 29, 2006. Plaintiff physician brought a defamation action against defendant physician, concerning allegedly defamatory remarks made by defendant in an independent medical exam ("IME") report. The IME report was authored by defendant in his capacity as an expert witness in an unrelated personal injury matter. Defendant, Michael Carter, M.D., moved to dismiss the complaint on the ground that the IME report was issued in the context of the unrelated judicial proceeding and, as such, his allegedly defamatory remarks regarding the competency and surgical judgment of plaintiff were protected by the absolute immunity afforded to statements made by witnesses in the course of judicial proceedings. At a minimum, defendant contended that his statements were protected opinion. The Court agreed with defendant that his statements made in the context of an IME relating to a personal injury action were afforded absolute immunity and dismissed plaintiff's complaint.

The Court held that "statements made by parties, attorneys and witnesses in the course of judicial or quasi-judicial proceedings are absolutely privileged, notwithstanding the motive with which they are made, so long as they are material and pertinent to the issue to be resolved in the proceeding." The question of whether a statement is pertinent to the issue to be resolved in the proceeding is construed broadly, so as to encompass not only statements that are pertinent, but also those statements that may become pertinent. Otherwise, opined the Court, witnesses, and particularly expert witnesses, would be unable to discharge their public duty freely and without fear of the harassment and financial hazard of subsequent litigation. Further, the privilege extends to both in-court and out-of-court statements, regardless of whether the statements would eventually be deemed admissible at trial. Accordingly, plaintiff's complaint was dismissed.

High Court Orders Disclosure Pursuant to Mental Hygiene Law

Reckess v. New York State Comm'n on Quality of Care for the Mentally Disabled, 7 N.Y.3d 555, 825 N.Y.S.2d 178 (2006). Petitioners Azriel and Paula Reckess operate five adult homes in Dutchess, Rockland and Ulster counties that provide long-term residential care and services to persons who are incapable of living independently, including some residents who would otherwise require placement in a nursing home. The facilities are licensed by the State Department of Health. In addition, because certain residents obtain services from mental health providers, petitioners' adult homes are also subject to oversight by the New York State Commission on Quality of Care for the Mentally Disabled (the "Commission").

In 2003, pursuant to its authority to examine the finances of any adult home in which at least 25 or 25% of the residents receive services from a mental health facility, the Commission conducted a financial review of four of petitioners' facilities. The Commission issued subpoenas *duces tecum* to petitioners requesting "[a]ll information pertaining to mortgages" on the four adult homes, including "applications, appraisals, title insurance documents, closing statements, mortgage notes and all records executed at the mortgage closings."

The Commission learned that title to the four properties were transferred to limited liability companies that petitioners controlled and these realty holding companies then leased the properties back to the partnerships originally owned and operated by petitioners. The Commission further discovered that, from 1999 to 2001, petitioners' holding companies had refinanced the homes, raising the outstanding debt on the properties by over $10 million.

The petitioners declined to produce documents pertaining to the transfers of title to the homes and the subsequent refinancings, contending that the Commission lacked statutory authority to compel the production of documents executed by petitioners in their capacities as corporate officers of the realty holding companies, rather than as the operators of the adult homes. The Court of Appeals disagreed.

The power to issue a subpoena exists only when it is expressly granted by the Legislature. Mental Hygiene Law §§ 45.09 and 45.10 supply the legislative authorization for the issuance of subpoena by the Commission in this case. The Court of Appeals found that the plain language of these provisions allow the Commission to subpoena documents held by adult home officers or corporations they control that were used in the sale-leaseback transactions and the related refinancings, in order to gauge the financial stability of the adult homes. Therefore, the fact that the mortgage and closing documents were executed by petitioners as officers of the holding companies did not deprive the Commission of its oversight and subpoena-issuing authority.

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a partner in the firm of 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 is Chair of the firm's litigation group, and his practice includes advising clients concerning general health care law issues and litigation, including medical staff and peer review issues, employment law, disability discrimination, defamation, contract, administrative and regulatory issues, professional discipline, and directors' and officers' liability claims.

In the New York State Legislature

By James W. Lytle

A new Administration arrived in Albany on January 1 and, as promised, a great deal changed on Day One. In addition to making appointments to the key health care positions within his Administration, Governor Spitzer highlighted health care issues in his inaugural address, his State of the Union address and in a special speech devoted to health care issues just days before he released his new budget. The "trifecta" of policy addresses left no doubt that the Governor intended to set forth an ambitious health care reform agenda—and the legislation he submitted to the Legislature as part of his Executive Budget confirmed that intent.

The overall approach, described by the Governor as "Patients First," envisions a health care system that places "patients, not institutions, . . . at the center of our health care system" and that meets "its responsibility to set standards, demand results, and hold institutions accountable to the State and the people those institutions serve." Expanding health insurance coverage, initially to the state's uninsured children, will be addressed by the Administration, along with steps to reduce growth in the Medicaid program and to restructure the program to promote high quality, cost-effective care. He also made clear that he remains committed to an all-out attack on Medicaid fraud, waste and abuse and has repeated his call to augment the Medicaid Inspector General's resources and to enact a Martin Act for Medicaid and a State False Claims Act.

The Executive Budget submitted by the Governor includes approximately $48 billion in Medicaid spending, including State, federal and local shares—a 1.8% increase over the prior fiscal year. In order to maintain this low level of growth, while simultaneously proposing initiatives to increase enrollment in Medicaid and Family Health Plus (FHPlus) and improve care coordination for beneficiaries with complex medical conditions, the Governor's budget imposes $1.5 billion (all funds) in Medicaid cuts, fraud savings, and provider assessments. The cuts fall primarily on hospitals, nursing homes, and pharmacies. Consistent with his commitment to shift the delivery system away from institutional care toward primary and community-based care, the Governor's budget imposes only modest cuts in home care and primary care. In addition, the Governor's budget would make permanent the cuts imposed in prior years that have been renewed annually through the budget process.

In order to improve the administration of key health care programs, the Governor has reorganized the Department of Health and created three new offices: the Office of Health Insurance Programs, the Office of Information Technology, and the Office of Long-Term Care Services and Programs. The Office of Health Insurance Programs (OHIP) will have responsibility for all government health insurance programs, including Medicaid, Child Health Plus, Family Health Plus and EPIC. It will also be charged with developing strategies to reduce the number of uninsured New Yorkers and will oversee rate-setting within DOH as well as OASAS, OMH, and OMRDD.

Among the key budget proposals are the following:

Medicaid Cuts and Adjustments. The Budget proposes a number of changes in hospital and nursing home reimbursement under Medicaid, including many of the proposals advanced in the new Governor's health policy speech. They include:

- Freezing trend factors for both hospitals and nursing homes;
- Elimination of the nursing home case mix enhancements for Medicare patients;
- Reducing hospital GME reimbursement to "actual" costs by removing the hold-harmless provisions and modifying the HCRA GME distribution methodology to target high Medicaid hospitals;
- Modifying the volume adjustment to eliminate length-of-stay relief for volume increases, while updating service intensity weights (SIWs) effective January 1, 2008;
- Implementing a new rate adjustment ($48 million) for Medicaid payments to public hospitals with a patient census that is more than 35 percent Medicaid beneficiaries.
- Reducing hospital workforce recruitment and retention funds and modifying the distribution methodology so that funding is allocated based on the hospital's volume of Medicaid patients. Nursing home worker recruitment and retention funding would be phased out under the Governor's proposal, reflective of the "re-basing" initiative that was enacted last year.

Indigent Care Funding. The Executive Budget proposes fundamental alterations in the allocation formulas for indigent care. The new formula is intended to more accurately reflect care to completely uninsured patients (as opposed to mitigating the "bad debts" of partially insured patients who paid a part of their bill, but not

all of it). The amount of care to uninsured patients would be measured by the actual volume of uninsured patients served at that hospital multiplied by the Medicaid rate that would have applied to those patients. High need hospitals and rural hospitals would continue to receive enhanced payments compared to other hospitals. The details of this proposal will be developed in regulations to be promulgated by the Department of Health.

Health Care Reform Act (HCRA): HCRA is scheduled to expire on June 30, 2007, and the Governor proposes to extend it until March 31, 2008, setting the stage for potentially more fundamental reforms in HCRA next year. The Governor's Budget includes initiatives to raise HCRA revenues, including increasing the covered lives assessments paid by private health plans by $75 million per year, enhancing HCRA auditing and authorizing the conversion of downstate not-for-profit health plans (such as the recently combined HIP-GHI) to convert to for-profit status, in the same fashion as Empire Blue Cross and Blue Shield converted, with the proceeds devoted to HCRA purposes. At the same time, the Governor has called for reducing some HCRA-related spending, including reduced GME and workforce recruitment and retention funding as discussed above, elimination of the discretionary HCRA funds, reduce funding for the health workforce retraining program, eliminate the Health Facility Restructuring Program, eliminate the nursing home and home care services quality improvement demonstration programs.

Expanding Coverage: The Executive Budget includes a substantial expansion of CHPlus eligibility to provide subsidized coverage for children with gross household income at or below 400% of the federal poverty level (FPL), effective September 1, 2007. The Budget establishes new initiatives to promote employer-sponsored health insurance programs by providing cost effective premium subsidies for families with children eligible for the CHPlus program and individuals eligible for FHPlus. These proposals are intended to satisfy the employer-sponsored insurance expansion requirement in the federal F-SHRP waiver.

The Budget includes $24 million (state share) to streamline enrollment and recertification for Medicaid and Family Health Plus effective January 1, 2008. Specific proposals include eliminating unnecessary documentation requirements for Medicaid and Family Health Plus at recertification and providing twelve months' guaranteed continuous coverage for Medicaid and FHPlus adults, unless the beneficiary moves out of the State.

Medicaid Fraud, Waste and Abuse: Last year's prolonged debate over Medicaid fraud legislation picks up where it left off with this year's budget proposing a "Medicaid Integrity Plan" that would strengthen the State's investigative and prosecutorial tools in combating fraud, establish new criminal penalties and establish a False Claims Act with a *qui tam* provision that would permit whistleblowers to share in the proceeds of Medicaid overpayment recoveries. The Budget projects total State savings of $400 million as a result of the new legislation and budgetary commitment to this effort—an increase of $104 million over current State savings attributable to anti-fraud activities. The elements of the Medicaid Integrity Plan include:

OMIG. The Budget would add 157 staff to the Office of the Medicaid Inspector General (OMIG), including 100 auditors, $5.6 million in new technology for OMIG over the next two years and twenty new staff to augment OMIG's technological capacity. The Budget legislation would also authorize OMIG to access the records of the Tax Department and the Workers' Compensation Board and would no longer consider a provider's compliance program as acceptable for state purposes based on its acceptance by the federal Department of Health and Human Services.

False Claims Act. The Budget proposes a New York False Claims Act that would broaden the State's ability to recover and impose penalties upon the knowing submission of false claims. The act would apply to any claim made to the State (not just related to Medicaid) and would expressly extend to claims for payment to Medicaid managed care plans. Treble damages for the false claims asserted, along with additional monetary penalties, may be assessed.

Qui Tam. In addition, the False Claims Act would authorize *qui tam* actions, modeled on similar federal legislation, that would permit a whistleblower to commence a civil action to assert that an entity, such as a Medicaid provider, had asserted false claims against the State. The Attorney General or a local government could choose to intervene in the action and substitute for the *qui tam* "relator" or whistleblower. If a governmental entity has converted the proceeding into a governmental civil enforcement action, the whistleblower is entitled to receive between 15% and 25% of any funds recovered in the action; if the whistleblower undertakes the action without governmental intervention, he or she is entitled to 25% to 30% of the recovery. Any retaliatory action taken against whistleblowers is also prohibited and would be subject to substantial penalties.

Increased State Share in Medicaid Recoupments. As a result of federal legislation enacted in 2006, by enacting a State False Claims Act and a *qui tam* provision, the federal government will permit the State to retain an additional 10% of Medicaid recoveries that would have otherwise been remitted to the federal government.

Insurance Fraud Reporting Reward. The Insurance Department would be authorized to establish a new fund to make monetary rewards for the reporting of insurance fraud.

New Crimes and Penalties. Five new crimes for deceptive health care practices and defrauding health plans would be established, the most serious of which would be a class B felony. In addition, five new crimes for possession of criminally diverted prescription medications and devices would be established.

"Martin Act" for Health Care Fraud. The Budget proposes the enactment of a new Article 49-A of the Public Health Law that would authorize the Attorney General to investigate and criminally prosecute health care fraud. Modeled on the Martin Act, which provides the Attorney General with broad investigatory and enforcement power over securities markets, the legislation permits the Attorney General to investigate health care fraud through compelling witnesses to be examined under oath, subpoenaing documents, impounding records and requiring the cooperation of other public officers.

Venue for Challenging Medicaid Actions. Any legal action to challenge a final administrative action against a Medicaid provider would have to be brought in Albany County Supreme Court.

By the time you read this report, the fate of the Governor's budget proposal will be known. Whatever the outcome, it is already clear that Governor Spitzer has placed the reform of the State's health care system at the tope of his agenda.

Mr. Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP. Mr. Lytle would like to acknowledge the assistance of his colleague from that office, Karen Lipson, with the preparation of this article.

In the New York State Agencies

By Frank Serbaroli

HEALTH DEPARTMENT

NYS AP-DRG Patient Classification System

Notice of emergency rulemaking. The Department of Health amended §§ 86-1.62 and 68-1.63 of Title 10 N.Y.C.R.R. to update the current regulations to make them consistent with changes made to the diagnosis related group ("DRG") classification system used by the Medicare prospective payment system and to modify existing DRGs and add new DRGs to more accurately reflect the pattern of health resource use. Filing date: August 14, 2006. Effective date: August 14, 2006. *See* N.Y. Register, August 30, 2006.

Language Assistance and Patient Rights

Notice of adoption. The Department of Health amended §§ 405.7 and 751.9 of Title 10 N.Y.C.R.R. to strengthen language assistance programs in hospitals to address the needs of individuals who do not speak English or do not speak it well and to add two rights to the Patient's Bill of Rights to be consistent with the Public Health Law. Filing date: August 28, 2006. Effective date: September 13, 2006. *See* N.Y. Register, September 13, 2006.

Licensure and Practice of Nursing Home Administration

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend Part 96 of Title 10 N.Y.C.R.R. to refine and streamline the existing regulations and ensure their consistency with the policies and directives of the Board of Examiners of Nursing Home Administrators. *See* N.Y. Register, September 27, 2006.

Statewide Perinatal Data System

Notice of adoption. The Department of Health added § 400.22 of Title 10 N.Y.C.R.R. to establish a State Perinatal Data System to provide useful data on the births and maternal health for perinatal care providers and the Department of Health and to promote expedited Medicaid eligibility determinations for newborns. Filing date: September 26, 2006. Effective date: October 11, 2006. *See* N.Y. Register, October 11, 2006.

Continuing Care Retirement Communities

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 901.9 of Title N.Y.C.R.R. to define the approvals required for any change in the current approved number of residential or health care units comprising the continuing care retirement community. *See* N.Y. Register, November 22, 2006.

Personal Care Services Program

Notice of adoption. The Department of Health amended § 505.14 of Title 18 N.Y.C.R.R. to repeal provisions that are obsolete due to court decisions and/or expired statutory authority. Filing date: November 17, 2006. Effective date: December 6, 2006. *See* N.Y. Register, December 6, 2006.

Expansion of the New York State Newborn Screening Panel

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend Subpart 69-1 of Title 10 N.Y.C.R.R. to add Krabbe disease to the New York State Newborn Screening Panel and clarify the requirement for timely specimen transfer. *See* N.Y. Register, December 6, 2006.

Neonatal Herpes Infection Reporting and Laboratory Specimen Submission

Notice of emergency rulemaking. The Department of Health amended §§ 2.1 and 2.5 of Title 10 N.Y.C.R.R. in order to enable proper identification and treatment of infected mothers and detection of early causes of neonatal herpes with the goal of assisting in diagnosis, prevention and effective management of neonatal herpes. Filing date: November 24, 2006. Effective date: November 24, 2006. *See* N.Y. Register, December 13, 2006.

Criminal History Record Check

Notice of emergency rulemaking. The Department of Health added Part 402 to Title 10 N.Y.C.R.R. to implement chapter 769 of the Laws of 2005 and a chapter of the Laws of 2006 (Section 6630) by requiring nursing homes, certified home health agencies, licensed home care services and long term home health care programs to request criminal background checks of certain prospective employees that provide direct care or supervision to patients, residents or clients of such providers. Filing date: November 29, 2006. Effective date: November 29, 2006. *See* N.Y. Register, December 20, 2006.

Self Attestation of Resources for Medicaid Applicants and Recipients

Notice of adoption. The Department of Health amended § 360-2.3(c)(3) of Title 18 N.Y.C.R.R. to allow an applicant for or recipient of Medicaid to attest to the amount of his or her resources unless the applicant or recipient is seeking Medicaid payment for long-term care services. Filing date: December 5, 2006. Effective date: December 20, 2006. *See* N.Y. Register, December 20, 2006.

Nursing Home Pharmacy Regulations

Notice of adoption. The Department of Health amended §§ 415.18(g) and (i) of Title 10 N.Y.C.R.R. to make a wider variety of medications available in nursing home emergency kits and to allow verbal orders from legally authorized practitioners in order to respond quickly to the needs of nursing home residents. Filing date: December 12, 2006. Effective date: December 27, 2006. *See* N.Y. Register, December 27, 2006.

Controlled Substances in Emergency Kits

Notice of adoption. The Department of Health amended § 80.11, 80.47, 80.49 and 80.50 of Title 10 N.Y.C.R.R. to allow Class 3a facilities (nursing homes, adult homes and other long term care facilities) to maintain controlled substances in emergency kits and administer them to a patient in an emergency situation. Filing date: December 8, 2006. Effective date: December 27, 2006. *See* N.Y. Register, December 27, 2006.

Hospice Residence Dually Certified Beds

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend Parts 700, 717, 790, 791 and 794 of Title 10 N.Y.C.R.R. to establish standards and procedures for hospice residence beds dually certified for residence care and inpatient care and update general standards for hospice residence. *See* N.Y. Register, December 27, 2006.

Serialized Official New York State Prescription Form

Notice of emergency rulemaking. The Department of Health added Part 910 and amended Parts 80 and 85 of Title 10 N.Y.C.R.R., and amended § 505.3 and repealed §§ 528.1 and 528.2 of Title 18 N.Y.C.R.R. to enact a serialized New York State prescription form to combat and prevent prescription fraud by curtailing theft or copying of prescriptions by individuals engaged in drug diversion. Filing date: December 13, 2006. Effective date: December 13, 2006. *See* N.Y. Register, January 3, 2007.

Payment for Federally Qualified Health Centers Psychotherapy and Offsite Services

Notice of emergency rulemaking. The Department of Health amended § 86-4.9 of Title 10 N.Y.C.R.R. to permit Medicaid billing for individual psychotherapy services provided by certified social workers in article 28 Federally Qualified Health Centers. Filing date: December 20, 2006. Effective date: December 20, 2006. *See* N.Y. Register, January 10, 2007.

INSURANCE DEPARTMENT

Healthy New York Program

Notice of emergency rulemaking. The Department of Insurance added § 362-2.8 and amended § 362-2.7 of Title 11 N.Y.C.R.R. in order to create additional health insurance options for qualifying small employers and individuals by requiring health maintenance organizations and participating insurers to offer high deductible health plans in conjunction with the Healthy New York Program. Filing date: December 8, 2006. Effective date: December 8, 2006. *See* N.Y. Register, December 27, 2006.

Claim Submission Guidelines

Notice of adoption. The Department of Insurance amended Part 217 (Regulation 178) of Title 11 N.Y.C.R.R. to update the claim payment guidelines setting forth what is needed in order to determine when a health care insurance claim is considered complete and ready for payment. Filing date: December 6, 2006. Effective date: December 27, 2006. *See* N.Y. Register, December 27, 2006.

Arbitration

Notice of proposed rulemaking. The Department of Insurance gave notice of its intent to amend § 65-4 (Regulation 68-D) of Title 11 N.Y.C.R.R. to provide the procedures for administration of the special expedited arbitration for disputes regarding the designation of the insurer for first part benefits. *See* N.Y. Register, December 27, 2006.

Rules Governing Individual and Group Accident and Health Insurance Reserves

Notice of emergency rulemaking. The Department of Insurance repealed Part 94 and added a new Part 94 (Regulation 56) to Title 11 N.Y.C.R.R. to prescribe rules and regulations for the valuation of minimum individual and group accident and health insurance reserves including standards for valuing certain accident and health benefits in life insurance policies and annuity contracts. Filing date: December 15, 2006. Effective date December 15, 2006. *See* N.Y. Register, January 3, 2007.

Physicians and Surgeons Professional Insurance Merit Rating Plans

Notice of Adoption. The Department of Insurance amended Part 152 (Regulation 124) of Title 11 N.Y.C.R.R. to establish guidelines and requirements for medical malpractice merit rating plans and risk management plans. Filing date: January 9, 2007. Effective date: January 24, 2007. *See* N.Y. Register, January 24, 2007.

Compiled by Francis J. Serbaroli. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft LLP's 16-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 Section. 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. Jared Facher, an associate at Cadwalader, Wickersham & Taft LLP, in compiling this summary is gratefully acknowledged.

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- *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, Jaime Staples King, Benjamin W. Moulton
- *Who Will Protect the "Disruptive" Dialysis Patient?*, Stella L. Smetanka

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- *Just Scanning Around with Diagnostic Medical Ultrasound: Should States Regulate the Non-Diagnostic Uses of This Technology?*, Archie A. Alexander
- *Excusable Neglect in Malpractice Suits Against Radiologists: A Proposed Jury Instruction to Recognize the Human Condition*, Dr. Caldwell & Evan R. Seamone
- *Give Them What They Want? The Legal and Ethical Permissibility of Pediatric Placebo-Controlled Trials Requested by the FDA Under the Best Pharmaceuticals for Children Act*, Holly Fernandez Lynch
- *Releasing Managed Care's Choke Hold on Texas Physicians*, Kristin L. Jensen
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- *Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Service Can, and Should Do*, Timothy Stoltzfus Jost

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For Your Information

By Claudia O. Torrey

It has been said in many ways by many people that the best way to have a window into the future is to study the past. Thus, "[s]tudying the rise and fall of health care 'regimes' is an important step toward understanding how the health of our society can be maintained and improved."[1] Health care is critical to the survival of the individual, the community, the nation, and the world.[2]

This columnist has never tried to critique a book for this column, nor will such start now; however, given the topic for the Winter issue of this *Journal*, it seemed prudent to inform the reader about a particular book—*The Rise and Fall of HMOs: An American Health Care Revolution* by Jan Gregoire Coombs, a medical historian.

Coombs presents the **micro-oriented** story of the Greater Marshfield Community Health Plan, a multi-specialty group medical practice in rural Wisconsin, against the **macro-oriented** historical story of the developing health maintenance organization ("HMO") movement. The concept of a group physicians' practice utilizing the latest medical techniques and providing quality care to all of its constituents has precedence in a few prepaid HMOs such as Kaiser Permanente Foundation Health Plan in California; the Ross-Loos Medical Clinic in Los Angeles, CA; and the Washington, D.C. entity known as the Group Health Association. Whether or not one agrees that the evolution of for-profit HMOs, also known as managed care organizations, has not achieved the original goal to reduce and streamline health care costs via competition and administrative service controls, it appears that Coombs' book is a valuable resource as our society continues to wrestle the never ending health care balancing act of access to care and limited resources.

Highlighting Coombs' book provides a segue to the November 2006 Berger Commission report regarding *The Commission on Health Care Facilities in the 21st Century* ("Commission").[3] After an eighteen-month review process, the Commission report lays the foundation for strengthening New York State's acute and long-term care delivery systems. In an attempt to carry out the mandated charge to "rightsize" these institutions, the report recognizes that the Commission was created to ensure that the statewide supply of hospital and nursing home facilities is best configured to respond to community needs for high-quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability (sounds like that familiar balancing act).[4]

According to the Commission report, rightsizing includes the possible consolidation, closure, conversion, and restructuring of institutions.[5] Among other things, the report gives: policy recommendations, facility recommendations, and financing recommendations; time will tell how the State Legislature will receive these recommendations. One of the policy recommendations submits that New York State "should strive for health coverage that is universal, continuous, affordable to individuals and families, and affordable and sustainable for society at large. New York should study coverage expansion efforts in other states, and adopt additional strategies to sustain its recent progress in reducing the number of uninsured New Yorkers. . . ."[6] Ironically, the Public Health Law Committee of the New York State Bar Association's Health Law Section is in the process of studying this very issue—Who knew? It appears that health law in 2007 is off to an interesting start!

Endnotes

1. Philip A. Shelton, M.D., J.D., F.C.L.M., 27 J. of Legal Medicine 367, 368 (September 2006).
2. *Id.*
3. The Commission on Health Care Facilities in the 21st Century, Executive Summary, www.nyhealthcarecommission.org/final_report.htm (last viewed on November 30, 2006).
4. *Id.* at 8.
5. *Id.*
6. *Id.* at 9.

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Patients First: An Agenda to Fundamentally Reform New York's Health Care System

By Governor Eliot Spitzer

In my State of the State Message, I pledged to reform our health care system to make health care affordable for each person, family, business, and for government.

Today, I will outline an agenda that begins to do just that. My Executive Budget will propose fundamental changes to reform and restructure our health care system—decreasing costs while increasing coverage. Our reforms will not only save taxpayers billions of dollars, but, most importantly, will lower the cost of health care while improving patient outcomes.

Our agenda is based on a single premise: patients, not institutions, must be at the center of our health care system. That means that every decision, every initiative and every investment we make must be designed to suit the needs of patients first. The result will be a high-quality health care system at a price we can all afford.

This guiding principle stands in stark contrast to the principle that has guided health care policy for the last decade. Instead of a "patient-centered" approach to health care policy driven by the needs and demands of New Yorkers, we have had an "institution-centered" system.

I am not saying that these other actors in the system are unimportant or irrelevant. Quite the contrary. They all have vital roles to play. But it is government's job to make sure that the first need we consider is that of our patients.

For too long, government has ignored the inevitable changes in health care delivery, technology, financing and planning. For too long, we have stared at the opportunities posed by progress, and made poor choices or simply no choices at all. For too long, we have financed the health care system we have, not the health care system we need. So we're left pumping billions of dollars into a broken system with no deliverables and no accountability.

This upcoming budget is designed to change all that. It is time, indeed the time is long overdue, to examine what went wrong and fix it.

The Status Quo: An Institution-First System

What went wrong is that health care decision-making became co-opted by every interest other than the patient's interest. Government abdicated its responsibility to set standards, demand results and hold institutions receiving billions in state tax dollars accountable to the State and to the people those institutions serve.

Let me give you a few examples:

Take the Berger Commission. This was a process that should never have been necessary in the first place. In most industries, when the demand for a specific service falls permanently, as has the demand for long stays in hospitals, supply inevitably follows. Yet because of wasteful State subsidies and the State's failure to make strategic choices, tax dollars have been spent on empty hospital and nursing home beds instead of insuring our 400,000 uninsured children. Now we face dramatic instead of gradual change to rationalize a system in desperate need of reform.

These changes are painful—and we will use every effort to implement them in a way that is sensitive to patients, communities and workers. But because of the State's inability to confront the status quo, these are the kinds of hard choices we must now make to increase health care quality and decrease health care costs.

Another example of institutions driving the system is the way the State pays for graduate medical education. New York's Medicaid program has spent more than $8 billion over the last five years on graduate medical education—$77,000 per graduate resident in 2005 compared to similar states like California that spent just $21,000 per resident.

This education is critically important, but we're currently funding it in an excessive and irrational way that isn't directly correlated to the actual students being taught—thus costing the State exorbitant amounts of money in what amounts to general subsidies to teaching hospitals. In fact, when we looked closer at this broken formula, we discovered that many of those dollars are going to pay for phantom residents and doctors who don't even exist.

The same lack of accountability has also been evident in the special subsidies the State gives hospitals to underwrite labor costs. In January 2002, with hundreds of millions in new revenue on the table for health care, the time was ripe for a debate on how best to invest this money. But instead of a public debate, the State committed billions of dollars in new spending to underwrite a portion of the increased costs of the hospitals' pending labor agreement.

As a result of this deal, well over $3 billion alone was pumped into the health care delivery system with little to no accountability. Don't get me wrong: labor costs are real, and the need for training is real. What made this a poor choice instead of a wise investment is that the money was not based on the number of patients served and it didn't create a robust system of accountability for institutions that were growing out of control.

And take prescription drugs: Despite years of scare tactics used by drug companies to block progress, New York finally implemented a Preferred Drug List for our Medicaid program, a commonsense reform other states and the private sector have used for years to save money. Every year we delayed implementing this program, it cost us $200 million. And once we finally did implement the program, it did not go far enough.

We must summon the will to do even more to lower drug costs. With the actions we will take in our upcoming budget to enhance the Preferred Drug List and ratchet down prescription drug costs, we will save an additional $200 million each year.

All of these examples have one thing in common: Whether it was spending on unused hospital and nursing home beds, excessive levels of Graduate Medical Education support, subsidized labor agreements, or soaring pharmaceutical drug costs, no one asked the essential questions: is this the best use of this money for the patients in the health care system? And do these expenditures help transform the health care system from the one we have into the one we need?

Given that our health care policy decisions have been driven by institutions instead of patients, it cannot be surprising that New York spends more money on Medicaid per capita than any state in the nation—$2,215, over double the national average. Our Medicaid budget costs taxpayers over $45 billion each year, with more money going to hospitals and nursing homes than any state in the country.

And for all this money, what are we getting? The answer is far too little.

Despite leading the nation in health care spending, we are not leading the nation in results:

2.6 million New Yorkers, including 400,000 children, are uninsured.

New York has a higher percent of deaths due to chronic disease than any other state in the nation.

New York's nursing homes rank among the nation's worst in citations for placing their residents at immediate risk for serious injury or death.

Statewide, one in every twelve of our children is afflicted with asthma. And almost one in four is obese.

All of this money and this is what we're getting in return.

Let me be very clear: the problem with our health care system is not our dedicated doctors, nurses, aides and other health care professionals. It is certainly not people on Medicaid, all of whom are low-income and many of whom are the most medically vulnerable residents of our State—these are our children, our disabled, our frail elderly and our chronically ill. The problem is a system—co-opted by entrenched interests—that resists making hard choices to change the status quo.

I was elected to change that. Here's how we will do it.

A Patient-First System

My first Executive Budget will begin to implement a new Patient-First Agenda to lower the cost of health care while improving patient outcomes. To do this, we will shift money away from the institution-centered health care system of our past, towards a more effective patient-centered system for our future. In the process, this paradigm shift will save taxpayers billions of dollars in efficiencies. But it is our desire to lower the cost of health care and increase quality that drives our agenda, not some arbitrary savings figure to close a budget gap. From now on, health policy, not health politics, will guide us.

Let me outline the main features of our plan:

Health Insurance Coverage

First, we will provide access to health insurance to all 400,000 of our uninsured children, making our first investment in the health care system to people, not to institutions. To do this, we will expand Child Health Plus to cover kids in families up to 400 percent of the federal poverty level, so that every family in New York will be able to provide their children with the health insurance they need.

And we will remove the bureaucratic hurdles that prevent vulnerable New Yorkers from getting on and staying on Medicaid. While implementing measures to guard against fraud, we will no longer require that families produce documents for continued eligibility of coverage, when the State can simply confirm that information from its own data.

These two steps will not only save the State hundreds of millions from reduced charity care in emergency rooms, but it will enable us to cut New York's uninsured population in half over the next four years.

But we won't stop there. As we achieve this goal, we will develop a plan for affordable, universal health insurance for all New Yorkers. To be clear, we cannot achieve this goal unless we first restructure our health care delivery system to lower health care costs. Otherwise, we will force an undue burden on families, businesses and government to cover the cost of universal coverage.

As more New Yorkers become insured and more health insurers play by the rules, hospitals and other health care providers will see increased revenue as well.

As we do all of this, we will demand that private HMOs and other health insurance companies also contribute to this effort. Our State Department of Insurance will demand a heightened level of transparency and accountability by reviewing regulations concerning provider contracting requirements, the pre-certification process and technical denials. We will not tolerate gamesmanship that results in denial of care or delay in payment for care.

Medicaid Reform

Second, as we expand coverage, we must reform Medicaid and the delivery system it supports. If we truly want to move toward universal health care coverage, we cannot continue to fully subsidize the old system while we build the new one. That's why we must intelligently redirect and reinvest our Medicaid dollars to further reform.

While we cannot complete the overhaul of our delivery system or fully rationalize our reimbursement system in the first year, we will start the process. We will impose a freeze on the Medicaid rates paid to nursing homes and hospitals and a partial freeze on managed care plans. New York spends more on hospitals and nursing home care than any State in the nation. This spending is unsustainable and unwise. We need to stop, evaluate and reallocate funds to more effective community-based settings instead of continuing to pour more money into a broken system. These freezes will be strategic. Because we want to move the system toward a patient-centered model of care, we will not freeze rates to home care providers.

But our reform effort must extend well beyond our reimbursement system. My upcoming budget will take the following steps to accomplish this patient-first Medicaid reform:

First, we will no longer pay for graduate medical residents who don't exist, freeing up money for uninsured New Yorkers who actually do exist. And while we will continue to invest in graduate-medical education at our academic medical centers and teaching hospitals, we will ensure that the GME system provides us with the value we want for the funds we invest.

Second, we will no longer use Medicaid dollars to bail out institutions for poor management decisions or pay for unrealistic labor deals or to underwrite inadequate reimbursement paid by Medicare and private health insurance companies. Medicaid will no longer cross-subsidize commercial insurers. We will not let health insurance companies get away with deep discounts that don't support the hospital services their members use.

Instead, the State will pay a fair reimbursement that reflects the true costs of providing high-quality care through a workforce whose needs are met fairly. And we will begin to redirect Medicaid money to those facilities that serve the bulk of Medicaid patients, which is where Medicaid dollars belong.

Third, we will no longer pay for out-of-control pharmaceutical costs. To do that, we must ensure that Medicare Part D plans cover the drugs needed by people on Medicare: seniors and people with disabilities. Once again, the State can't be the path of least resistance—allowing Medicare to shirk its responsibility. For example, EPIC, a vital program whose resources must be protected, should be the insurer of last resort when identical coverage exists elsewhere that is not funded by New York's taxpayers.

We will also strengthen the State's Preferred Drug List. It has already saved the state millions of dollars without harming patients' access to medications. Increasing the use of clinical equivalents and other strategies already widely used by other states and commercial health plans will allow us to promote best practices among doctors and save money. Let me be clear on this last point: under our proposed system, physicians will always be able to ensure patients get the drugs they need. Beyond these changes in the budget, we will look at other ways to save costs, like bulk purchasing and the federal 340B drug discount program.

Fourth, we will buy health care in the right settings, at the highest standards and at the best price. We will start by addressing the way care is delivered for vulnerable patients with multiple medical needs, who require care across different systems. These are the people whose mental illnesses, substance abuse problems and diabetes or pulmonary diseases require coordinated care.

While there is much we can and will do administratively, we will also seek legislative authority to fund additional initiatives that zero in on this vulnerable population. It is the right thing to do clinically, and it is certainly the right thing to do financially. Medically complicated Medicaid patients make up 20 percent of beneficiaries but account for 75 percent of all Medicaid spending. With coordinated care, medically complicated patients get

better care, their diseases are better managed—and, we estimate, taxpayers will save tens of millions of dollars from greater efficiencies over the next four years.

Fifth, we will expand the managed long-term care program which has proven so successful in managing and coordinating long-term care needs. As we know, the vast majority—our grandparents, parents, children or neighbors—want to live in their community and in their home. Yet this is another example where the demand for health care services has changed, yet the supply has remained the same. This successful program reaches less than 20 percent of the 100,000 people who could potentially benefit. Our actions will realize the potential—both in savings and in quality of care—of coordinated long-term care.

Sixth, we will drive the implementation of health information technology, vital to improving quality, reducing bureaucratic barriers and saving money. We will invest in electronic health records, electronic prescribing, telemedicine and other innovative approaches. And, we will make certain that commercial insurers fully participate in reform of the delivery system.

Seventh, we will increase our efforts to ferret out Medicaid fraud, an insidious parasite that saps precious resources and hurts quality of care. We will increase our efforts in this area by not only devoting more resources to the Medicaid Inspector General, but will augment these resources by proposing to the Legislature a Martin Act for Medicaid and a State False Claims Act—legislation that has saved the federal government billions of dollars since inception.

Finally, no patient-first health care strategy can be complete without a comprehensive effort to address public health. I will arm Dr. Daines and the Department of Health with the resources and the mandate to implement a strategy that targets primary and preventive care—resources that will go to support programs that decrease obesity rates and increase healthy eating and physical exercise, prevent childhood lead poisoning, expand access to cervical cancer vaccines, prenatal and postpartum home visits, and public health education on the quality of mammograms and other important issues.

To meet these challenges, we need a Department of Health that is organized to implement a patient-first agenda. We have already established an Office of Health Insurance Programs to bring together all of our public insurance programs in order to coordinate, streamline and simplify these programs so they reach the maximum number of eligible people. And we will establish an Office of Long Term Care to zero in on efforts to expand options for long-term care in the least restrictive, most integrated settings possible. We will continue to take these kinds of steps to remake our Department of Health into the preeminent health agency in the nation.

This is an ambitious agenda and I know that change, especially such fundamental change, will not be easy. But its time has come.

I want us to work together for a real solution, the main components of which I have outlined here today in this Patient-First Agenda. We will need partners to get this big job done—from individual New Yorkers whose paychecks are consumed by soaring health care costs, to businesses that want to lower New York's cost structure, to health care workers who are a vital component to high-quality care, to taxpayers who are paying too much for a broken system of care.

Because for us to transform our broken health care system, we will have to come together as One New York. I know that those who have benefited from the status quo will fight hard to resist these necessary reforms. I hope we can convince them to become part of the solution. But, if we can't, then I will do what the people elected me to do and fight for what I believe is right and for the good of all New Yorkers.

This is the text of a speech delivered by Governor Spitzer on January 26th, 2007 at The Nelson A. Rockefeller Institute, Albany, NY.

The Pros and Cons of "Medicare for All": A Series of Public Forums on Health Reform

By Paul Clay Sorum, MD, PhD

The New York Capital District Chapter of Physicians for a National Health Program (PNHP) sponsored, in alliance with the New York State League of Women Voters, a series of four public forums in spring 2006 on the pros and cons of "Medicare for All." PNHP is a 14,000-member national organization, founded in the late 1980s, that advocates universal access to comprehensive, affordable, high-quality health care financed through a single payer, in short, for an improved and expanded Medicare for All.[1] The purposes of the forums were 1) to put Medicare for All fully on the table as health care reform is debated, 2) to show its strengths and weaknesses in comparison to the current system and to other types of reforms, 3) and to investigate whether it could be applied first on a state level. The forums were held at the Linda Norris Auditorium of WAMC, the regional public radio station. The first hour of each forum—devoted to a round-table discussion among the panelists moderated by Alan Chartock, the President and CEO of WAMC—was recorded, was subsequently broadcast over WAMC, and is available at www.wamcarts.org (click on "Archive"). The rich and wide-ranging round-table discussions are summarized here (grouping comments according to themes that may have been discussed at different times during a roundtable).

First Forum: What Are the Problems?

The first forum, designed to introduce the issues, brought together four experts with quite different views:

- William Cromie, MD, MBA, a pediatric urologist and President and CEO of a regional not-for-profit health plan, the Capital District Physicians' Health Plan, Inc.
- Oliver Fein, MD, an internist, Professor of Public Health and Associate Dean for Affiliations at Weill Medical College of Cornell University, and Chair of the New York Metro chapter of PNHP.
- Jeremy Lazarus, MD, a Colorado psychiatrist and Vice-Speaker of the House of Delegates of the American Medical Association (AMA).
- Glenn McGee, MD, a bioethicist, Director of the Alden March Bioethics Center, and Editor of the *American Journal of Bioethics*.

1. The uninsured

Elizabeth Higgins, MD, a local internist and pediatrician, introduced the forum with the case of an adolescent whose mother lost her health insurance (when she lost her job) and whose psychiatric condition subsequently deteriorated because her mother could not afford to buy her medications. All the panelists agreed that, with cases like this and with 46 million uninsured[2] and 18,000 dying every year because they lack health insurance,[3] we face, in the words of Lazarus from the AMA, "a national tragedy." Indeed, McGee of the Bioethics Center labeled the current situation "a kind of perfect storm": "everything that could go wrong in American health care has gone wrong, despite years, decades of innovation in health care reform." As Cromie of the local health plan declared, one of America's great problems, therefore, is "how do we provide care for everyone in this country in a reasonable, rational way?" The disagreements among the panelists were, in essence, how, in Cromie's words, to "get a system where people have equal access," namely whether to expand coverage through the current mixed system of public and private insurers or to institute a single payer system.

2. The link between employment and insurance

Fein of PNHP pointed out, "We are the only industrialized nation that links its health insurance to employment. You lose your job, and you lose your health insurance." With this happening more and more, the only solution, for Fein, is to institute a Medicare for All system through which everyone would be covered, unrelated to employment, "a Medicare for All program that is based and financed publicly but is delivered through private sources."

Lazarus agreed with Fein that health insurance must no longer be linked to employment but offered a very different solution. Insurance should belong to the individual, to carry with her wherever she goes, and should rely on "a free market in insurance and insurance plans." The AMA's plan would provide tax credits to people of low income sufficient to buy "reasonable" health insurance and "would allow people to make their own choices about the kind of health insurance they want."[4] Fein objected that the tax credits plan maintained the higher expenses of the private insurance system. Lazarus responded that, "if you really open up markets and people can buy the kind of insurance that they think is best for

themselves and their families," the cost of insurance would drop (citing studies done through the Kaiser Family Foundation).[5] Fein also pointed out that even the AMA estimates that tax credits by themselves would solve only part of the problem of uninsurance.[6]

3. The contributions of private insurance

Fein dismissed the widespread concern, raised by the moderator, Alan Chartock, that government's involvement in Medicare for All would lead to "massive inefficiency." He argued that, in fact, private health insurance is the most inefficient means of paying for care. The overhead costs of private health insurers in the U.S. range from 16 to 30 % of the premium dollars collected. In contrast, the overhead of our single-payer system, Medicare, is only 3%.[7] Fein asserted that, even though Medicare could be improved by expanding its coverage of services, it is "extraordinarily popular among the elderly," it is "the most efficient way of getting services," and in contrast to most private insurance, "you have access to virtually any doctor or hospital that you want, you have the maximum amount of choice."

Cromie, too, criticized the "unconscionable" profits of the for-profit insurance industry and agreed that we must eliminate "the inefficiencies and the waste in the system." But he responded to Fein that the overhead figures he cited are misleading. On the one hand, at CDPHP, a not-for-profit health plan, the overhead is only 8-9% (including a thin profit margin of only 1.8%, in line with state requirements to have some reserves), i.e., "91 cents on the dollar goes for health care." On the other hand, he contended, a single-payer system would have, in truth, the administrative costs associated with government that are, incorrectly, not counted as Medicare costs: "Just remember: you're paying for the Congress, you're paying for the Center of Medicare and Medicaid services, you're paying for the infrastructure of the federal government."[8] Furthermore, administering Medicare in the U.S. would be more expensive than in Canada, he pointed out, because our country is so much larger and more complex. Lazarus added that "the cost of transition to a single payer system would be phenomenal."

Cromie mentioned the value added by CDPHP in providing choice and ensuring quality. He noted, in particular, that "the Medicare system is completely supported by the private insurance industry because that is the group that pays the physicians appropriately," that, as the CEOs of the Albany hospitals complain, Medicare reimbursements are not sufficient to sustain their operations. In addition, Lazarus argued that, in contrast to private insurance companies, Medicare "is a large ship which is very hard to turn." Cromie pointed out, at the end of the forum, that we want not only access but also high quality: "What we're talking about with this young lady that started the discussion is, how do we provide quality integrated care across the system and reward physicians and hospitals for quality outputs?"

4. Adverse selection

Cromie brought up the problem of "adverse selection." Young people are not paying for health insurance and, therefore, are not in the risk pool.[9] In addition, many insurance companies are able to use "experience rating," in which premiums depend on individual health risk and prior health care consumption (in contrast to the "community rating" used by CDPHP for their HMO and required by N.Y. state law). "The crisis that we're having," Cromie argued, "is the progressive dilution of the risk pool, which is adversely selecting the sickest people who drive health care costs, and as the cost of health care goes up, more and more people fall out of that system and have to fall into a government system." He praised the State of Massachusetts where health insurance will be mandatory for everybody on the model of auto insurance. Fein responded that the problem could not be cured using the private health insurance system because "the for-profit insurer wants to attract essentially the healthy person," because it makes a profit by "excluding the sick person," leading to the "insurance death spiral" already described by Cromie. Lazarus agreed with Cromie and Fein that expanding the risk pool "brings down the cost for everyone" but proposed nonetheless the creation of high-risk pools, financed by general tax revenues, so that there would be "robust markets" where the younger, lower risk people "could buy insurance that's more appropriate for them." Fein objected that going through the private insurance system is "the most expensive way" of getting everyone into a risk pool.

5. Rationing

Chartock raised the issue of waiting lines in the single-payer systems in Canada and Great Britain (and was seconded by Lazarus and McGee). Fein responded that, although waiting lines in Canada are a problem and a result of Canada spending too little on health care, the waiting times are exaggerated by the right-wing think tanks and are decreasing.[10] [This issue would be a major topic of the second forum.]

McGee linked the problem of waiting lines to the issue of rationing, to the problem that people demand expensive medical care. Fein responded that the $300 billion in administrative savings from instituting a single payer system could be reinvested and used to provide better insurance and better access.[11] He asked why we need to address the question of rationing "before we eliminate the waste." McGee argued that Hillary Clinton's refusal to talk about rationing, about the question of "how much health do we really need" killed the Clinton health care

plan.[12] Fein objected that what killed the Clinton plan was that "the private insurance industry lobbied so strongly against it, the pharmaceutical industry did not want to create an entity that could negotiate with prices." McGee responded with two points. First, that people believed that, under the Clinton plan, "they wouldn't get their drugs and they wouldn't be able to see their doctors," that they wouldn't be able to get their in-vitro fertilization because they would have to underwrite the huge expenses of people in their last two years of life. Second, that "the twenty-six year olds who work in the offices out there are going to be hard pressed to vote for a reform system that means that they will, for example, be asked to pay for liver transplants for alcoholics, for diabetes medication for those who refuse to stop engaging in behaviors that are associated with their type II diabetes." In short, McGee contended, it makes no sense to declare that everyone has a right to health care until we decide what it means to be healthy and to what health care each of us is entitled: "we have to have a conversation about . . . what we're owed by each other in terms of health care." Lazarus pointed out that the rationing plan used for Medicaid in Oregon, which is based on what the community wants,[13] has not caught on in any other state. Cromie expanded on this issue, arguing that "we have an entitled society" so that "part of the solution to the problem is engaging the public, having the public understand the true cost of health care." "At the end of the day," Cromie stated, "health care is rationed." Currently, he pointed out, rationing is done in the U.S. by the marketplace, so that people who cannot pay are outside the system (which, he insisted, outraged him as well as Fein) and in Canada and Britain by waiting lines: "The ideas that there will be no rationing in a single payer system is not rational."

6. Political realism

Lazarus called for realism, arguing that, whatever the merits of Fein's plan, "the reality right now is that a single Medicare for All here at the federal level is not going to happen." In the present political climate, he asserted, the only "politically viable" way to get insurance for all the 46 million uninsured was through "incremental reform." Fein responded that we have tried incremental expansions for 40 years, when we included the elderly and the poor, and "that people's patience is being exhausted with this." The fact that even 32% of Chief Financial Officers think that a single payer Medicare for All program "should be on the horizon" illustrates that "there is a growing popular sentiment in this country that we should move to a Medicare for All program." Lazarus replied that the polls he reads indicate "that the American population is deeply divided on this issue."[14]

Second Forum: What Can We Learn from Other Countries?

The second forum focused on the lessons for the United States of Canada and other countries that provide universal access to care at far lower per capita costs than in the U.S.[15] The panelists were:

- P.J. Devereaux, MD, a cardiologist and Assistant Professor in the Department of Clinical Epidemiology and Biostatistics at McMaster University in Canada.
- Martha Livingston, PhD, Associate Professor of Health and Society at the State University of New York at Old Westbury and Vice-Chair of the New York Metro chapter of PNHP.
- Victor Rodwin, PhD, Professor of Health Policy and Management at the Robert F. Wagner Graduate School of Public Service at New York University and Director of the World Cities Project.
- Robert Scher, MD, former Chief of Ophthalmology at Huntington Hospital and current President of the Medical Society of the State of New York.

1. U.S. exceptionalism

Livingston from SUNY-Old Westbury pointed out that, in all the other rich industrialized nations of the world, people get "world class, first-rate health care" and, unlike in the U.S., all of them "are able to get that health care when they need it." "We're unique" she stated, "in not affording health care as a right to all of our people." Rodwin from NYU agreed: "We are the only country in the world, of the rich countries in the world—to which we should compare ourselves—which does not have a system of universal coverage."

The panelists agreed that universal coverage was the goal. Livingston represented the position of PNHP, which works for access to affordable, high-quality health care for everybody in the United States and "promotes public funding for privately delivered health care." Rodwin agreed with Livingston that Medicare for All makes sense and proposed gradually lowering the age of eligibility and eventually arriving at Medicare for All. He thought that the only hope for arriving there is the "increasing sense of vulnerability among the American public largely due to the erosion of private employer-based insurance coverage." Scher from the Medical Society of the State of New York declared that we probably have enough money now in the system "to care for everybody," but that, "a tremendous amount of money is being taken out of the system by the administrative costs in the country." The administrative costs in Canada, he said, are about 1.3%, in Medicare about 3.6%, and in the private sector between

11 and 12%. The difference could be used to "cover all Americans with the insurance they want."[16] Devereaux seconded Scher's point, though he cited 3.5% for U.S. Medicare and 1.5% for Canada. "As soon as you have hundreds of insurance companies, the hospital has to hire its own army of people to figure out all the loopholes through all these insurance companies." He pointed out that a universal national health insurance program would help the U.S. economy: since General Motors spends $1,500 per vehicle made in the U.S. on health insurance but only $120 in Canada, lots of GM jobs are going to Canada.

The panelists compared the U.S. primarily to two other developed countries, Canada and France.

2. Canada and waiting lines

In describing the Canadian "Medicare" system—truly a Medicare for All—Devereaux stressed the distinction between the financing of health care and its delivery.[17] Health care in Canada is publicly funded, through tax dollars, so that if any Canadian gets sick and goes to a doctor or hospital, she gets no bill because society covers the charges. On the other hand, the delivery of health care is private. Even the hospitals are not owned or run by the government but are private not-for-profit. In general, he asserted, the majority of Canadians believe that "health is a right, the same as education is a right, the same as freedom is a right" and that access to care should be based on need, not on ability to pay. Livingston said that, if we adopted a Canadian-type system (as proposed by PNHP), the only change in how we get our health care would be that "when we call a doctor's office for an appointment, the first question will not be 'What is your insurance?'" i.e., what her Canadian friends call "the obscenity of the system of demanding money up front."

Scher pointed to the waiting lines, suggesting they function the same as lack of insurance in the U.S.: "Our 46 million uninsured get medical care when they need it badly, not when they need it. The queue does the same thing in Canada." Devereaux responded that access to cardiac procedures is not a problem in Ontario where he works, but there are wait times for certain things such as cataract, hip, and knee surgery. He stated: "I'm not going to say that no one waits, but at the same time you have ask yourself, with America at the moment, if you in fact have 46 million people with zero insurance and, according to my understanding, 40 million with not great insurance, what is your reality in terms of waits?"[18] Rodwin challenged Scher's equation of being uninsured and being on a waiting list for non-urgent care: waiting lists in Canada, he proposed, are actually the equivalent in the U.S. of waiting for an appointment. He noted that the Medicaid population does not have immediate access to primary care because reimbursement rates for physicians are so low. Scher cited his own recent hip surgery as an example of surgery without a queue; Devereaux responded that his example shows that a publicly-funded system, U.S. Medicare, is able to provide rapid access. Livingston responded, in turn, that her own experiences contradicted Scher's, citing her difficulty finding a specialist who took her private insurance and could see her sooner than in a couple of months as well as the many months before she could get a routine mammogram. Livingston contended that, were we to take the money we spend on trying not to give people the care they need and put that money in actual health care, we would not have any problems of waiting lines or rationing: "We're paying for national health care, we're simply not getting the care that we're already paying for."

Scher explained that the difficulty of obtaining mammograms is a result of the liability system: radiologists are declining to read mammograms because of the tremendous number of lawsuits.[19] The implication was that the way to improve access was not to adopt a Canadian system, but to reform the liability system. Livingston pointed out that liability is a lesser problem in the other rich industrialized countries (and Rodwin agreed). In particular, Livingston explained, the cost of malpractice insurance is greatly lower because these other countries have universal health care whereas in the U.S. the victims of medical error need to sue in order to pay for the lifetime of medical care resulting from the harm they suffered.

In Canada, private insurers have not been allowed to offer insurance that covers the services paid for by Medicare. Devereaux discussed the implications of the recent, controversial case in which the Supreme Court of Canada, in a split decision, ruled that the government of the province of Quebec can not "disallow people to purchase private insurance for medically necessary care" that is not being provided in a timely fashion. The Quebec government plans to have the doctors determine time limits for the provision of various procedures, and if the time limit is surpassed the government will pay for them to go somewhere else. In addition, the Quebec government said that, if physicians want to deliver care in the private, for-profit sector, they cannot also practice in the public, not-for-profit sector. It is not clear, Devereaux said, that enough patients and physicians will opt out of Medicare for private insurance to be viable.

3. France as a model

Rodwin pointed to France as "a model for the United States." France achieved truly universal coverage on April 1, 2000, after a long period of gradual expansion. Like the U.S., it relies a great deal on the private sector, including private complementary Medigap-type insurance. The

payment of health care is 40% general revenue taxation, 50% mandatory payroll tax (like U.S. Social Security), and 10% out-of-pocket. The provision of hospital care is 2/3 public hospitals, 1/3 private hospitals (run for the profit of doctor-owners, but not publicly traded). In ambulatory care, "they have a fiercer attachment to fee-for-service private practice than we do" and "consider our managed care and HMOs bastions of socialism." In France, moreover, access is not a problem: there are no waiting lists and no complaints about waiting lists.[20]

4. Physicians in the other countries

Chartock asked about recompense for physicians. Livingston explained that, while physicians make less in Canada than in the U.S., their incomes are approximately five times the average industrial wage, and this did not change when national health programs were instituted. In the U.S. the ratio is about six to one. So, she argued, U.S. physicians would not have to worry that their incomes would decline greatly under Medicare for All, and "as doctors from other countries have said to us, not having to have full-time staff to deal with a thousand different insurance bureaucrats, and so forth, actually makes their lives a lot easier, and they don't wind up suffering economically." Scher also explained that physicians make less than people think because of their other expenses: most have educational debts of some $150,000; they start earning money only after all their training, in Scher's case not until age 35; they have to fund their own pensions; and they have to pay the office personnel to interface with insurers. Rodwin said that in France too physicians' incomes are about five times the average income in the country. What American physicians have to give up in exchange for their higher income, he continued, is "that they are the most litigated against, the most second-guessed, and the most intruded upon of all physicians in industrially advanced nations." Physicians in national health insurance systems make less money but have "greater clinical autonomy."

5. Profit vs. not-for-profit health delivery

Devereaux turned from funding to delivery of care, discussing the difference between for-profit and not-for-profit care. Studies of U.S. hospitals and dialysis centers have shown that both costs and risk-adjusted death rates are higher in investor-owned private for-profit facilities than in private not-for-profit ones.[21] Canadian hospitals are all not-for-profit, whether public or private. Scher agreed that not-for-profit care is better than for-profit.

6. Could Americans adopt a national health system?

Devereaux suggested that, for the most part, Americans and Canadians share values, that Americans care about their fellow citizens and want to help the poor, but that Americans fear that, if they help the disadvantaged, they will compromise their own good health care even though this does not need to happen. Rodwin reassured people who fear egalitarianism that, even in national health insurance systems, "you can still, if you're at the top of the pile, get much better care than if you are at the bottom."

Third Forum: What Would "Medicare for All" Be Like?

The third forum was intended to deal with the practical as well as theoretical issues raised by the proposal to institute Medicare for All in the U.S. The panelists were

- Diane Archer, JD, a lawyer and the founder and past President of the Medicare Rights Center.
- Kevin Fleming, MD, a geriatrician at the Mayo Clinic and a critic of a single-payer system for the U.S., currently working in association with the Heritage Foundation.
- David Himmelstein, MD, a general internist, Associate Professor at the Harvard Medical School, and co-founder of PNHP.
- David Pratt, Professor of Law at the Albany Law School, an expert on Medicare law, and a former practicing attorney both in the United Kingdom and in the U.S.

1. What is Medicare?

Pratt from Albany Law School outlined the structure of Medicare A (hospital), B (outpatient), C (HMO), and D (medication). It currently covers people over age 65, people who have receiving Social Security disability benefits for at least two years, and people with end-stage kidney disease. It is an entitlement program, not (like Medicaid) a means-tested program.[22]

Archer from the Medicare Rights Center pointed out the strengths of Medicare. First, "it's guaranteed, automatic coverage," i.e. people don't have to sign up; as a result, 97% of all people who are eligible actually have it. "If you want everybody covered, you want to have a model where it's automatic coverage." Second, "people get to go basically to whatever doctor, whatever hospital they want. That's the kind of choice Americans want. That's what they get from Medicare." Third, "it's really insurance. You are protected from financial risk." You may need a lot of health care and I don't, but we both pay the same amount. "You're not punished for being sick." With private insurance, the more you need, the more you pay [except if there is "community rating," as is required

in New York state]. As a result, if "you need a lot of care, you're pushed into bankruptcy."[23] Fourth, "it's efficient. It's cost effective. Negotiating on behalf of 43 million people achieves way better efficiencies than private plans that are negotiating on behalf of a million, two million, or fewer people." Archer insisted that we know from survey after survey that the citizens, both Republicans and Democrats, love Medicare: it's gotten them the care they need and kept them from impoverishment.

Himmelstein from Harvard and PNHP pointed out several shortcoming of Medicare that need to be rectified. First, it doesn't cover everything that people need, such as nursing home care. Second, it has co-payments and deductibles that many people can't afford. Third, HMOs were brought into the middle of Medicare through part C: "they do nothing but waste money and make care worse." Fourth, the prescription drug program (Part D) is a mess: "it has been contracted out to private insurers who take a huge chunk for their pocketbooks and have restricted coverage," and in addition there are "giant co-pays." Archer agreed with Himmelstein that coverage should be expanded and that the Medicare Part D drug benefit is "unlike Medicare in every way," that it is a private insurance scheme and is in fact "emblematic of everything that's wrong with the private health insurance marketplace."

2. Would Medicare for All deliver on its promises?

Would it be desirable to expand Medicare so that it provided comprehensive services to all the population?

Fleming from the Mayo Clinic, the advocate of a true "private health care system" free from the current government "hyper-regulation" of insurance companies, attacked Medicare's deficiencies.[24] First, he complained that Medicare pays at such a low rate that "the fee I get for seeing somebody is insufficient to pay for the people who work for me, nurses, paying for the lights, basically all those kinds of overhead expenses." "If I were to only do Medicare," he declared, "I would go broke." His workplace as a geriatrician can stay open only through "the hugely generous donations of people who are quite wealthy." Similarly, he pointed out that for the 15 years up to 2003, physicians left Canada at a rate of 50-200 per year. Second, Fleming claimed that administrative costs of Medicare are low "because I must perform their administration for them. And so do the beneficiaries. You do all the paperwork for free, I do all the paperwork for free, they do nothing other than move a few of these pieces of paper around." Third, he pointed to the side effects of a single payer system: waiting in long lines, frequent strikes by doctors and nurses, shortages both of personnel and of the products and services people request, yearly increases in taxes, and giving away some of our freedom to choose. As shown in the UK, "if you want this program for everybody, you must agree that to limit costs we're going to have to ration. Especially those things," such as dialysis, "that older people now routinely get in Medicare."

In response, Archer pointed out that, since most doctors and hospitals across the country accept Medicare's rates, there are not long lines for Medicare. In contrast, people who sign up for HMOs wait "long periods of time to get referrals to specialists and get the care they need." And the private health insurers are deciding, *sub rosa*, all around the country that "people are too old to be worthy of heart transplants or dialysis at the age of 85 or 90." Himmelstein added that real wait times in Canada (in contrast to the fake survey on waiting lists done by a right wing think tank) are little different than for insured people in the U.S. (as shown by a survey done cooperatively by the federal governments in the U.S. and Canada).[25] Dialysis, for example, is as available in Canada as in the U.S. He charged that claiming that you give up your freedom to choose under a Medicare for All program is "empty rhetoric" since "in fact, every Canadian can go to any doctor in the country of Canada and any hospital, and every Medicare patient has a wider choice of doctors they can go to than I have with my private insurance plan or than anyone else in this room has with a typical private insurance plan."

Fleming responded that saying that people have a choice of doctors in a single payer plan is "a bit of a falsity": "You do have a choice to go to doctors, but what you won't have a choice on is what services and products you have available. It makes no difference if I can travel from here to California and see a doctor, if I can't get what I want done." The example is the number of people traveling to Minnesota to get their hips operated on because hip surgery is not in this year's budget in Canada.

Himmelstein responded that the actual number of patients coming to the northern tier U.S. hospitals is "trivial" and that Americans sometimes travel north because Canadians are the leaders in many fields of medicine.[26] He pointed out that Canadians have not in fact had "budget busting tax increases" because their costs have gone up more slowly than ours. If we took the Canadian style single payer system, call it Medicare for All, and double their per capita expenses, "we could deliver superb care to everybody in this country." Finally, Himmelstein argued that the decision to pay primary care physicians, like Fleming and him, at low rates and to pay some specialists at "princely rates" came from the medical establishment—from a commission dominated by the AMA—not from Medicare itself. He added that in 2004-2005 doctors are moving back from the U.S. to Canada.[27]

Pratt pointed out that employer-provided health insurance, "the centerpiece of the delivery of health insurance" for the last 60 years is "falling apart."[28] It was "a historical accident," and employers are anxious to get out of it because it's expensive and causes tensions with their employees (who blame the employer when they can't get the care they want or need). So Pratt predicted that "within a very short period of time," "the system is going to implode, and whether we want to or not, we're going to have to find a way of delivering care to those 150 million people who are not going to be getting it through their employers anymore."[29] He warned that "if we were to make Medicare for All work," one essential thing would be to try to free it from financial micromanaging by Congress and try to set up an agency that's relatively independent.

Fleming insisted that the future of Medicare, without some kind of private intervention, can best be described by what happens in nursing homes. Since they are almost entirely funded by government, government dictates the rules, and these rules are more extensive, he claimed, than for running a nuclear power plant. Nurses and physicians are refusing to work in them "because it's so hard and so difficult and so under-funded and so chronically short of everything."

3. Britain's National Health Service

Fleming pointed repeatedly to the deficiencies in Britain.[30] Pratt, who grew up there, was also critical of Britain: "The national health service, which has been born and died during my lifetime, is a shambles because they don't fund it adequately. But," he continued, "if you look at France, if you look at Canada, if you look at virtually every other developed country that has a universal payer system and actually funds it better, you don't get those little horror stories." Furthermore, Pratt objected to Fleming's analysis: "But the problem with the National Health Service is not the fact that it's centrally run, it's not the fact that it's a government program, it's under-funded. They don't put enough money into it. And you cannot provide adequate health care if you have no money." Himmelstein pointed out that the health of people in Canada and Britain has improved under single payer systems and is better than ours.[31]

Fleming responded that every centrally planned system is under-funded and will always be under-funded, unless you decide to keep care at today's level "so that there will be no new technology, no new services, no new innovation, no new medications." "The problem with the single payer program is it's going to set 1990s medicine as the floor and the ceiling, and nothing will ever change." He also pointed to the "massive shortage" of physicians that now faces the Canadians and us as an example of the failure of central planning, here as well in Canada (though Himmelstein objected that medical school class sizes in the U.S. are made by the medical schools themselves). In the UK, he suggested, administrative costs are too low: "they're under-funding even administration."

4. Could Medicare for All be a health insurance option?

Archer proposed offering an expanded Medicare to everyone as a health insurance option.[32] Given that some people like their private insurance, "the way to make the health care system work in this country is not to force people to give up what they have if they like it, but it's to demonstrate to them that there is another option and make that option available to anybody who wants it." People will choose Medicare because it will cost less. If private insurers are able to deliver better care to people, they will succeed and will compete with Medicare; if they can't, "then Medicare will become the insurer in this country."

Himmelstein responded that letting Medicare compete with private insurers will set up a competition that "the public system is sure to lose." First, "because the Congress always sets the playing field in favor of the private insurers" as they did by giving the Medicare HMOs tremendous financial advantages (Part C) and by subsidizing private insurers in Part D. Second, because "Medicare can't do what the private insurers do, which is that they avoid sick people and essentially shift those sick people onto the Medicare program. . . . What you're saying is, we'll pay for the sick people and then you pay for the healthy people, who are low cost, and you'll compete with us."

Archer responded that there is competition right now between traditional Medicare and private HMOs (in Part C) and traditional Medicare is "winning big time, hands down": the only reason 15% are in private HMOs is because we're overpaying them" (i.e. subsidizing them in Part C). When we get an enlightened Congress, she argued, it will realize that it should not be over-paying the HMOs. In addition, not just the sick would sign up for Medicare for All: "a lot of people would opt for Medicare if only because it gives them access to the doctors and hospitals they want anywhere in America and because it's less expensive."

Himmelstein was unconvinced, and added that allowing private insurances to persist means continuing "to throw away hundreds of billions a year in useless administrative costs" for two reasons. First, private plans have 14 or 15% overhead: "so for every dollar we pay in, we get 86 cents worth of care from Blue Cross; whereas, from Medicare and public insurance programs, we get 98 cents

worth of care."[33] Second, "when you've still got multiple insurance plans in the market, the hospitals and doctors have to maintain their billing offices to fight with the different insurance plans." He pointed out that Toronto General Hospital had 3 people in its billing office, Massachusetts General had 352, and that U.S. doctors have 2 people billing for each doctor in the country, while Canadian doctors don't need them. If we allow private competition along with Medicare, he argued, we will have to spend an extra $100 billion to cover everyone; if we don't, we will cover everyone and still save $200 billion. Archer agreed that it would be more efficient if everyone had Medicare, but cited the political realities: at the present moment, she asserted, Himmelstein's plan is a "pipe dream."[34]

5. What is the American way?

Pratt pointed out that, even if the American people would agree with people in Europe that all persons have "a right to decent health care," our political leaders are not willing to accept this. How then to arrive at universal coverage?

Fleming proposed a "federal approach"(as "the American approach"): "let 50 flowers bloom, or 51 if you count D.C." "I cannot see the fault in allowing and promoting and enforcing some form of coverage in every state, but letting the states try different things." Himmelstein agreed that "it would be reasonable to try programs as demonstration projects in a couple of states before we go with the national program" (as in Canada where Saskatchewan tried Medicare first).[35]

Archer objected: "I think it's only one step removed from every man for himself to call for every state for itself." The states have had 40 years to come up with plans and have failed miserably. She worries about the poorer states. She thinks that "we need to demonstrate that the federal government can be a force of good" (just as the Heritage Foundation has been challenging the effectiveness of government).[36]

Fourth Forum: Could We Institute "Medicare for All" in New York State?

In the fourth forum, the panelists were asked to assume that the New York legislature had passed a Medicare for All bill and to discuss the feasibility and desirability of setting this up. They were:

- Alexander B. ("Pete") Grannis, Chair of the Finance Committee of the N.Y. Assembly and co-sponsor of a bill to set up a single payer system in N.Y. State.
- Paul Macielak, JD, a lawyer and President and CEO of the New York Health Plan Association.
- Deborah Richter, MD, a family practitioner formerly in Buffalo, now in Vermont, past President of PNHP, and Chair of Vermont Health Care for All.
- Len Rodberg, PhD, Chair of the Urban Studies Department at Queens College and treasurer of the N.Y. Metro chapter of PNHP.
- Robert Scher, MD, making a second appearance, former Chief of Ophthalmology at Huntington Hospital and current President of the Medical Society of the State of New York.
- Elliott Shaw, director of government affairs and chief health care lobbyist for the New York Business Council.

1. What would Medicare for All in N.Y. be like?

The panelists were asked to assume that the N.Y. legislature had passed and the governor had signed, in the words of Chartock the moderator, "a law that entitles every New York resident to comprehensive health care through a single payer financing mechanism" and to discuss whether and how it would be possible to implement it and whether implementing it would benefit New Yorkers. The supposition was, as Assemblyman Grannis put it, that, with 3 ½ million New Yorkers without health care coverage and many more under-insured or struggling to pay for their insurance, New York got tired of waiting and watching "the federal government fumble the ball."[37] Grannis described the single payer bill he was co-sponsoring with Assemblyman Gottfried, the chair of the assembly health committee, as "a comprehensive health care plan paid for with a combination of payroll taxes, redirection of Medicaid money and other public monies that go into our programs, our bad debt and charity care money, and many other government sources of funds for our many, many programs." Even after paying off "shareholders and everybody else that has to profit from these managed care plans that are operating today in New York," "the payroll tax will end up being less expensive for employers and for self-employed individuals than their current health care costs because it will not include all of the administrative costs." The plan will be administrated "through a public benefit corporation" with representatives from "consumer advocacy organizations, the professionals, the people who will pay for this system, the people who use the system."[38]

Rodberg from CUNY explained why this could be done in one state. First, New York's 18 million people would make it "the largest risk pool in the country other than Medicare," "certainly enough of a pool to provide this spread of risk that you need in a good insurance system." Second, savings in addition to the administrative costs of insurance companies would come from eliminat-

ing "the redundant billing systems that the hospitals have to maintain, that every physician's office has to maintain." Third, "most importantly, it would provide us with a mechanism for controlling the cost of the system, which we don't have now and which is what really scares everybody" today.

Macielak from the New York Health Plan Association pointed to the legal issues preventing the institution of a state-level single payer system, asserting that neither Medicare nor ERISA self-insured companies could participate.[39] Richter responded that, while ERISA legislation prevents the state from telling self-insured employers what benefits they have to provide, it does not prevent the state from taxing these businesses. She added that, while the state cannot mandate what rates Medicare pays, it could standardize rates so that the system reimburses at Medicare rates. Macielak replied that this was taking "a simplified approach" and that it was unrealistic to think that large employers in N.Y. would be willing to pay a tax in addition to paying for their employees' health insurance. Grannis reassured Macielak that the bill under consideration had addressed these concerns. But Macielak later reiterated that neither Medicare nor self-insured companies would be able to participate in the single risk pool imagined by single payer advocates.

2. Would Medicare for All save money or cost more?

Shaw from the New York Business Council was skeptical about the finances. "How long will the tax rate that we set in the law remain at that level? And how will the spending projections hold up?" He cited the history of increases in Medicaid costs. Macielak too pointed to Medicaid as a model we would not want to emulate. Grannis responded to Shaw that the aging of the population is bound to lead to a rise in costs[40]: "We're going to experience extraordinary pressures on our health care system, and the best time to deal with this is now." Especially, he added, "if we're going to compete in the global economy effectively" and if "we're going to be able to have a workforce that can carry out the duties that the Business Council members think are so important." Shaw replied that the business community is well aware of the problems, but does not think single payer is the way to solve them: "the fact of the matter is that our Medicare system is terribly under-funded and is on bad financial footing."[41] He doubted that "government" could "run this program on its own through a taxing program and a spending program." Richter responded that "the idea that somehow Medicare is under-funded is really a myth": we are spending "twice as much as any other industrialized nation spends per person, but we are wasting money on unnecessary administration." Furthermore, she added, a single payer system would pool the contributions from both the young and healthy and from the old and sick: with one pool, there would be more than enough money "to fund a universal health care system."

Macielak argued that it is untrue that Medicare is more efficient than the private sector: as shown in a study by the Council for Affordable Health Insurance, Medicare administrative costs are actually much higher than claimed.[42] In addition, the health insurance companies "provide the services the government has not thought of, or has been unable to provide to date," in particular, they have been the innovators in "health care management" (disease management, quality measurement, transparency). In response, Scher from the Medical Society of the State of New York, pointed to the 1.6% overhead in Canada,[43] and Richter questioned that funneling the money to finance health care "through hundreds of insurance companies with various ways of skimming money from us" was truly a "service." Reiterating early points, Richter pointed out that the administrative costs in question involved not only insurance companies but also hospitals and doctors' offices "that have to hire armies of people to collect the money to keep their doors open."[44] It makes sense to have, as in other countries such as England, Japan, and Canada, a single risk pool with "one set of rules and everybody covered."

3. Would Medicare for All benefit businesses?

Grannis pointed out that the current employer-based health insurance system is not working: "It's 2006, we have 3½ million people without insurance, a million of those people are working New Yorkers, working for small employers that can't afford or have chosen not to provide health care coverage."[45] With health care costs moving up rapidly, the small employers "are looking for ways to offload health care costs," e.g., by making people pick up more of the costs themselves (under "the completely wrong assumption" that "somehow Americans are aware of the health care costs and will use health care more wisely if they have to pay more for it"). Scher reviewed the origin of employer-based insurance as an employee benefit during the Second World War and pointed out that now only 60% of companies provide health insurance.[46]

Richter pointed out to Shaw that the single payer law would be an advantage from the business community perspective. It would put more money in the pockets of poor and middle-class consumers (since they currently spend a larger percentage of their income on health care than do wealthier people), and their increased spending on consumer goods would have a multiplier effect on the economy. She pointed out that taxes already pay for 60% of health care spending (in form of Medicare, Medicaid, public employee's health insurance, and various

tax subsidies)[47] and reiterated that a single payer system provides a mechanism to control costs.

4. Would N.Y. physicians welcome Medicare for All?

Scher stated that physicians would look favorably on Medicare for All in New York.[48] First, he argued that physicians would welcome "a single set of rules, one set of forms, nobody in the back office" in place of the different interfaces with each managed care company.[49] Second, he pointed to the increasing consolidation of health insurance companies, so that, for example, in New York State, 75% of the population is under the control of only 7 health insurers[50]: "The physician is the advocate for his patient, or her patient. And it is not easy for us to do that when there is a goliath on the other side. And, if this [single-payer] system levels the playing field for the physician to advocate for his patient or her patient, it would be a very, very good thing." Rodberg added that the physicians, as well as the business community, would be in better positions when "the spending and the fees are politically determined." Whereas when facing insurance company goliaths, physicians have no negotiating power, they have demonstrated, Rodberg asserted, that in politics they are very effective both in N.Y. State and nationally.

But Macielak warned Scher that the single payer model "would create a monopoly of one payer that would dictate to you your level of reimbursement" and that would diminish "your ability to negotiate with that payer." He pointed to the physician strikes and physician brain drain that occurred in Canada.[51] Scher responded later, "If a single payer system came in, there would probably be something like a negotiation between the payer system and the physician, where the physician would be the one who is advocating for you, not an intermediary with administrative costs." When Chartock reminded him of the physicians' difficulties with Medicare's policy of trying to lower its reimbursements to physicians,[52] Scher responded that each time physicians have been able to prevent the fee contraction because "you can talk to Medicare and you can talk to the government" because legislatures are enacting the rules: "to talk to a goliath is one thing, to talk to your government, which is a bigger goliath but which is representative of you, that's a different story."

Grannis added, from his experience listening to physicians' complaints as head of the insurance committee, that managed care contracts with providers are extraordinarily one-sided, overbearing, and arbitrary; that doctors have no ability to negotiate; that "it's a take-it or leave-it proposal" that they cannot refuse because they are then not part of the provider network and "their practice can't survive without insurance reimbursements." When we worry about "who is going to dictate to the providers," Grannis, like Scher, is more comfortable with "this collaborative effort that goes on in Medicare today" than with "the contracting process" used by insurance companies.

5. Is Massachusetts a model for New York?

Grannis argued that health care delivery is not "a partisan issue": all parties need to come to the negotiating table and "everybody has to agree on what the best approach is." Like Shaw, he welcomed the effort of Massachusetts to find a new approach. It had recently, in Richter's words, "enacted a bill that would mandate that everyone would have to have insurance."[53]

Richter charged that this insurance will not be affordable for those who are sick. It will, therefore, never work because "the whole goal in the private insurance industry is to get as many healthy people as you can" and "avoid the sick people," the 10% of the population that uses 70% of the health care dollar. Macielak pointed out that N.Y. state requires health insurers to offer insurance to everyone at the same rate and that, as a result, applying the Massachusetts model to New York is not "as outlandish or outrageous" as she portrayed it. Subsidies would enable the poor to purchase insurance, as is proposed in Massachusetts and as takes place already in New York. But Grannis later again charged for-profit insurance companies in New York with "cherry picking, avoiding risks" as well as, based on his own experience running an insurance company, with avoiding paying claims.

Shaw described the scene of Ted Kennedy standing behind Mitt Romney as he signed the bill and asked the panel and the audience, "Who's going to be a leader—to lead us towards some shared sacrifice?" In Massachusetts, "one of the pills that the business community swallowed was a tax on employers who don't provide health insurance coverage for their workers." Grannis pointed out, however, that this tax was only $280 per employee, "hardly a bitter pill." Shaw pointed to a second "shared sacrifice": conservatives had to accept individual mandates.[54]

6. Who will lead the way to reform?

When asked by Shaw to say "who will lead us," Grannis responded, "it's going to be government." It won't be the business community. It won't be shareholder-driven companies. He pointed to the example of Oregon where government "bit the bullet" to ration health care by setting up a priority list of procedures that Medicaid would pay for. Shaw responded: "Count me as skeptical. That's the same government who brought us Medicare, Part D."[55] And Macielak argued that, in his experience in government, it "doesn't have much of an appetite to ration care." He continued, "frankly, that, I

think, is a function that health plans provide that government is more than happy to have provided by someone other than themselves."

Rodberg, however, did look to the business community to play this leadership role, because "forward looking business people have throughout American history seen that there are certain roles that government can play better than private business and can help private business" (such as creating the post office and regulating the railroads). "The business community is at least as effective politically in N.Y. State as the physicians are and will see that the financing [of N.Y. Medicare for All] is done rationally and will help the economy of the state as a whole." Thus he envisioned "an active citizens' movement for affordable health care for all" in combination with "an enlightened business community," hospital administrators, and physicians, all seeing that "we will all be better off with health care seen as a public responsibility and a right of every resident of this country."

Grannis, like Richter, contended that, when the people have had enough, when they cannot afford health care and are tired of seeing their doctors "second-guessed by shareholders and bottom-line companies that build up reams and reams of costly files . . . , they will rise up and demand that government institute the changes that will make our health system better."

All the panelists thought that change was coming in New York, even if not the single payer system under scrutiny today. Richter, Rodberg, and Grannis expected some version of Medicare for All, and Scher would welcome it. Macielak expected a change that, as in Massachusetts, "builds on the existing system" but "looks to expand it to provide additional coverage." Shaw insisted that "we have to get away from the corners we're all in, we have to come to the middle." Where that middle ground might be found—between the ideas of a publicly-funded single-payer system and a system based on multiple private insurers—was not clear.

Lessons of the Forums

Medicare for All—universal comprehensive health coverage financed through a single payer system—involves both expanding the services covered by Medicare[56] and bringing everyone into it. It is often dismissed as politically impossible (as suggested by Dr. Lazarus in the first forum)[57] or is presented as a bogeyman, what we will end up with if we don't watch out (for example, the Stanford University health economist Alain Enthoven, bemoaning in 2004, "It is late, probably too late, to avert the inexorable progression to 'Medicare for All'"[58]). A major purpose of the WAMC forums was to get Medicare for All on the table and to get intelligent and knowledgeable experts of varying points of view to discuss seriously its pros and cons.

The lessons of the four forums include the following. First, all sides want to provide all Americans with access to needed health care, or at least they are unwilling to admit they do not want this. The issue is how to achieve this universal access (and how long to continue to let people fall through the cracks). Second, all sides seem to be willing to see states experiment with different plans, even a single-payer plan (at least as long as it is not in their state). Third, as shown in the third and fourth forums, it is very difficult to get people beyond statements of principles and ideology—to grapple with practical issues of what might actually happen if we tried to institute a single-payer or another fundamental reform. The format of a public round-table was, of course, partly responsible because it favored short, ideological statements over the presentation of detailed, logical, and empirically-support arguments. Fourth, many of the disagreements were, nonetheless, over concrete facts, e.g., how many patients are coming to the U.S. from Canada, or does ERISA actually prevent multi-state companies from participating in a state plan? These disagreements could be resolved by obtaining the needed information. Fifth, in spite of the appeal of Elliott Shaw in the final panel, it may be impossible to expect people who disagree on fundamentals to give up something to achieve a concrete reform when, to achieve any consensus, this something would have to include what they see as fundamental. The issues here are both ideological and institutional: they involve the tension between individual interest and social solidarity, the role of government and other public authorities in our lives, the limits of private enterprise, and the very existence—or at least the central role—of the private health insurance industry.

When the newly elected U.S. Congress, New York Legislature, and New York Governor confront the increasing dysfunctions of our health care system, they will not, therefore, be able to find solutions that will please all sides. They will need to look seriously at the option of instituting the plan for "Medicare for All" that was debated at these forums.

Endnotes

1. Information about the Physicians for a National Health Program can be found at www.pnhp.org and about the Capital District chapter at http://capitaldistrictpnhp.blogspot.com.
2. The latest estimate by the U.S. Census Bureau of the uninsured in 2005, i.e. the number of people who did not have health insurance at any time during the year, is 46.6 million (15.9%) in 2005: http://www.census.gov/hhes/www/hlthins/hlthin05.html. Todd Gilmer and Richard Kronick argue that, without a substantial increase in public coverage, the number of uninsured can be expected to rise to 56 million in 2013: It's the premiums, stupid:

projections of the uninsured through 2013. Health Aff. 2005; w5-143-51. The Commonwealth Fund team estimates that in 2003 nearly 16 million people ages 19-64 were underinsured: Schoen C, Doty MM, Collins SR, Holmgren AL. Insured but not protected: how many adults are underinsured? Health Aff. 2005; w5-289-302.

3. The estimate of deaths was made by the Institute of Medicine in its 2004 report, Insuring America's Health: Principles and Recommendations; the summary is available at http://www.iom.edu/CMS/3809/4660/17632.aspx?printfriendly=true.

4. Subsequently the AMA adopted a policy in favor of requiring non-poor individuals to purchase health insurance: http://www.ama-assn.org/ama1/pub/upload/mm/372/a-06cmsreport3.pdf. The need for adequate tax credits (focusing on the Bush administration' proposal) is argued by Rescholvsky JD, Hadley J. The effect of tax credits for nongroup insurance on health spending by the uninsured. Health Aff. 2004; w4-113-27. Another plan based on individual mandates is by Leif Wellington Hause of The Century Foundation in A New Deal for Health: How to Cover Everyone and Get Health Costs under Control. New York: The Century Foundation Press, 2005, available at http://www.tcf.org/Publications/HealthCare/newdealhealth.pdf. Victor Fuchs and Ezekiel Emanuel argue for an alternative to individual mandates, universal vouchers, in Emanuel EJ, Fuchs VR. Health care vouchers—a proposal for universal coverage. N Engl J Med. 2005;352:1255-60. See also their discussion of the alternatives in Fuchs VR, Emanuel EJ. Health care reform: Why? What? When? Health Aff. 2005;24:1399-1414.

5. This issue is discussed at greater length on p. 20 of Expanding Health Insurance: The AMA Proposal for Reform (2005), available at http://www.ama-assn.org/ama1/pub/upload/mm/363/ehi0705.pdf.

6. In addition, the National Center for Policy Analysis released subsequently a report by Greg Scandlon pointing out that, although all but 3 states mandate auto insurance, 14.6% of American drivers were uninsured in 2004: http://www.ncpa.org/pub/ba/ba569/ba569.pdf.

7. John Geyman gives the following estimates for overhead in Geyman JP. Myths and memos about single-payer health insurance in the United States: a rebuttal to conservative claims. Int J Health Serv. 2005; 35:63-90: Medicare 3.1%, non-profit Blues 16.3%, commercial carriers 19.9%, and investor-owned Blues 26.5%. See also Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. N Engl J Med. 2003; 349:768-75. Henry Aaron argues for a smaller difference in Aaron HJ. The costs of health care administration in the United States and Canada—questionable answers to a questionable question. N Engl J Med. 2003; 349:801-3. But James Kahn and colleagues calculated that billing and insurance-related functions represent 20-22% of privately insured spending in California acute care settings (and adding other administrative costs brings the total to 25%): Kahn JG, Kronick R, Kreger M, Gans DN. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. Health Aff. 2005; 24:1629-39.

8. This argument, repeated in the 4th panel, is based on, or at least supported by, Merrill Matthews of the Council for Affordable Health Insurance, in a report available at http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf. Matthews argues that the overhead is actually 5.2% if hidden administrative costs are included and 6-8% if adjustments are made for the higher expenditures of Medicare patients.

9. The Census Bureau's report on 2005 (cited in note 2 above) gives uninsured rates by age group: under 18 years 11.2%, 18-24 years 30.6%, 25-34 26.4%, 35-44 18.8%, 45-64 14.6%, and 65 years and older 1.3%.

10. The Canadian Institute on Health Affairs presents the facts about the contentious issue of wait times in Waiting for Health Care in Canada: What We Know and What We Do Not Know (2006), available at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1385_E. The widespread conviction in the US about wait times elsewhere is based on such articles as Coyte PC, Wright JG, Hawkes GA, et al. Waiting times for knee-replacement surgery in the United States and Canada. N Engl J Med. 1994; 331:1068-71.

11. John Hadley and John Holahan, in Covering the Uninsured: How Much Would It Cost? Health Affairs 2003; W3:250-65, estimate a cost of $33.9-68.7 billion in 2001 dollars of additional health care expenses if the uninsured were provided with health insurance. David Himmelstein, Steffie Woolhandler, and Sidney Wolff calculated that administrative expenses would consume at least $399.4 billion out of total health expenditures of $1,660.5 billion in 2003 and that streamlining administrative overhead to Canadian levels would save approximately $286.0 billion: see http://www.citizen.org/publications/release.cfm?ID=7271&secID=1158&catID=126. In addition, Wilhelmine Miller, Elizabeth Richardson Vigdor, and Willard G. Manning estimate that the economic losses resulting from uninsurance are $60-130 billion each year: Covering the uninsured: what is it worth? Health Aff. 2004; w-4-157-67.

12. The failure of the Clinton health plan has been attributed to a variety of factors. See, for example: Mechanic D. Failure of health care reform in the USA. J Health Serv Res Policy 1996; 1:4-9.

13. Oregon's efforts to allocate the Medicaid budget to those services rated by the community as most beneficial have been much discussed: Hadorn DC. Setting health care priorities in Oregon. Cost-effectiveness meets the rule of rescue. JAMA 1991;265:2218-25. Tengs TO, Meyer G, Siegel JE, Pliskin JS, Graham JD, Weinstein MC. Oregon's Medicaid ranking and cost-effectiveness: is there any relationship? Med Decis Making 1996; 16:99-107. Blumstein JF. The Oregon experiment: the role of cost-benefit analysis in the allocation of Medicaid funds. Soc Sci Med 1997; 45:545-54.

14. When an ABC News/Washington Post poll in October 2003 asked people if they would prefer a "universal health insurance program, in which everyone is covered under a program like Medicare that's run by the government and financed by taxpayers" or "the current system, in which most people get their health insurance from private employers, but some people have no insurance," 62% preferred a universal health insurance program and 32% the current system. But support for universal coverage dropped to 39% if it meant waiting lists for some non-emergency treatments and to 35% if the system limited choice of doctors. The poll results are available at http://abcnews.go.com/sections/living/US/healthcare031020_poll.html. In a 2004 poll, 84% agreed that the government should ensure funding for health care for all children and 87% for all the elderly (without further specification): Beck ML, Schur CL, Chang DI, Knight ER, Kleinman LC. Americans' views about the adequacy of health care for children and the elderly. Heatlh Aff. 2004; W4-446-454. Similarly, in the 2005 poll for the Pew Forum on Religion and Public Life, people favored 2:1 a government guarantee of health care for all: http://pewforum.org/docs/index.php?DocID=115. In the 2005 Commonwealth Fund survey, 20% indicated that the US health care system needs only minor changes, 46% that it needs fundamental changes, and 30% that it needs to be rebuilt completely: http://www.cmwf.org/usr_doc/Schoen_publicviewsfuturehltsystem_948.pdf. The recent Pace University poll of New Yorker residents in October 2006, available at http://www.wnyc.org/blog/lehrer/archives/files/PacePoll.pdf, asked people to choose between New York requiring people to purchase health insurance (with government paying for those who cannot afford it) and New York creating "a government-

run health care system to replace private insurers and provide health insurance to everyone." Twenty-two percent were strongly and 13% somewhat (total 35%) in favor of purchasing private insurance; 29% were strongly and 19% somewhat (total 48%) in favor of creating a government-run system. The complexity of the public's positions is discussed by Ruy Texeira of The Century Foundation in What we think about universal coverage (2005), available at http://www.tcf.org/list.asp?type=NC&pubid=1104. See also Bodenheimer T. The political divide in health care: a liberal perspective. Health Aff. 2005; 24:1426-35.

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28. The 2005 Health Confidence Survey by the Employee Benefit Research Institute found that 59.8% of Americans were covered by employment-based health benefits in 2004, in comparison with 63.6% in 2000: http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-20051.pdf. The J. Kaiser Family Foundation/Health Research and Educational Trust survey reports a greater decrease, from 69% in 2000 to 60% in 2004: Gabel J, ClaxtonG, Gil I, et al. Health Benefits in 2005: premium increases slow down, coverage continues to erode. Health Aff. 2005; 24:1273-80.

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31. For Canada, see *supra* note 25. For the United Kingdom, see Banks J, Marmot M, Oldfield Z, Smith JP. Disease and disadvantage in the United States and in England. N Engl J Med. 2006; 295:2037-45. Also Schoen C, Doty MM. Inequalities in access to medical care in five countries: findings from the 2001 Commonwealth Fund International Health Policy Survey. Health Policy. 2004; 67:309-22.

32. Jacob Hacker of Yale has a similar "Medicare Plus" proposal, described at http://pantheon.yale.edu/~jhacker/Medicare%20Plus.pdf.

33. See *supra* note 7.

34. The charge that a single payer system is politically impossible is common in informal discussions and in print: e.g., Oberlander J. The politics of health reform: why do bad things happen to good plans? Health Aff. 2003;w3-392-404.

35. Henry Aaron of the Brookings Institution and Stuart Butler of the Heritage Foundation call jointly for states to "try widely differing solutions with federal support": How federalism could spur bipartisan action on the uninsured. Health Aff. 2004; w4-168-78.

36. See *supra* note 24 about the Heritage Foundation.

37. The Kaiser Family Foundation determined that 15.1% of the nonelderly in New York were uninsured in 2004-5 (compared to 17.7% nationally): The Uninsured: A Primer. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2006. Available at http://www.kff.org/uninsured/upload/The-Uninsured-A-Primer-PDF.pdf.

38. The Gottfried bill, A06576, to create a New York Health Plan can be read at http://www.assembly.state.ny.us/leg/?bn=A06576.

39. Basic information on ERISA, the Employment Retirement Income Security Act, is available at http://www.dol.gov/dol/topic/health-plans/erisa.htm, Details are available at http://benefitslink.com/erisa/crossreference.html.

40. See *supra* note 2 for a projection of the rise in health care costs.

41. The underfunding of Medicare—inevitable as the relative size of the Medicare population, the cost of health care, and the coverage of services all grow—is repeatedly trumpeted by opponents of Medicare such as Stuart Butler of the Heritage Foundation (see *supra* note 24).

42. See *supra* note 8.

43. On overhead in Canada, see Woolhandler and colleagues, *supra* note 7.

44. Administrative expenses in physicians' offices and hospitals in California are calculated by Kahn JG, Kronick R, Kreger M, Gans DN. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. Health Aff. 2005; 24:1629-39.

45. See *supra* note 37 on uninsured in NY.

46. See *supra* note 28 and 29 on the erosion of employment-based insurance.

47. The cost of tax-exempt health benefits is detailed in Shells J, Haught R. The cost of tax-exempt health benefits in 2004. Health Aff. 2004;w4-106-12. See also Woolhandler S, Himmelstein DU. Paying for national health insurance—and not getting it. Health Aff. 2002;21:88-98.

48. In a national survey in 2002, 49% of physicians supported governmental legislation to establish national health insurance, but only 26% supported a plan in which all health care is paid for by the federal government: Ackermann RT, Carroll AE. Support for national health insurance among U.S. physicians: a national survey. Ann Intern Med 2003; 139:795-801. In Massachusetts, however, the majority of physicians in 2003 supported a single-payer system: McCormick D, Himmelstein DU, Woolhandler S, Bor DH. Single-payer national health insurance. Physicians' views. Arch Intern Med 2004; 164:300-4.

49. The classic complaint was by Grumet GW. Health care rationing by inconvenience. The third party's secret weapon. N Eng J Med, 1989; 321:807-11. The broader issue of physician dissatisfaction is discussed by Zuger A. Dissatisfaction with medical practice. N Engl J Med, 2004; 350:69-75.

50. The AMA's report on market consolidation: See also Robinson JC. Consolidation and the transformation of competition in health insurance. Health Aff 2004; 23:11-24.

51. In Canada, see *supra* note 27 about departures of physicians. The initial introduction of Canadian Medicare provoked physician strikes. In France and Germany, physicians have gone on strike to protest changes and to demand better reimbursements; see, for example, Sorum PC. Striking against managed care: the last gasp of *la médecine libérale?*. Letter from France. JAMA. 1998; 280:659-64.

52. Organized medicine is repeatedly involved in pressure to reduce the declines in reimbursement required by the payment formula of the Balanced Budget Act of 1997 that requires no increases in total compensation to physicians above "the sustainable growth rate." The law is available at http://thomas.loc.gov/cgi-bin/query/z?c105:H.R.2015.ENR:.

53. See Turnbull NC. The Massachusetts model: an artful balance. Health Aff. 2006; 25:w453-6.

54. For conservative criticism of individual mandates, see the analysis by Greg Scanlen of the National Center for Policy Analysis: Will mandatory insurance work? Brief Analysis, no. 569. Available at http://www.ncpa.org/pub/ba/ba569/.

55. Medicare Part D is explained by Altman DE. The new Medicare prescription-drug legislation. N Engl J Med. 2004; 350:9-10. It is discussed on Public Health Radio at http://www.publichealthradio.org (programs 62 and 63).

56. A first step is proposed by Davis K, Moon M, Cooper B, Schoen C. Medicare Extra: a comprehensive benefit option for Medicare beneficiaries. Health Aff. 2005; w5-442-54.

57. See *supra* note 34 on charge of political infeasibility.

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A Blueprint for Universal Health Insurance Coverage in New York*

By Danielle Holahan (United Hospital Fund), Elise Hubert (United Hospital Fund) and Cathy Schoen (The Commonwealth Fund)

Executive Summary

This report presents the *Blueprint for Coverage in New York,* a project undertaken by the United Hospital Fund and The Commonwealth Fund to explore options for achieving universal health insurance coverage in New York. We developed approaches that would address the specific characteristics of New York's 2.8 million uninsured and establish a more secure foundation of coverage for all New Yorkers. We explored a combination of voluntary public program reforms, premium subsidies to make coverage more affordable, a new group insurance purchasing mechanism, and employer and individual mandates to reach these goals. While these changes could be made individually, when implemented together they would achieve universal coverage and improve coverage options for the insured to provide a more stable health insurance system for all New Yorkers. We present the estimated costs and coverage impacts of these expansion scenarios as prepared by The Lewin Group using its Health Benefits Simulation Model.

Our approach is designed to be implemented as a series of "building blocks" with which reforms would first be made to public programs, to increase participation rates and make affordable coverage available to a greater share of low- and moderate-income persons. Specifically, we would simplify public program rules to enroll those who are currently eligible but uninsured, expand Family HealthPlus (FHP) eligibility for childless adults, and allow low-to-moderate-income New Yorkers to "buy in" to FHP with income-related premium assistance. With the introduction of the buy-in, New York would implement a new statewide purchasing mechanism—an "Insurance Exchange"—that would provide individuals with a choice of additional coverage options at group rates. These changes would lay the foundation for other reforms.

The following policy changes were modeled:

- **Public Programs.** Simplification and expansion of existing public programs with three components:
  - Simplification of public program rules to ease enrollment and renewal in order to increase participation rates among eligible but uninsured persons;
  - Expansion of Family HealthPlus eligibility for childless adults to 150 percent of the federal poverty level (FPL);
  - Subsidized buy-in to FHP so that affordable coverage is available to more moderate-income New Yorkers (up to 300 percent FPL);
- **Insurance Exchange.** Implementation of a new purchasing entity for individual purchase of coverage at pooled group rates;
- **Employer Requirements.** Two variations of assessments on employers with 10 or more employees that do not offer health insurance:
  - A modest employer assessment of $400 per worker per year;
  - An employer "pay-or-play" assessment of 8 percent of payroll or a credit toward this assessment for coverage offered (on average, the assessment would be $3,200 per worker);
- **Individual Mandate.** A requirement that all residents purchase health insurance coverage, with income-related premium assistance.

Summary of Findings

The modeling results indicate that implementing the simplification, FHP expansion, and FHP buy-in together ("combined public program changes") would achieve only a one-third reduction in the uninsured, and leave two million uninsured New Yorkers. In addition, the availability of subsidized coverage through the FHP buy-in would improve the affordability of coverage for currently insured low-to-moderate-income individuals and families, compared with what is currently available through employer-sponsored insurance (ESI) and non-group insurance. As a result, there would be a significant shift from ESI and non-group insurance into this new coverage option. We therefore explored mandatory coverage scenarios, including requirements for employers to offer coverage, contribute financially toward the cost of coverage, or both—as well as mandates on individuals to purchase coverage. Ultimately, an individual mandate is required to achieve universal coverage.

The costs of such reforms are borne by government, employers, and families and are distributed differently

depending upon the specific approach. Scenarios that do not include any employer requirements would result in significant shifts out of employer-sponsored coverage into new subsidized options available through the Insurance Exchange, without any new sources of financing for this shift. This would place the burden of new spending on the state and families, and ultimately result insignificant net savings to employers.

As this analysis makes clear, only policy options with individual mandates achieve the goal of universal coverage. Among these options, those that require some shared responsibility from employers achieve greater equity among employers, limit erosion of employer coverage, and reduce state fiscal responsibility. Two options, therefore, bear special scrutiny: 1) the combination of public program expansions, individual mandate, and a modest employer assessment, and 2) the combination of public program expansions, individual mandate, and employer pay-or-play.

Universal Coverage: Individual Mandate and Modest Employer Assessment

This option for universal coverage is modeled closely on the 2006 Massachusetts Health Reform law. This policy scenario includes public program reforms (as described above), a modest assessment on employers of $400 per worker for firms with more than 10 workers, and an individual mandate. Our modeling results indicate that this combination of policy reforms would:

- Cover 2.4 million uninsured New Yorkers, achieving a 98 percent coverage rate.
  - The individual mandate would compel a significant increase in take-up of available public and employer-sponsored coverage, driving the reduction in the number of uninsured.
  - The employer assessment, because it is small, would not provide an incentive for many employers to newly offer coverage, and so there would be no direct impact on coverage rates from the assessment itself.
- Result in a shift of people from employer and non-group coverage into public programs and the Exchange, due to the availability of subsidized coverage;
- Raise $400 million in revenues to offset the state's cost of the coverage expansions;
- Result in a net cost of $4.1 billion. This includes, by payer
  - New York State. Increased spending of $5.5 billion, mostly for subsidies in the Exchange;
  - Federal government. Increased spending of $1.2 billion in matching payments for currently eligible public program enrollees;
  - Families. Increased spending of $600 million because of premium requirements in the Exchange; and
  - Employers. Savings of $3.2 billion because some employers currently offering coverage would drop it with the availability of subsidized coverage in the Exchange.
    - Currently insuring employers would save $3.6 billion;
    - Currently non-insuring employers would spend $400 million more than under current law.

Universal Coverage: Individual Mandate and Employer Pay-or-Play

This universal coverage option is modeled on a "Creating Consensus" proposal that shares responsibility among employers, as well as with federal and state governments and individuals. In addition to public program expansions for low-income individuals, it includes both an individual mandate and an employer pay-or-play contribution. The employer pay-or-play policy assessment (8 percent payroll assessment on firms with more than 10 workers) is comparable to the typical contribution toward an individual premium by employers that finance health benefits for employees. It would encourage a greater number of employers to continue to offer coverage directly than the more modest assessment, and would provide a source of financing to support the cost of other reforms.

The policy would reduce the number of uninsured by 2.4 million, as would the modest employer assessment combined with public program expansion and the individual mandate. However, it would reduce state outlays from $5.5 billion under the modest employer assessment to $4 billion under the employer pay-or-play option. Employers would save $600 million overall relative to the current system of financing. Currently insuring employers' costs would decrease by $1.7 billion because some would drop coverage and pay the assessment as a result of low-wage worker subsidies, while employers that do not currently finance coverage would see an increase in spending of $1.1 billion on newly offered coverage or assessments. Families would save $300 million compared with current law.

A key issue in making universal coverage work is whether or not New York has sufficient money to finance it. Financing options include redirecting uncompensated

care subsidy funds (an estimated $1.3 billion in state and local payments), tapping employers for contributions, seeking federal financial participation for the FHP expansion and buy-in, and raising the residual funds required.

Ultimately, universal coverage would eliminate the most significant source of inequity and inefficiency from the health care system and would provide a foundation for making large-scale improvements. Coverage would allow formerly uninsured persons to access services more easily and receive timely and appropriate care. Providers would be reimbursed directly rather than through indirect subsidies, and linking payments to people would allow for a greater level of accountability in the system. Further, significant enrollment in the Exchange could make it a vehicle for driving cost control and quality reforms. Once all persons are covered, the state can approach system change to achieve the most comprehensive and effective solutions to the enduring challenges of the quality and cost of care. Universal coverage is a significant achievement in its own right. It is also a fundamental step toward realizing a high-performance health care system.

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The Ongoing Angst Between Health Plans and Nonparticipating Providers*

By Whitney Magee Phelps and Jeffrey Gold

I. Introduction

How much should a provider be paid for out of network services rendered when the provider does not have a contractual relationship with a health plan? This question continues to receive attention both in New York and throughout the country and the search for answers continues.

In part, the answer to how much compensation will be paid depends significantly on whether the payer is administering a government-sponsored product or a commercial product, and on whether the type of services rendered were for emergency or non-emergency services. Because both the federal and New York State governments have enacted legislation that applies to government-sponsored products, there is some clarity regarding the payment rates for nonparticipating providers.[1] With regard to commercial products, however, the guidance is less clear.

This article will discuss the applicable rules that determine the compensation owed by health plans to nonparticipating providers both for emergency services and non-emergency services for the various health plan products. We will also look at decisions from other jurisdictions for insight into how New York courts may handle questions, which as of yet, are unresolved in New York.

II. Background: The Obligations of Plans and Providers

A. Emergency Services

In New York, pursuant to both federal and state law, providers are obligated to treat patients who present for emergency services. Emergency Departments in Medicare participating hospitals are required by the Emergency Medical Treatment and Labor Act (EMTALA) to provide a medical screening and stabilizing treatment to all patients regardless of ability to pay.[2] In addition, New York law requires hospitals to admit, as quickly as is practicable, patients in need of immediate hospitalization without asking for insurance information.[3]

Health plans are obligated to pay for these services pursuant to New York's mandated benefit laws, which require all health plans that provide for inpatient care to also provide for emergency services.[4] Also, New York prohibits the denial of any emergency services necessary to treat and stabilize an emergent condition.[5] In addition, the Medicaid Managed Care and Family Health Plus Model Contract ("the Model Contract"), the contract between the New York State Department of Health and health plans for the management and administration of Medicaid managed care and Family Health Plus, specifies that health plans are required to pay for emergency services whether or not the services are performed by a provider within the managed care organization's network.[6] Moreover, health plans are expressly prohibited from requiring providers to seek authorization from a health plan before rendering emergency medical services.[7] As a result, where a health plan and provider do not have an express written agreement in place for the provision of services, the question of how much the nonparticipating provider is entitled to be paid by the health plan for emergency services provided, often arises.

Plans generally must pay for emergency services provided by a nonparticipating provider up to the point of stabilization, and nonparticipating providers must treat the plan's member up to the point of stabilization before either transferring the patient to a participating provider or seeking authorization from the plan for any necessary continued services.[8] The Model Contract and Medicare Advantage regulations expressly authorize the treating physician to conclude when the member is considered stabilized for transfer or discharge, whose determination is binding on the health plan.[9]

B. Post-Emergency Services

As already stated, prior to the point of stabilization, New York forbids health care plans from requiring any type of authorization. Moreover, with respect to Medicaid managed care and Family Health Plus plans, the Model Contract prohibits notification from being a condition of payment for emergency services rendered.[10] However, once the patient is stabilized the health plan then has the authority to manage the patient's care by requiring authorization for any post-stabilization care, and the nonparticipating provider—either hospital or physician—that elects to render unauthorized non-emergent services to the patient may not be compensated.[11] Because these precise points in time are often unclear, disputes can arise regarding the amount, if any, to be paid by the health plan to a nonparticipating provider for any services rendered that are deemed non-emergent.[12]

III. The Payment Rules Applicable to Medicare Advantage

Under Medicare Advantage ("MA"), nonparticipating providers who participate in traditional Medicare must

accept the Medicare fee-for-service rate for their services and are prohibited from accepting payment in excess of the Medicare allowable amount.[13] Skilled nursing facilities and other "providers of services" defined in 42 U.S.C. § 1395x(u) are similarly limited.[14] This rule applies regardless of the type of services that are rendered (i.e. emergency services or non-emergency services).[15]

The rules for providers that do not participate in traditional Medicare are more complex and depend in part on whether or not the provider accepts the assignment of the patient's Medicare benefits. The rules get even more complex in New York because New York, like the federal government, has its own law, which limits the maximum charge that a provider may collect from a Medicare beneficiary.[16] Fortunately, these rules are rarely applicable and will not be discussed here because most New York providers participate in traditional Medicare.

IV. The Payment Rules Applicable to Medicaid Managed Care and Family Health Plus

In a few instances, the federal and New York state governments have set the rate of reimbursement for health care services that are rendered by nonparticipating providers to members enrolled in Medicaid managed care and Family Health Plus ("Medicaid Member"). These rules do not apply to Child Health Plus. The date and type of services rendered dictate if a default rate set by either New York or federal statute will apply.

A. Emergency Services

Beginning in January 2007, with the passage of the Deficit Reduction Act of 2005, the rate for emergency services provided to Medicaid Members by nonparticipating hospitals after the first of the year shall be the state Medicaid fee-for-service rate and capital component (less any payments for indirect costs of medical education and direct costs of graduate medical education). In addition, emergency services provided to a Medicaid Member by a nonparticipating physician (such as the emergency physician, radiologist or anesthesiologist that are not employed by the hospital) shall be paid at the Medicaid fee-for-service rate in effect on the date of service.[17]

However, prior to the passage of the Deficit Reduction Act of 2005, there was no statutory or regulatory default rate for emergency services provided by nonparticipating providers (hospitals or physicians) to Medicaid Members, even though the Model Contract requires a plan to pay for emergency services. For emergency services rendered prior to January 1, 2007, disagreements among Medicaid managed care and Family Health Plus plans and providers occurred as to whether the plan was obligated to reimburse based upon billed charges or the usual and customary rate (UCR). In some circumstances, providers sought and obtained full charges from the plan. Non-New York case law, now mostly applicable to analysis of commercial plans, which will be described in more detail below, suggests that providers were entitled to receive—and plans were required to pay—the reasonable value for the services rendered.

For years, questions also arose as to the obligations of plans and providers when a patient presented to the emergency room and either the plan or provider determined the patient's condition did not constitute an emergency medical condition.[18] Providers are required under EMTALA to at least perform a medical screening examination to assess the existence of an emergency condition. To compensate for this, the New York State Model Contract required Medicaid managed care and Family Health Plus plans to pay hospitals a "triage fee" of forty dollars for services rendered to Medicaid Members in the absence of a negotiated rate if the presenting symptoms did not meet the definition of an emergency medical condition.[19] However, beginning January 1, 2007, New York State Department of Health eliminated the distinction between the triage fee and the fee paid for emergency services. Therefore, Medicaid managed care and Family Health Plus plans must now pay nonparticipating hospitals the Medicaid fee-for-service emergency room rate, including the capital component but excluding graduate medical education regardless of whether the services are necessary to treat an emergency condition as determined by a prudent layperson.

B. Non-Emergency Services

For inpatient hospital services rendered to Medicaid Members, a Medicaid managed care and Family Health Plus plan must pay the amount that would be paid under fee-for-service Medicaid—namely, the Medicaid DRG unless the health plan negotiated a rate with the hospital.[20] This is the case regardless of whether the Medicaid Member received prior authorization for the inpatient services or was admitted for inpatient services from the emergency room for an emergency medical condition. There is no comparable statutory default rate for other health care services such as outpatient surgery or non-emergency physician services.

In the case of elective services rendered by nonparticipating physicians, the plan may first determine if the services were pre-authorized. If not, then the plan may have the right to deny payment and the rate of payment is irrelevant. If the plan authorizes the services, then the plan can seek to negotiate a rate at the time it authorizes the services.

V. Commercial Plans

A. Implied Contracts

In the commercial market, there are no federal or state statutes that set forth the rate of reimbursement for health

care services provided by nonparticipating providers. In addition, the issue has not been publicly litigated in New York. Implied or quasi contract theories, litigated in other jurisdictions, suggest that nonparticipating providers are only entitled to receive, and health plans are only obligated to pay, the reasonable value for the services rendered. One might argue that this amount should be a number somewhere between the provider's billed charges and the Medicaid rate.

A legal contract is either express or implied. An express contract occurs when the parties manifest their assent in writing. An implied contract is found when the parties manifest their assent by their conduct and by the facts surrounding the circumstances (implied-in-fact). An implied contract can also occur when absent mutual assent of the parties, an obligation is imposed by law (implied-in-law).[21] When there is no express agreement in place, claimants typically assert a claim based on unjust enrichment or *quantum meruit*—the reasonable value of the services rendered.[22]

"The doctrine of quantum meruit is used as a device for the prevention of unjust enrichment of one party at the expense of another in the absence of a valid contract on which liability may be based."[23] In a formal complaint for unjust enrichment or *quantum meruit*, a claimant must establish: (1) that the services were performed in good faith; (2) the services were accepted by the recipient of the services; (3) there was an expectation of compensation; and (4) the reasonable value of the services.[24]

In addition, to recover for unjust enrichment in New York, the plaintiff must show privity with the defendant. There must be a direct dealing or actual relationship with the defendant, so that the services performed for the defendant result in the plaintiff's unjust enrichment. '"It is not enough that the defendant received a benefit from the activities of the plaintiff . . . if the services were performed at the behest of someone other than the defendant, the plaintiff must look to that person for recovery."'[25] As noted by the court in *Travelers Indemnity Co. of Ct. v. Losco Group, Inc.*:

> It is counterintuitive to say that services provided to an insured are also provided to its insurer. The insurance company derives no benefit from those services; indeed, what the insurer gets is a ripened obligation to pay money to the insured—which hardly can be called a benefit.[26]

The added requirement to show privity between the plaintiff and defendant is the factual hurdle most difficult to establish in bringing an action in *quantum meruit* for services rendered by nonparticipating providers.

B. Emergency Services

When a nonparticipating provider and health plan dispute the appropriate rate of payment for these services, the resolution will most likely rest on an implied-in-law contact theory since there is no written contract in place or other relationship between the parties. The law dictates that providers must treat emergency conditions and that plans must pay for such services, which is the impetus for courts to impose an implied-in-law contract in order to prevent the plan's unjust enrichment.

For example, in *River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc.*,[27] the Tennessee appellate court held that there was an implied-in-law contract, where the hospital sued for the difference between its billed charge and the parties' previously negotiated contract rate for the emergency services it provided to the health plan's members after the termination of the plan and hospital contract. The court's decision was based on the fact that the hospital was required to treat all emergency patients under EMTALA, and that the health plan was required to pay for all emergency services—the parties had no choice but to deal with each other. The Tennessee court referenced the following factors to consider when assessing the reasonable value for the services: the hospital billed charges, the plan's average in-network rates, and the volume (or lack thereof) of members seeking services from nonparticipating providers.[28]

In another case, *Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alternatives, Inc.*,[29] the court imposed an implied contract where the hospital and health plan had terminated its written contract but, the hospital continued to provide emergency services to the plan's members after the relationship ended. The plan refused to pay the hospital the published charges that the hospital had billed. The court found that the circumstances warranted a finding for unjust enrichment because (i) the hospital was compelled to provide the services and (ii) the health plan could not prevent its members from accessing these services at the hospital and was, therefore, compelled to pay for them. However, the court rejected the hospital's claim for its full billed charges, finding that the hospital would then, itself, be "unjustly enriched." Instead, the court awarded the hospital its average annual collection rate.[30]

In *Bell v. Blue Cross of Calif.*,[31] nonparticipating emergency room physicians sought relief under the state's Unfair Competition Law and pursued a theory of *quantum meruit*; the court upheld their claim, holding that the plan must pay the provider a "reasonable" amount. In addition, *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*,[32] is an interesting case to follow that is pending before the California Supreme Court. In this case, a corporation (similar to a New York Independent Practice Association "IPA") sued a group of nonparticipating

physicians over the "reasonableness" of rates charged for the provision of emergency services and its practice of balance billing the plan's members.

On the basis of these cases, health plans and providers may assert implied-in-law contract and other common law theories in litigating a dispute over payment terms for emergency services rendered by nonparticipating physicians. Yet to be determined is what rate is considered a reasonable amount to pay nonparticipating providers for emergency services. A Pennsylvania court stated in dicta that paying the Medicaid fee-for-service rate to nonparticipating providers was not necessarily reasonable—"reasonable costs" fell somewhere between the Medicaid rate and the provider's full billed charges.[33]

C. Non-Emergency Services

Nonparticipating providers routinely have difficulty getting paid by insurers for non-emergency services provided to their insured patients because the plan, in general, has no legal obligation to pay for such services. Unlike in the context of emergency services, providers in general are not obligated to provide non-emergency services and health plans are not obligated to pay for non-emergency services.

In fact, a New York court dismissed a cause of action for a contract claim founded in *quantum meruit*, where the nonparticipating provider sought payment from a health plan for non-emergency services. In *Kirell v. Vytra Health Plans L.I., Inc.*,[34] a podiatrist brought an action against Vytra Health Plan, an HMO, for its failure to reimburse the provider for services he rendered to plan members. The court held that the *quantum meruit* claim could not be sustained against the HMO because the services were performed at the behest of the patient and not the HMO.[35]

Could a court come to a different conclusion and find an implied-in-fact contract where the intention of the parties is evidenced by something other than a writing so that an agreement could be inferred from the conduct of the parties? For example, could a court draw such an inference where a plan first verified eligibility and then authorized the treatment of its member? Could a promissory estoppel theory also be sustained under these facts?

Regardless of the legal theory asserted, whether implied-in-fact or implied-in-law, the amount recoverable would still be the reasonable value of the services rendered.[36]

In as much as it is difficult to determine this magic amount, nonparticipating providers and health plans would be wise to negotiate a price for services on a case-by-case basis at the time such services are authorized and, if possible, confirm such understanding in writing.

VI. Other States

Florida provides that reimbursement should be based on the lesser amount of either (1) the provider's charges (2) the usual and customary rate ("UCR") for similar services in the community or (3) a negotiated rate agreed to by the provider and plan within 60 days after the claim was submitted.[37] In California, the Department of Managed Health Care (the DMHC) has promulgated six factors that must be considered (with the applicable rate to be synthesized based on some sort of analysis of these factors) when determining the reasonable and customary value for the emergency services rendered, which must be based upon annually updated credible statistics: (1) the provider's training, qualifications and years of experience, (2) the nature of the services provided, (3) the provider's usual charged fee, (4) the prevailing rates charged in the community, (5) any other relevant economic aspects of the provider's practice and (6) any unusual circumstances.[38]

Also of interest is California's establishment of a voluntary pilot project to resolve claims payment disputes among nonparticipating providers and health plans for all services—emergency and non-emergency. The Independent Dispute Resolution Process ("IDRP") mimics "baseball style" arbitration, which allows the third party to determine the reasonable value for the services rendered by taking into consideration the regulatory criteria set forth above. To participate the provider must agree to not balance bill members, except for applicable cost sharing amounts, and the health plan must pay the amount found to be determined within fifteen (15) days of the final determination. This process has the potential to be a fair, economical and reasonable approach to determine the value for services that are rendered by nonparticipating providers. In addition, this approach could alleviate the prevailing angst amongst nonparticipating providers and health plans who are grappling with this question.

VII. Conclusion

New York can take similar legislative steps to address these options. The regulatory agencies can provide guidance and leadership and plans and providers can try to sort through it all in a collaborative fashion. Alternatively, the providers and plans can sort it out in the courtroom. Regardless, it will be interesting to see how the landscape will change with the implementation of the Deficit Reduction Act of 2005.

Endnotes

1. *See* 42 U.S.C. §§ 1395w-4, 1395-22, 1396u-2(b)(2)(D) (2006); N.Y. Public Health Law § 2807-c(a-2) (McKinney 2006).
2. 42 U.S.C. § 1395dd (2006); 42 C.F.R. § 489.24 (2007).
3. N.Y. Pub. Health Law § 2805-b (McKinney 2006) (requiring hospitals "to admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission

question the patient or any member of his or her family concerning insurance . . .").

4. N.Y. Ins. Law §§ 3216(i), 3221(k)(4), 4303(a)(2) (McKinney 2006).
5. N.Y. Pub. Health Law § 4902(1)(h) (McKinney 2006).
6. *See* Appendix G "SDOH Requirements for the Provision of Emergency Care Services," Medicaid Managed Care and Family Health Plus Model Contract dated October 1, 2005. *See also* 42 C.F.R. § 422.113 (2007) (requiring the same rule for Medicare Advantage products).
7. *See* N.Y. Pub. Health Law § 4905(13) (McKinney 2006).
8. *See* Appendix G "SDOH Requirements for the Provision of Emergency Care Services," Medicaid Managed Care and Family Health Plus Model Contract dated October 1, 2005. Under Medicare regulations, the term "stabilized" with respect to an emergency medical condition means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.'" 42 C.F.R. § 489.24(b).
9. *See* Appendix G "SDOH Requirements for the Provision of Emergency Care Services," Medicaid Managed Care and Family Health Plus Model Contract dated October 1, 2005. *See also* 42 C.F.R. § 422.113.
10. *See* Appendix G "SDOH Requirements for the Provision of Emergency Care Services," Medicaid Managed Care and Family Health Plus Model Contract dated October 1, 2005 (stating that a Medicaid managed care plan cannot refuse to cover emergency services because the provider or enrollee failed to notify the plan of the emergency room visit). Notification provisions are often contract terms between the payer and provider or the payer and subscriber covering utilization management, and therefore, would not apply to a nonparticipating provider.
11. 42 C.F.R. § 422.113 (c) (setting forth when the MA plan is financially responsible for post-stabilization care, such as when the MA does not respond to a request for approval).
12. Some of the various scenarios when this plays out are: when services are provided either subsequent to the patient's stabilization (or there is deemed to have been no emergency in the first place); when a non-emergent patient "re-presents" at the emergency room for non-emergent follow-up care; or when a patient is admitted inpatient to the hospital and treated by a nonparticipating physician.
13. *See* 42 U.S.C. § 1395w-4(a)(1).
14. 42 U.S.C. § 1395cc(a)(1)(O) (2006).
15. *See* 42 CFR § 422.214 (2007). *See also* MA Payment Guide for Out of Network Payments dated July 15, 2006. This payment guide is updated periodically and sets forth payment methodologies for all types of services. http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf.
16. 42 U.S.C. § 1395w-4(g)(1)(A). *See also* N.Y. Pub. Health L. § 19 (McKinney 2006) (stipulating that providers may not charge a Medicare recipient more than 105% of Medicare's reasonable charge).
17. *See* 42 U.S.C. § 1396u-2(b)(2)(D).
18. *See* N.Y. Pub. Health Law § 4900(3) (McKinney 2006) (defining an emergency condition).
19. *See* Appendix G "SDOH Requirements for the Provision of Emergency Care Services," Medicaid Managed Care and Family Health Plus Model Contract dated October 1, 2005. There is no comparable provision in New York for the private commercial market.
20. N.Y. Public Health Law § 2807-c(a-2) (McKinney 2006).
21. *See* John D. Calamari & Joseph M. Perillo, The Law of Contracts § 1.11 (4th ed. 1998).
22. *See* 22A NEW YORK JUR *Contracts* § 600 (2006).
23. *See* 22A NEW YORK JUR *Contracts* § 594 (2006). An action in quantum meruit can also be referred to as an action in unjust enrichment. *Id.*
24. *Travelers Indemnity Co. of Ct. v. Losco Croup, Inc.*, 150 F. Supp. 2d 556, 562 (N.Y. Dist. Ct. 2001).
25. *See Shortcuts Editorial Svcs., Inc. v. Kaleidoscope Sports and Entm't, LLC*, 706 N.Y.S.2d 572, 573 (N.Y. Sup. Ct. 2000).
26. *Travelers Indemnity Co. of Ct.*, 150 F. Supp. 2d at 562.
27. 173 S.W.3d 43 (Tenn. Ct. App. 2002).
28. *Id.* at 40-41 (remanding to the trial court to determine reasonable rates).
29. 832 A.2d 501, 504 (Pa. Super. Ct. 2003).
30. *Id.* at 508-509 (stating that the important question is to see what the hospital actually receives for services to determine the value of the benefit given the fact that the hospital rarely collects its charged amounts).
31. 131 Cal. App. 4th 211, 222 (2005).
32. 136 Cal. App. 4th 1155 (2006), superseded by grant of review, 44 Cal. Rptr. 3d 631 (2006).
33. *Hosp. & Health System Assoc. of Pa. v. Dept. of Public Welfare*, J-177-2004 (Pa. 2005) (supporting its position based on evidence in *Temple Univ. Hospital, Inc. v. Healthcare Mgmt. Alternative, Inc.*, where the health plan expert admitted that the Medicaid rate was significantly lower than costs).
34. 815 N.Y.S.2d 185, 187 (N.Y. App. Div. 2006).
35. *Id.* (citing *JLJ Recycling Contrs. Corp v. Town of Babylon*, 745 N.Y.S.2d 897 (App. Div. 2003), which states that "[u]nder the theory of quantum meruit, if the services were performed at the behest of someone other than the defendant, the plaintiff must look to that party for recovery").
36. *See Huntington Hosp. v. Abrandt*, 779 N.Y.S.2d 891, 892 (N.Y. Sup. Ct. 2004) (holding that "[t]he fact that lesser amounts for the same services [were] accepted from commercial insurers or government programs as payment in full does not indicate that the amounts charged to defendant were not reasonable.").
37. Fla. Stat. 641.513(5). Recently, a Florida District Court of Appeals held that an orthopedist who provided emergency services had a private right of action under the state statute to sue an HMO because the compensation paid was lowered than required by the statute. *Merkle v. Health Options, Inc.*, 940 So. 2d 1190 (Dist. Ct. 2006).
38. Cal. Code. Regs. tit. 28, § 1300.71(a)(3) (2006).

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***This article focuses on New York State. However, excerpts from this article may also be contained in the article "Developing Law Governing the Compensation of Nonparticipating Providers," *Managed Care Quarterly*, Fall 2006, which was written for a national audience by the authors in collaboration with Terese A. Mosher Beluris and J. Peter Rich.**

Tilting the Playing Field: How "Tiering" and "Steering" Alter the Fundamental Presumptions Upon Which Managed Care Agreements are Based

By James G. Fouassier

> *[I]n New York, all contracts imply a covenant of good faith and fair dealing in the course of performance. The covenant of good faith and fair dealing embraces a pledge that neither party shall do anything which will have the effect of destroying or injuring the right of the other party to receive the fruits of the contract. While the duties of good faith and fair dealing do not imply obligations inconsistent with other terms of the contractual relationship they do encompass any promises which a reasonable person in the position of the promisee would be justified in understanding were included. (Read, J, dissenting in* Evans v. Famous Music Corporation, *1 N.Y.3d 452, 775 N.Y.S.2d 757 (2004)).*

Providers of goods and services offer discounts in exchange for volume. In the normal commercial context the buyer agrees to purchase a quantity of goods or accept a service in an established minimum amount in exchange for a rate of payment which reflects the volume. Differentials or discounts may be based on a variety of commercial and even personal factors but most often are justified by volume.

With commodities the factors used to determine an appropriate price include the cost of producing one more item, which declines as the manufacturer produces each additional unit until the point of "diminishing return," at which production costs and price theoretically even out and there no longer is a profit incentive to continue to produce. With services the question is more complex because the cost related to the performance of each unit of service is more of a function of human labor than the production of a unit of a tangible mass-produced commodity. For services, the analogy is more valid if we distinguish between the service provider's fixed costs and its variable costs.

In either case, then, and as a general proposition we can expect gradually reducing costs generated by additional units of provision or production. If the supplier can reasonably anticipate the volume required by the purchaser it can develop a price methodology reasonably expected to meet its required margin of return.

It is well settled in the sphere of commercial health insurance that a provider of health care may contract with a health care insurer or other third party payer for whatever discounted rates are acceptable to both parties, presumably because of the expected volume of patients and payments, promptness in paying, and the assurance of payment from a financially responsible source.[1] There is a marked distinction, however, between the provision of health care for a discount and discounts in commercial contexts generally. The terms of the usual contract establish the level of volume; even "requirements" contracts almost always provide for a minimum quantity or volume upon which the seller has relied in agreeing to a sale price which is reasonably expected to return an acceptable profit margin. In health care contracting, however, there can be no "minimums" because no one can guarantee volume. In addition to all the usual risks inherent in a commodity or service contract, the selling health care provider and the buying payer (be it an insurance company, a self funded ERISA plan, or any of the many hybrid health payers now in the market) have to accommodate the additional variable of who among the subject patient membership may get sick or injured and thus contribute to the volume which both sides attempted accurately to gauge when they agreed to the compensation rates in the contract. This added element effectively combines two distinct types of risk in one commercial context—the usual risk inherent in any relationship between a producer and a buyer of commodities or services, and additionally a kind of risk akin to that of an insurer. (True risk agreements between providers and payers, the so-called "capitation" contract, are rarely seen today, a victim of the inability of both providers and payers to assume that much risk.)

A provider anticipates that a contact rate schedule will return a certain margin based upon the volume the contract will generate. The skill of the provider in evaluating the principal factors which allow an accurate estimate of volume (such as the number of covered lives, the demographics of the population covered by the payer's membership and perhaps most importantly the cost of providing the services covered by the managed care contract) should result in an accurate estimate of the revenue to be generated from the agreement. Secondary considerations then will be based on these primary determinations, such as anticipated levels of claims denials (both for substantive clinical reasons and for technical claims

submission problems) and the risks inherent in collecting patient balances, a growing concern as more plans offer high deductible products that may be coupled with health savings accounts (whether "qualified" or unqualified for tax purposes). A "bottom line" rate schedule is developed and advanced by the provider in its negotiations with the payer. Most commercial payers (as well as government regulators) require a full menu of acute care services, because the plans must offer the same full menu to their customers and covered members. Consequently, it is not possible for the parties simply to eliminate any particular service upon which a compensation amount may not be agreed. This requires flexibility and significant compromise on rates for a variety of services. (The plan invariably is heard to argue that the provider should establish lower rates for specialty services because the plan's members will be using that provider for many "routine" services that afford relatively higher margins, the so called "bread and butter" services.) At the end of the process some rates may be expected to generate greater net revenue and others even a possible loss. The reasonable understanding of the parties, however, is that the rate schedule in its entirety is intended to yield an acceptable margin of profit for the provider.

The fundamental presumption upon which a provider bases all of its negotiations and estimates with an institutional third party payer is that the provider will have access to a known universe of the payer's members. A provider will accept the risk that no one in that universe will get sick or hurt, or that a small percentage of its claims will be denied as not medically necessary, or that some of its direct member responsible payments will not be paid and will have to be written off as bad debt. What a provider cannot accept is the risk that after calculating all of the variables and contractually obligating itself to accept the scheduled rates for all of its services for all of a plan's members, the plan then "tilts the playing field" by directing certain of its members away from the provider. This has been happening more often as plans expand their provider networks and enroll more specialized health care providers capable of rendering some "covered services" at a lower cost to the plan payer than other providers (acute care hospitals and other "traditional" providers) already enrolled in the network.

Providers see this happening in several ways which fall under the general headings of "tiering" and "steering." Although the concepts overlap, each is characterized by the creation of economic incentives in a plan's members to use services of a competing provider which are offered to the payer at lower cost.

"Tiering" is the establishment by a plan of a variety of levels of provider access, ostensibly based upon medical "quality" but in reality developed to a significant extent in consideration of the cost to the plan payer of the service in question. In the typical model a plan selects several major categories of "covered services," usually clinical specialties such as cardiothoracic surgery, and then examines selected provider data to establish each provider's position in one of several "tiers." Data may be "claim based" or "outcome based" and may be generated from the plan's own claims processing system or derived from a variety of "objective" quality data bases such as Leapfrog, NCQA, AHRQ and JCAHO.[2] A plan member may continue to access any provider in the network, regardless of tier. The plan, however, will make available to members via mailings, web sites, print advertisements and a variety of other publicity devices the grading of various plan providers to make the members aware of the "quality" tier into which the provider falls. The plan's stated goal is to encourage members that it is in their best interest to utilize the "higher quality" provider. Just to be certain that the members do what is best for them, the plan invariably offers financial incentives to members to use the "higher quality" (read "less expensive") provider by reducing or eliminating coinsurance and other co-payments whenever a member uses a top tier provider. Providers complain that some plans go so far as to engage members individually, as when the customer service representative raises the "quality" issue when the member calls for authorization, reminding the caller that the selection of a "higher" tiered provider is also in his or her best financial interest.

Providers have no objection to plan proposals which truly advance quality initiatives, such as "pay for performance" programs that reward quality improvements with payment bonuses. Providers routinely object to tiering methodologies as cost control masquerading as quality. When the plans point out that they employ objective criteria established upon independent data from recognized national sources, the providers argue that the precise methodologies used by plans to extrapolate the data and establish the tiers are closely guarded secrets and that provider demands for access to the process ("a place at the table," so to speak) are routinely denied. There are no avenues of appeal or review. Providers astutely observe that while concerns over "quality" are not new, plans only became interested in "tiering" initiatives when the cost of selling their products to institutional purchasers such as employers and union welfare funds became so high. It is ironic, the providers observe, that every tiering proposal is accompanied by financial "incentives" to the membership. Is it not sufficient that the plans put all that quality data out in front of their members? Further complicating the environment is the rise of "consumer directed health care" options with high deductible benefit designs and health savings account features. Providers and plans both appreciate that the impact of tiering "incentives"

will be much greater when so much more of the cost of care, including the choice of providers, will be borne by the members in the forms of higher deductibles and/or coinsurance, and a significant reduction or elimination of a copayment becomes more meaningful.

Plan representatives justify financial incentives by claiming that they and their group customers no longer want to pay for poor performance. If patient quality were the real concern of plans and employers, however, the issue would be addressed not by way of tiering, but instead in the context of rate negotiations. A plan would present a provider with quality data and the resulting conclusions which were of concern to the plan, and propose a financial remedy based upon a rate or other incentive as a part of the contract itself. In other words, the provider would be offered higher rates in exchange for quality improvements. This process would result in a *mutual* acknowledgement of a plan's quality concerns based upon an agreed set of facts, and a *mutual* proposal for a solution based upon the needs and interests of *both* parties. The unilateral analysis of data which some providers fear will confirm certain preconceived goals based principally on cost is eliminated from the problem-solving process because plan and provider contribute as equal partners. The plans do not want providers to address this issue in contract *negotiations*, however. They will not risk breakdowns in contract talks and the failure to include essential providers in their networks by addressing their so-called "quality" concerns at that stage. Their goal may be to sign up as many providers as they can and later tier them when the providers are contractually powerless to avoid the consequences. Plans want to have a broad base of providers to offer all services which may be required by their customers (and to guarantee access to specialty services in underserved areas) while the plans later are free to tier high cost specialty services and steer members to lower cost subnetworks when in their own best financial interest to do so.

Some plans concede that doctors, for example, who score higher on quality criteria also may be less "cost effective" than other physicians, and thus will be placed in "standard" (i.e. lower quality) tiers. The plans' position is that if consumers want those physicians they can select them in the standard tiers but will have to pay more out of pocket for them. The plans overlook the obvious—they claim to be encouraging their members to be more "quality conscious" but the tier placement in effect may drive some members to *lower* quality physicians. This plan argument also ignores the financial objection raised by providers, which is that the doctors who contracted for participation in all of the plan's network are now being denied the benefit of their bargain.

Plans also are heard to complain that they cannot cave in to economic pressure and simply agree to include "important" providers (i.e. those with sufficient market power to compel their being included) that do not otherwise meet the quality criteria because the plans make representations of certain quality levels to their customers. The reality, however, is that plans already are doing this everywhere the need for specific types of providers is not met under "quality" programming. For example, several major plans already may make geography a specific part of their current selection criteria notwithstanding their claim that the tiering is solely for "quality." These programs inquire into whether specialists are in an area where members can easily reach them. If a specialty is underrepresented the plan will add physicians who otherwise would not have made the quality "cut." This manipulation is accomplished by the expedient of developing separate quality criteria for different specialties. Variations of this theme abound. For example, in some large areas nearly all cardiac surgeons will be included in the "quality" tier but some internists will be denied quality tier status because their specialty is overrepresented. These kinds of practical determinations challenge the credibility of plan claims about the need to preserve the "quality" of the tier.

The known data criteria for almost every plan are heavily outcome oriented, that is, data based on the plan's own membership and the clinical results of certain procedures undertaken for plan members only. Overreliance on outcome criteria is problematic, however, because it requires a large volume of data which is both highly accurate and very relevant. This gives rise to several significant issues:

a. How difficult will it be for a plan to tier, even using its own criteria, when providers participate in so many other plans? Presumably a plan's own methodology for analysis (a "proprietary secret") requires at least a minimal amount of data to be statistically significant. (Literally dozens of quality areas are considered, giving rise to the need for a lot of data.) Will we see plans cheating on their own criteria?

b. The question of limited data also presents itself when plans rate small practices as opposed to larger groups. In those cases there are even less quality data available. Some plans' responses have been to cut down on number of criteria they consider, in some cases to as little as six or seven. Again, data deficiencies may create significant and serious compromises in a plan's ability accurately to generate quality tiers.

c. While some of the data used by plans are gleaned from available sources such as Leapfrog, JCAHO, AHRQ and NCQA, not all providers contribute the same data to the standard data banks and to the same extent. Also, how cost effective is it for small practices, and even some larger groups and hospitals, to invest in the technology needed to provide these organizations with accurate and relevant data on a regular basis? (Not many plans offer financial incentives to providers to facilitate the acquisition and use of the up-to-date information technology needed to accurately develop these criteria.)

d. A heavy reliance on outcome criteria may have the effect of encouraging some providers to avoid treating sicker high risk patients, to be sure their statistics continue to qualify them for participation in a higher tier.[3]

In short, providers simply do not trust plans to be fair. The current class action litigation against United Healthcare over the use of the Ingenix data bases to establish "usual and customary charges" does nothing to reassure providers that the data sources and methodologies plans will use to develop quality criteria will be any more objective.[4]

"Steering" is distinct from tiering in that it makes no pretense to quality. Steering is not manifested in a program or policy advanced by a plan to its customers and patients. Steering is difficult to anticipate in advance of contracting and difficult to address in the language of the agreement between provider and plan. It more often affects the essential "bread and butter" services upon which the provider relied to make its margins than the specialty services which frequently are the subject of tiering.

The consideration of a hypothetical situation may be helpful. A year into a managed care contract a provider discerns that volume for a particular "covered service" (a service included in the scope of the contract, and for which a specific rate of compensation is established) is noticeably lower than in past years. Disturbing reports from primary care referring physicians, from employees and even from business and personal acquaintances evidence a trend: potential patients who thought that the facility was in their network and who wished to use its services find that they cannot. Authorization requests for this profitable "bread and butter" service (laboratory, radiology and physical therapy are three that immediately come to mind) are sometimes declined. The facility is not being included in lists of participating providers given to some plan members who call for such lists. Some members are flatly told that the facility is not "in network" for the covered service they require. Other plan members are being advised that if they elect to use a competing provider in the network their copayment will be reduced or there will be no copayment. Obviously, it is difficult if not impossible to discern to what extent this activity is impacting on volume and the profitability of a particular contract, since a provider cannot know who is *not* using its services or precisely why volume may be diminishing. One thing is certain, however; the fundamental premise upon which the provider based its rate schedules—anticipation of a certain volume—has changed. The volume of users of lower cost, higher margin "bread and butter" services is being steered *away*, while the provider remains contractually committed to the plan to extend deep discounts on the high cost specialty services that plan members continue to require of that provider.

This is a growing trend. Utilization of traditional carveout services, especially mental health and substance abuse, may be subject to significant increases by virtue of proposed regulatory changes mandating expanded coverage. At both the state and federal levels there are calls to eliminate distinctions between these services and all other medical services generally.[5] Also, the higher cost of health insurance generally, as well as the advent of high deductible plans, will drive more benefit administrators to select carveouts for "bread and butter" services such as laboratory work, radiology, and even cardiac catheterization, to make the coverage more affordable.

Surprisingly, there is a dearth of regulation and cases dealing with these important issues. Although almost half the states have adopted some protection from outright discrimination by commercial plans in the recruitment of network providers, New York does not have an "any willing provider" law.[6] In any event, it is questionable whether a law or regulation proscribing such a practice in the development of the overall network could be interpreted to apply to quality or even cost tiering and the many subtle forms of steerage. The few cases that even mention "steering" do so incidental to their analyses of the possible anti-competitive effects of mergers or acquisitions and are not particularly helpful.[7] More instructive is *Gateway Contracting Services v. Sagamore Health Network*,[8] a case in which providers responding to subnetwork steering allegedly violated the Sherman and Clayton Acts and engaged in a conspiracy in restraint of trade. No cause of action is asserted under any common law theory of fair dealing and the issue is not discussed. The case nevertheless is noteworthy not only in the detail of its presentation of facts (evidencing the incredibly complex managed care environment) but also for a provider's view of the harm incurred by steerage and the practical inability of the provider to redress that harm. The court denied the subnetwork's request for a preliminary injunction on the

ground, *inter alia*, that it had not demonstrated a likelihood of success on the merits. The only "good" news for providers is that the court's decision may be read as tacit approval of the parallel yet independent activities undertaken by the defendants to protect themselves.

How does a plan steer members *away* from a provider? Several techniques seem to be prevalent:

1. If the plan is administering its own fully insured benefit designs, it may develop a subnetwork of specialty carveouts (radiology, labs, etc.) which provide only one or a few "covered services" at much lower cost to the plan than a traditional provider such as a hospital. Even without pressure from institutional customers (i.e. without any customer complaints about costs) the plan will offer all of its insured or administered members a financial incentive (lower or no copayments) to use the carveout instead of the service;

2. The plan contracts to administer a group payer (such as a union welfare fund governed by ERISA) which has a limited benefit design which requires members to use only the carveout providers for some of those "bread and butter" services. Even though the provider agreement contains rates for the covered service in question, when the provider, the member or the primary care physician calls for authorization for one of those members the plan advises that the service is not "covered" by that group payer's benefit schedule;

3. The plan signs up a group payer which, because of limited benefits, already has entered into some type of contract with some other plan to provide a particular service, so the group does not even need the plan's carveout subnetwork;

4. The plan delegates the administration of certain covered services to a "carveout" company. Obviously, unless the provider has agreed to a separate contract with the carveout under which the provider now agrees to accept the carveout's lower rates, the carveout must entertain and pay the provider's claims at the original rate contracted with the plan. However, the provider finds that it is experiencing a larger than normal volume of short payments on claims administered by the carveout (i.e. payments made at the carveout's par provider rate rather than the contracted rate) and also members whose authorization requests "accidentally" were denied.

For a provider, addressing these issues is very difficult. Assuming that the provider has sufficient market strength to have these issues even considered by a plan, let alone resolved in the provider's favor, there is a fundamental problem which defies contractual resolution. Although highly unlikely, in theory the plan may agree that all participating providers will be protected from the tiering and steering of fully insured members. It is another matter altogether for the plan administering benefits for a fee (such as a "preferred provider organization," an "administrative services organization" or a "third party administrator") to agree to turn away business if any customer group wants the plan to administer limited or restricted benefits which do not provide for certain "covered services" to be performed at the traditional provider's facility. The plan will argue, with some merit, that it has little if any control over the benefit design of the local union employee welfare fund and cannot be expected to enter into provider contracts under which it must turn away such a significant source of business. In addition, a plan will not prejudice its existing agreements with constituent payers which cannot be renegotiated simply because a particular provider does not want to incur steerage risk. In short, even if a plan is inclined to agree to broad proscriptions on steerage in the context of its fully insured products, it never will agree to give up customers that wish to use it to administer limited benefit designs (which is always the case in a "preferred provider organization" or PPO) and who simply will not pay for some of the traditional provider's routine but more expensive covered services.

As we have discussed, possible legal remedies include traditional breach of contract claims based on the implied duty of fair dealing, with the assurance that courts entertaining these cases in the contexts of tiering and steering will be breaking ground. Other legal remedies might include causes of action for tortious interference but that theory is unlikely to succeed under the current state of New York law.[9] Statutory or regulatory remedies would be welcome by the provider community but also are unlikely, given the current political environment.

Consequently, for the foreseeable future providers will have to be left to their own designs and the best abilities of their contract negotiators given the limitations of their competitive market power. Several alternatives (some more practical than others) present themselves:

a. an outright contractual prohibition on plan tiering and/or steering;

b. where the plan does not currently tier providers, a provision allowing the provider to "opt out" of any later plan or payer benefit design which establishes such tiers. This means that the plan must advise its potential customer that a limited benefit design that does not allow access to that provider

for all covered services means that a member cannot access that provider for any services;

c. a provision allowing the provider to exclude any constituent payer from the contract's discounted rates if the payer later offers a tiered product or steers away a covered service;

d. a refusal to contract for any service which the plan anticipates tiering or steering during the life of the contract. This means that all plan members otherwise using the provider's covered services will be "out of network" for the excluded services. (This may cause significant political headaches for a hospital with specialists in the areas under consideration for exclusion, especially if the plans already have "favorable" contracts with those physicians. It also may result in significant increases in patient responsible balances and general confusion with a sizeable number of patients);

e. rate schedules which anticipate possible tiering or steering by providing for higher rates of reimbursement for covered services not likely to be tiered or steered away. (The obvious problem here, of course, is that this strategy makes a provider's rate requirements even less competitive than heretofore, a real concern in most markets);

f. a variation of the above—an agreement that any difference in utilization rates for a covered service which is or later may become the subject of tiering or steerage will result in an overall rate adjustment in the following contract year. (This provision would be in the nature of a liquidated damage clause. Both sides assume that all lost utilization must be attributed to the effects of the tiering or steering, and no other causes will be allowed to ameliorate the plan's liability. While the concept is simple, developing an accurate method for doing this is very problematic.); and

g. litigation alleging breach of contract, deceptive trade practices and even defamation and RICO claims.[10]

Finally, one other troubling concern is the impact of a provider's acquiescence in these activities on situations in which the provider seeks reimbursement at full charges. As discussed at the beginning of this article, courts generally have acknowledged that discounts to institutional payers are justified based on anticipated volume directed through the network in which the provider participates. Schemes which allow members to choose lower cost subnetwork providers, be it by tiering or steering, seriously compromise the most significant rationale for pricing distinctions by classes of payer. This also may affect the manner in which courts routinely establish that a particular hospital charge is the fair and reasonable value of the services rendered in the absence of an express or implied agreement by the patient to pay a sum certain.[11]

Endnotes

1. *Flushing Hospital and Medical Center v. Woytisek,* 41 N.Y.2d 1081, 396 N.Y.S.2d 349 (1977); *see also Albany Medical Center v. Johnston,* 102 A.D.2d 915, 477 N.Y.S.2d 499 (3d Dep't 1984); *Huntington Hospital v. Abrandt,* 4 Misc. 3d 1, 779 N.Y.S.2d 891 (App. Term 2d Dep't 2004) *Albany Medical Center v. Huberty,* 76 A.D.2d 949, 428 N.Y.S.2d 746 (App. Term 3d Dep't 1980).

2. The Leapfrog Group is a consortium of more than 145 large health care purchasers committed to a common set of purchasing principles through which to leverage dramatic improvements in the safety, quality, and overall value of health care. www.leapfroggroup.org The Joint Commission (formerly the Joint Commission for the Accreditation of Healthcare Organizations) is an independent, not-for-profit organization, established more than 50 years ago. Joint Commission is governed by a board that includes physicians, nurses, and consumers. Joint Commission sets the standards by which health care quality is measured in America and around the world. www.jointcommission.org The Agency for Healthcare Research and Quality is the lead federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. As one of 12 agencies within the Department of Health and Human Services, AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making. www.ahrq.gov. The National Committee for Quality Assurance is an independent, 501(c)(3) non-profit organization whose mission is to improve the quality of health care. www.ncqa.org.

3. I am indebted to James C. Robinson, professor of health economics at the School of Public Health at University of California (Berkeley), and Thomas Priselac, president and chief executive officer of Cedars-Mount Sinai Medical Center, for insights into some of the issues I developed in this section of this article. In particular I direct the reader to the Health Affairs Web Forum of March 19, 2003. Their articles may be found at www.healthaffairs.org/WebExclusives/CHCF_Web_Excl_031903.htm Professor Robinson's article is entitled *Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Incentives*, and Mr. Priselac's is *The Erosion of Health Insurance: The Unintended Consequences of Tiered Products by Health Plans.*

4. *American Medical Association v. United Healthcare Corporation,* 00 CV 2800 (SDNY; McKenna, J.). Plaintiffs allege that the defendants relied on flawed data bases they then manipulated in determining "usual, customary and reasonable" reimbursement amounts to nonparticipating providers. Most recently the Court granted the plaintiff's motion to amend the complaint a third time, to add claims under RICO and state and federal antitrust laws.

5. National Conference of State Legislatures: "State Laws Mandating or Regulating Mental Health Benefits," January 2007; "Two More States Enact Parity Laws," January 22, 2007.

6. The rights of healthcare providers in managed care contracting and payment generally, such as they are, are found in the Insurance Law at 3217-b, 3224-a, 3224-b, 4325 and 4803; and in the Public Health Law at 4403, 4406-c and 4406-d.

7. *See, e.g., F.T.C. v. Tenet Health Care*, 186 F. 3d 1045 (8th Cir., 1999), reversing 17 F. Supp. 2d 937 (ED Mo. 1998); *U.S. v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (EDNY 1997); *California v. Sutter Health System*, 84 F. Supp. 2d 1057, amended opinion, 130 F. Supp. 2d 1109 (ND Cal. 2001).

8. 2002 US Dist LEXIS 7328, 2002-1 Trade Cases (CCH) P 73,640 (DC Indiana 2002).

9. "To the extent that the express words of the contracts failed to prohibit some acts arguably inconsistent with the nature of the relationship, the franchisees could—and did—invoke the implied covenant of good faith and fair dealing. The intervention of tort law to regulate when a franchisor may or may not compete with its franchisees is neither necessary nor useful." *Carvel Corp. v. Noonan*, 3 N.Y.3d 182, 785 N.Y.S.2d 359 (2004).

10. In September 2006, the Washington State Medical Association and six physicians filed suit in King County Superior Court against Regence Blue Shield for defamation, breach of contract and deceptive trade practices. The complaint alleges that physicians were penalized for failing to treat individuals who were not their patients and failing to provide certain medical services which the doctors deemed not necessary or proper. Of relevance to the subject of this article are the allegations that charge Regence with violation of the state's Unfair Business Practices Act, defamation and libel, intentional interference with the physician-patient relationship and breach of contract in that the participating provider agreement entitled them to participate in all Regence products. The lawsuit sought an injunction preventing implementation of the "performance-based" SelectNetwork program together with money damages to compensate the physicians for harm caused by the insurer's statements respecting the physician's exclusion as a result of the network's "evaluation." The American Medical Association joined the suit in November.

    On February 6, 2007, Jamaica Hospital Medical Center and Flushing Hospital Medical Center, both in Queens, New York, filed a RICO suit in the US District Court for the Eastern District of New York against United Healthcare and United Health group, alleging that the defendants and their subsidiaries were implemented a "rogue business plan" and asserting a variety of illegal activities. Again, for our purposes, relevant allegations are that the defendants and their subsidiaries wrongfully denied coverage for members by falsely telling them that Flushing Hospital was not a network provider, thus allocating a greater share of the costs of the medical services as the patients' responsibility.

11. For an example of the way in which the trier of fact may make such a determination, see, *Ellis Hospital v. Little*, 65 A.D.2d 644, 409 N.Y.S.2d 459 (3d Dep't 1978).

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Managed Care in New York: Recent Legislative Actions

By Laurie T. Cohen

The 2006 legislative session in New York resulted in the passage of legislation which addresses certain physician complaints against managed care plans. Chapter 551 of the Laws of 2006 which became effective January 1, 2007 has three key provisions.

Claims Processing

Chapter 551 of the Laws of 2006 adds a new section to the insurance law, Section 3224-b, which contains two provisions. First, Section 3224-b of the insurance law requires health plans to "accept and initiate the processing of all health care claims submitted by physicians pursuant to and consistent with the current version of the American Medical Associations' current procedural terminology (CPT) codes, reporting guidelines and conventions and the Centers for Medicare and Medicaid Services healthcare common procedure coding system (HCPCS)." Health plans are defined to include insurers licensed to write accident and health insurance as well as insurers licensed pursuant to article 43 of the insurance law or certified pursuant to article 44 of the public health law. A health plan is also required to publish on its provider website and in its provider newsletter the name of the commercially available claims editing software product that the plan is utilizing and any significant edits to such software made by, or at the request of, the plan. Such information is also to be made available upon a written request by a physician who is a participating provider in the plan's network.

Regardless of the new requirement to accept and initiate the processing of claims as set forth above, the statute also provides that a health plan may determine a claim is not eligible for payment, in whole or in part, for a variety of reasons including, but not limited to, the claim is not a "clean claim" as defined in regulation (e.g. the claim is missing information); the service provided is not a covered benefit; the patient did not follow certain administrative rules such as failing to obtain a referral or failure to obtain pre-certification; or the plan has a reasonable suspicion of fraud or abuse.

Overpayment Recoveries

In addition to addressing claims processing, Section 3224-b sets forth a notice requirement and time limit on a health plan's ability to recover overpayments made to physicians. The statute states that except in cases to recover payment of duplicate claims, plans must provide 30 days' written notice to physicians prior to seeking recovery of overpayments. The notice must include patient names, services dates, payment amounts, proposed adjustments and a reasonably specific explanation of proposed adjustments. There is a maximum 24-month look-back period from the date the original payment was received by the physician. There are several exceptions to this time limit including when the overpayment recovery is based upon a reasonable belief of fraud or other intentional misconduct or abusive billing, or when it is initiated at the request of self-insured plan or as required by state or federal health care programs. "Abusive billing" is defined as "a billing practice which results in submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct." The 24-month look-back limit does not apply if a plan gave notice of recovery efforts prior to January 1, 2007. In such case, the contractual limit of six (6) years would remain applicable.

Physician Credentialing

Lastly, Chapter 551 amended both the insurance and public health laws to require insurers and health plans to complete their review of health care professional's applications for participation in an insurer's or plan's network in a more timely manner. Specifically, the insurer or health plan must notify professionals whether they are credentialed to participate in the insurer's or plan's network within 90-days of receiving a completed application. There are a number of limited exceptions to this 90-day rule. Of course, this does not mean that an insurer or health plan is required to credential all providers but merely sets forth the timeframe for notification of the insurer or health plan's decision.

It is worth noting that these statutory provisions can trace their origins to several terms contained in the national class-action settlements involving Aetna, Cigna and HealthNet as well as the Medical Society of the State of New York's settlement with Excellus. The final legislation most closely resembles the Excellus Settlement which provided for claims processing consistent with AMA CPT code guidelines and conventions; 30 days' written notice of overpayment demands; 24-month look-back limit in the first 18 months after the effective date of the settlement and then a 12-month look-back limit thereafter (included were exceptions for reasonable suspicions of fraud or other misconduct or if recovery was initiated at the request of a self-insured plan); and 90 days to complete primary source verification when credentialing providers

seeking to participate in Excellus' network. The Aetna and Cigna settlements contained similar provisions regarding AMA CPT coding and timeframe for processing credentialing applications. The most notable differences among settlements was that Cigna agreed to a 12-month look-back for overpayment recoveries and Aetna agreed to a twenty-four (24) month look-back period.

The original proposals, which were introduced at the urging of various provider organizations, had a six-month look-back limit with an exception for cases where the health plan could demonstrate clear evidence of fraud. Several physician organizations opposed the final legislation on the grounds that: 1) the recovery timeframe remained too long, and 2) the definition of "abusive billing" was so broad that it potentially eliminated any benefit to be derived by the 24-month limit included in the final legislation.

What's Next

Interestingly, the claims processing and overpayment recovery provisions contained in the new law apply only to physicians. As a result, it is reasonable to assume that other providers will seek amendments to expand the applicability of these provisions. These efforts may afford a new opportunity to modify certain aspects of these provisions, including the look-back timeframe as well as the definition of "abusive billing." There are also indications that both the Health and Insurance Departments will be weighing in on certain managed care practices with the submittal of specific legislative proposals potentially addressing limitation on the denial of preauthorized services, prompt payment, continuity of care, as well as the expansion of the scope of external appeals among other issues. These proposals are in addition to the myriad of legislative proposals which have already been introduced.

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Provider Contract Guidelines for Managed Care Organizations and IPAs

New York State Department of Health[1]

I. Requirement to Obtain Contract Approval

A. An applicant shall submit for DOH approval drafts of all contracts (and material amendments to such contracts) related to the provision of medical services. This includes contracts between:

- a managed care organization (MCO) and a provider;
- an MCO and an independent practice association (IPA), for the IPA to make the services of providers available to the MCO's enrollees, as described in 10 NYCRR § 98-1.2(w);
- an IPA and providers; and
- an IPA and another IPA, in accordance with 10 NYCRR § 98-1.5(b)(6)(vii)(e)(1).

Such contracts and amendments must comply with the requirements of these Guidelines, 10 NYCRR Subpart 98-1, and all other applicable statutes and regulations.

Contracts between a workers' compensation preferred provider organization (PPO) and a provider or IPA must also be submitted for Department approval. However, separate guidelines have or will be developed with respect to the submission and approval of such contracts.

B. A contract or amendment subject to these Guidelines should be for medical services and technical and administrative services (as defined in Section I.D.5 below) only. Arrangements to delegate management functions (as defined in Section I.D.4. below) should be addressed in a separate agreement. Therefore, these Guidelines do NOT apply to contracts:

- between an MCO and a management contractor; or
- between an MCO and IPA, for the IPA to perform management functions (see Section I.C. below).

C. Delegation of Management Functions to an IPA. When an IPA agrees to make the services of a network of providers available to an MCO's enrollees, the MCO and the IPA enter into an agreement (IPA medical services contract). If the MCO also wishes to delegate management functions to the IPA, the MCO and the IPA must enter into a management contract separate from their IPA medical services contract. These Guidelines set forth requirements applicable to IPA medical services contracts. The requirements for management contracts are dealt with in a different set of guidelines.

As indicated in the previous paragraph, an IPA medical services contract must not address management functions (as defined in Section I.D.4. below) that the IPA will be furnishing to the MCO. An IPA medical services contract may address related technical and administrative services (as defined in Section I.D.5. below), including provider credentialing, that the IPA will be furnishing to the MCO, as long as those technical and administrative services are not related to delegated management functions.

Claims adjudication/payment is defined as a management function in 10 NYCRR § 98-1.11(j). Therefore, if claims adjudication/payment is to be delegated to the IPA, it must be addressed in the management contract, and not in the IPA medical services contract.

D. As used in these Guidelines:

1. **"MCO" includes**:
   - traditional health maintenance organizations certified pursuant to Public Health Law (PHL) § 4403;
   - special purpose MCOs, also known as prepaid health services plans (PHSPs), certified pursuant to PHL § 4403-a;
   - HIV Special Needs Plans (HIV SNPs) certified pursuant to PHL § 4403-e; and
   - managed long term care plans certified pursuant to PHL § 4403-f.
2. **"IPA"** includes, in addition to independent practice associations, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.
3. **"Material amendments"** include but are not limited to:

- any change to a required contract provision;
- any change to or addition of a risk sharing arrangement other than the routine trending of fees or other reimbursement amounts;
- the addition of an exclusivity, most favored nation, or non-compete clause;
- any proposed subcontracting of the existing contractual obligations of an IPA;
- any proposed subcontracting of the statutory or regulatory responsibilities of an MCO; and
- any proposed revocation of an approved subcontract.

Authority: 10 NYCRR § 98-1.2(aa).

4. **"Management functions"** are elements of an MCO governing body's management authority. Some management functions, listed in 10 NYCRR § 98-1.11(i), must not be delegated by an MCO to another person or entity. Other management functions, listed in 10 NYCRR § 98-1.11(j), may be delegated to another person or entity, but only pursuant to a management contract approved by DOH.
5. **"Technical and administrative services"** refers to any functions (other than medical services) that an MCO is not prohibited from delegating by 10 NYCRR § 98-1.11(i), and that are not functions listed in 10 NYCRR § 98-1.11(j) requiring DOH approval of a management contract. Administrative services include administrative expenses provided through the contract that the MCO would otherwise have reported on the MCO's own cost report. They do not include administrative expenses incurred by an IPA or provider in the course of performing the IPA or provider's business.
6. The revisions to the Guidelines issued January 1, 2007 and contained herein apply to new contracts, template contracts with new providers, and amendments to existing approved contracts submitted to the New York State Department of Health (DOH) for review on or after January 1, 2007. They shall not apply to previously approved contracts and approved amendments in effect as of January 1, 2007, or contracts and amendments submitted to DOH for review and approval and received by close of business December 31, 2006.

   Existing contracts approved before January 1, 2007, and contracts and amendments submitted by close of business December 31, 2006 and subsequently approved by DOH, should be revised to conform to the provisions of these Guidelines no later than the following, whichever occurs first:

   1. the next material change to the contract;
   2. the next renewal of the contract;
   3. the deadline specified by DOH as a condition of approving an MCO change of control, acquisition, merger, expansion, or the like; or
   4. for all contracts other than hospital contracts, December 31, 2008.

   Contract amendments to conform to these Guidelines do not have to be submitted for DOH review and approval if the only changes to the contract are: (a) the substitution of the January 1, 2007 Standard Clauses Appendix for the previous version; and (b) the addition or amendment, as necessary, of language to provide that in the case of inconsistencies between the Standard Clauses Appendix and other provisions of the contract, the Standard Clauses shall control, except to the extent that applicable law requires otherwise.

   Authority for Department of Health review of provider contracts: PHL § 4402(2)(a), 10 NYCRR §§ 98-1.5(b)(6), 98-1.7(b)(2), 98-1.8(b), 98-1.13(a), 98-1.18(a), (b).

II. Contract Review Process

A. Submission Requirements. DOH review will commence upon receipt of ALL of the following:

   1. One (1) electronic copy of each contract or material amendment submitted for approval, in a standard searchable PDF format on a closed session CD-R (not CD-RW), with copy/read permissions, that meets the following requirements:
      - the Standard Clauses Appendix (Attachment 1), without modification, must be attached to the contract (not required for material amendments) and the provisions of such Appendix must be expressly incorporated by reference in the contract;
      - each contract or contract amendment must be for medical services and technical and

administrative services only (see Section I.B. above);

- each contract or contract amendment must have an MCO-assigned unique identifier made up of any combination of letters and numbers; a new unique identifier must be assigned whenever the contract or amendment is modified;
- each contract or contract amendment must be dated, and all amendments must reference the date of the originally approved contract;
- all new and amended language shall be underlined and all deleted language bracketed, or otherwise highlighted (e.g. a redlined version) for ease of review;
- a contract between an MCO and IPA must be submitted together with all related contracts between the IPA and providers; contracts between an IPA and an IPA must be submitted together with all related MCO/IPA and IPA/participating provider contracts; in the case of material amendments to approved contracts, only the specific contracts being amended must be submitted for review.

2. A completed DOH-4255, "Contract Statement and Certification" (Attachment 2) for each contract or material amendment, bearing the same MCO-assigned unique identifier as the submitted contract or amendment. In all cases, the certification must be signed by an officer of the MCO or the MCO's legal counsel.

3. All required supporting documentation as described in these Guidelines and on the DOH-4255

   This material should be submitted: (a) if the MCO is a managed long term care plan, to DOH's Bureau of Continuing Care Initiatives, Empire State Plaza, Corning Tower Building, 20th Floor, Albany, New York 12237; or (b) for all other MCOs, to DOH's Bureau of Managed Care Certification and Surveillance, Empire State Plaza, Corning Tower Building, 19th Floor, Albany, New York 12237. **Incomplete submissions will not be accepted for review.**

   If at any time during the review process, modifications are made to the submitted contract or contract amendment that render inaccurate any statements made in the "Contract State-ment and Certification" (DOH-4255), the MCO must submit a new, corrected, and signed DOH-4255.

   After DOH approval is received, the MCO must submit an electronic copy of the executed contract or contract amendment in a standard searchable PDF format on a closed session CD-R (not CD-RW), with copy/read permissions. The signature page demonstrating execution of the contract or contract amendment may be a scanned electronic image included in the electronic submission, or submitted as a hard copy with the CD-R. If a material amendment is made to a contract that permits amendment by notice to a provider, then an electronic copy of the notice sent to providers to implement the amendment must be sent to DOH to fulfill this requirement.

B. 30 Day Review: Contracts and material amendments will be reviewed within 30 days of receipt of a complete submission if:

   1. there are no risk arrangements, or the payment arrangement is fee-for-service with withholds or bonuses less than 25% of payments, or all risk arrangements fall under State Insurance Department (SID) Regulation 164, or the risk transferred is for a single, directly-provided service (except inpatient hospitalization), for which the provider accepts all medical risk (see risk levels one and two in section VI.B. below); and
   2. the DOH-4255 certification is signed, dated and notarized; and
   3. the contract expressly provides that the parties agree to incorporate all modifications required by DOH for approval, or to terminate the contract if so directed by DOH.

C. 90 Day Review: Contracts and material amendments will be reviewed within 90 days of receipt of a complete submission if:

   1. there are risk arrangements that do not meet the requirements of the 30 day process in B.1 above (see risk levels 3, 4, and 5 in section VI.B. below); and
   2. all information and supporting documentation required, as described in the Financial Review of MCO Contracts section of these guidelines (see section VI. below), is included (including the contractor's or guaranteeing parent's most recent certified audited financial statements

and proof of financial security deposit, if required); and

3. the DOH-4255 certification is signed, dated and notarized; and the contract expressly provides that the parties agree to incorporate all modifications required by DOH for approval, or to terminate the contract if so directed by DOH.

D. Contract templates

1. MCO/provider. DOH will approve template provider contracts (or amendments to such contracts) that: (a) conform to the requirements of these guidelines; and (b) involve only a Level 1 or Level 2 risk arrangement, and/or fall under Regulation 164, as described in section VI.B of these guidelines. An approved template contract may be executed with multiple providers without separate DOH approval unless material revisions are included in the individual contract with the provider. Notwithstanding DOH approval of a template agreement, MCOs must still obtain separate SID approval of each specific provider agreement if so required under Regulation 164.

   DOH must issue separate prior approval for each specific provider contract involving Level 3, Level 4, or Level 5 risk arrangements, as described in section VI.B of these guidelines.

2. MCO/IPA. DOH will approve template MCO/IPA contracts (or amendments to such contracts) that conform to the requirements of these guidelines. However, upon execution of an MCO/IPA contract and prior to implementation, the executed contract must be submitted to DOH, along with the IPA/participating provider contract, to ensure that the entity with which the MCO is contracting is an approved IPA and to review the financial arrangements, if applicable.

3. IPA/IPA. DOH will approve template IPA/IPA contracts (or amendments to such contracts) that conform to the requirements of these guidelines. However, upon execution of an IPA/IPA contract and prior to implementation, the executed contract must be submitted to DOH, along with the MCO/IPA and IPA/participating provider contracts, to ensure that the entities are approved IPAs and to review the financial arrangements, if applicable.

E.

1. If, after submission of a contract for both State Insurance Department (SID) and DOH review, SID determines that the risk arrangement does not fall under Regulation 164, the plan should prepare a revised contract statement and resubmit the contract for DOH review. If DOH issues comments requesting revisions to the agreement, and the MCO fails to satisfactorily respond within the timeframe specified by DOH, DOH will disapprove the agreement and require the MCO, if it wishes to pursue the contract, to restart the review process by sending a new submission of the agreement to DOH. The new submission must address any outstanding comments. DOH will consider extenuating circumstances before terminating its review of the agreement.

2. If at any time after DOH approval, a contract originally certified on the DOH-4255 as falling under Regulation 164 but exempt from filing for SID approval of the risk arrangements, loses its exempt status, that is, the 12 month medical payments are expected to exceed threshold amounts, the MCO is responsible for seeking SID approval of the agreement and notifying DOH in writing of the change in status and the application for SID approval.

III. Date of Contract Implementation

A. Any contract or amendment that does not satisfy the requirements of Section II above may not be implemented without the prior written approval of DOH.

B. The parties may implement a contract or a material change when 30 or 90 days, as applicable, have elapsed after receipt by DOH of an application that meets the requirements of Section II above, including but not limited to: expressly incorporating by reference in the agreement the terms of the Standard Clauses Appendix; submitting a signed DOH-4255; and submitting all required financial documentation and other supporting documentation. Such implementation is subject to DOH final approval and to making any modifications required by DOH.

   A contract or material amendment that is implemented after 30 or 90 days, as applicable, but prior to final approval by DOH, shall contain express provisions whereby the parties agree that the contract or material amendment is subject to final

DOH approval, that the parties will make any modifications to the contract or material amendment required by DOH, and that the parties will terminate the contract or material amendment if so directed by DOH.

C. Contracts and material amendments cannot be implemented prior to the 30th or 90th day, unless DOH (and, if applicable, SID) has completed its review and issued written approval.

D. Contracts between an MCO and IPA may not be implemented in accordance with the requirements of this Section unless all related contracts between the IPA and providers meet the same requirements.

E. Under no circumstance may the applicant implement a contract or material amendment if:

1. DOH, by written notice, has expressly withheld permission for the parties to proceed pending further review of the contract, or DOH has issued a written disapproval of the contract or material amendment; OR

2. SID approval under Regulation 164 is required, and SID has not issued a written approval or has issued a written disapproval of the contract or material amendment.

F.

1. DOH will routinely select a sample of approved contracts and contract amendments submitted from all MCOs for full verification of consistency with applicable laws, regulations, guidelines, and the submitted "Contract Statement and Certification" (DOH-4255).

2. Notwithstanding the issuance by DOH of a final written approval of a contract or material amendment, DOH may require the parties to make modifications to the contract or take other corrective action if DOH subsequently discovers, through verification review or by any other means, that, contrary to representations made by the MCO, including the Contract Statement and Certification (DOH-4255), the contract contains provisions which are inconsistent with such representations and/or which are not in conformance with applicable laws, regulations, or Guideline provisions. An MCO's failure to make required modifications to the contract or to take other corrective action, as directed by DOH, may result in enforcement action in appropriate circumstances.

IV. General Contracting Requirements and Prohibitions

Contracts must be between the MCO and the provider, or the MCO and an IPA. It is not acceptable for provider contracts to be between the provider or IPA and the MCO's parent or subsidiary corporation, or between a provider and an MCO's management contractor.

An MCO may contract with its parent, or a sister or subsidiary entity or other entity licensed or certified in another state, in order to make available (i) services and (ii) the benefit of discounted rates for its enrollees traveling out-of-state. An MCO may contract with a sister or subsidiary MCO or other MCO operating within New York to make available services and discounted rates to its enrollees incidentally when traveling within New York but outside of the MCO's New York service area. An MCO may contract with purveyors of pharmaceutical supplies to purchase such supplies at discounted rates, and with entities performing laboratory testing to obtain discounted rates, provided that arrangements with providers of such services to New York enrollees comply with federal fraud and abuse requirements and New York law.

The prohibition against the unauthorized corporate practice of medicine precludes any corporation or unlicensed entity from providing or arranging to provide professional services unless licensed or otherwise authorized in statute or regulation. In light of this, an MCO may only contract with licensed providers, professional corporations, professional services limited liability companies or partnerships, limited liability companies or corporations legally licensed, registered or certified to provide the contracted for services, or IPAs. An MCO may not contract for health care services with any other entity that arranges to provide professional services through a contracted provider network.

V. Mandatory Contract Provisions

A. **Generally**. This section lists provisions that must be included or addressed in contracts between providers and the MCO, or providers and an IPA. In addition, a contract between an MCO and an IPA, or between an IPA and an IPA, must require these provisions to be included in IPA contracts with providers.

Many of these required provisions are included within the Standard Clauses Appendix that must be attached to and incorporated into the contract. If a required provision is addressed in the Standard Clauses Appendix, it does not need to be duplicated in the main body of the contract. No

amendments or revisions to the Standard Clauses Appendix will be approved. In the list below, required provisions that are addressed in the Standard Clauses Appendix are indicated by a parenthetical reference to the location of the provision within such Appendix.

1. The contract must include a provision stating that it is the only agreement between the parties regarding the arrangement established therein. **(SC § B.1)**

2. If a contract is to be implemented prior to DOH approval, as discussed in Section III.B above, it must include a provision to the effect that any changes to the contract required by DOH will be made by the parties and that the parties agree to terminate the contract at the direction of the Department effective 60 days subsequent to notice, subject to PHL § 4403(6)(e).**(SC § B.1)**

3. The contract must include a provision whereby the parties agree to be bound by the Standard Clauses attached to and incorporated into the agreement. The parties must further agree that to the extent there are any inconsistencies between the other provisions of the agreement and the Standard Clauses, the Standard Clauses shall control, except to the extent applicable law requires otherwise and/or to the extent the parties to the contract have voluntarily agreed to provisions that exceed the minimum requirements of the Standard Clauses. The following is a sample of an acceptable incorporation by reference provision:

   "New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts," attached to this Agreement as Appendix, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of this Agreement exceeds the minimum requirements of the Standard Clauses.

4. The contract must include enrollee non-liability language that prohibits providers from billing enrollees, the New York State Department of Health, or the City of New York, for services covered by the MCO. **(SC § C.1)**

   Authority: Insurance Law § 4307(d); PHL § 4403(1)(c); 10 NYCRR §§ 98-1.5(b)(6)(ii), 98-1.6(c), 98-1.13(i), 98-1.18(b).

5.

   a. The contract must include a provision that requires providers to make enrollee medical records and other personally identifiable information available to the MCO and to the IPA (if applicable), with appropriate consent/authorization, for purposes including preauthorization, concurrent review, quality assurance, and payment processing; and to the NYSDOH, at no expense to the State, for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals and as otherwise required by State law. This provision shall include an express acknowledgment by the provider or, if applicable, an IPA, that it shall also provide to the MCO and to the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, to the extent authorized by law. These provisions shall by express statement in the contract survive termination of the contract for any reason. **(SC § D.1)**

      Authority: 10 NYCRR §§ 98-1.13(l), 98-1.18(b); PHL 4404(1); HIPAA and 45 CFR §§ 164.502(a)(1)(iii); 164.512(a), (d). See also 45 CFR § 164.506(b).

      See also paragraph 26(e) below with respect to Medicaid and Family Health Plus records access.

   b. The contract must include a provision whereby the MCO and the provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to

agree as provided above. If the agreement is between an IPA and a provider, the provider agrees to obtain consent from the enrollee if the enrollee has not previously signed a consent for disclosure of medical records. **(SC § D.4)**

Please note that under existing law, an adult is without legal authority to consent to the release of medical records of another adult.

6. In primary care practitioner contracts, there must be a provision for 24-hour coverage and back-up coverage when the participating physician is unavailable. Twenty-four (24) hour back-up call service is acceptable provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice. **(SC § B.6)**

   Authority: 10 NYCRR §§ 98-1.6(f), 98-1.13(d), (h), 98-1.18(b).

7. The contract must include clear provisions on the reimbursement of providers, including fees for each service or risk arrangements. The contract must prescribe:

   a. the method by which payments to a provider, including any prospective or retrospective adjustments thereto, shall be calculated;

   b. the time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;

   c. the records or information which the MCO will rely upon to calculate payments and adjustments; and

   d. the dispute resolution procedures.

   See Section VI below for additional financial requirements.

   NOTE: If a contract is to be amended, the revised contract must specify the calendar date on which any proposed change to a payment rate will take effect, without regard or reference to the date the contract amendment is fully executed.

   NOTE: DOH approval of a contract or amendment is based upon provider solvency and related financial standards and does not constitute an affirmation as to the reasonableness of the payments agreed to by the parties in the contract or amendment. Approval of a contract or amendment by DOH does not guarantee that the level of reimbursement in the contract or amendment will be recognized in premium rates paid to the MCO by New York State for participation in and services provided under any government sponsored managed care or health insurance program.

   Authority: PHL §§ 4403(1)(c), (e), 4403-a(3), 4406-c(5-a); 10 NYCRR §§ 98-1.5(b)(6)(i), 98-1.6(b), 98-1.11(d).

8. MCOs may not impose deductibles. Copayments and coinsurance are the only allowable enrollee cost-sharing mechanisms. Contracts should not reference deductibles. The exception is that an MCO may impose deductibles pursuant to: (a) a point of service (POS) contract; or (b) to the extent permitted by DOH and SID, a High Deductible Health Plan (HDHP) combined with a health savings account (HSA). Use of the term "deductible" may be made in these contexts, or the contract may refer to "permitted deductibles", defined as a deductible associated with a POS contract or approved HDHP.

   Authority: 10 NYCRR § 98-1.6(f) requires the availability and accessibility of health care services to enrollees. The department interprets that regulation as prohibiting the imposition of front-end deductibles since they impede access to care.

9. The contract must include a provision stating that any material amendment to the contract requires prior approval of the Department of Health, and shall be submitted for approval at least 30 days, or at least 90 days if there are risk arrangements that do not meet the 30 day criteria, in advance of anticipated execution. **(SC § B.2)**

   Authority: 10 NYCRR §§ 98-1.5(b)(6)(iv), 98-1.18.

10. The contract must include provisions that are not inconsistent with the following:

    a. Assignment of an agreement between a MCO and an IPA, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and an

institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner. **(SC § B.3)**

Contracts between a hospital (as defined in PHL § 2801) and licensed practitioners, professional corporations or professional services limited liability companies do not require DOH approval; however such contracts should include provisions necessary to permit the hospital to meet its contractual obligations to the MCO or IPA.

b. Termination or non-renewal of an agreement between a MCO and an IPA, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner. Notice to the Commissioner is also required if the termination or non-renewal of a medical group provider contract will leave fewer than two participating providers of that type within the county. Unless otherwise provided by statute or regulation, the effective date of termination should not be less than 45 days after receipt by the Commissioner of notice by either party, provided, however, that termination by an MCO may be effected on less than 45 days notice when it can be demonstrated to the department prior to termination that, e.g., a hospital has lost JCAHO accreditation or malpractice insurance coverage, or other circumstances have arisen which justify or require immediate termination. Notice to the Commissioner must include an impact analysis of the termination or non-renewal on enrollee access to care. **(SC § E.1)**

NOTE: PHL § 4406-d prohibits termination of a health care professional contract by an MCO or IPA without notice and the opportunity for a hearing, subject to certain exceptions; non-renewal is permitted on 60 days notice and shall not be considered a termination under § 4406-d. **(SC § E.2)**

Authority: PHL § 4406-d(2)(f), 4406-d(3); 10 NYCRR §§ 98-1.8(b), 98-1.13(c), 98-1.18(a), (b).

11. In a contract providing for arbitration or mediation of disputes, there must be a provision expressly acknowledging that the Commissioner of the Department of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the contract shall provide that the Commissioner will be given notice of all issues going to arbitration or mediation, and copies of all decisions. **(SC § F.1)**

12. The contract must include a provision ensuring the retention of enrollee medical records generally for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later. **(SC § D.3)**

    Authority: 10 NYCRR §§ 98-1.12(n), 98-1.18(b).

13. The contract must include a continuation of treatment clause whereby the provider agrees that in the event of MCO or IPA insolvency or termination of the contract for any reason, the provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. Such provision shall by express statement survive termination of the agreement. **(SC § E.4)**

    Contractors may also include express provisions addressing the ninety day transitional care available to enrollees involved in an ongoing course of treatment at the time his/her provider's disaffiliation with the plan at the enrollee's option or, as to an enrollee who has entered the second trimester of pregnancy on the effective date of termination, through the delivery of post-partum care directly related to the delivery pursuant to PHL § 4403(6)(e). Addressing this enrollee option in provider contracts will help ensure provider awareness of these provisions.

    Authority: PHL § 4403(6)(e); 10 NYCRR §§ 98-1.6(f), 98-1.13(a), 98-1.18(a), (b). (See also paragraph 25(b) below).

14. Contracts between MCOs and IPAs may provide for automatic assignment of the IPA's provider contracts to the MCO in the event of termination of the MCO/IPA contract; the IPA,s contracts with providers should also contain this provision. In the alternative, the MCO/IPA contract and the IPA's provider contracts shall provide that in the event of termination of the MCO/IPA contract, the provider agrees to continue to provide care to the MCO's enrollees pursuant to the terms of the MCO/IPA provider agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. Such provisions shall by express provision survive termination of the MCO/IPA contract. **(SC § E.3)**

    Authority: PHL §§ 4403(1), (5), (6), 4404.

15. Coordination of Benefits (COB) monies generally become property of the MCO. Providers may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO. Pursuant to contract, COB may accrue to providers. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, providers must maintain and make available to the MCO records reflecting COB proceeds collected by the provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds. **(SC § C.2)**

    MCOs are subject to audits under the Medicaid, Child Health Plus and Family Health Plus programs, including audits which can be conducted without notice by the Office of the State Comptroller for COB collected for enrollees in these government programs, and therefore must have records concerning collection of COB proceeds available.

16. An MCO or IPA may not transfer liability for its own acts or omissions to a provider, by indemnification or otherwise. **(SC § B.7)** (See also paragraph 25(e) below)

    Authority: PHL § 4406-c(5), 10 NYCRR § 98 1.18(a), (b).

17. A contract between an MCO and an IPA for the IPA to make the services of providers available to the MCO's enrollees should not address any utilization review activities to be conducted by the IPA. An IPA may only perform utilization review activities for an MCO if: (a) the MCO has delegated this function to the IPA in a separate management contract approved by DOH; and (b) the IPA has registered as a utilization review agent in accordance with the requirements of Article 49 of the PHL. **(SC § G.1)**

    Authority: 10 NYCRR §§ 98-1.5(b)(6)(vii), 98-1.11(j)(7), 98-1.18 and PHL Article 49.

18. In provider contracts, there must be a provision indicating that the provider shall comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the provider at least thirty (30) days in advance of implementation, including but not limited to:

    - quality improvement/management;
    - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
    - member grievances; and
    - provider credentialing. **(SC § B.4)**

    Authority: 10 NYCRR §§ 98-1.12, 98-1.14, PHL §§ 4402, 4403.

19. In provider contracts, there must be a provision indicating that the provider will not discriminate against the enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition. **(SC § B.5)**

    Authority: The Constitutions of the United States and of New York State; applicable state and federal statutes.

20. Contracts must provide for compliance with the Federal Americans with Disabilities Act (ADA). **(SC § B.10)**

21. In provider contracts, there must be a provision requiring the provider to agree to comply with the HIV confidentiality requirements of Article 27-F of the Public Health Law. **(SC § B.11).**

    Authority: 10 NYCRR § 98 1.13(m).

22. "Exclusivity" clauses, whereby a provider must agree not to contract with any other MCO or IPA, while not per se illegal under the anti-trust laws, are not viewed favorably by DOH as they may limit access and provider choice by enrollees.

23. "Exclusion" clauses, whereby a provider must agree not to accept enrollees of one or more specified MCOs, are not viewed favorably by DOH as they may limit access and provider choice by enrollees.

24. "Most Favored Nation" clauses, whereby, for example, a plan may unilaterally reduce a negotiated rate to a provider where the provider negotiates a more favorable rate with a competing plan, while not per se illegal under the anti-trust laws, have been actively discouraged by DOH.

25. The contract must include a provision whereby the parties agree to comply with the requirements of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) and Chapter 551 of the Laws of 2006, and all amendments thereto. (SC § B.8) In addition, at the option of the parties, contracts may expressly address specific provisions of these chapter laws, such as:

    a. Sections 4403(6) and 4408(1)(m) and (n) of the PHL require plans to establish procedures for enrollees who meet certain criteria to access certain specialist care.

    b. Section 4403(6)(e) of the PHL requires that plans allow for a period of "transitional care", for enrollees who meet certain criteria, from health care providers who will no longer be members of the plan network, provided that the providers agree to certain terms under which they will provide such care.

    c. Section 4406-c of the PHL provides that a health care provider shall not be prohibited from engaging in certain patient advocacy activities. PHL § 4406-c applies to IPA's as well as to MCO's.

    d. Section 4406-d of the PHL requires an MCO to complete its review of a health care provider's application to be credentialed and participate in the in-network portion of the MCO's network within 90 days. In addition, Section 4406-d affords certain protections to health care providers with respect to termination of their contracts (with certain exceptions), including notice and the right to a hearing.

    e. Section 4406-c(5) of the PHL provides that the plan may not transfer liability for any act or omission by the plan to the health care provider except when the provider is a medical group. The intent of this provision was to recognize the joint and several liability of individual members of a medical group for the acts or omissions of the group or any member thereof. A plan may not transfer liability for its own acts or omissions to a medical group; it may, however, contractually impose or ascribe liability for the acts or omissions of an individual member of a medical group to another member of the group, or all members of the group.

    f. Section 4408-a sets forth requirements for plan grievance procedures for issues other than determinations of medical necessity, which are governed by PHL Article 49.

    g. Section 4410(4) of the PHL requires that the New York State Commissioner of Health have access to patient specific information maintained by a plan for purposes of quality assurance and oversight.

    h. Article 49 of the PHL provides detailed standards for utilization review activities performed either by the plans themselves or by registered independent utilization review agents that contract with plans to provide these functions and external appeals.

    i. Section 4900(3) of the PHL provides a standard definition for the term "emergency condition."

    j. Section 3224-b(a) of the Insurance Law requires an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).

    k. Section 3224-b(b) of the Insurance Law prohibits an MCO from initiating overpayment recovery efforts more than 24

months after the original payment was received by a physician, with certain exceptions. In addition, other than recoveries of duplicate payments, an MCO must provide a physician with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.

26. For MCOs that enroll individuals covered by the Medicaid and/or Family Health Plus programs, the contract must include a provision incorporating into the agreement the pertinent MCO obligations under the terms of the Medicaid managed care contract between the Plan and DOH (or between the Plan and New York City) and/or the Family Health Plus contract between the Plan and DOH. **(SC § B.9)**

    In addition, provider and IPA agreements must contain all provisions specifically required to be present by the Medicaid managed care/Family Health Plus contracts and applicable laws. These currently include:

    a. Provisions specifying that the MCO will monitor the performance of IPAs and providers with which it contracts, and that the MCO will terminate such a contract, and/or impose other sanctions, if the IPA's or the provider's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contract. **(SC § B.9.a)**

    b. A provision whereby: (i) the IPA or the provider agrees that the work it performs under the contract with the MCO will conform to the terms of the Medicaid managed care contract between the Plan and DOH (or New York City) and/or the Family Health Plus contract between the Plan and DOH; and (ii) if the IPA's or the provider's performance under the contract with the MCO does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contract, the IPA or the provider agrees to take corrective action. **(SC § B.9.b)**

    c. A provision whereby the IPA or the provider agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care and/or Family Health Plus contract. **(SC § B.9.c)**

    d. A provision whereby the MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility. **(SC § B.9.d)**

    e. If a contract provides for a Physician Incentive Plan, compliance with applicable CMS regulations is required. This compliance is separate from the actual approval of the risk transfer arrangement. The contract must include a provision whereby the parties agree to comply with the requirements of 42 CFR § 438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210, and to incorporate such requirements into any agreements between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under the contract. **(SC § C.3)**

    f. A provision for access by the Centers for Medicare and Medicaid Services (CMS) to providers' enrollee medical records, encounter data and financial information. **(SC § D.2)**

    g. The MCO must include in its contracts with providers and IPAs the provisions in the Medicaid managed care/Family Health Plus contract prohibiting the use of Federal funds for lobbying, including requiring the provider or IPA, in the case of contracts that exceed $100,000, to make all required certifications and disclosures.

B. Risk sharing requirements.

    1. For a contract involving Level 3, 4, or 5 risk arrangements, as described in section VI.B. of these guidelines, the contract must:

        a. provide for the MCO's ongoing monitoring of provider financial capacity and/or periodic provider financial reporting to the MCO to support the transfer of risk to the provider, and include a provision to address circumstances where the provider's financial condition indicates an inability to continue accepting such risk; and

b. address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting under funding of the deposit to be maintained by the MCO.

2. For any contract involving an MCO sharing risk with an IPA, the contract must include provisions whereby:

   a. the parties expressly agree to amend or terminate the contract at the direction of DOH;

   b. the IPA will submit both quarterly and annual financial statements to the MCO, and the MCO will notify DOH of any substantial change in the financial condition of the IPA; and

   c. the parties agree that all provider contracts will contain a provision prohibiting providers, in the event of a default by the IPA, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA pursuant to the financial risk sharing agreement.

VI. Financial Review of MCO Contracts

DOH financial review and approval is required for all MCO agreements that transfer financial risk for services to another entity, except for prepaid capitation agreements effective after August 22, 2001. Such prepaid capitation agreements fall under the State Insurance Department (SID) Regulation 164 and require separate SID financial approval, in addition to the DOH legal and program review. This section describes the regulatory framework for risk and risk sharing, defines different levels of risk transfer and the financial criteria that DOH applies to each level, and the criteria for determining what type of financial review a contract or amendment requires.

A. Statutory and Regulatory Framework for Sharing Risk

1. PHL Article 44. MCOs are licensed under Article 44 as entities that assume the obligation to provide or arrange for provision of a comprehensive range of medical services, including inpatient, in exchange for a predetermined payment amount per person per month. This is referred to as acceptance of full risk by the MCO as required by PHL § 4403(1)(c).

   The MCO always retains its statutory obligation to maintain full risk under PHL § 4403 (1)(c) on a prospective basis for the provision of comprehensive health services pursuant to a subscriber contract or governmental program. The MCO must fulfill its non-transferable obligation to provide comprehensive health services to subscribers and enrollees in any event, including the failure of a medical risk sharing arrangement with a provider.

2. DOH regulations at 10 NYCRR Part 98. "Risk sharing" is defined in §98-1.2(kk) as the contractual assumption of liability by a provider or IPA for the delivery of health care services to enrollees of the MCO. This assumption of liability may be by means of a capitation arrangement or some other mechanism (e.g. through withhold, pooling, or postpaid provisions). Risk sharing is sometimes referred to as accepting financial risk or "medical risk".

   Section 98-1.11 imposes financial requirements for entities licensed under Article 44, and allows an MCO to share risk with providers.

   Section 98-1.5(b)(6)(vii)(e)(1) allows an IPA, incidental to its primary IPA powers and purposes, to share risk for the provision of medical services with MCOs, and to subcapitate or otherwise compensate providers and IPAs with which it has contracted.

   Section 98-1.18(e) prohibits an MCO from entering into a risk sharing arrangement with an IPA without first obtaining approval from DOH or SID, as applicable, in accordance with these Guidelines and Regulation 164.

3. SID Regulation 164. SID Regulation 164, "Standards for Financial Risk Transfer Between Insurers and Health Care Providers" (11 NYCRR Part 101) requires MCOs to submit to SID for approval any prepaid capitation arrangement whereby an insurer transfers all or part of its financial risk to a health care provider. If in addition to prepaid capitation payments, there is medical risk transferred via any other provisions (i.e., withhold, pooling, postpaid, etc.), DOH financial review and approval of these additional provisions is also required.

B. Financial Review Criteria Used for Specific Risk Level Categories

   Depending on the type of entity the MCO is contracting with, and the extent of the services

for which risk is transferred, different criteria will be used by DOH for contract review. Entities who provide services directly, such as physicians or physician groups, hospitals, clinics, etc. are referred to as providers. IPAs do not provide services directly but must subcontract with providers for service provision. Based on these definitions for MCO contracting entities, five general categories, or levels, of medical risk transfers, are described below:

1. **Level 1**: Contracts with providers or IPAs based on fee-for-service arrangements, including withholds or bonuses up to 25% of the payment to the provider.

   Such contracts do not need to demonstrate the provider's financial viability or establish a financial security deposit.

2. **Level 2**: Contracts that transfer financial risk to providers or group of providers (e.g. capitation) for a single specific service the providers directly provide, i.e., primary care, (except inpatient hospitalization) with the provider accepting all medical risk for that service.

   Such contracts do not need to demonstrate the provider,s financial viability or establish a financial security deposit.

3. **Level 3**: Contracts that transfer broader risk to providers (multiple services provided directly, inpatient hospitalization, or fee-for-service with withholds or bonuses of greater than 25%).

   Such contracts must demonstrate the provider's financial viability. If the provider's net worth or guaranteeing parents' net worth is greater than zero, the contract is approvable, with no security deposit required for services provided directly. If the provider's net worth is less than or equal to zero, a financial security deposit must be established for the provider's in-network cost, as described in the next section.

4. **Level 4**: Contracts that transfer risk to IPAs for a single or multiple services.

   Such contracts must demonstrate the IPA's financial viability and establish a financial security deposit, as described in the next section.

5. **Level 5**: Contracts falling under risk level 3 or 4 above that include services not provided directly (out-of-IPA/provider network services).

   Such contracts must clearly state that the estimated part of the payment needed to provide the covered services to be referred or otherwise arranged by the IPA/provider to non-participating providers must be deposited by the MCO into a separate account designated as the "out-of-health care provider network account", in addition to meeting the criteria indicated for risk level 3 or 4 above, as applicable.

C. Specific DOH Requirements

   1. Demonstration of Financial Viability

      The MCO must provide such information as necessary to allow DOH to determine whether a provider sharing risk with the MCO, or an IPA sharing risk with the MCO, or a provider or IPA sharing risk with an IPA, is financially responsible and capable of assuming such risk, and has satisfactory insurance, reserves, or other arrangements to support an expectation that it will meet its obligations. The provider or IPA accepting risk must demonstrate sufficient capital and solvency via submission of certified audited financial statements or comparable means, such as an accountant,s compilation in cases where the provider/IPA is a new entity. If the contract includes a provision that a provider's parent organization (such as a hospital system) guarantees the provision and payment of services, the guaranteeing parents, certified audited financial statement can be used to establish the provider's solvency.

   2. Financial Security Deposit Requirement

      If a financial security deposit is required, the provider/IPA must establish and provide evidence of a financial security deposit equal to 12.5% of the estimated annual medical costs for the medical services covered under the risk arrangement and paid to the provider/IPA. The financial security deposit must consist of cash and/or short-term marketable securities and be held by the MCO. Under limited circumstances, a parental guarantee may be allowed, where the parent is a provider of all services covered under the agreement. The entire amount of the required security deposit must be available prior to contract approval. Any funds already retained by the MCO for out of contracting provider's participating network services are not subject to the financial security deposit. To the extent that contractual limits are imposed on the ultimate amount of provider financial risk, such as risk corridors or caps on

provider losses, the above requirements may be mitigated.

3. Out-of-Network Account Requirements

   The estimated part of the payment needed to cover services to be referred or otherwise arranged by the contracting provider or intermediary to non-participating providers must be deposited by the MCO into a separate account designated as the "out of health care provider network account". This account must be maintained by the MCO for the sole purpose of paying for the services covered by the risk agreement that were rendered by providers outside the IPA/provider's network. Amounts deposited in the out-of-IPA/provider network account must be reconciled at least annually with out-of-IPA/provider network incurred claims and expenses for the period covered by the reconciliation, and any excess in the account must be remitted to or otherwise settled with such IPA/provider within six months of the ending date of the reconciliation period.

   In the event the reconciliation reports a deficit, then the MCO must bill such deficit or otherwise settle such deficit with the IPA/provider within six months of the ending date of the reconciliation period.

4. Requirements for IPA Risk Sharing

   a. The MCO must provide a current list of the IPA's owners, officers, directors, and limited liability company managers and members.

   b. The MCO must submit the complete text of the proposed IPA contract(s) and all attachments thereto.

   c. The MCO and the IPA must demonstrate, to DOH's satisfaction, that the proposed arrangement will not constitute improper incentives to providers, in accordance with physician incentive plan guidelines, and will not result in a decrease in access to, or quality of, care provided to enrollees.

New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts

Appendix
(Revised 1/1/07)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. Definitions For Purposes Of This Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of arranging by contract for the delivery or provision of health services by individuals, entities and facilities licensed or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed and/or certified as required by applicable federal and state law.

B. General Terms And Conditions

1. This Agreement is subject to the approval of the New York State Department of Health and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by the Department of Health for approval or, alternatively, to terminate this Agreement if so directed by the Department of Health, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403(6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of the Department of Health, and any such amendment shall be submitted for approval at least 30 days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to Department of Health review, in advance of anticipated execution. To the extent the MCO provides and arranges for the provision of comprehensive health care services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or New York City, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH.
3. Assignment of an agreement between an MCO and (1) an IPA, (2) institutional network provider, or (3) medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA and (1) an institutional provider or (2) medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or SID guidelines or policies and (b) has provided to the provider at least thirty (30) days in advance of implementation, including but not limited to:
   - quality improvement/management;
   - utilization management, including but not limited to precertification procedures, referral process

or protocols, and reporting of clinical encounter data;

- member grievances; and
- provider credentialing.

5. The provider or, if the Agreement is between the MCO and an IPA, or between an IPA and an IPA, the IPA agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
6. If the provider is a primary care practitioner, the provider agrees to provide for twenty-four (24) hour coverage and back up coverage when the provider is unavailable. The provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA which is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA's own acts or omissions, by indemnification or otherwise, to a provider.
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) and Chapter 551 of the Laws of 2006, and all amendments thereto.
9. To the extent the MCO enrolls individuals covered by the Medical Assistance and/or Family Health Plus programs, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH (or New York City) and/or the Family Health Plus contract between the MCO and DOH as if set forth fully herein, including:
    a. The MCO will monitor the performance of the Provider or IPA under the Agreement, and will terminate the Agreement and/or impose other sanctions, if the Provider's or IPA's performance does not satisfy standards set forth in the Medicaid managed care and/or Family Health Plus contracts;
    b. The Provider or IPA agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH, and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA's performance; and
    c. The Provider or IPA agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH (or between the MCO and New York City) and/or the Family Health Plus contract between the MCO and DOH.
    d. The MCO and the Provider or IPA agree that a woman's enrollment in the MCO's Medicaid managed care or Family Health Plus product is sufficient to provide services to her newborn, unless the newborn is excluded from enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.
    e. The MCO shall not impose obligations and duties on the Provider or IPA that are inconsistent with the Medicaid managed care and/or Family Health Plus contracts, or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
10. The parties to this Agreement agree to comply with all applicable requirements of the Federal Americans with Disabilities Act.
11. The provider agrees, or if the Agreement is between the MCO and an IPA or between an IPA and an IPA, the IPA agrees and shall require the IPA's providers to agree, to comply with the HIV confidentiality requirements of Article 27-F of the Public Health Law.

C. Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, provider agrees that, during the time an enrollee is enrolled in

the MCO, he/she/it will not bill the New York State Department of Health or the City of New York for Covered Services within the Medicaid Managed Care Benefit Package as set forth in the Agreement between the MCO and the New York State Department of Health. In the case of Family Health Plus, provider agrees that, during the time an enrollee is enrolled in the MCO, he/she/it will not bill the New York State Department of Health for Covered Services within the Family Health Plus Benefit Package, as set forth in the Agreement between the MCO and the New York State Department of Health. This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefor prior to providing the service. Where the provider has not been given a list of services covered by the MCO, and/or provider is uncertain as to whether a service is covered, the provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the provider. However, with respect to enrollees eligible for medical assistance, or participating in Child Health Plus or Family Health Plus, the provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.

3. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (provider, IPA, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA if applicable), for purposes including preauthorization, concurrent review, quality assurance, provider claims processing and payment. The provider will also make enrollee medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The provider shall provide copies of such records to DOH at no cost. The provider (or IPA if applicable) expressly acknowledges that he/she/it shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.

2. When such records pertain to Medicaid or Family Health Plus reimbursable services the provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.

4. The MCO and the provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity,

or that the provider will obtain consent from enrollees at the time service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA or to third parties. If the Agreement is between an MCO and an IPA, or between an IPA and an IPA, the IPA agrees to require the providers with which it contracts to agree as provided above. If the Agreement is between an IPA and a provider, the provider agrees to obtain consent from the enrollee if the enrollee has not previously signed a consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination, by the MCO may be effected on less than 45 days notice provided the MCO demonstrates to DOH's satisfaction prior to termination that circumstances exist which threaten imminent harm to enrollees or which result in provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days notice of its decision to not renew this Agreement.

3. If this Agreement is between an MCO and an IPA, and the Agreement does not provide for automatic assignment of the IPA's provider contracts to the MCO upon termination of the MCO/IPA contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA's providers agree, that the IPA providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever first occurs. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The provider agrees that in the event of MCO or IPA insolvency or termination of this contract for any reason, the provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract, or Family Health Plus contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "provider" shall include the IPA and the IPA's contracted providers if this Agreement is between the MCO and an IPA.** This provision shall survive termination of this Agreement.

5. Notwithstanding any other provision herein, to the extent that the provider is providing health care services to enrollees under the Medicaid Program and/or Family Health Plus, the MCO or IPA retains the option to immediately terminate the Agreement when the provider has been terminated or suspended from the Medicaid Program.

6. In the event of termination of this Agreement, the provider agrees, and, where applicable, the IPA agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation, and copies of all decisions.

G. IPA-Specific Provisions

1. Any reference to IPA quality assurance (QA) activities within this Agreement is limited to the IPA's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

Endnote

1. Now available on the DOH website at http://www.health.state.ny.us/health_care/managed_care/hmoipa/hmo_ipa.htm.

Editor's Selected Court Decision

Catholic Charities of the Diocese of Albany et al., Appellants, v. Gregory V. Serio, as Superintendent of Insurance, Respondent

No. 110
Decided October 19, 2006

Michael L. Costello, for appellants.
Shaifali Puri, for respondent.

R. S. Smith, J.:

Plaintiffs challenge the validity of legislation requiring health insurance policies that provide coverage for prescription drugs to include coverage for contraception. Plaintiffs assert that the provisions they challenge violate their rights under the religion clauses of the federal and state constitutions. We hold that the legislation, as applied to these plaintiffs, is valid.

The Challenged Legislation

In 2002, the Legislature enacted what is known as the "Women's Health and Wellness Act" (WHWA), mandating expanded health insurance coverage for a variety of services needed by women, including mammography, cervical cytology and bone density screening (L 2002, ch 554). At issue here are provisions of the WHWA requiring that an employer health insurance contract "which provides coverage for prescription drugs shall include coverage for the cost of contraceptive drugs or devices" (Insurance Law § 3221 [l] [16], § 4303 [cc]).

The legislative history makes clear that the WHWA in general, and the provisions relating to contraception in particular, were designed to advance both women's health and the equal treatment of men and women. The Legislature was provided with extensive information showing the need for the legislation.

For example, the Legislature had before it a study showing that women paid 68% more than men in out-of-pocket expenses for health care, and that the cost of reproductive health services was a primary reason for the discrepancy. The American College of Obstetricians and Gynecologists advised the Legislature that better access to contraception would mean fewer abortions and unplanned pregnancies, and that the ability to time and space pregnancies was important to women's health. These conclusions are supported by studies contained in the record of this litigation, showing among other things that unintended pregnancies are often associated with delayed prenatal care; that such conditions as diabetes, hypertension, arthritis and coronary artery disease can be aggravated by pregnancy; that children born from unintended pregnancies are at risk of low birth weight and developmental problems; and that there are 3 million unintended pregnancies in the United States each year, of which approximately half end in abortion.

At the heart of this case is the statute's exemption for "religious employers." Such an employer may request an insurance contract "without coverage for . . . contraceptive methods that are contrary to the religious employer's religious tenets" (Insurance Law § 3221 [l] [16] [A]; § 4303 [cc] [1]). Where a religious employer invokes the exemption, the insurer must offer coverage for contraception to individual employees, who may purchase it at their own expense "at the prevailing small group community rate" (Insurance Law § 3221 [l] [16] [B] [1]; § 4303 [cc] [1] [A]). A "religious employer," as defined in the statute, is:

> "an entity for which each of the following is true:
>
> "(a) The inculcation of religious values is the purpose of the entity.
>
> "(b) The entity primarily employs persons who share the religious tenets of the entity.
>
> "(c) The entity serves primarily persons who share the religious tenets of the entity.
>
> "(d) The entity is a nonprofit organization as described in Section 6033 (a) (2) (A) i or iii, of the Internal Revenue Code of 1986, as amended."

(Insurance Law § 3221 [l] [16] [A] [1]; see § 4303 [cc] [1] [A] [i] - [iv]). Plaintiffs say that this definition is unconstitutionally narrow.

The Legislature debated the scope of the "religious employer" exemption intensely before the WHWA was passed. A broader exemption was proposed, one that would have been available to any "group or entity . . . supervised or controlled by or in connection with a religious organization or denominational group or entity" (2001 Senate Bill S 3, § 14). Supporters of this version of the exemption argued, as do plaintiffs here, that religious organizations should not be forced to violate the commands of their faith. Those favoring a narrower exemption asserted

that the broader one would deprive tens of thousands of women employed by church-affiliated organizations of contraceptive coverage. Their view prevailed.

This Action

Plaintiffs are 10 faith-based social service organizations that object to the contraceptive coverage mandate in the WHWA. Eight plaintiffs are affiliated in some way with the Roman Catholic Church: of these, three are large entities that provide a variety of social services, including immigrant resettlement programs, affordable housing programs, job development services, and domestic violence shelters; three primarily operate health care facilities, such as hospice centers, nursing homes and rehabilitative care facilities; and two operate schools. The other two plaintiffs are affiliated with the Baptist Bible Fellowship International: one of them offers a variety of social services to the public, including prison ministry, crisis pregnancy centers, job placement and homeless services; the other operates a K-12 school and provides day-care, pre-school and youth services.

None of the plaintiffs qualifies as a "religious employer" under the WHWA. This is essentially because plaintiffs are not, or are not only, churches ministering to the faithful, but are providers of social and educational services. Each of the plaintiffs asserts that its purpose is not, or is not only, the inculcation of religious values; most of the plaintiffs acknowledge that they employ many people not of their faiths; all of the plaintiffs serve people not of their faiths; and only three of the plaintiffs are exempt from filing tax returns under Internal Revenue Code § 6033 (a) (2) (A) i or iii, provisions applicable to churches and religious orders.

Plaintiffs believe contraception to be sinful, and assert that the challenged provisions of the WHWA compel them to violate their religious tenets by financing conduct that they condemn. The sincerity of their beliefs, and the centrality of those beliefs to their faiths, are not in dispute.

Contending that they are constitutionally entitled to be exempt from the provisions of the WHWA providing for coverage of contraceptives, plaintiffs brought this action against the Superintendent of Insurance, seeking a declaration that these portions of the WHWA are invalid, and an injunction against their enforcement. The complaint asserts broadly that the challenged provisions are unconstitutional, but plaintiffs do not argue that they are unenforceable as to employers having no religious objections to contraception; in substance, plaintiffs challenge the legislation as applied to them. Supreme Court rejected the challenge, and granted summary judgment dismissing plaintiffs' complaint and declaring the legislation valid. The Appellate Division affirmed, with two Justices dissenting. We now affirm.

Discussion

Plaintiffs argue that the provisions of the WHWA requiring coverage of contraception violate the Free Exercise Clauses of the New York and United States Constitutions, and the Establishment Clause of the United States Constitution. Plaintiffs' strongest claim is under the New York Free Exercise Clause, but our analysis of that claim may be clearer if we discuss the federal Free Exercise Clause first.

I

The First Amendment to the United States Constitution provides that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." By virtue of the Fourteenth Amendment, this provision is binding on the states as well as the federal government (*Cantwell v. Connecticut*, 310 US 296, 303 [1940]).

The United States Supreme Court's decision in *Empl. Div. v. Smith* (494 US 872 [1990]) bars plaintiffs' federal free exercise claim. In *Smith*, the Court interpreted its First Amendment decisions as holding "that the right of free exercise does not relieve an individual of the obligation to comply with a 'valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)'" (*id.* at 879) (quoting *United States v. Lee*, 455 US 252, 263 n 3 [1982] [Stevens, J., concurring]). The Court held that where a prohibition on the exercise of religion "is not the object . . . but merely the incidental effect of a generally applicable and otherwise valid provision, the First Amendment has not been offended" (494 US at 878).

By that test, the First Amendment has not been offended here. The burden on plaintiffs' religious exercise is the incidental result of a "neutral law of general applicability," one requiring health insurance policies that include coverage for prescription drugs to include coverage for contraception. A "neutral" law, the Supreme Court has explained, is one that does not "target[] religious beliefs as such" or have as its "object . . . to infringe upon or restrict practices because of their religious motivation" (*Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 US 520, 533 [1993]). Religious beliefs were not the "target" of the WHWA, and it was plainly not that law's "object" to interfere with plaintiffs' or anyone's exercise of religion. Its object was to make broader health insurance coverage available to women and, by that means, both to improve women's health and to eliminate disparities between men and women in the cost of health care.

The fact that some religious organizations—in general, churches and religious orders that limit their activities to inculcating religious values in people of their own faith—are exempt from the WHWA's provisions on contraception does not, as plaintiffs claim, demonstrate that these provisions are not "neutral." The neutral purpose of the challenged portions of the WHWA—to make

contraceptive coverage broadly available to New York women—is not altered because the Legislature chose to exempt some religious institutions and not others. To hold that any religious exemption that is not all-inclusive renders a statute non-neutral would be to discourage the enactment of any such exemptions—and thus to restrict, rather than promote, freedom of religion. As the California Supreme Court explained, in a decision upholding a statute nearly identical to the WHWA:

> "The high court has never prohibited statutory references to religion for the purpose of accommodating religious practice. To the contrary, the court has repeatedly indicated that 'it is a permissible legislative purpose to alleviate significant governmental interference with the ability of religious organizations to define and carry out their religious missions'"

(*Catholic Charities of Sacramento, Inc. v. Superior Ct.*, 32 Cal 4th 527, 551, 85 P3d 67, 83 [2004], quoting *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 US 327, 335 [1987]).

Nor can plaintiffs escape the force of the Supreme Court's decision in *Smith* by relying on the so-called "hybrid rights" exception. The notion of "hybrid rights" is derived from a dictum in which the *Smith* Court distinguished certain of its previous cases by saying:

> "The only decisions in which we have held that the First Amendment bars application of a neutral, generally applicable law to religiously motivated action have involved not the Free Exercise Clause alone, but the Free Exercise Clause in conjunction with other constitutional protections, such as freedom of speech and of the press, or the rights of parents . . . to direct the education of their children"

(494 US at 881 [internal citations omitted]).

Assuming that the above language does create an exception to the general rule of *Smith*, the exception does not apply here, for this is not a case that involves free exercise "in conjunction with other constitutional protections." Plaintiffs claim that the challenged legislation interferes with their rights of free speech and association, but the claim is insubstantial. The legislation does not interfere with plaintiffs' right to communicate, or to refrain from communicating, any message they like; nor does it compel them to associate, or prohibit them from associating, with anyone (*see Rumsfeld v. Forum for Academic and Institutional Rights, Inc.*, __ US __, 126 S. Ct. 1297, 1309-1313 [2006]). It does burden their exercise of religion—but that alone, under *Smith*, cannot call the validity of a generally applicable and neutral statute into question.

Plaintiffs also suggest that an exception to the holding of *Smith* can be derived from the doctrine of church autonomy, which prevents states from interfering in matters of internal church governance (*Serbian E. Orthodox Diocese v. Milivojevich*, 426 US 696, 709-710 [1976]; *Kedroff v. St. Nicholas Cathedral*, 344 US 94, 107-108 [1952]) or determining ecclesiastical questions (*Presbyterian Church v. Mary Elizabeth Blue Hull Mem. Presbyterian Church*, 393 US 440, 447 [1969]). But church autonomy is not at issue in this case. The Legislature has not attempted through the WHWA to "lend its power to one or the other side in controversies over authority or dogma" (*Empl. Div. v. Smith*, 494 US at 877, citing *Presbyterian Church*, 393 US at 445-452, *Kedroff*, 344 US at 95-119, and *Serbian E. Orthodox Diocese*, 426 US 708-725). The WHWA merely regulates one aspect of the relationship between plaintiffs and their employees.

Relying on the church autonomy cases, some lower federal courts have recognized a "ministerial exception" which exempts religious institutions from complying with Title VII of the Civil Rights Act with respect to their ministers (*see e.g. EEOC v. Roman Catholic Diocese*, 213 F3d 795, 800 [4th Cir 2000]; *Alicea-Hernandez v. Catholic Bishop of Chicago*, 320 F3d 698, 702- 703 [7th Cir 2003]). But the ministerial exception has no bearing here; this case does not involve the right of a church to determine who it will employ to carry out its religious mission. The existence of a limited exemption for ministers from anti- discrimination laws does not translate into an absolute right for a religiously-affiliated employer to structure all aspects of its relationship with its employees in conformity with church teachings. The ministerial exception has been applied only to employment discrimination claims, and only to "ministers," broadly defined. This case involves neither.

In short, no exception to *Smith* is applicable in this case. *Smith* is an insuperable obstacle to plaintiffs' federal free exercise claim.

II

Article I, § 3 of the New York Constitution provides:

> "The free exercise and enjoyment of religious profession and worship, without discrimination or preference, shall forever be allowed in this state to all humankind; and no person shall be rendered incompetent to be a witness on account of his or her opinions on matters of religious belief; but the liberty of conscience hereby secured shall not be so construed as to excuse acts of licentiousness, or justify practices inconsistent with the peace or safety of this state."

In interpreting our Free Exercise Clause we have not applied, and we do not now adopt, the inflexible rule of *Smith* that no person may complain of a burden on religious exercise that is imposed by a generally applicable, neutral statute. Rather, we have held that when the state imposes "an incidental burden on the right to free exercise of religion" we must consider the interest advanced by the legislation that imposes the burden, and that "[t]he respective interests must be balanced to determine whether the incidental burdening is justified" (*La Rocca v. Lane*, 37 N.Y.2d 575, 583 [1975], citing *People v. Woodruff*, 26 A.D.2d 236, 238 [1966], *aff'd* 21 N.Y.2d 848 [1968]). We have never discussed, however, how the balancing is to be performed. Specifically, we have not said how much, if any, deference we will give to the judgments of the Legislature when the result of those judgments is to burden the exercise of religion. We now hold that substantial deference is due the Legislature, and that the party claiming an exemption bears the burden of showing that the challenged legislation, as applied to that party, is an unreasonable interference with religious freedom. This test, while more protective of religious exercise than the rule of *Smith*, is less so than the rule stated (though not always applied) in a number of other federal and state cases.

Before *Smith*, the leading United States Supreme Court case involving burdens imposed on religious exercise by generally applicable laws was *Sherbert v. Verner*, in which the Court held that justification of "any incidental burden on the free exercise of . . . religion" requires "a 'compelling state interest in the regulation of a subject within the State's constitutional power to regulate'" (374 US 398, 403 [1963], quoting *NAACP v. Button*, 371 US 415, 438 [1963]). This test has been characterized as "strict scrutiny" (*e.g., Catholic Charities of Sacramento*, 32 Cal 4th at 548, 85 P3d at 81), and it might be thought that few laws would pass the test. However, after upholding a claim of free exercise against a neutral and generally applicable statute in *Wisconsin v. Yoder* (406 US 205 [1972]), the Supreme Court "rejected every claim for a free exercise exemption to come before it" for 18 years (McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 Harv. L. Rev. 1409, 1417 [1990]). During that period, many thought the Court's claim to be applying strict scrutiny—a claim finally abandoned when *Smith* was decided in 1990—less than convincing (*e.g., United States v. Lee*, 455 US 252, 262-263 [1982] [Stevens, J. concurring]).

Since *Smith*, a number of state courts have interpreted their states' constitutions to call for the application of strict scrutiny (*e.g., Smith v. Fair Empl. and Hous. Commn.*, 12 Cal 4th 1143, 913 P2d 909 [1996]; *Swanner v. Anchorage Equal Rights Commn.*, 874 P2d 274 [Alaska 1994]; *Attorney General v. Desilets*, 418 Mass 316, 636 N.E.2d 233 [1994]). Often, however, as in the California and Alaska cases just cited, the courts rejected claims to religious exemptions, and it is questionable whether the scrutiny applied by those courts is really as strict as their statement of the rule implies. Justice Brown of the California Supreme Court, dissenting in Catholic Charities of Sacramento (32 Cal 4th at 583, 85 P3d at 105), remarked:

> "Strict scrutiny is not what it once was. Described in the past as 'strict in theory and fatal in fact' (Gunther, Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection (1972) 86 Harv. L. Rev. 1, 8), it has mellowed in recent decades. . . ."
>
> "If recent precedent is any guide, a state's interest is compelling if the state says it is."

The apparent reluctance of some courts to pay more than lip service to "strict scrutiny" may be an implicit recognition of what we now explicitly decide: Strict scrutiny is not the right approach to constitutionally-based claims for religious exemptions. Where the State has not set out to burden religious exercise, but seeks only to advance, in a neutral way, a legitimate object of legislation, we do not read the New York Free Exercise Clause to require the State to demonstrate a "compelling" interest in response to every claim by a religious believer to an exemption from the law; such a rule of constitutional law would give too little respect to legislative prerogatives, and would create too great an obstacle to efficient government. Rather, the principle stated by the United States Supreme Court in *Smith*—that citizens are not excused by the Free Exercise Clause from complying with generally applicable and neutral laws, even ones offensive to their religious tenets—should be the usual, though not the invariable, rule. The burden of showing that an interference with religious practice is unreasonable, and therefore requires an exemption from the statute, must be on the person claiming the exemption.

The burden, however, should not be impossible to overcome. As Professor (now Judge) McConnell has pointed out, a rule that the Constitution never requires a religious exemption from generally applicable laws could lead to results plainly inconsistent with basic ideas of religious freedom:

> "Under the no-exemptions view . . . religious believers and institutions cannot challenge facially neutral legislation, no matter what effect it may have on their ability or freedom to practice their religious faith. Thus, a requirement that all witnesses must testify to facts within their knowledge bearing on a criminal prosecution . . . if applied without exception, could abrogate the confidentiality of the confessional. Similarly, a general prohibition of alcohol consumption could make the Christian sacrament of commu-

nion illegal, uniform regulation of meat preparation could put kosher slaughterhouses out of business, and prohibitions of discrimination on the basis of sex or marital status could end the male celibate priesthood."

(*The Origins and Historical Understanding of Free Exercise of Religion*, 103 Harv. L. Rev. at 1418-19).

We find these hypothetical laws to be well beyond the bounds of constitutional acceptability. And we by no means exclude the possibility that, even in much less extreme cases, parties claiming an exemption from generally applicable and neutral laws will be able to show that the state has interfered unreasonably with their right to practice their religion. We conclude, however, that plaintiffs here fall short of making such a showing.

The burden the WHWA places on plaintiffs' religious practices is a serious one, but the WHWA does not literally *compel* them to purchase contraceptive coverage for their employees, in violation of their religious beliefs; it only requires that policies that provide prescription drug coverage include coverage for contraceptives. Plaintiffs are not required by law to purchase prescription drug coverage at all. They assert, unquestionably in good faith, that they feel obliged to do so because, as religious institutions, they must provide just wages and benefits to their employees. But it is surely not impossible, though it may be expensive or difficult, to compensate employees adequately without including prescription drugs in their group health care policies.

It is also important, in our view, that many of plaintiffs' employees do not share their religious beliefs. (Most of the plaintiffs allege that they hire many people of other faiths; no plaintiff has presented evidence that it does not do so.) The employment relationship is a frequent subject of legislation, and when a religious organization chooses to hire non-believers it must, at least to some degree, be prepared to accept neutral regulations imposed to protect those employees' legitimate interests in doing what their own beliefs permit. This would be a more difficult case if plaintiffs had chosen to hire only people who share their belief in the sinfulness of contraception.

Finally, we must weigh against plaintiffs' interest in adhering to the tenets of their faith the State's substantial interest in fostering equality between the sexes, and in providing women with better health care. The Legislature had extensive evidence before it that the absence of contraceptive coverage for many women was seriously interfering with both of these important goals. The Legislature decided that to grant the broad religious exemption that plaintiffs seek would leave too many women outside the statute, a decision entitled to deference from the courts. Of course, the Legislature might well have made another choice, but we cannot say the choice the Legislature made has been shown to be an unreasonable interference with plaintiffs' exercise of their religion. The Legislature's choice is therefore not unconstitutional.

III

Plaintiffs' final claim is that the challenged sections of the WHWA violate the Establishment Clause of the federal Constitution. We find this claim to be without merit.

The claim rests essentially on a misreading of a single United States Supreme Court case, *Larson v. Valente* (456 US 228 [1982]). *Larson* held that the Establishment Clause was violated by a statute designed to exempt from certain regulatory requirements all religious faiths except a disfavored one, the Unification Church. The Court found the statute to violate the Establishment Clause's "clearest command": "that one religious denomination cannot be officially preferred over another" (*id.* at 244). Nothing of the kind has happened in this case. It cannot be convincingly argued that the WHWA was designed to favor or disfavor Catholics, Baptists or any other religion. The statute is, as we explained above, generally applicable and neutral between religions.

Plaintiffs contend that the legislation is invalid under *Larson* because it distinguishes between religious organizations that are exempt from the contraception requirements and those that are not. But this kind of distinction—not between denominations, but between religious organizations based on the nature of their activities—is not what *Larson* condemns. Plaintiffs' theory would call into question any limitations placed by the Legislature on the scope of any religious exemption—and thus would discourage the Legislature from creating any such exemptions at all. But, as we pointed out above, legislative accommodation to religious believers is a long-standing practice completely consistent with First Amendment principles. A legislative decision not to extend an accommodation to all kinds of religious organizations does not violate the Establishment Clause.

IV

Accordingly, the order of the Appellate Division should be affirmed with costs.

Order affirmed, with costs. Opinion by Judge R.S. Smith.

Chief Judge Kaye and Judges Ciparick, Rosenblatt, Graffeo and Read concur. Judge Pigott took no part.

Decided October 19, 2006

Annual Meeting

The Health Law Section held its 2007 Annual Meeting at the New York Marriott Marquis on January 24. The Program had four topics:

- *New Era—New Priorities* examined recent changes in Washington and Albany and included as speakers David C. Rich and Patricia J. Wang from the Greater New York Hospital Association.
- *The Berger Commission Recommendations* included presentations by DOH General Counsel Donald P. Berens, Assemblyman Richard N. Gottfried and Mark R. Ustin, Deputy Director and General Counsel to the Commission on Health Care Facilities in the 21st Century.
- *Fraud and Abuse: New Regulations and Requirements, and Longstanding Ethics Concerns* was presented by Stephen A. Warnke of Ropes & Gray.
- *Physician/Hospital Relations*, which had on its panel Melinda Hatton, General Counsel, American Hospital Association and Joseph J. LaBarbera of The Law Offices of Joseph J. LaBarbera, P.C.

At the Section Luncheon, DOH General Counsel Donald P. Berens, who recently left the position of DOH General Counsel, spoke about the job of the DOH General Counsel.

The Annual Program was co-chaired by Edward S. Kornreich of Proskauer Rose LLP, Anne Maltz of Herrick, Feinstein LLP, and Peter J. Millock, Esq. of Nixon Peabody LLP, Albany.

David C. Rich, Senior VP, Greater NY Hospital Association; Edward S. Kornreich, Proskauer Rose; and Patricia J. Wang, Senior VP, Greater NY Hospital Association.

NEWS flash

What's Happening in the Section

New Officers

At the Annual Meeting, the membership elected the following new officers of the Section

- Chair-Elect—Ross Lanzafame
- Vice-Chair—Edward Kornreich
- Secretary—Ari Markenson
- Treasurer—Francis Serbaroli

Upcoming Programs

Introduction to Health Law

In this program leading health law attorneys from across the state will cover these topics:

- An Overview of the Healthcare System in New York
- The Regulatory Framework Applicable to Healthcare Providers
- Healthcare Payment Systems
- Fraud and Abuse
- Patient Confidentiality Laws—HIPAA and Beyond
- Labor and Employment Law in the Healthcare Context
- Mental Health Issues; and
- Basic Bioethical Issues in Health Law

The program will take place:

New York City	May 4
Melville, LI	May 11
Albany	May 17

The overall Planning Chair for the Program is Salvatore J. Russo of the New York City Health and Hospitals Corporation. The local chairs are Robert A. Wild of Garfunkel, Wild & Travis (Melville, LI), Phil Rosenberg of Wilson, Elser, Moskowitz, Edelman, Dicker, LLP (Albany). For more information, go to NYSBA.org and click on "Events."

Upcoming *Journal* Edition

The Spring '07 Edition will be a special edition on "Legal Issues in Long Term Care." Raul A. Tabora, Jr. of Ruffo Tabora Mainello & McKay P.C. in Albany will be Special Editor. Persons wishing to submit an article for

Further information about upcoming programs is always available at www.nysba.org/health. Just click on "Events."

the edition should contact Raul Tabora at rtabora@ruffotabora.com.

NYSBA supports living will proposal, over objection of Health Law Section

At the NYSBA 2007 Annual Meeting, the NYSBA Executive Committee and then the NYSBA House of Delegates voted to support legislation governing living wills. The proposal was developed jointly by the Trusts and Estates Law Section and the Elder Law Section. It would amend the Health Care Proxy Law (NYS Public Health Law Article 29-C) to add provisions defining a living will, providing that a competent adult may execute a living will, and creating a rebuttable presumption that a living will that meets the statutory standards reflects the wishes of the person who created it.

The Health Law Section opposed the proposal. The Section's memorandum in opposition stated, in part, as follows:

> The joint proposal of the Trusts and Estates and Elder Law Sections would amend the Public Health Law for the purpose of "permitting the use of living wills." That objective is misguided: the legality of living wills in New York is well-established and well-known. It is recognized in Court of Appeals decisions and NYS Health Department regulations. Most important, it is reflected in clinical practice: the wishes of patients expressed in their living wills are honored by health care providers across the state every day. Indeed, noncompliance by a health care provider, without good grounds, would subject the provider to civil liability and Department of Health sanctions.
>
> While there are serious drawbacks to living wills as an advance directive as compared to health care proxies, nothing in this proposal would address those drawbacks. Instead, the proposal seeks to codify the already irrefutable legality of living wills. The view of the Health Law Section is that such attempt will only sow confusion on a matter that is settled, and invite the New York State Legislature modify the proposal to restrict the rights that patients in New York now have.

Several members of the Health Law Section and its Executive Committee spoke in opposition to the proposal at meetings of the NYSBA Executive Committee and the House of Delegates. Nonetheless, the proposal was approved, and is now officially supported by the NYSBA.

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.

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