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Health Law Journal

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HEALTH LAW JOURNAL

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NEW YORK STATE BAR ASSOCIATION

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HEALTH LAW AND POLICY PROGRAM

A Message from the Section Chair

It is my pleasure to report to you on some of the initiatives the Health Law Section has completed in recent months and on others that are underway. Overall, the Section has clear goals for the year, seeking to continue the strength of our programs, to enhance the Section's Web site as a valuable information resource for health law practitioners, and to contribute to public consideration of critical health policy and legal issues.

Section Programs

The program on fraud and abuse regulation related to physician practice held on October 11, 2000 in conjunction with the Medical Society of the State of New York was a tremendous success in several respects. The feedback on the program was excellent. In addition, it was the first time the Health Law Section has collaborated with another organization to present a program. Both our Section and the Medical Society were enthusiastic about the opportunity to work together. I believe this is a good model for future programs; it can enrich the program content, and recognizes the shared interests of the profession and the clients we serve. I extend my congratulations and appreciation to Jim Horwitz, Chairperson of the Committee on Fraud, Abuse and Compliance, to Bob Abrams, Vice Chairperson of the Section, and to Ari Markenson for organizing the program.

This fall we once again held the primer on health care law in three cities: New York, Rochester and Albany. As I write this letter, we do not yet have feedback on the programs, but know that we expect attendance to be high.

The focus of the program on January 24, 2001 at our annual meeting will be the health care Internet. The explosion of medical information, products and services offered online presents extraordinary challenges for medical practice, health law and public policy. The program on January 24 will cover market analysis of trends online as well as the legal and regulatory issues posed as physicians, health care facilities, health plans, and pharmacies use the Internet to communicate with patients and to market their products and services. Our keynote speaker at lunch will be Carla Stovall, the Attorney General of Kansas and Chairperson of the National Association of State Attorneys General on Regulation of Internet Pharmacies.

We are in the early stages of planning a series of continuing legal education programs for spring 2001. At this time, we are leaning towards a program that would examine developments on health care quality and the extensive legal issues health care providers face as they prepare to implement the Health Insurance Portability and Accountability Act. Both issues are timely. In October 2000, Governor Pataki signed into law the Health Information and Improvement Act. The Act requires broad public dissemination of profiles on physicians including malpractice judgments and other information, and hospital and health plan report cards on key quality indicators.

Section Web Site

Building on the launch of the Section Web site last year, we are in the process of increasing the links on the site to provide our members ready access to updated information on the wealth of substantive areas encompassed by health care practice. In addition, the Committee on Consumer Rights has undertaken the task of creating a section of the site for consumers, providing information and links about their legal rights and concerns. At the same time, the Bar Association is conducting a major evaluation of the Association's Web site, in order to redesign the site to better serve its membership.

Election of Section Leadership

This is the first year the Health Law Section will hold elections under the bylaw amendments adopted at the Section meeting in January 2000. In accord with the bylaws, the Nominating Committee solicited candidates for Section officers from the membership, and prepared the slate of candidates presented to you in December. The amendments were designed to create a more open process and to engage the broader membership in the election process. The bylaw changes also limited the term for committee chairpersons to two years to expand the opportunities for leadership in the Section.

Ultimately, the Section has two broad goals—to provide a public service by timely, thoughtful analysis of critical policy issues in the health care arena, and to serve our members by offering outstanding programs and information, and the opportunity to exchange ideas with colleagues. I know that I speak on behalf of all members of the Executive Committee in inviting you to become more active in the Section to help us meet these goals. We welcome, and need, your ideas and your participation.

Tracy E. Miller

From the Editors

In addition to our regular columns, we are pleased to present in this issue an article by Henry M. Greenberg, former general counsel of the New York State Department of Health, on New York's legal framework for ensuring the safety of patients treated by HIV-infected health care workers, and for protecting those workers against discrimination based on their HIV status. In addition, this issue contains an article by Leslie Levinson and Gerard Catalanello on recent developments in health care financing transactions.

Recently, the suggestion made by Claudia Torrey in her *For Your Information* column, p. 16, was adopted in a Department of Labor ruling calling for more specificity in group health plan summaries. *See* 65 Fed. Reg. 70226 (Nov. 21, 2000).

We invite all Section members and readers of this *Journal* to submit articles for publication. Information on where to submit articles is contained on the back page of this issue.

Audrey Rogers and
Barbara Atwell

In the New York State Courts

Court Upholds Restrictive Covenant Barring Terminated Physician from Practicing in Connecticut

Gismondi, Paglia, Sherling, M.D., P.C. v. Franco, 2000 W.L. 973615 (S.D.N.Y. 2000). In this case, a New York professional medical corporation (P.C.) sued to enforce a restrictive covenant contained in the employment contract of a physician it had discharged from employment. The P.C. is a multi-office general medical practice with its main office in Mamaroneck, New York and other offices throughout Westchester County. The P.C.'s employment agreement with Dr. Franco contained a restrictive covenant that—for a period of three years following termination of employment—prohibited him from engaging in the practice of medicine in Mamaroneck, New York; Port Chester, New York; and within a 15-mile radius of those towns. The covenant made an exception so that Dr. Franco would not be restricted from practicing medicine in the City of Stamford, Connecticut. The restrictive covenant area encompassed Greenwich Hospital, but permitted him to practice at Stamford Hospital.

Over time, the P.C.'s relationship with Dr. Franco deteriorated, and while Dr. Franco was still employed by the P.C., he brought a lawsuit against the P.C. and its shareholders alleging fraud, failure to pay bonuses and other compensation due to him, and sought a judgment declaring the restrictive covenant unenforceable. As a result of Dr. Franco's commencement of suit against the P.C. as well as other conduct the P.C. deemed inappropriate, the P.C. terminated Dr. Franco's employment. Dr. Franco immediately commenced working out of a Stamford, Connecticut office and continued working at Greenwich Hospital.

After a bench trial, the court ruled that Dr. Franco had orchestrated his own termination with the hope that it would invalidate the restrictive covenant. The court also found that Dr. Franco had made arrangements to start a new practice in Connecticut prior to his termination from employment by the P.C.

The court ruled that the restrictive covenant was fully enforceable in this case. First, the court held that the phrase "practice of medicine" encompassed Dr. Franco's service as a faculty member in a teaching hospital. Although the court acknowledged case law holding that an employer cannot enforce a non-compete agreement against an employee whose termination is wholly involuntary and without cause, the court ruled that Dr. Franco was terminated for cause. To hold otherwise would permit employees to avoid reasonable non-compete agreements simply by creating cause for their dismissal, in breach of their duty of good faith and fair dealing.

The court further held that the P.C. had a protectable interest in Connecticut, as its short-term business plan included expansion into that area and Dr. Franco's employment had been one of the first steps in carrying out that plan. Finally, because the court granted the P.C. a permanent injunction enforcing the terms of the restrictive covenant, it denied the P.C.'s request for $130,000 in liquidated damages which had been provided for under the non-compete agreement. Given enforcement of the non-compete clause, the court viewed an award of liquidated damages to be a penalty.

Court Denies Summary Judgment to Medical Group Seeking Enforcement of Restrictive Covenant

Lindenhurst OBS/GYN Group, P.C. v. Lazo, Index No. 25219/1998 (Sup. Ct., Suffolk Co. Sept. 27, 2000). In this case, the court held that a medical practice may not enforce a restrictive covenant against a former physician employee if the physician can establish that the medical practice had previously breached their employment agreement.

In *Lazo*, a medical practice moved for summary judgment seeking to enforce a restrictive covenant against a former physician employee who opened up her own medical practice. The former physician employee opposed the motion, contending that the practice had breached terms of the parties' agreement concerning her percentage compensation. The former employee also alleged that the practice had failed to honor its contractual obligation to make her, over time, a one-third shareholder in the practice.

The court denied the medical practice's summary judgment motion, finding that the former physician employee had raised triable issues of fact regarding the medical practice's prior material breaches of the parties' agreement, thereby precluding summary enforcement of the restrictive covenant. Specifically, the court noted that the physician's arguments were sufficient to raise triable issues as to whether she was effectively forced out of the medical practice by the president's oppressive conduct. The court also found that the physician had raised triable issues regarding an alleged scheme to divert monies away from the medical practice and thereby reduce her percentage compensation. [Garfunkel, Wild & Travis represents the defendant in this case].

Court Dismisses Antitrust and RICO Claims by Physician Suspended From Hospital Staff

Piccone v. Board of Directors of Doctors Hospital of Staten Island, Inc., 2000 U.S. Dist. LEXIS 12249 (S.D.N.Y. Aug. 28, 2000). In this decision, the court reaffirmed the high threshold that physicians must meet to establish antitrust claims arising out of hospital peer review actions.

In *Piccone*, a local community hospital commenced peer review proceedings against a surgeon, alleging that the surgeon threw instruments in the operating room during a procedure and refused to permit the nurses to count instruments after the operation. The hospital's medical board suspended Dr. Piccone's privileges after a peer review hearing. The hospital's board of directors modified the medical board's recommendation by restoring the surgeon's privileges on the condition that he apologize to the operating room staff.

Rather than apologize, the surgeon commenced this federal antitrust and RICO action against the hospital and various hospital board members and employees. The surgeon's antitrust claims alleged that the peer review proceedings were part of a larger conspiracy among the controlling shareholders and physicians of this proprietary hospital to exclude him from the market for providing surgical services in the hospital's area.

The court granted the hospital's motion to dismiss, finding that the surgeon failed to allege antitrust injury. Reviewing numerous physician-peer review antitrust cases decided in the last decade, the court held that to survive dismissal, the surgeon had to allege injury to competition in general, not just injury to himself as a competitor. Because the surgeon's antitrust claims were devoid of any allegations of injury to competition in general, the court dismissed the claims.

The court also dismissed the surgeon's RICO claims, finding that the surgeon had failed to allege any detrimental reliance or injury flowing from the hospital's alleged acts of mail fraud. Finally, the court granted the hospital's motion for sanctions, noting that this lawsuit was the fourth unsuccessful proceeding that the surgeon had commenced to redress the peer review proceedings at the hospital. The court sanctioned the surgeon $500, payable to the hospital.

Court Rules That HHC Is Not a Hospital as Defined by the Public Health Law, and Thus its Quality Assurance and Peer Review Records Are Not Privileged Under PHL Article 28

In Re Grand Jury Subpoena Duces Tecum, 709 N.Y.S.2d 513 (1st Dep't 2000). In this proceeding, the New York County District Attorney's Office issued three grand jury subpoenas to The New York City Health and Hospitals Corporation (HHC). The subpoenas sought, among other things, HHC quality assurance and peer review records. HHC moved to quash portions of the subpoenas, and the DA's office moved to compel compliance. HHC moved to quash the subpoenas upon the ground that the records sought were privileged from disclosure under Public Health Law article 28 (presumably § 2805), Education Law § 6527(3), and the "public interest" privilege. The Appellate Division rejected all three grounds.

First, the court held that since HHC is not a hospital as defined under Public Health Law § 2801(1), the confidentiality protections of PHL article 28 do not apply. Next, the court held that the quality assurance protections of Education Law § 6527 did not apply, as that non-disclosure statute applies only in civil proceedings. Third, the court ruled that the public interest privilege was not established, as the state demonstrated the information subpoenaed was necessary to its investigation and not duplicative of other information already provided.

The court, however, ruled that documents prepared by Island Peer Review Organization, as an outside independent professional standards review firm retained to make recommendations to the hospital concerning patient care and administration, were privileged under Education Law § 6527(3).

Physician Practicing at Hospital While Under Psychiatric Disability Is Sufficient Danger to Public Health to Support Whistleblower Claim

Finkelstein v. Cornell University Medical Center, 702 N.Y.S.2d 285 (1st Dep't 2000). This "whistleblower suit" arose after the plaintiff physician's faculty appointment was terminated and he was reassigned to another hospital subsequent to his complaint to Cornell University Medical Center ("Cornell") that a colleague was exhibiting bizarre and erratic behavior. Plaintiff alleged that his termination and reassignment was in retaliation for his reports, and was thus a violation of Labor Law § 740. (Labor Law § 740 requires that a plaintiff allege that he complained to his employer of a violation of a law, rule or regulation that creates a substantial danger to public health and safety.)

The Court ruled that a physician practicing medicine at a hospital while impaired by a psychiatric disability constitutes a substantial danger to public health and safety for Labor Law § 740 purposes. The Court also found that since this occurred at the Hospital, the conduct is "attributable to the defendant employer, clearly implicating the whistleblower statute." The Court therefore held that there were a sufficient number of disputed facts, including the reasons for plaintiff's termination and reassignment, so as to warrant reversal of the motion court's grant of summary judgment.

Court Holds That Dismissal of Whistleblower Claim Against Hospital Was Premature Prior to Discovery

In ***Bordan v. North Shore University Hospital***, 712 N.Y.S.2d 155 (2d Dep't 2000), an employee of North Shore University Hospital alleged that the hospital retaliated against him after he raised concerns about the quality of medical care provided to two patients by Dr. Abumrad, a physician on the hospital's medical staff. The plaintiff alleged that this retaliatory action by the hospital violated Labor Law § 740 (known as the whistleblower law), and constituted a breach of contract.

Although the motion court granted the hospital's motion to dismiss on the grounds that plaintiff failed to plead adequately an actual violation of law, rule or regulation (a required element of Labor Law § 740 claim), the Appellate Division held that the plaintiff had sufficiently demonstrated that such facts may exist but could not be pled without discovery of information concerning the two surgical patients at issue. Thus, prior to such discovery, dismissal of the whistle blower claim was premature. However, the court ruled that plaintiff was not entitled to discovery concerning a prior disciplinary proceeding before the New York State Department of Health involving Dr. Abumrad, as that issue was deemed unrelated to the alleged retaliatory action.

Court Affirms Medical P.C.'s Denial of Severance Pay to Discharged Employee

Kosakow v. New Rochelle Radiology Associates, P.C., 2000 WL 1528077 (S.D.N.Y., Sept. 6, 2000). This is an update of a prior decision reported in this column (Summer/Fall 2000). This case arises from a medical practice's termination of an x-ray technician after she returned from medical leave. In that column, we reported that the court had granted summary judgment dismissal of plaintiff's Family and Medical Leave Act claim based on the collateral estoppel effect of a state administrative proceeding. The court then remanded to the Plan Administrator plaintiff's ERISA claim for severance pay.

After a full review of party submissions, the court affirmed the Plan Administrator's decision denying severance benefits. The court held that although plaintiff was "terminated" from her position (rejecting the defendant's argument that its offer of per diem employment constituted a continuing relationship), the defendant's employee manual granted sufficient discretion to the Plan Administrator to deny benefits in this case. The court noted that plaintiff was part-time, and that the Plan Administrator could certainly find that severance was not to be paid to terminated part-time employees. The court also held that severance paid to another subsequently separated employee was irrelevant to plaintiff's claims.

Both the March 2000 and September 2000 decisions have been appealed to the Second Circuit. [Garfunkel, Wild & Travis represents the P.C. in this case].

Neither Tort Claims Nor Punitive Damages Lie Against Health Insurer for Denial of Coverage

Logan v. Empire Blue Cross and Blue Shield, 2000 WL 1513149 (2d Dep't October 10, 2000). Defendant Empire Blue Cross and Blue Shield ("Empire") was the health insurance provider for each of several plaintiffs. The plaintiffs filed multiple causes of action against Empire, including breach of contract, fraud and a demand for punitive damages, stemming from Empire's denial of coverage for plaintiffs' intravenous Lyme disease treatments.

At the heart of plaintiffs' complaint was Empire's practice of revising its coverage policy concerning various Lyme disease treatments between 1992 and 1998. Plaintiffs claimed that with each of the three revisions that took place over that time period, Empire intentionally and "underhandedly raised the bar," making it more difficult for the plaintiffs to obtain coverage for expensive longer-term treatments.

On appeal, the Second Department upheld the motion court's dismissal of all tort causes of action, finding that the relationship between Empire and the plaintiffs was governed by the contractual terms of the insurance policy, and that the contract "did not create a relationship for which a duty is owed to the plaintiff separate from the contractual obligation." The court rejected arguments that Empire's multiple revisions of its coverage policy was an attempt to fraudulently evade payment of claims, finding instead that such revisions represented an attempt by Empire to remain current with "the latest research and findings within the medical community concerning what is appropriate treatment of a given medical condition."

The court also upheld dismissal of the demand for punitive damages, reasoning that "one of the necessary elements in such a case is that the defendant's conduct must be actionable as an independent tort." Since the court dismissed plaintiffs' tort claims, no claim for punitive damages would stand.

Physician License Revocation and $90,000 Fine Upheld Even In Absence of Patient Injury

Corines v. State Board for Professional Medical Conduct, 700 N.Y.S.2d 303 (3d Dep't 1999). After 15 days of hearings, Dr. Corines was found guilty of negligent patient care, record-keeping deficiencies, false billings to insurance companies, and misleading statements on hospital staff applications. The hearing committee revoked the physician's license, assessed a fine of $90,000,

and also revoked the certificates of incorporation of his two medical P.C.s. The physician commenced an article 78 proceeding to challenge the determination on multiple grounds.

The physician challenged the Board's interpretation of the definition of "negligence on more than one occasion." The state hearing panel sustained 13 separate instances of negligence, even though only eight patients were at issue. The physician argued that the Board improperly aggregated separate and distinct acts to conclude that he failed to provide due care on a "particular occasion." The court held that the Board properly identified "petitioner's care with respect to a particular patient [as] negligent and that the negligence consisted of several misdeeds."

The physician also challenged the Board's holding that he could be found negligent based upon record keeping violations. The court held that "where there is a relationship between inadequate record-keeping and patient treatment, the failure to keep accurate records may constitute negligence." Although the court noted that there was conflicting testimony on this issue, it held that "it is the exclusive province of the hearing committee to determine issues of credibility."

The physician also challenged the Board's jurisdiction on statute of limitations grounds, arguing in part that delay in bringing the case had precluded him from introducing beneficial testimony from a physician who had died. However, the court held that absent actual prejudice, a statute of limitations defense did not apply in this type of disciplinary proceeding.

Finally, the physician contended that the penalty of revocation was excessive, as no injury to patients had been shown. The court disagreed, noting that there is no legal requirement that injury be established before discipline can be imposed. Under the "totality of the offenses" sustained, the court found the penalty in this case neither unduly harsh nor excessive.

Hospital Not Liable for Negligent Acts of Independent Contractor Anesthesiologist

Robinson v. Jewish Hospital and Medical Center of Brooklyn, 712 N.Y.S.2d 585 (2d Dep't 2000). The plaintiff sustained permanent injuries during an operation performed at defendant hospital when an anesthesiologist negligently administered general anesthesia to her. The anesthesiologist was an independent contractor, hired on a part-time basis through Obstetrical Anesthesia Service (OAS). The plaintiff sued the hospital for medical malpractice, and the hospital commenced a third-party action against a partner in OAS, for indemnification and contribution, claiming that he was vicariously liable for the anesthesiologist's negligence.

On appeal from trial of the hospital's third-party claim, the Appellate Division for the Second Department cited the general rule that an employer who hires an independent contractor is not liable for independent acts of negligence by the contractor, except when the employer knows or has reason to know that the work of the contractor involves special inherent dangers which the employer should reasonably anticipate. The court found that public policy is not served by applying the inherently dangerous work exception to the provision of anesthesiology services. Such work is an accepted medical service provided by a medical professional who is under a duty to perform in accordance with her legal and professional responsibilities. In such circumstances, the employer should not be required to anticipate that a medical professional hired as an independent contractor would exercise his or her professional judgment in a manner that is dangerous.

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

In the New York State Legislature

With the commencement of a new session in January 2001, the New York State Legislature will begin focusing on a range of important health care issues. Because this January marks the beginning of a new two-year legislative session, bills introduced during the prior two years are not automatically carried over and must be re-introduced. Even though the Legislature begins on a clean slate, a number of proposals that have been under active consideration in prior years can be expected to emerge again in the upcoming session:

1. Assisted Living

The question of whether and how to regulate assisted living "look-alike" facilities has been under discussion in the Capitol for at least two sessions. The Governor has proposed legislation that would create two models of assisted living facilities: (1) licensed programs, largely financed with Medicaid funds, for the low-income, most frail population; and (2) registered facilities for the healthier, private-pay population. The bill imposes standards for residency agreements and mandates certain disclosures to consumers. Licensed facilities would be heavily regulated and would be authorized to provide home health care and personal care directly. Registered facilities would be subject to more limited regulatory oversight. Personal care and home health care could be provided on the premises of a registered facility only through certified or licensed agencies. The bill would also eliminate the public need requirement for the establishment of new adult homes and enriched housing programs. The bill has not been introduced in the Assembly, and, although it was introduced in the Senate (during last session), the bill never reached the Senate floor.

2. Prompt Payment

Late payments and payment denials by health insurers have been hot topics in the Legislature for several years. Health care providers maintain that reimbursement is improperly withheld or denied all too frequently. Health plans respond that the late payments and denials are the exception, rather than the rule, and are generally attributable to poor claim submissions by providers.

Last session, the two most comprehensive bills were introduced in the Senate and Assembly to address this problem. Both bills amend the deadlines for prompt payment of claims by health plans. The Assembly bill reduces the time frame for payment of claims by health plans from 45 days to 15 days for electronically submitted claims and to 30 days for all other claims. The Senate bill reduces the time frame to 30 days for electronically submitted claims only.

Both bills provide relief from late payment penalties for insurers who meet a compliance standard. The Assembly bill provides that a health plan that pays 98 percent of its claims in compliance with statutory requirements, and pays the remaining 2 percent within 60 days of submission together with statutory interest, would not be in violation of the prompt pay requirements, provided that the outstanding 2 percent does not constitute more than 5 percent of the receivables owed by the insurer to a particular health care provider. The Senate bill exempts from enforcement of the prompt pay requirements health plans that pay 95 percent of all "reasonably clear and clean claims." It defines a "clean claim" as one without defects, supported by necessary documentation and not requiring special treatment.

Both bills also provide for a dispute resolution mechanism to resolve contested claims between health plans and providers, although the bills differ with respect to the details of the mechanism and the disputes that would be covered. In addition, both bills set forth circumstances under which a health plan's prior authorization of care is binding. And, the Assembly bill sets a one-year deadline for recouping payments made to providers, except in cases of fraud.

In addition to the prompt pay and utilization review provisions, the Assembly bill establishes a guaranty fund to ensure the payment of claims in the event that a plan becomes insolvent and contains a number of provisions intended to protect subscribers in the individual market from inappropriate denials and terminations of coverage.

3. Empire Conversion

Empire Blue Cross/Blue Shield has sought authorization from the Insurance Department and the Attorney General to convert to a for-profit entity. In compliance with New York's Not-for-Profit Corporation Law, Empire proposes to contribute the value of the non-profit corporation to a charitable foundation dedicated to health care. The Attorney General maintains that Empire's conversion is barred by § 4301(j) of the Insurance Law.

Legislation was introduced in the Assembly and the Senate to permit the conversion. Each bill sets forth somewhat different road maps for future conversions and effectively grandfathers the Empire proposal. A second Senate bill was introduced at the request of the Governor that would simply amend § 4301(j) to permit conversions authorized by the Insurance Department.

4. Prescription Drug Pricing

The escalating cost of prescription drugs has placed mounting pressure on lawmakers to regulate drug prices. In the 2000 legislative session, the Legislature expanded the state's EPIC program and considered several proposals to limit the prices charged for prescription drugs. One bill, introduced in the Senate and the Assembly would prohibit pharmaceutical

manufacturers from selling drugs in New York at a price higher than the lowest price they charge anywhere else. Other proposals would have limited prices charged by pharmacies and capitalized on the state's purchasing power to demand higher drug rebates which, in turn, would be allocated to pharmacies selling drugs at the reduced prices. While none of these bills reached the floor in their respective houses last session, this issue is likely to attract significant attention in the next session.

5. CHIP Reauthorization

The Child Health Plus program expires in June 2001. The contours of the reauthorization will be one of the most significant health issues of the session. Debate will likely center around the question of enrollment and retention in the program, as well as the mechanism for transitioning Medicaid-eligible CHIP enrollees into the Medicaid program without interrupting coverage or care. In addition, New York is designated to receive a significant allocation of additional unspent federal funds, which will trigger consideration of how these new funds might be spent.

6. Health Coverage for Low-Income Immigrants

As part of the 1996 federal welfare reform legislation, the federal government withdrew its funding of Medicaid coverage for many legal immigrants. When New York enacted its own welfare reform act, with two narrow exceptions, it opted to provide Medicaid coverage only to those immigrants for whom federal financial participation was available. While Medicaid coverage is provided for emergency care, many immigrants who require post-acute outpatient care or long-term care are essentially uncovered. As a result, hospitals and clinics that serve low-income communities are increasingly seeing uninsured immigrants who have no access to primary care and no source of payment for chronic or catastrophic illnesses. The Senate has not yet agreed to Assembly proposals to restore Medicaid coverage to immigrants. Renewed efforts to address the issue are likely to be initiated in the 2001 session.

7. Medicaid Buy-In for Disabled Workers

In 1999, the federal government enacted the Ticket to Work and Work Incentive Improvement Act (TWWIA). This legislation includes a provision permitting states to implement programs that would enable disabled workers to purchase Medicaid coverage on a sliding fee scale. In the 2000 legislative session, the Work and Wellness Act was introduced in the Senate and Assembly to implement the new federal law. Although the proposal was included in the conference agreement on the budget, lawmakers were unable to agree on its fiscal impact and talks stalled. Given the proposal's bipartisan support, legislators are likely to take action to implement the federal law in New York during the 2001 session.

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

In the New York State Agencies

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

Medicaid Payments for Inpatient Hospital Services, Long-Term Care Services, and Non-Institutional Services

Pursuant to Public Health Law § 2807(10), the Department of Health proposed to amend Title XIX (Medicaid) State Plan for hospital inpatient services to conduct a pilot reimbursement plan in order to fund studies and activities to identify and implement changes to health care delivery systems. These changes will be implemented to improve the fiscal status of three financially distressed hospitals. The proposed amendment outlines the criteria used to select the three hospitals. Effective: July 1, 2000. *See* N.Y. Register, June 28, 2000.

The Department of Health also proposed to amend Title XIX (Medicaid) State Plan for hospital inpatient services, long-term care services and non-institutional services for the time period from June 1, 2000 through August 31, 2000. The regulations would change Medicaid per diem rates of reimbursement for inpatient psychiatric services; determine a statewide average to limit total reimbursable base year administrative and fiscal services costs for long-term care services; and increase fee-for-service rates for non-institutional services provided to Medicaid patients by diagnostic and treatment centers whose principal mission is to service the developmentally disabled. Effective date: July 1, 2000 through March 31, 2003. *See* N.Y. Register, May 31, 2000.

The Department of Health also gave public notice of a proposal to amend the Title XIX (Medicaid) State Plan for non-institutional services. The proposed amendment would discontinue fee reimbursement of the 5.98% assessment on Medicaid net patient service revenue received for referred ambulatory clinical laboratory services of hospitals and diagnostic treatment centers and services provided by freestanding clinical laboratories. These amendments are effective for visits made or services performed on or after October 1, 2000. *See* N.Y. Register, September 20, 2000.

Reportable Communicable Diseases

Amendment of Parts 2 and 23 of Title 10 N.Y.C.R.R. This revision has been promulgated by the Department of Health to update the list of communicable diseases that must be reported to the Department of Health. The list includes sexually transmissible and nosocomial diseases. These regulations include definitions of diseases, additions to the list of diseases, and expansions to the process through which physicians report certain disease outbreaks to the State Department of Health. Expiration date: August 16, 2000. *See* N.Y. Register, May 31, 2000.

Smoking Cessation Products

Emergency amendment of § 85.21 of Title 10 N.Y.C.R.R. and amendment of § 505.3 of Title 18 N.Y.C.R.R. The Department of Health promulgated these amendments to make over-the-counter smoking cessation products Medicaid reimbursable because many smoking cessation and nicotine replacement products are now available only over-the-counter. Filing date: May, 15, 2000. Effective date: May 15, 2000. *See* New York Register, May 31, 2000.

CON Requirements for Acute Care Beds and Major Medical Equipment

Amendment of §§ 401.1 and 701.1 of Title 10 N.Y.C.R.R. by the Department of Health. The purpose of these amendments was to remove from CON review the transfer of beds and equipment within established article 28 hospital networks. Filing date: September 5, 2000. Effective date: September 20, 2000. *See* N.Y. Register, September 20, 2000.

Patient Review Instrument (PRI) Instructions

Emergency amendment of § 86-2.30 of Title 10 N.Y.C.R.R. The Department of Health promulgated these emergency amendments. The amendments allow for new admission qualifiers in claiming medical treatments on PRIs, which are patient assessment forms filled out by nursing homes, to provide the basis for Medicaid reimbursement. The amendments also are intended to enable nursing facilities to provide more responsive medical services by allowing the use of a nurse practitioner or physician assistant where a physician is required. Filing date: April 25, 2000. Effective date: April 25, 2000. *See* N.Y. Register, May 10, 2000.

Part-Time Clinics

Emergency amendment of §§ 703.6 and 710.1 of Title 10 N.Y.C.R.R. The Department of Health repealed §§ 703.6 and 710.1 (c)(4)(ii), replaced them with new §§ 703.6 and 710.1(c)(4), and added new § 710.1(c)(6)(v) to establish more standards for the operation of part-time clinics under article 28 of the Public Health Law. The regulations clarify and enhance the requirements for

part-time clinics, as well as require prior limited review of all part-time clinic sites. Section 703.6 outlines the location and type of service, as well as policy and procedure requirements for part-time clinics. Section 710.1(c)(4)(ii) outlines which proposals to add, relocate, or discontinue a part-time clinic site of a medical facility do not require an application. Section 710.1(c)(6) outlines which proposals to operate or relocate a part-time clinic require prior review. Filing date: August 15, 2000. Effective date: August 15, 2000. *See* N.Y. Register, August 30, 2000.

CON Applications

Amendment of §§ 600.3 and 710.5 of Title 10 N.Y.C.R.R. by the Department of Health. The amendments provide guidelines for amendments to CON applications; that is, changes to the application after the Public Health Council has approved an applicant, but prior to the actual issuance of an operating certificate. The amendments describe changes such as an increase in basic construction costs; a change in location of the site of construction; a change in the applicant; and a change in the ownership interest of the land. The purpose of these amendments is to simplify the CON amendment process. *See* N.Y. Register, July 26, 2000.

Nurse Practitioners, Licensed Nurses, Midwives

Department of Health amendment of §§ 12.2, 12.3, 12.13 and 23.4 of Title 10 N.Y.C.R.R. The amendments were promulgated to provide consistency between the regulations and the amendments of article 140 of the Education Law (Midwife Practice Act) and article 139 of the Education Law (Nursing). The amendments changed provisions of 10 N.Y.C.R.R. to more adequately reflect the scope of practice for nurse practitioners, and licensed nurses. The amendments also add licensed midwives and nurse practitioners as a provider category within the regulations. Filing date: June 30, 2000. Effective date: July 19, 2000. *See* N.Y. Register, July 19, 2000.

Consensus rule making to amend §§ 86-14.10, 405.3, 415.26, 444.23, 700.2, 751.6, 754.1, 754.2, 754.6, and 763.13 of Title 10 N.Y.C.R.R. Pursuant to the authority vested in the State Hospital Review and Planning Council and the Commissioner of Health by §§ 2803, 2803-b and 3612 of the Public Health Law, the above sections were amended to bring the regulations in conformance with amendments by reflecting existing law. Conformity was achieved by simple language corrections, such as inserting the term "licensed midwife" instead of "certified midwife" or "nurse midwife." *See* N.Y. Register, July 19, 2000.

Additions to the NHTSA Conforming Products List

The Department of Health adopted these emergency amendments to §§ 59.1 and 59.4 of 10 N.Y.C.R.R. pursuant to § 1194(4)(c) of the Vehicle and Traffic Law. The amendments were adopted to enable state law enforcement agencies to use new breath testing devices approved for use by National Highway Traffic Safety Administration. The purpose of the amendments is to fortify and protect prosecutions for alcohol-related offenses against legal challenges. Filing Date: May 26, 2000. Effective Date: May 26, 2000. *See* N.Y. Register, June 14, 2000.

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

The assistance of Ms. Alison Heller, an associate at Cadwalader, Wickersham & Taft, in compiling this summary is gratefully acknowledged.

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Compiled by Steven Seidman, M.D. Dr. Seidman is a third year student at Pace Law School.

For Your Information

By Claudia O. Torrey

Approximately seven months ago, the United States Supreme Court decided the case of *Pegram v. Herdrich*.[1] The unanimous decision delivered by Justice Souter held that mixed eligibility (coverage) and treatment decisions by physicians in a health maintenance organization (HMO) are not fiduciary decisions under the Employee Retirement Income Security Act of 1974 (ERISA).[2] While the decision had the managed care industry cheering, yet fearful of increased state court lawsuits; legal scholars ponder whether *Pegram* stands for support of rationed care, or a missed opportunity.

The salient facts are that petitioner Pegram is a physician with Carle HMO. The HMO owners are physicians who provide prepaid medical services to participants whose employers contract with Carle to provide health care. Respondent Herdrich was a beneficiary of health care by Carle through her husband's employer, State Farm Insurance Company.

Respondent complained to petitioner about pain in her abdomen. Upon examination, petitioner discovered an inflamed mass in respondent's abdomen. Despite the noticeable inflammation, petitioner did not order an ultrasound at a local hospital. Petitioner decided that respondent should wait eight days in order for an ultrasound to be performed at a facility more than 50 miles away, but staffed by Carle. Respondent's appendix ruptured causing peritonitis.[3]

Respondent sued petitioner and Carle in state court for medical malpractice. Later, respondent amended her complaint to add two counts of fraud. Petitioner responded that ERISA preempted the new counts, and removed the case to federal court. Petitioner sought summary judgment on both fraud counts, which the District Court granted for one count, but respondent was granted leave to amend the remaining fraud count.

Respondent alleged that the Carle HMO rewarded its physician owners for limiting medical care. Thus, such a reward meant the medical services received by respondent from the Carle HMO constituted an inherent or anticipatory breach of an ERISA fiduciary duty. Because ERISA requires fiduciaries to discharge their duties solely in the interest of the participants and beneficiaries with respect to a plan,[4] respondent concluded that the Carle HMO terms created an incentive to make decisions in the physicians' self-interest, rather than in the exclusive interests of plan participants.

Carle moved to dismiss the ERISA count for failure to state a claim upon which relief could be granted. The District Court granted the motion, whereupon respondent appealed to the Court of Appeals for the Seventh Circuit ("Seventh Circuit"). The Seventh Circuit reversed the District Court, and the United States Supreme Court, as stated earlier, reversed the Seventh Circuit.

A reading of *Pegram* highlights two conundrums: (1) the "ethics" of rationed care and treatment / payment decisions; and, with regard to ERISA, (2) the dichotomy between fiduciary duties founded on the principles of trust law, and the Hippocratic ideals of *always* putting the patient's interest first. Justice Souter makes clear that the very essence of an HMO is *rationed care*. When a health plan denies payment or coverage for a treatment item, such a decision is necessarily a treatment decision if said payment decision directly impedes upon the care the patient will be able to afford. The Court recognizes that Congress created HMOs, and that Congress, *not* the judicial system, is better suited to draw a line between good and bad HMOs.[5]

As for the second conundrum, there is no question that the ERISA fiduciary cannot be equated with the medical ethics standard / duty of putting the patient's best interest first regarding treatment concerns. To be sure, "(u)nder ERISA, . . . a fiduciary may have financial interests adverse to beneficiaries. Employers . . . can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers . . . , or even as plan sponsors."[6] Thus, there exists tension, or warring opposites, regarding an ERISA fiduciary, and the undivided loyalty to a patient demanded by medical ethics (a Hippocratic ethic).

The erosion of public trust and confidence in the medical community due to managed care could lead to legal challenges under the ERISA statute for material plan information to be specifically disclosed to participants.[7] Perhaps this was a missed opportunity by respondent in not alleging such a claim in her lawsuit. Our nation's insistence on high quality health care without treatment compromises, and the concomitant desire to control costs must find common ground and consensus.

Endnotes

1. __U.S.__, 120 S. Ct. 2143, 147 L. Ed. 2d 164 (2000).
2. 29 U.S.C. §§ 1001-1461 (1994 ed. and Supp. IV).
3. *Supra.* n.1 at 2147.
4. *Supra.* n.2 at § 1104(a)(1).
5. *Supra.* n.1 at 2150.
6. *Id.* at 2152.
7. *Id.* at 2153-54 n.8 (Respondent could have alleged that the petitioner had a fiduciary duty to disclose characteristics of the plan and of those who provide services to the plan, if that information affects beneficiaries' material interest.).

Claudia O. Torrey, Esq. is a member of the New York State Bar Association and the American Bar Association.

New York's Legal Framework for Preventing Transmission of HIV by Infected Health Care Workers

By Henry M. Greenberg

In 1985, the federal Centers for Disease Control & Prevention (CDC) issued a report[1] whose repercussions continue to be felt. CDC then theorized that infected health care workers[2] can transmit the Human Immunodeficiency Virus (HIV)[3] to patients. HIV is the generally recognized cause of the disease known as Acquired Immunodeficiency Syndrome (AIDS).[4]

Before long the risk of HIV transmission from health care workers to patients moved from scientific theory to fact. In 1990, CDC announced it was investigating the cause of HIV infection of Kimberly Bergalis—a woman who allegedly acquired the virus from her dentist, Dr. David Acer, while having two molars extracted.[5] Ultimately, CDC concluded Dr. Acer had transmitted HIV to Ms. Bergalis as well as five other patients.[6]

A vast literature emerged in the wake of the Acer case. In law reviews and medical journals scholars jousted (and still do) over related issues such as discrimination, liability, informed consent, privacy, and confidentiality. These are not only matters of academic concern, however; they have drawn the attention of policymakers, too. In fact, in 1991 CDC developed public health guidelines concerning the practice of certain HIV-infected health care workers,[7] followed by federal legislation requiring states to adopt CDC's guidelines or equivalent standards.[8]

In response, New York fashioned a comprehensive legal framework to enhance the safety of patients treated by HIV-infected health care workers and protect such workers against discrimination. Here I venture to summarize that framework—and, in so doing, show how New York has balanced the interests of patients and providers.

I. What Science Teaches

Given that the first duty of health care workers is to "do no harm,"[9] there are two questions, the answers to which form the foundation of New York's legal structure: Do HIV-infected health care workers put patients or co-workers at risk of contracting the virus? Are these infected health care workers able to perform their health care-related duties?

Policymakers turned to science for answers to these questions. What they learned, first and foremost, is that the risk of transmission of HIV through medical and dental procedures is remote and largely preventable.

HIV is a fragile virus that can be transmitted only through blood and other bodily fluids.[10] One way HIV may be transmitted is through blood-to-blood contact between an infected and uninfected person. Therefore, a patient possibly could contract HIV from an infected surgeon.[11] For example, transmission might occur if an infected surgeon bleeds into the patient's open wound after the surgeon suffers a skin puncture or cut while using a sharp instrument, such as a needle or scalpel.[12]

But simply because we can hypothesize how transmission *could* take place does not mean it *will*. Far from it! CDC has estimated that, for any single procedure performed by an HIV-infected care surgeon, the risk that a patient will contract HIV is somewhere between 1 in 42,000 and 1 in 417,000.[13] Others have estimated the risk to be between 1 per 100,000 to 1 per 1,000,000 surgical procedures,[14] and 1 in 28,000 to 1 in 500,000 per hour of surgery.[15]

"But simply because we can hypothesize how transmission could *take place does not mean it* will*. Far from it!"*

These estimates are for surgeons who by the very nature of their work enter surgical wounds with sharp instruments during virtually every procedure they perform. The activities of most other health care workers—particularly those not involved in any type of invasive procedures—pose even smaller risks.[16] Indeed, a CDC study performed on more than 20,000 patients treated by 57 infected health care workers revealed that not a single patient was infected due to the treatment.[17]

Thus, after over 20 years of experience with the AIDS epidemic and millions of procedures, the scientific evidence proves that the risk of patients becoming infected with HIV based on transmission from an infected health care worker is vanishingly slight. As one doctor has put it: "The risk of dying from being hit by lightning in New York is clearly greater than this risk of transmission."[18]

Science teaches us another important fact: health care workers with HIV often remain in good health for many years after becoming infected. An HIV-infected worker, who is otherwise healthy, probably has *at least* 8 to 10 years of good health from when the initial infec-

tion was dated.[19] This is particularly significant, given that there are presumably many such people now working (knowingly and unknowingly) at health care facilities throughout the nation.[20]

In view of these scientific lessons, a few more questions leap to mind: Should the rights of patients to refuse to subject themselves to the remotest of risks trump the rights of health care workers to practice provided their skills remain unimpaired? Do we want to eliminate highly trained, qualified persons with disabilities from jobs they are competent to safely perform?[21]

"The public interest is best served by retaining trained, able health care workers, rather than allowing remote risks justify discrimination."

New York law answers these questions in the negative. Our statutes and regulations pay homage to the principle that people who invest so much time and effort to become health care workers should have the right to work in their field, as long as they can perform their jobs well and not put others at unreasonable risk. The public interest is best served by retaining trained, able health care workers, rather than allowing remote risks justify discrimination.

II. What the Law Provides

We turn now to the legal structure New York has put in place to enhance patient safety and guard against discrimination of infected health care workers.

A. Mandatory Infection Control Training for Health Care Workers

There is general agreement among public health officials that the most effective means of preventing HIV infection in health care settings is through rigorous adherence to "universal precautions" and other scientifically accepted infection control practices.[22] Universal precautions are measures taken in health care settings to prevent transmission of HIV by decreasing the opportunity of blood-to-blood exposure between workers and patients (i.e., appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments).[23]

In 1992, New York enacted legislation providing that, once every four years, all licensed health care professionals should complete a course of study in universal precautions and infection control to prevent transmission of HIV.[24] Required courses—tailored to the infection control training needs of specific types of work—include work practices and engineering controls, universal precautions, and disinfection and sterilization procedures.[25] Course content must be approved by the New York State Department of Health (DOH) and/or the New York State Education Department (SED).[26]

Physicians, physician assistants and specialist assistants must submit to DOH proof of completion of the required training;[27] dentists, registered and licensed nurses, optometrists, podiatrists, and dental hygienists must provide such proof to SED.[28] Health professionals with hospital privileges should present the necessary documentation to the hospital (in lieu of DOH or SED) during the process of renewing hospital privileges.[29] A waiver of the required training may be granted by DOH and SED to those demonstrating it is unnecessary due to the nature of their work or have met criteria for equivalency.[30]

Further, licensed health care facilities are responsible for training their staffs in infection control techniques.[31] Training should be provided by facilities to health care workers in infection control techniques, including engineering and work practice controls, universal precautions, and work practices that help prevent needle-sticks or other injuries and splashes of blood and body fluids.[32]

B. Enforcement of Infection Control Standards

The law ensures not only that strict infection practices are taught to health care workers, but also that they are followed.

DOH and SED regulations describe scientifically accepted barrier precautions and infection control practices as standards of professional medical conduct for licensed health professionals.[33] Under these regulations, universal precautions must be used in all situations where there is potential for the transmission of infections.[34] Charges of professional misconduct may be brought against licensed health professionals who fail to either comply with these regulations or ensure persons under their supervision comply.

Likewise, all licensed health care facilities are responsible for implementing and enforcing a program for the prevention of circumstances which could result in employees or patients becoming exposed to blood or body fluids which could put them at "significant risk of contracting or transmitting HIV infection."[35] Such programs must provide appropriate equipment and supplies and make provisions for enforcing the proper use by staff of universal precautions and other infection control practices.[36] Additionally, facilities where invasive procedures are performed should provide appropriate staff with policy guidelines for the prevention of

HIV transmission during such procedures, and guidelines for improving infection control practices, where indicated.[37]

Failure to comply with these requirements may result in DOH citation, potential fines, and/or other disciplinary action against the facility. Patient or employee complaints regarding lax infection control practices in a facility will prompt a DOH investigation.

C. Promoting Voluntary HIV Testing

Article 27-F of the New York Public Health Law, commonly known as the AIDS Confidentiality Law,[38] with narrow exceptions, prohibits HIV testing of any citizen without written, informed consent.[39] The law also places severe limits on the disclosure of confidential HIV information[40] and imposes civil and criminal penalties on anyone who unlawfully discloses such information.[41] The theory behind the law—questioned by some—is that infected individuals will only come forward and engage the health care system through voluntary testing accompanied by the protection of confidentiality.[42]

The protections of article 27-F extend to HIV-infected health care workers and, thus, prohibit the involuntary or coerced testing by health care facilities of their employees. The law effectively creates a presumption that voluntary testing of workers—without fear of disclosure or discrimination—is the most effective means of encouraging those at risk for HIV to learn their HIV infection status.[43] Consistent with this presumption, facilities should provide information to their staffs on HIV risk factors and the availability of voluntary testing and counseling, and instruct those who have personal and occupational risks of exposure about the value of knowing their HIV status.[44]

D. Establishing Processes for Evaluating Infected Health Care Workers

All licensed health care facilities are responsible for ensuring their employees do not have impairments related to HIV infection which interfere with job performance or pose a risk to patients.[45] To assist facilities in discharging this responsibility while ensuring the fair treatment of health care workers, the law establishes processes for the evaluation of workers when they voluntarily disclose their positive HIV status to facilities or when it otherwise becomes known.[46] These processes offer a framework for evaluating workers and making decisions about their employment, by attention to functional abilities and infection control competence.

1. DOH Regulations and Guidelines

Under DOH regulations and guidelines, facilities are responsible for establishing and maintaining procedures for the management of individuals who are exposed to blood or body fluids "under circumstances which constitute significant risk of transmitting or contracting HIV infection."[47] Such procedures should contain at least three elements: (1) a system for reporting to a designated individual in the facility when workers are exposed to a significant risk of transmitting or contracting HIV infection;[48] (2) a mechanism for evaluating whether practice limitations ought to be imposed on workers;[49] and (3) assurances for the protection of confidentiality.[50]

"The theory behind the [AIDS Confidentiality] law—questioned by some—is that infected individuals will only come forward and engage the health care system through voluntary testing accompanied by the protection of confidentiality."

DOH has elaborated on these requirements in written guidelines.[51] Institutional evaluations of individual workers known to be infected with HIV should be based on the guidelines and involve consultation with experts who can provide a balanced perspective.[52]

The premise of a facility's evaluation process must be that HIV infection, standing alone, is not a sufficient justification to limit a health care worker's professional duties. As long as they are physically and mentally able to work, adhere to basic infection control practices, and have not been linked to HIV transmission in the workplace, there should be no restrictions on job duties.[53]

Accordingly, a decision to impose practice limitations, modifications or restrictions is warranted where workers pose a significant risk of transmitting infection through an inability to meet basic infection control standards or if they are functionally unable to care for patients.[54] For instance, a nurse with open, weeping wounds cannot by definition meet basic infection control standards. Nor can a surgeon who is significantly impaired by reason of HIV dementia be expected to perform at accepted standards in the operating room.[55]

Any limitation of work practice must seek to impose the least restrictive alternative.[56] When facilities impose practice limitations, they should periodically monitor and reevaluate workers on a case-by-case basis, involving their personal physicians in the process.[57] Facilities should offer these workers supplementary voluntary education and training in improving infection control practices in specific medical, nursing and dental procedures.[58]

Additionally, facilities should make known to their staffs the procedures they use for evaluating practice limitations for workers infected with HIV. These workers should be encouraged to seek periodic evaluation for functional limitations that could significantly compromise quality care, and to inform the facility when there is a significant risk of compromised patient care or when re-evaluation is appropriate.[59]

2. State-Appointed Review Panel

Any health care worker believing that, owing to HIV-infection status, his or her employment has been restricted or terminated without just cause, may file a complaint with the New York State Division of Human Rights.[60] In addition, the worker may ask for a second opinion from a DOH review panel pursuant to article 27-DD of the Public Health Law.

Enacted by the Legislature in 1992, article 27-DD establishes in DOH an advisory Panel whose purpose is to provide timely advice and consultation to HIV-infected health care workers voluntarily seeking review of the risk of HIV transmission to others through the workplace, and to recommend practice limitations, modifications or restrictions where the evidence suggests there is a significant risk to patients.[61] In addition to providing a second opinion for the worker dissatisfied with a facility evaluation, the Panel can function as a primary evaluation resource for the worker who is not affiliated with a facility.[62]

"Any health care worker believing that, owing to HIV-infection status, his or her employment has been restricted or terminated without just cause, may file a complaint with the New York State Division of Human Rights."

The Panel is composed of three to five members, including a public health official, an infectious disease expert, and an expert in infection control or epidemiology. For the purpose of the Panel's deliberations on a specific case, an individual from the infected worker's area of practice and the individual's private physician may be asked to serve as Panel members.[63]

A worker seeking the Panel's review must be advised of the Panel's authority to: investigate; recommend practice restrictions or modifications; advise facilities of such restrictions; and refer cases to professional licensing, registration and certification boards when compliance with the Panel's recommendations cannot be determined or does not occur.[64] If the worker is affiliated with, or employed at, a facility licensed by DOH, the Panel may evaluate and advise the worker only after the facility has completed its review of the worker's scope of practice.[65]

The Panel's evaluation process shall consider comprehensive medical criteria, including: physical and mental impairments interfering with the worker's ability to provide quality care; the worker's susceptibility to infectious diseases; the presence of exposed, exuding or weeping lesions; the worker's history of compliance with infection control guidelines; and the type of invasive procedures performed by the worker.[66] Only when evidence indicates the worker's practice poses a significant risk of harm to patients must the Panel make appropriate recommendations. These recommendations must be least restrictive with respect to the worker's practice, including, but not limited to, training or monitoring, or if necessary reassignment or practice restrictions.[67]

To protect the confidentiality of information concerning the HIV-infected worker, the information and decisions of the Panel are generally not subject to disclosure, with only a few exceptions.[68] One exception, applicable to institutionally based workers, permits the Panel to request information from the facility about the worker's practice so the Panel can conduct an adequate evaluation.[69] The Panel may also disclose information to appropriate professional disciplinary bodies, upon finding the worker failed to comply with the Panel's recommendations or "compliance cannot be determined by the Panel after reasonable effort."[70]

If the Panel recommends practice limitations, the worker shall provide written assurance to the Panel that all health facilities where she practices are informed and shall identify the person or persons at the facilities so informed. If assurance is not forthcoming, the Panel will inform the facilities.[71] Within all facilities, the normal rules of confidentiality apply.[72]

Notably, although article 27-DD has been on the books for several years, DOH has never received a request by a worker to have her case reviewed by the Panel.

3. Enforcement of Practice Restrictions

Health care facilities are responsible for enforcing the practice limitations they recommend to their employees.[73] Similarly, if the State-appointed review Panel recommends practice limitations for a community-based health care worker, the Panel may periodically monitor and reevaluate the worker, with the worker's consent, at a frequency and through a mechanism to be determined by agreement between the worker and the Panel.[74] If the worker does not follow the recommended practice restrictions or if compliance is uncertain, the Panel may notify the appropriate state disciplinary bodies and the worker may be charged with professional misconduct.[75]

E. Disclosure of HIV-Positive Status

An issue that often sparks debate is whether all health care workers—or select categories—should be required to disclose to patients their HIV-positive status.[76]

Those urging mandatory disclosure point to studies which demonstrate that a majority of the public wants to know if their surgeons and dentists have HIV or AIDS.[77] And, indeed, many jurisdictions compel doctors to disclose their HIV-positive status to patients, under certain conditions,[78] based on theories such as informed consent.[79]

New York law, however, does not require health care workers to disclose their HIV-positive status to patients or employers when engaging in medical activity.[80] (Different rules obtain with respect to the disclosure of information to health care workers about the HIV infection of patients.[81]) Mandatory disclosure has been rejected in this state on the grounds that it would serve as a deterrent to workers seeking voluntary testing and may jeopardize their careers without materially decreasing the risk of transmitting HIV to patients.[82]

"New York . . . has resisted the temptation of succumbing to . . . unsubstantiated fears and constructed a legal framework on a firm foundation of scientific evidence."

In a similar vein, New York law imposes no obligation upon health care facilities to disclose information to patients about the HIV infection status of personnel.[83] A facility's disclosure of the identity of an HIV-infected health care worker to a patient, without the worker's consent, would likely violate the AIDS Confidentiality Law.[84]

But a different question is presented if a facility learns for a fact that the blood of a health care worker contacted a patient's blood stream or mucous membranes.[85] In such circumstances, the patient should be advised to receive testing for potential HIV.[86] A facility must obtain the worker's written consent to release their identification.[87] The facility may choose to otherwise provide information to patients, but should take all necessary steps not to identify the worker. Facilities that decide to disclose this information should inform DOH, which will provide technical assistance.[88]

III. Conclusion

Few things frighten people more than infectious diseases.[89] It thus comes as no surprise that some experience "AIDS phobia" in the health care setting, despite the demonstrably low risk of HIV transmission by health care workers to patients. New York, however, has resisted the temptation of succumbing to such unsubstantiated fears and constructed a legal framework on a firm foundation of scientific evidence.[90]

Endnotes

1. Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Recommendations for Preventing Transmission of Infection with Human Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace,* 34 Morbidity & Mortality Wkly. Rep. 681 (1985).
2. The terms "health care workers" and "workers," as used in this article, mean persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health care setting.
3. HIV infection is a communicable disease which weakens the body's immune system, rendering the infected individual susceptible to disease. *See Bragdon v. Abbott,* 524 U.S. 624, 633-37 (1998) (describing course followed by HIV infection). HIV is transmitted by the exchange of certain bodily fluids such as blood, semen, vaginal secretions, and breast milk. *Doe v. University of Md. Med. Sys. Corp.,* 50 F.3d 1261, 1262 (4th Cir. 1995).
4. "AIDS is the end-stage of HIV infection and is characterized by the presence of HIV and one or more 'opportunistic' infections, i.e., diseases that occur only rarely in individuals who do not carry HIV. . . . Years may pass before an HIV-positive individual develops AIDS; such persons are considered 'asymptomatic' for AIDS." *Doe,* 50 F.3d at 1263. Although there have been remarkable advances in treatment, as of today, AIDS remains a fatal disease. AIDS has thus "evolved from a swiftly fatal illness whose etiology was unknown, to a well-studied, treatable chronic disease where death can frequently be staved off for a lengthy time, although not forestalled altogether." Linda C. Fentiman, *AIDS As a Chronic Illness: A Cautionary Tale for the End of the Twentieth Century,* 61 Albany L. Rev. 989, 990 (1998) (citing Deborah J. Cotton, *Improving Survival in Acquired Immunodeficiency Syndrome: Is Experience Everything?,* 261 JAMA 3016, 3016 (1989) (discussing the progress in treatment for AIDS)).
5. Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Update: Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Dental Procedure,* 39 Morbidity & Mortality Wkly. Rep. 489 (1990).
6. Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Update: Investigations of Persons Treated by HIV-Infected Health-Care Workers—United States,* 42 Morbidity & Mortality Wkly. Rep. 329, 329 (1993) (hereinafter "CDC, *Infected Health Care Workers*"]; Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Update: Transmission of HIV During Invasive Dental Procedure—Florida,* 40 Morbidity & Mortality Wkly. Rep. 377, 377-381 (1991). CDC's conclusions regarding the Acer case have been criticized on the ground that the true cause of the infections is unknown. *E.g.,* Stephen Barr, *The 1990 Florida Dental Investigation: Is the Case Really Closed?,* 124 Annals Internal Med. 250 (1996); *see also* Jeffery W. Cavender, *AIDS in the Health Care Setting: The Congressional Response to the Kimberly Bergalis Case,* 26 GA. L. REV. 539, 540 (1992) (noting CDC did not exclude the possibility of infection from another source).
7. Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures,* 40 Morbidity & Mortality Wkly. Rep. 1 (1991). For an analysis of CDC's guidelines,

see Mark D. Johnson, *HIV Testing of Health Care Workers: Conflict Between the Common Law and The Centers for Disease Control*, 42 Am. U.L. Rev. 479 (1993).

8. 42 U.S.C. § 300ee-2. The focus of the national effort has not been directed toward the vast numbers of HIV-infected persons who function safely in health care settings and who are not involved in any type of invasive procedures (e.g., clerks, laundry, food services), but rather, on those who foreseeably may come into contact with blood and body fluids of patients during the course of their professional activities.

9. This duty is embodied in the Hippocratic oath, which dates from the Fifth Century B.C.E. and is the seminal source of the principles of medical ethics and the goals of medical treatment. *See generally*, Curly Bonds, *The Hippocratic Oath: A Basis for Modern Ethical Standards*, 264 JAMA 2311 (1990). Under the oath, physicians pledge "to do no harm" and act only in the best medical interests of their patients. *See* Tom L. Beauchamp & James F. Childress, Principles Of Biomedical Ethics 189 (4th ed. 1994); Ludwig Edelstein, The Hippocratic Oath: Text, Translation, And Interpretation 3 (Henry Sigerist ed. 1943).

10. *Doe*, 50 F.3d at 1262-63. "Studies show no evidence that the infection is transmitted by casual contact. Individuals with HIV infection may or may not develop signs of infection and the disease can lead to AIDS. AIDS is a disease which damages the individual's immune system: those who develop it are vulnerable to unusual infections and cancers that do not generally pose a threat to anyone whose immune system is intact." *New York State Socy. of Surgeons v. Axelrod*, 77 N.Y.2d 677, 682, 572 N.E.2d 605, 607, 569 N.Y.S.2d 922, 924 (N.Y. 1991).

11. *Doe*, 50 F.3d at 1263.

12. Larry Gostin, *The HIV-Infected Health Care Professional: Public Policy, Discrimination, and Patient Safety*, 18 Law Med. & Health Care 303, 304 (1990).

13. *Doe*, 50 F.3d at 1263 (citing Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Open Meeting on the Risks of Transmission of Blood-borne Pathogens to Patients During Invasive Procedures* (Feb. 21-22, 1991) (statement of Dr. David Bell, Centers for Disease Control)); *see also* Phillip L. McIntosh, *When the Surgeon Has HIV: What To Tell Patients About the Risk of Exposure and The Risk of Transmission*, 44 U. Kan. L. Rev. 315, 328-30 (1996) (reviewing different estimations of risk).

14. Frank S. Rhame, *The HIV-Infected Surgeon*, 264 JAMA 507, 507 (1990), *cited in* New York State Department Of Health, Policy Statement & Guidelines—Health Care Facilities & HIV-Infection Medical Personnel, at 2 (Jan. 1991) (hereinafter "DOH, Policy & Guidelines").

15. Albert B. Lowenfels & Gary Wormser, *Risk of Transmission of HIV from Surgeon to Patient*, 325 New Eng. J. Med. 888, 891 (1991).

16. *Estate of Mauro v. Borgess Medical Center*, 137 F.3d 398, 411 (6th Cir. 1998) (Boggs, J., dissenting), *cert. denied*, 525 U.S. 815 (1998).

17. CDC, *Infected Health Care Workers*, *supra* note 6, at 349. The Acer case (discussed *supra* notes 5 to 6 and accompanying text) represents the only documented case of HIV transmission of a health care worker to a patient, with the exception of a handful of possible cases of transmission from a French surgeon to his patients. *See Transmission of HIV from an Infected Surgeon to a Patient in France*, 7 Communicable Disease Re. Wkly., Jan 24, 1997, at 1.

18. *Symposium: Job Restrictions and Disclosure Requirements for HIV-Infected Health Care Professionals: Whose Privacy Is It Anyway?*, 41 N.Y.L. Sch. L. Rev. 5, 37 (1996) (statement of Dr. Norton Spritz); Susan L. DiMaggio, *State Regulations and the HIV-Positive Health Care Professional: A Response to a Problem that Does Not Exist*, 19 AM. J. L. & MED. 497, 501 (1993) (describing patient's risk of becoming infected with HIV by a surgeon of unknown HIV status as being "one-tenth the chance of being killed by lightning, one-fourth the chance of being killed by a bee and one-half the chance of being hit by a falling aircraft"). The risk of transmission from patient to health care worker has been found to be greater than the risk from health care worker to patient. *See* Mary Anne Bobinski, *Patients and Providers in the Courts: Fractures in the Americans with Disabilities Act*, 61 Albany L. Rev. 785, 793-96 (1998). Indeed, CDC has found occupational transmission in over 50 cases—of which over half occurred in patient treatment settings—and suspects that occupational transmission occurred in an additional 144 cases. Centers For Disease Control & Prevention, U.S. Dep't Of Health & Human Servs., HIV/AIDS Surveillance Report 15 tbl.11 (Midyear ed. 1997).

19. New York State Department Of Health, Supplement To DOH Memorandum 86-32, Update Of Program Standards For Designated Aids Center Hospitals, Health Facilities Series: H-22 93-25, at 1 (1993) ("The median time from infection to CDC-defined AIDS is 8 to 10 years, with survival even after AIDS is diagnosed being several years."); AIDS Institute, New York State Department Of Health, HIV Prophylaxis Following Occupational Exposure 2 (1998) ("The availability of potent antiretrovial drugs which exert profound and durable suppression of viral replication has revolutionized the care of HIV-infected individuals. For some patients, this has translated to the arrest or even reversal of disease progression.") (hereinafter "AIDS Institute, HIV Prophylaxis").

20. DOH, Policy & Guidelines, *supra* note 14, at 1.

21. *See* Ronald Bayer, *Discrimination, Informed Consent, and the HIV Infected Clinician: We Must Ask Whether Patients' Rights to Avoid the Remotest of Risks Should Override Clinicians' Rights to Practice As Long As Their Skills Remain Unimpaired*, 314 British Medical Journal 915 (1997).

22. New York State Department Of Health, Policy Statement And Guidelines To Prevent Transmission Of HIV And Hepatitis B Through Medical/Dental Procedures, at 4 (August 1992) (hereinafter "DOH, Medical/Dental Procedures").

23. Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings*, 37 Morbidity & Mortality Wkly. Rep. 377, 377-82 (1988).

24. N.Y. Pub. Health Law § 239 (McKinney Supp. 1998) (requiring classes and training in HIV infection control methods for physicians, physician assistants and specialist assistants); N.Y. Comp. Codes R. & Regs. tit. x, subpart 92-1 (DOH regulations); N.Y. Educ. Law § 6505-b (McKinney Supp. 1998) (requiring classes and training in HIV infection control methods for dentists, registered and licensed nurses, optometrists, podiatrists, and dental hygienists); N.Y. Comp. Codes R. & Regs tit. viii, pt. 58 (SED regulations).

25. N.Y. Pub. Health Law § 239 (McKinney Supp. 1998); N.Y. Educ. Law § 6505-b (McKinney Supp. 1998); N.Y. Comp. Codes R. & Regs. tit. viii, pt. 58; DOH, Medical/Dental Procedures, *supra* note 22, at 2.

26. *Id.*; N.Y. Comp. Codes R. & Regs. tit. x, § 92-1.1.

27. N.Y. Pub. Health Law § 239 (McKinney Supp. 1998); N.Y. Comp. Codes R. & Regs. tit. x, § 92-1.8.

28. N.Y. Educ. Law § 6505-b (McKinney Supp. 1998).

29. N.Y. Pub. Health Law §§ 239, 2805-K(1)(f) (McKinney 1993); N.Y. Comp. Codes R. & Regs. tit. x, 92-1.8; N.Y. Educ. Law § 6505-b (McKinney Supp. 1998).

30. N.Y. Pub. Health Law §§ 239, 2805-K(1)(f)(McKinney 1993); N.Y. Educ. Law § 6505-b (McKinney Supp. 1998). DOH's regulations elaborate on the circumstances under which a waiver may issue, as follows:

> No need to complete work or training exists when health professionals are in settings where they do not provide direct patient care, do not have responsibility for supervising staff who provide direct patient care or reprocess used patient care equipment, or do not perform services to which these standards would be expected to apply, or when the professional does not practice in New York State. A physician, [a physician assistant] . . . or [a specialist assistant] . . . who has been granted an exemption shall notify the department in writing of any change in the nature of his or her practice within 30 days of the occurrence of such change. The physician, [physician assisant] . . . or [specialist assistant] . . . shall obtain necessary course work or training within 90 days of the change in practice.

N.Y. Comp. Codes R. & Regs. tit. x, § 92-1.9 (1995).

31. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(1); DOH, Policy & Guidelines, *supra* note 14, at 3; *see also* N.Y. Comp. Codes R. & Regs. tit. x, § 415.19 (requiring health care facilities to establish and maintain an infection control program). More specifically, DOH regulations require that facilities provide training at the time of employment to all employees whose job-related tasks involve, or may involve, exposure to "significant risk body substances." N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(1)(iii). The term "significant risk body substances" is defined as "blood, semen, vaginal secretions, breast milk, tissue and the following body fluids: cerebrospinal, amniotic, peritoneal, synovial, pericardia, and pleural." *Id.* § 63.9(b). Additionally, facilities should provide employees with yearly staff development programs on the use of protective equipment, preventive practices, and circumstances which represent a significant risk of exposure to significant risk body substances. *Id.* § 400.20(a)(1)(iii); DOH, Policy & Guidelines, *supra* note 14, at 2-3.

32. DOH, Medical / Dental Procedures, *supra* note 22, at 3.

33. N.Y. Comp. Codes R. & Regs. tit. x, § 92-2.1 (DOH regulations); N.Y. Comp. Codes R. & Regs. tit. viii, § 29.2(a)(13) (SED regulations); *see also* N.Y. Pub. Health Law § 230-a (McKinney Supp. 1998) (requiring DOH to establish rules and regulations describing scientifically accepted barrier precautions and infection control practices as standards of professional medical conduct for physicians, physician assistants and specialist assistants); N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(1)(i) and (ii) (requiring DOH licensed facilities to implement and enforce a program which includes use of scientifically accepted preventive practices in appropriate circumstances).

34. *Cahill v. Rosa*, 89 N.Y.2d 14, 24, 674 N.E.2d 274, 278, 651 N.Y.S.2d 344, 348 (N.Y. 1996) (citing N.Y. Comp. Codes R. & Regs. tit. viii, § 29.2 (a)(13) (SED regulations)); N.Y. Comp. Codes R. & Regs. tit. x, § 92-2.1(a) (DOH regulations).

35. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(2); DOH, Policy & Guidelines, *supra* note 14, at 3; *see also* N.Y. Comp. Codes R. & Regs. tit. x, § 415.19 (requiring health care facility to establish and maintain an infection control program). Under DOH's regulations, three factors are necessary to create a "significant risk of contracting or transmitting HIV infection": "(1) the presence of a significant risk body substance; (2) a circumstance which constitutes significant risk for transmitting or contracting HIV infection; and (3) the presence of an infectious source and a noninfected person." N.Y. Comp. Codes R. & Regs. tit. x, § 63.9(a). Circumstances constituting a "significant risk of transmitting or contracting HIV infection" include:

> (1) sexual intercourse (vaginal, anal, oral) which exposes a noninfected individual to share blood, semen or vaginal secretions of an infected individual; (2) sharing of needles and other paraphernalia used for preparing and injecting drugs between infected and noninfected individuals; (3) the gestation, birthing or breast feeding of an infant hen the mother is infected with HIV; (4) transfusion or transplantation of blood, organs or other tissues from an infected individual to an uninfected individual, provided such blood, organs, or other tissues have not tested negatively for antibody or antigen and have not been rendered noninfective by heat or chemical treatment; (5) other circumstances not identified in paragraphs (1) through (4) of this subdivision during which a significant risk body substance (other than breast milk) of an infected individual contacts mucous membranes (e.g., eyes, nose, mouth), nonintact skin (e.g., open wound, skin with a dermatitis condition, abraded areas) or the vascular system of a noninfected person. Such circumstances include, but are not limited to needlestick or puncture wound injuries and direct saturation or permeation of these body surfaces by the infectious body substance.

Id. § 63.9(c). Circumstances which do *not* involve a significant risk of contracting or transmitting HIV infection include:

> (1) exposure to urine, feces, sputum, nasal secretions, saliva, sweat, tears or vomitus that does not contain blood that is visable to the naked eye; (2) human bites where there is no direct blood to blood, or blood to mucous membrane contact; (3) exposure of intact skin to blood or any other substance; or (4) occupational settings where individuals use scientifically accepted barrier techniques and preventive practices in circumstances which would otherwise pose a significant risk.

Id. § 63.9(d).

36. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(1)(iv) and (v).

37. DOH, Policy & Guidelines, *supra* note 14, at 2; *see also* N.Y. Comp. Codes R. & Regs. tit. x, §§ 400.20(a)(1)(iii) (requiring facilities to provide training to appropriate staff in infection control techniques); *id.* § 415.19 (requiring health care facilities to establish and maintain an infection control program).

38. N.Y. Pub. Health Law §§ 2780-2787 (McKinney 1993).

39. *See* N.Y. Pub. Health Law § 2781(1) (McKinney 1993) (requiring written, informed consent be obtained from subject before HIV related test can be performed, unless such a test is otherwise specifically authorized by state or federal law).

40. *See id.* § 2782 (providing limits on disclosure).

41. *See id.* § 2783 (listing penalties for unauthorized disclosure).

42. *See* Act of Sept. 1, 1988, ch. 584, 1988 N.Y. Laws 1132, (noting that the legislature believed voluntary testing accompanied by the protection of confidentiality would increase the number of people willing to come forward and learn their health status). *But see* Hermes Fernandez, *Is AIDS Different*, 61 Albany L. Rev. 1053, 1076 (1998) (questioning whether—in light of recent social, medical and legal developments—it is still reasonable to expect that at risk individuals will avoid the health care system if they face the possibility of involuntary HIV testing).

43. *See* DOH, Policy & Guidelines, *supra* note 14, at 3.

44. *Id.*

45. Employees of health care facilities must be free of any health impairment which would present a risk to patients which cannot be reasonably accommodated, or which might interfere with the performance of professional duties. N.Y. Comp. Codes R. & Regs. tit. x, §§ 405.3, 415.19, 415.26, 417.17, 751.6, 763.4, 766.3, 771.2, 793.5. To this end, facilities are require to evaluate each

worker at least annually for their ability to work without danger to patients. *Id.* § 405.3(b)(10), (b)(11).

46. *See* DOH, Policy & Guidelines, *supra* note 14, at 1.

47. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(2); *see id.* § 415.19 (requiring health care facility to establish and maintain an infection control program); *supra* note 35 (setting forth regulatory definition of the phrase "significant risk of transmitting or contracting HIV infection"). *See generally,* AIDS Institute, HIV Prophylaxis, *supra* note 19.

48. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(2)(i); DOH, Policy & Guidelines, *supra* note 14, at 3.

49. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(a)(2)(ii).

50. *Id.* § 400.20(a)(2)(iii).

51. *See* DOH, Policy & Guidelines, *supra* note 14.

52. Such experts include an infectious disease physician and / or hospital epidemiologist with an understanding of HIV, a representative from the infected health care worker's practice area, and the personal physician of the infected worker. DOH, Policy & Guidelines, *supra* note 14, at 3.

53. New York State Department Of Health, Recommendations For The Management Of Communicable Diseases Among Employees In Health Care Facilities, Memorandum 94-32, at 12 (1994) (hereinafter "DOH, Management Of Communicable Diseases"); DOH, Policy & Guidelines, *supra* note 14, at 3.

54. *See* DOH, Medical / Dental Procedures, *supra* note 22, at 2; DOH, Management Of Communicable Diseases, *supra* 53, at 6. *See also* N.Y. PUB. HEALTH § 2661(4) (McKinney 1993) (State-appointed review board may only impose practice limitations where worker's practice imposes risk of harm to patients).

55. DOH, Policy & Guidelines, *supra* note 14, at 1. Factors that may have a bearing on potential limitation, modification or reassignment of duties for all health care workers, including health care workers with HIV infection, include the following:

> 1. Illness that may interfere significantly with the health care worker's ability to provide quality care. Both physical and mental competence are to be considered.
>
> 2. The immunologic status of the health care worker and susceptibility to infectious diseases.
>
> 3. The presence of exudative or weeping lesions.
>
> 4. Functional inability to perform assigned tasks or regular duties.
>
> 5. Documentation or evidence of previous transmission of bloodborne pathogens, including [Hepatitis B virus].
>
> 6. Noncompliance with established guidelines to prevent transmission of disease.

DOH, Policy & Guidelines, *supra* note 14, at 3; *see also infra* notes 66 to 67 and accompanying test (discussing factors which would be utilized by State-appointed review Panel when deciding whether practice limitations ought to be imposed on health care workers).

56. DOH, Medical / Dental Procedures, *supra* note 22, at 2; *see also* N.Y. Pub. Health Law § 2761(1) (McKinney 1993).

57. *See* DOH, Policy & Guidelines, *supra* note 14, at 4. "Such reevaluation should consider the worker's adherence to universal precautions and other infection control practices. Incident and operative reports should be reviewed for the occurrences of needle sticks, scalpel cuts or other injuries." *Id.*

58. *Id.*

59. *Id.* at 3.

60. The New York State Division of Human Rights is charged with enforcing New York's Human Rights Law, which proscribes certain discriminatory practices in employment. *See* N.Y. Exec. Law art. 15 (McKinney 1996). In particular, the Human Rights Law makes it an unlawful discriminatory practice for health care facilities, because of an employee's disability, to refuse to employ or discharge such employee or discriminate against them in compensation or in the terms, conditions or privileges of employment. N.Y. Exec. Law § 296(1) (McKinney 1996); *see also Arnot Ogden Memorial Hospital v. State Div. of Human Rights*, 67 A.D.2d 543, 546, 416 N.Y.S.2d 372, 373-74 (N.Y. App. Div. 1979) (upholding Division of Human Rights' determination that hospital had engaged in an unlawful discriminatory act by denying employment to a nurse because of high blood pressure; court found no evidence nurse's high blood pressure would interfere with job performance or likely result in harm to patients); *Cahill v. Rosa*, 89 N.Y.2d 14, 674 N.E.2d 274, 651 N.Y.S.2d 344 (N.Y. 1996) (holding that private dental offices are places of public accommodation subject to human rights law and that dentists in private practice were guilty of unlawful discriminatory practice because they failed to treat patients who were known or suspected to be HIV-positive). Similarly, HIV infection constitutes a disability under the Americans with Disability Act of 1990, which prohibits discrimination against any individual "on the basis of disability in the . . . enjoyment of the . . . services . . . of any place of public accommodation by any person who . . . operates [such] a place." 42 U.S.C. § 12182(a); *Bragdon v. Abbott*, 524 U.S. 624, 630-47 (1998).

61. N.Y. Pub. Health Law §§ 2660, 2661 (McKinney 1993); DOH, Policy & Guidelines, *supra* note 14, at 4. The Panel also has jurisdiction to assist workers infected with Hepatitis B. *Id.*

62. *Id.*

63. N.Y. Pub. Health Law § 2760(1) (McKinney 1993).

64. *Id.* § 2661(1), (4).

65. *Id.* § 2661(1).

66. *Id.* § 2661(2).

67. *Id.*

68. *Id.* § 2661(4).

69. *Id.* §§ 2661(1), 2782(9).

70. *Id.* § 2661(5).

71. *Id.* § 2661(3).

72. DOH, Medical / Dental Procedures, *supra* note 22, at 4.

73. *See* N.Y. Comp. Codes R. & Regs. tit. x, § 400.21(a)(2) (requiring enforcement of facility procedures for managing individuals exposed to circumstances constituting a significant risk of contracting or transmitting HIV).

74. N.Y. Pub. Health Law § 2761(3) (McKinney 1993).

75. *Id.* § 2761(4).

76. *Compare, e.g.,* Michael L. Closen, *HIV—AIDS Infected Surgeons and Dentists and the Medical Profession's Betrayal of Its Responsibility to Patients*, 41 N.Y.L. Sch. L. Rev. 57 (1996), *with* Marc E. Elovitz, *Why the Debate on Restricting Health Care Workers with HIV Should End: A Response to Professor Closen*, 41 N.Y.L. Sch. L. Rev. 141 (1996).

77. *See, e.g.*, Barbara Gerbert et al., *Physicians and Acquired Immunodeficiency Virus in Medical Practice,* 262 JAMA 1969, 1971 (1989) (reporting that 80% of patient-respondents believed physicians infected with HIV should inform their patients of their HIV-positive status).

78. *See* Grace Kathleen Higan & Nicole Wertz, Note: *Privacy, Privilege and the Right to Know: Disclosure of AIDS/HIV Status in the Physician-Patient Relationship*, 11 St. John's J.L. Comm. 805, 825-28 (1996) (discussing case law and other authorities); Eric N. Anderson & Salvatore J. Russo, *Calming AIDS Phobia: Legal Implications of the Low Risk of Transmitting HIV in the Health Care Setting*, 28 U. Mich J.L. Reform 733, 766-71 (1995) (same) (hereinafter "Anderson & Russ, *Calming AIDS Phobia*").

79. The doctrine of informed consent imposes a duty upon health professionals to disclose to patients information that a reasonable patient would want to know. *See* N.Y. Pub. Health Law § 2805-d (McKinney 1993).

80. DOH, Medical/Dental Procedures, *supra* note 22, at 4. It should be noted, however, that nothing in New York law prohibits a patient from asking an individual health care provider about their HIV-infection status.

81. In certain circumstances, a health care worker, upon request, may learn the HIV status of patients when an exposure incident happens to the health care worker in the performance of employment or professional duties in a medical or dental office or in a regulated facility or if the person is an emergency response worker. *See* N.Y. Comp. Codes R. & Regs. tit. x, § 63.8(m). Disclosure to a health care worker who may have been exposed to HIV by a patient will be made if an evaluation indicates that the information is necessary for immediate treatment decisions, and the exposed person is either HIV negative or unknown. *Id.* § 63.8(m)(6). (If the health care worker's status is unknown, he/she must consent to an HIV test. *Id.)* Additionally, the alleged exposure incident must involve blood, semen or other listed body substance which has come into contact with mucus membranes, non-intact skin or the vascular system of another. *Id.* § 63.8(m)(1).

82. DOH, Policy & Guidelines, *supra* note 14, at 4. As two commentators recently observed:

> [T]he consequences of requiring patient notification can be devastating for an employee. Patient notification would breach the confidential nature of the employee's HIV status. Once disclosed, knowledge of the HIV status often spreads quickly, ruining the worker's career. Moreover, studies suggest that the majority of patients do not want to be treated by HIV-infected providers. Further, those infected with HIV may face discrimination for nonoccupationally related reasons. Thus, any balancing that considers the health care professional's personal rights should be resolved in favor of voluntary disclosure, rather than mandatory patient notification. Finally, notification of patients is unnecessary in light of the CDC's findings that the risk of transmission in the health care setting is infinitesimal. . . . Proper infection control procedures should allow HIV-positive health care workers to continue to perform their jobs safely and make mandatory disclosure unnecessary.

Anderson & Russo, *Calming AIDS Phobia*, *supra* note 78, at 772 (citations omitted); *see also New York Soc'y of Surgeons v. Axelrod*, 77 N.Y.2d 677, 686, 572 N.E.2d 605, 607, 569 N.Y.S.2d 922 (N.Y. 1991)(recognizing disincentives of disclosure for HIV-infected persons due to discrimination in a variety of areas).

83. DOH, Policy & Guidelines, *supra* note 14, at 4; *see also* 10 N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(2)(iii) (requiring facility to assure the confidentiality of persons exposed to HIV).

84. *See supra* notes 38 to 44 and accompanying text (discussing N.Y. Pub. Health Law Article 27-F, the AIDS Confidentiality Law).

85. *See generally*, Stephen B. Joyce, *The Consequences of Disclosure: One Hospital's Response to the Presence of an HIV-Positive Physician*, 40 Hospital & Health Services Administration 457 (1995) (discussing one hospital's response upon learning that an emergency room physician was HIV-positive).

86. *See generally*, *McBarnette v. Feldman*, 153 Misc. 2d 627, 582 N.Y.S.2d 900 (N.Y. Sup. Ct. 1992) (granting DOH access to the records of dentist who reportedly died of AIDS for the purpose of protecting the public health and studying the epidemiological nature of an epidemic of HIV).

87. N.Y. Comp. Codes R. & Regs. tit. x, § 400.20(2)(ii)(b) ("Disclosure of the HIV status of the source individual can be made with the express written consent of the protected individual, or a person authorized pursuant to law to consent to health care for the protected individual if such person lacks capacity to consent, or pursuant to court order, if the HIV status is not known to the exposed individual[.]"); *see also* N.Y. Pub. Health Law §§ 2781(1) (McKinney 1993) ("no person shall order the performance of an HIV related test without first receiving the written, informed consent of the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, of a person authorized pursuant to law to consent to health care for such individual"); *id.* § 2782 (providing limits on disclosure of confidential HIV-related information).

88. *See* DOH, Policy & Guidelines, *supra* note 14, at 4.

89. *See School Board v. Arline*, 480 U.S. 273, 284 (1987) ("Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness.").

90. So science has prevailed, and that is as it should be. *See id.* at 288 ("courts normally should defer to the reasonable medical judgments of public health officials"). But science is not static; it's a work in progress. How we interpret scientific facts can evolve over time in response to societal changes. And with each new scientific discovery that alters our understanding of the physical world, there may be cause to revisit applicable areas of law. *See generally*, Ludwik Fleck, Genesis And Development Of A Scientific Fact 102 (University of Chicago Press ed. 1979) ("[E]very fact reacts upon many others. Every change and every discovery has an effect on a terrain that is virtually limitless. It is characteristic of advanced knowledge, matured into a coherent system, that each new fact harmoniously—though ever so slightly—changes all earlier facts. Here every discovery is actually a recreation of the whole world as construed by a thought collective.").

Henry M. Greenberg is a partner in the firm of Couch White, LLP. He is the former General Counsel, New York State Department of Health. This article grew out of an address the author delivered at the New York Academy of Medicine on January 22, 1998 as part of a conference entitled: "The Infected Health Care Worker: Medical, Legal and Ethical Perspectives."

Health Care Financing Transactions: Recent Developments

By Leslie J. Levinson and Gerard S. Catalanello

A. Introduction

Two fundamental issues continue to create uncertainty and debate in the credit markets for financing health care providers: 1) whether a health care provider may assign to a lender as collateral its interest in receivables due from insurers; and 2) whether any assignment of receivables due from insurers may be perfected by compliance with article 9 of the Uniform Commercial Code (UCC). Indeed, given the failure of many health care providers in recent years,[1] the debate and uncertainty surrounding two issues has only heightened, particularly in the bankruptcy context where secured transactions are intensely scrutinized and the stakes are extremely high. Most importantly, the uncertainty surrounding these issues has invariably had, and continues to have, a negative impact on the amount and terms of secured credit available to health care providers. However, recent revisions to the UCC, along with a recent decision from the United States Bankruptcy Court for the District of Massachusetts[2] could facilitate greater certainty in this area, which will hopefully help create a better atmosphere for credit facilities generally in the health care industry.

B. Background: Assignment of Health Care Receivables and the UCC

Pursuant to federal statutes, health care providers are prohibited from assigning the right to receive payment from the federal government.

The three relevant federal anti-assignment statutes provide as follows:

> No payment which may be made to a provider of services under this subchapter for any service furnished to an individual shall be made to any other person under an assignment or power of attorney.[3]

> No payment under this part for a service provided to any individual shall . . . be made to anyone other than such individual or . . . the physician or other person who provided the service.[4]

> A State plan for medical assistance must–(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise.[5]

The legislative history reveals that the primary intent behind the enactment of the federal anti-assignment statutes was to prevent "factoring" agencies from purchasing governmental accounts receivable (Medicare and Medicaid) at a discount and then collecting on the right of payment or submitting a claim for payment under the applicable reimbursement program.[6] However, while this may have been the intention, the restrictions imposed by these provisions created the impression that there was a strict, if not absolute, prohibition against any assignment of health care receivables under a loan agreement or similar financing arrangement. In 1986, a key decision interpreting the federal anti-assignment provisions was rendered by the United States Court of Appeals for the Fifth Circuit which provided some comfort to health care providers and lenders.

In *Wilson v. First National Bank, Lubbock, Texas (In re Missionary Baptist Foundation of America, Inc.)*,[7] the court was confronted with the issue of whether a health care provider's grant of a security interest in its Medicaid reimbursement payments to its lender as collateral for a line of credit was valid and enforceable in the health care provider's subsequent bankruptcy proceeding. Specifically, following Missionary Baptist's bankruptcy filing, the bankruptcy trustee commenced an action against the bank alleging, among other things, that the grant of a security interest in the Medicaid accounts receivable to the bank was invalid in view of 42 U.S.C. § 1936(a)(32).[8] The bankruptcy court rejected the argument and dismissed the trustee's complaint on all accounts. On appeal, the Fifth Circuit affirmed the bankruptcy court's ruling on this issue.[9] The court stated as follows:

> Viewed in terms of the federal standard, the Bank's reimbursement agreement with the Debtor passes muster. 42 U.S.C. § 1396a(32) provides that 'nothing in this paragraph shall be construed . . . to preclude an agent of [the person or institution providing the care or service involved] from receiving any such payment' so long as a 'factoring' arrangement is not used.[10]

The court then reviewed the facts as determined by the bankruptcy court and noted, in relevant part, that there was no evidence that the bank was acting as a "factor,"[11] and that the monies were initially deposited into Missionary Baptist's account at the bank and then immediately removed by the bank and credited to the line of credit.[12] Applying these facts to the federal statue, the court held that "[t]here is nothing in these arrangements to suggest a violation of 42 U.S.C. § 1396(a)(32)."[13]

The holding in *Missionary Baptist*, that the federal anti-assignment provisions contained in 42 U.S.C. § 1396(a)(32) did not prohibit the assignment of health care receivables to a bank as collateral for a loan, was widely embraced by the financial markets and by other courts as well.[14] However, *Missionary Baptist* did not discuss the enforcement of a security interest in health care receivables and placed great emphasis upon the fact that the government paid the monies directly to the health care provider, and not the lender. Thus, according to *Missionary Baptist*, the existence of a valid security interest in health care receivables depends upon, among other things, the mechanism employed for collecting such receivables.[15]

Additionally, neither *Missionary Baptist* nor its progeny directly addressed the important distinction between a valid *grant* of the security interest in the health care receivables and the *perfection* of such interest in said receivables. Clearly, absent a perfected security interest, a lender is in no better position than other unsecured creditors, an issue of particular importance in a bankruptcy setting. Fueling this confusion is the current version of § 9-104(a)(g) of the UCC,[16] which provides as follows:

> This Article does not apply
>
> (g) to a transfer of an interest or claim in or **under any policy of insurance** or contract for an annuity including a variable annuity, except as provided with respect to proceeds (Section 9-306) and priorities in proceeds (Section 9-312).[17]

One could read this section as exempting from article 9 a security interest in the claims of a health care provider to payment under insurance policies which cover patients who received services from the health care provider.[18] However, health care providers and lenders should be comforted by certain revisions to the UCC which will become effective in many states after July 1, 2001 (discussed below)[19] and a recent ruling by the United States Bankruptcy Court for the District of Massachusetts.

C. *East Boston Neighborhood*, *Capital Home Care* and Changes to Article 9: A Path to Clarity?

In *In re East Boston Neighborhood Health Center Corporation*,[20] the debtor was a company that provided health services to residents of East Boston both before and after its Chapter 11 bankruptcy filing. Shortly after the bankruptcy filing, the Committee of Unsecured Creditors (the "Committee") commenced an action challenging, among other things, the validity and perfection of the liens held by bondholders and a bank in the debtor's claims for reimbursement from public and private insurers (the "Health Insurance Claims"). If these liens were found to be invalid, these receivables would then be available for other creditors of East Boston. In support of its complaint, the Committee argued that: 1) the respective security agreements did not grant security interests in the Health Insurance Claims; 2) any such grant was not properly perfected because article 9 of the UCC did not apply to the Health Insurance Claims; and 3) the federal anti-assignment statutes prohibited an assignment of the Health Insurance Claims to the defendants.[21] The court addressed each argument *seriatim*.

First, with regard to the language of the security agreements at issue, the court found that the language contained in the documents was sufficiently broad to encompass the Health Insurance Claims.[22] Second, the court addressed the Committee's argument that § 9-104(g) of the UCC excludes the Health Insurance Claims from article 9[23] and rejected the argument. In so doing, the court adopted the defendants' position, and stated as follows:

> The Debtor's [East Boston] claims against its patients for services rendered and goods sold (the "patient accounts") are 'accounts' within the meaning of § 9-106; and the Debtor's claims against the Health Insurers for payment of such accounts are proceeds of the patient accounts within the meaning of § 9-306(1). Both Medford and the Bondholder Defendants have security interests in the Debtor's accounts. Medford's security interest expressly extends to proceeds of accounts; the Bondholder Defendants' security interest, though not expressly extended to proceeds of accounts, nonetheless continues in such accounts by operation of law.[24]

Further, the court found that there was nothing in the UCC's definitions of "accounts" and "proceeds" that excluded insurance claims. Accordingly, the court concluded that the Health Insurance Claims were proceeds of accounts within the meaning of article 9.[25] The court also addressed and rejected the Committee's argument that the Health Insurance Claims are excepted from article 9 because they are "claims under policies of insurance" within the meaning of § 9-104(g) of the UCC. The court reasoned that: 1) the Health Insurance Claims clearly fall within the definition of "proceeds" under § 9-306(1); and 2) the Committee's argument that only insurance claims payable by "loss or damage" are proceeds under § 9-306(1) was misplaced. In this regard, the court stated that the second sentence of § 9-306(1), which states that "insurance payable by reason of loss or damage to the collateral is proceeds," was meant to be inclusive, and "not to exclude insurance claims that are payable by reason other than loss or damage to the collateral."[26] Concluding this section of the opinion, the court stated as follows:

> The Debtor's Health Insurance Claims are proceeds within the meaning of that sentence. Therefore, Article 9 applies to the Defendants' security interests on those claims; and, having been perfected in accordance with Article 9, those security interests are perfected and enforceable against the estate.[27]

Having determined that article 9 governed the perfection of the security interests in the Health Insurance Claims, the court then dismissed the Committee's argument that the federal anti-assignment provisions prohibited the assignment of the claims at issue.[28] In this regard, the court reasoned as follows:

> By prohibiting the governmental insurer from making payment on the receivables to anyone other than the Debtor, the statutes may impair the Defendants' ability to seek payment on the receivables from the governmental insurer without the provider's cooperation, but that cooperation may well be available, and the statutes do not impair the Defendants' ability to enforce their security interests once payment has been issued.[29]

As a result of the holding in *East Boston*, lenders and health care providers can breathe a bit easier with respect to perfection of security interests in health care receivables under article 9 of the UCC. Yet, challenges to health care financing transactions continue. Specifically, a review of the docket sheet in *In re Capital Home Care Providers* and a recent article tracking the case reveals that Capital Home has commenced an action against its lender, Healthcare Capital Resources, Inc., seeking, among other things, a determination that the financing agreement entered into by the parties violates the federal anti-assignment statutes. Challenges to the perfection of the security interest may also be at the core of the litigation between the parties. While no opinion has been rendered, health care providers and lenders should keep this case on the radar screen.

Effective July 1, 2001, 27 states and the District of Columbia have adopted extensive revisions to article 9 of the UCC.[30] Given the state of uncertainty surrounding health care financing transactions, revisions to the UCC have been proposed to provide uniform guidance in this market. Article 9 of the UCC, as it presently exists in New York (as well as in many other states), excludes insurance claims from the scope of the article except to the extent that they may constitute proceeds under § 9-306.[31] Because of the uncertainty, as noted above with respect to the perfection of security interests in these types of receivables, the revisions to article 9 were intended to bring clarity into this area. Specifically a new § 9-102(a)(46) is included which defines "health care insurance receivables" as an "interest in or claim under a policy of insurance which is a right to payment of a monetary obligation for health care goods or services provided."[32] The definition of "account" under proposed 9-102(2) also specifically includes health care insurance receivables. Other insurance claims continue to remain outside of article 9, except to the extent they constitute proceeds under 9-109(d)(8). While these changes should bring clarification into this area, the validity and perfection of security interests created prior to the effective date of the proposed changes will be subject to various transition rules under §§ 9-701-708[33] and pre-existing judicial interpretations (such as the *East Boston* case described above). On April 17, 2000, a bill was introduced in the New York State Legislature to effectuate these changes, but as of the date of this article, the legislation remains in Committee.

D. Conclusion

As noted above, the markets for financing of health care providers has at best been difficult in recent years. Compounding this issue in some measure is undoubtedly the uncertainty that lenders and other creditors may face when attempting to create and perfect security interests in health care receivables. In light of divergent judicial treatment, the proposed changes to the UCC brings greater certainty to this area and provides creditors greater comfort in knowing that their security interests are valid and can be enforced using well established remedial mechanisms under the UCC. As a result, this can, potentially enhance the availability of credit to health care providers in New York and elsewhere.

Endnotes

1. Recent bankruptcy filings in the health care industry include *Capital Home Care Providers Inc. v. Healthcare Capital Resources Inc.*, Case No. 99-15289 (October 1999) and *Coram Healthcare Corporation*, Case No. 00-03299 (August 2000).
2. *See In re Boston Neighborhood Health Center Corporation*, 242 B.R. 562 (Bankr. D. Mass. 1999).
3. 42 U.S.C. § 1395g(c).
4. 42 U.S.C. § 1395u(b)(6).
5. 42 U.S.C. § 1396a(a)(32).
6. *See* H.R. Rep. No. 231, 92nd Cong., Sess., reprinted in 1972 U.S. Code Cong. & Ad. News 4989, 5090; H.R. Rep. No. 393, 95th Cong., 1st Sess. 48-49, reprinted in 1977 U.S. Code Cong. & Ad. News 3039, 3051-52; *see also Danvers Pathology Associates, Inc. v. Atkins*, 757 F.2d 427 430 (1st Cir. 1985).
7. 796 F.2d 752 (5th Cir. 1986).
8. *Id.* at 755.
9. *Id.* at 758. Although not relevant to this article, it is noted that the Fifth Circuit reversed and remanded certain of the bankruptcy court's other rulings in the case.
10. *Id.* (citation omitted).
11. *Id.*, fn. 7.
12. *Id.*
13. *Id.*
14. *See, e.g., United States v. Northwest Commerce Bank*, 727 F. Supp. 403 (N.D. Ill. 1989); *In re American Care Corporation*, 69 B.R. 66 (Bankr. N.D. Ill. 1986).
15. For example, if the government was compelled to pay the Medicare or Medicaid receivables directly to the lender, the grant of the security interest could run afoul of the federal anti-assignment provisions.
16. Unless otherwise noted, all references to the UCC in this article are to New York's Uniform Commercial Code (NYUCC).
17. NYUCC § 9-104(g) (emphasis added).
18 This article does not discuss the perfection of a security interest outside of the UCC. However, it is noted that there are other mechanisms for the perfection of a security interest, not discussed herein, which may afford a lender protection under these circumstances.
19. The revisions to the NYUCC discussed in this article are currently pending before the New York State Legislature.
20. 242 B.R. 562 (Bankr. D. Mass. 1999).
21. *Id.* at 567.
22. *Id.* at 568-70. Specifically, the court found that the term "receivables' used in the Trust Indenture, and the terms "account" and "account receivable" used in the Loan and Security Agreement, included the Health Insurance Claims even though such claims were not specifically stated in the documents. Additionally, the court rejected the Committee's argument that the phrase "to the maximum extent possible pursuant to the UCC" excluded the Health Insurance Claims because article 9 does not apply to such claims. The court's rejection of this argument was supported by its finding that article 9 does, in fact, apply. *Id.* at 569.
23. The relevant sections of Massachusetts's UCC at issue in *East Boston*, § 9–104(g) and § 9-306, are virtually identical to the NYUCC. In particular, § 9-306(1) of the NYUCC defines "proceeds," exactly the same way as the Massachusetts UCC. Section 9-306(1) of the NYUCC states, in relevant part, as follows:

    > "Proceeds" includes whatever is received upon the sale, exchange, collection, or other disposition of collateral or proceeds. Insurance payable by reason of loss or damage to the collateral is proceeds, except to the extent that it is payable to a person other than a party to the security agreement.

24. *East Boston*, 242 B.R. at 570.
25. *Id.*
26. *Id.* at 572.
27. *Id.*
28. *Id.* at 573.
29. *Id.*
30. The number of states that have adopted the revisions to article 9 is as of October 24, 2000. *See* Uniform Law Commissioners Web site—www.nccusl.org.
31. NYUCC 9-104(g).
32. 1999 NYS.B. 7484(SN), Part 1.
33. 1999 NYS.B. 7484(SN), Part 7.

Leslie J. Levinson is a member of Baer Marks & Upham LLP in New York City, where he concentrates in merger and acquisitions and corporate finance with an emphasis on the health care and telecommunications industries. Gerard S. Catalanello is an associate at Baer Marks, where he concentrates in bankruptcy and creditors' rights.

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

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

Section Officers

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