

1998

## A Look Back at the Year in Health Law

Jeffrey R. Bennett  
*Epstein, Becker & Green*

Follow this and additional works at: <http://lawcommons.luc.edu/annals>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Jeffrey R. Bennett *A Look Back at the Year in Health Law*, 7 *Annals Health L.* 217 (1998).  
Available at: <http://lawcommons.luc.edu/annals/vol7/iss1/10>

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in *Annals of Health Law* by an authorized administrator of LAW eCommons. For more information, please contact [law-library@luc.edu](mailto:law-library@luc.edu).

# A Look Back at the Year in Health Law

*Jeffrey R. Bennett\**

1997 was another fascinating year in health law and the health care industry. In a year marked by the continued criminalization of the industry, thoughts of 1997 will probably call to mind the indelible image of federal agents carrying boxes of documents from Columbia/HCA facilities and Columbia's subsequent fall from grace.<sup>1</sup> 1997 was also a year of peculiar events. In August, for example, the American Medical Association ("AMA") agreed to allow Sunbeam Corporation to include an "AMA Seal of Approval" on some of its home-care products.<sup>2</sup> The AMA's top executive and four senior staffers eventually lost their jobs over the ill-fated agreement.<sup>3</sup> In short, 1997 was just another year in the seemingly eternal evolution of the American health care system.

This Article presents a survey of some of 1997's highlights and low-lights in four major areas of health law: Medicare, antitrust, taxation, and the Employment Retirement Income Security Act ("ERISA"). Although not a comprehensive review, it provides a general overview of the major trends, cases, and legislation in each of the aforementioned areas.

## I. MEDICARE

Without question, the hottest Medicare issues of 1997 revolved around the federal government's relentless attempts to control fraud and abuse in federal health care programs. A year-end report from the Office of the Inspector General of the

---

\* Mr. Bennett is an associate with the law firm of Epstein, Becker & Green in Washington, D.C. where he practices health law. Mr. Bennett received his Bachelor of Arts in International Studies and Economics from West Virginia University, his Juris Doctor from the Ohio State University College of Law, and his Master of Laws in health law from Loyola University Chicago School of Law. The author would like to thank his wife, Angela Bennett, for her love, support, and encouragement and his parents, Joseph and Linda Bennett, for always believing in him. He would also like to thank Professor Joan Krause and Ellen Luepke for their editorial comments and suggestions.

1. See generally, Daniel W. Roslokken, *Columbia/HCA Under Siege*, *MANAGED HEALTH CARE*, Dec. 1997, at 34.

2. See *1997 Year in Review*, *MOD. HEALTHCARE*, Dec. 22-29, 1997, at 52, 54.

3. See *id.*

Department of Health and Human Services boasted that “an aggressive assault on Medicare fraud, waste, and abuse produced \$7.6 billion in savings in fiscal 1997 and removed nearly 3,000 ‘unsuitable’ health care providers from the system.”<sup>4</sup> These savings included an unprecedented \$1.2 billion recovered through criminal and civil investigations.<sup>5</sup>

The government also expanded its Operation Restore Trust (“ORT”) initiative in 1997.<sup>6</sup> Originally, ORT targeted fraud only in the home health care, durable medical equipment, and nursing home industries, and was limited to five states: New York, Pennsylvania, California, Florida, and Texas.<sup>7</sup> On the eve of ORT’s March 31, 1997 sunset date, the Clinton Administration expanded ORT into twelve new states and expanded its focus to four additional areas of fraud: clinical laboratories, psychiatric hospitals, community mental health centers, and rural health clinics.<sup>8</sup> In addition to the expansion of ORT, three other fraud and abuse developments in 1997 warrant special attention. The Health Care Finance Administration (“HCFA”) released proposed “Stark II” regulations, Congress passed two controversial Medicare provisions in the Balanced Budget Act of 1997, and the Fifth Circuit Court of Appeals issued an interesting opinion interpreting the False Claims Act.

### A. Proposed Stark II Regulations

The original Stark law, now known as “Stark I,” was enacted in 1989 and prohibited physicians from referring Medicare and Medicaid patients to clinical laboratories with which the physicians had a prohibited financial relationship.<sup>9</sup> Stark II<sup>10</sup> expanded this self-referral prohibition to include ten additional “designated health services.”<sup>11</sup> Stark II took effect on January 1,

---

4. *Medicare: Fraud Crackdown Recoups \$7.6 Billion*, HEALTH LINE, Dec. 11, 1997, available in LEXIS, Health Library, Medical and Health News CURNWS File.

5. *See id.*

6. *See Expanded Operation Restore Trust to Target More Providers in More States*, Health Care Daily (BNA) Mar. 25, 1997, available in LEXIS, BNA Library, BNAHLT File.

7. *See id.*

8. *See id.*

9. *See* 42 U.S.C. § 1395nn (1989) (the self-referral prohibition laws are known as “Stark” laws in reference to their principal author, Rep. Fortney Stark (D-Cal.)).

10. *See* Omnibus Budget Reconciliation Act of 1993 [hereinafter “OBRA”], § 13562, Pub. L. No. 103-66, 107 Stat. 312, 596-605 (1993) (amending 43 U.S.C. § 1395nn).

11. *See* OBRA § 13562, 107 Stat. at 596, 604.

1995, but HCFA did not issue proposed regulations until January 9, 1998.<sup>12</sup> In the interim, health care providers struggled to comply with the expanded statutory prohibitions by relying on regulations promulgated for Stark I. However, issues unique to the ten newly designated health services have left providers guessing about the legality of many common business arrangements.

Stark II is an immensely complex piece of legislation, and many attorneys have suggested that the proposed regulations raise more questions than they answer.<sup>13</sup> Although the proposed regulations do not have any legal effect until they are officially adopted, they offer insight into the government's view on a number of critical issues, and several of the provisions represent a significant departure from the health care industry's interpretation of the Stark II prohibitions. Specifically, the proposed regulations contain several definitional provisions which may substantially alter the industry's delivery of health care.

One of the most significant definitional provisions of the proposed regulations defines the "designated health services" to which the Stark II referral prohibition applies.<sup>14</sup> In general, the definitions follow those used for Medicare Part B coverage purposes.<sup>15</sup> However, HCFA specifically stated in the proposed regulations that designated health services include those services which are components of other services or which are subsumed within another service category.<sup>16</sup> For example, although skilled nursing services are not designated health services, the fact that a skilled nursing facility may provide services that are designated health services (such as laboratory services) means that physician referrals to a skilled nursing facility may be prohibited by Stark II.<sup>17</sup>

The proposed regulations also further define "financial relationships" under Stark II. The statute declares that an ownership or investment interest "includes an interest in an entity that

---

12. See Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 63 Fed. Reg. 1659 (1998) (to be codified at 42 C.F.R. pt. 411, 424, 435, and 455) [hereinafter "Physicians' Referrals"].

13. See *Impact of Stark II Proposal Studied; GAO to Review PATH Audits of Hospitals*, 7 Health L. Rep. (BNA) 131 (Jan. 22, 1998).

14. See Physicians' Referrals, *supra* note 12, at 1664.

15. See *HCFA Expands, Clarifies Self-Referral Prohibition in Proposed Rule*, 7 Health L. Rep. (BNA) 299, 300 (Feb. 19, 1998).

16. See Physicians' Referrals, *supra* note 12, at 1664.

17. See *HCFA Expands, Clarifies Self-Referral Prohibition in Proposed Rule*, *supra* note 15, at 300.

holds an ownership or investment interest in any entity providing the designated health service.”<sup>18</sup> The proposed regulations state that a “financial relationship” includes any ownership or investment interest in an entity, “no matter how many levels removed from a direct interest.”<sup>19</sup> Therefore, under the proposed regulations, physicians may not own or invest in companies that own or invest in other companies to which the physician refers patients for designated health services.<sup>20</sup>

Physician group practices may qualify for various exceptions to the referral prohibitions, and the proposed regulations make significant changes to these provisions. For example, under the Stark I regulations, a group practice must be composed of one legal entity to qualify for the group practice exception.<sup>21</sup> Under the proposed regulations, however, a group practice composed of individual professional corporations owned by physicians could qualify as a group practice.<sup>22</sup> The proposed regulations also confirm that hospitals may own and operate group practices.<sup>23</sup>

Finally, the proposed regulations would also change the definition of group practice by eliminating the inclusion of independent contractors as “members” of the group.<sup>24</sup> This may benefit some groups because to qualify as a group practice, members of the group must “personally conduct no less than 75 percent of the physician-patient encounters.”<sup>25</sup> Under the proposed Stark II regulations, the services of independent contractors would not be counted when making this determination.<sup>26</sup> However, contract physicians would not be able to oversee the provision of ancillary services for purposes of the in-office ancillary services exception because those services must be either directly furnished or directly supervised by a member of the group.<sup>27</sup>

---

18. 42 U.S.C. § 1395nn.

19. See Physicians' Referrals, *supra* note 12, at 1664.

20. See HCFA Expands, Clarifies Self-Referral Prohibition in Proposed Rule, *supra* note 15, at 300.

21. See 42 C.F.R. § 411.351 (1997).

22. See Physicians' Referrals, *supra* note 12, at 1687.

23. See *id.* at 1689.

24. See *id.*

25. 42 U.S.C. § 1395nn(h)(4)(A)(v).

26. See Physicians' Referrals, *supra* note 12, at 1687.

27. See 42 C.F.R. § 411.355(b) (1997).

### B. *The Balanced Budget Act of 1997*

The Balanced Budget Act of 1997 (“BBA”)<sup>28</sup> includes two extremely controversial Medicare provisions. First, it imposes a new civil money penalty for violations of the Medicare and Medicaid anti-kickback law.<sup>29</sup> Second, the statute includes a provision that allows physicians to privately contract with Medicare beneficiaries if the physicians agree to forgo Medicare reimbursement for *all* services rendered to *any* Medicare patient for two years.<sup>30</sup>

The new civil money penalty provision allows the government to recover treble damages plus \$50,000 for each violation of the anti-kickback law.<sup>31</sup> Before the enactment of the BBA civil monetary penalty provision, although the government occasionally obtained large monetary settlements from health care providers, the government’s only statutory remedies for anti-kickback violations in the absence of voluntary settlements were criminal prosecution or exclusion from federal health care programs.<sup>32</sup> The new civil money penalty provision requires a lower burden of proof than the criminal sanctions, and because cases brought under the anti-kickback statute typically involve allegations of numerous anti-kickback violations, the \$50,000 per violation sanction gives the government unprecedented leverage in settlement negotiations. If a physician chooses to forgo a settlement offer from the government, litigating and losing a case under the new civil money penalty provision could easily lead to financial ruin for the physician. Some health care attorneys believe that the new civil money penalty will dramatically increase the number of anti-kickback cases, and some have expressed concern that the government will use the potentially massive sanctions in a coercive manner.<sup>33</sup>

The second controversial Medicare provision in the BBA allows physicians to privately contract with Medicare beneficiaries

---

28. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4304, 111 Stat. 251 (1997).

29. *See id.* § 4304, Ill. Stat. at 383-84.

30. *See id.* § 4304, Ill. Stat. at 439-42.

31. *See id.* § 4304, Ill. Stat. at 383-84. This civil money penalty provision is similar to the civil money penalty available under the False Claims Act, but is far more expansive.

32. *See Budget’s Anti-Fraud, Abuse Provisions Build on Last Year’s Health Reform Law*, Health Care Daily (BNA) Aug. 19, 1997, available in LEXIS, BNA Library, BNAHLT File.

33. *See id.*

for services that would otherwise be covered by Medicare.<sup>34</sup> Pursuant to that provision, physicians may enter into a private contract with a Medicare beneficiary only if the physician also executes an affidavit agreeing not to submit any claims to Medicare for any Medicare beneficiary for a two-year period beginning on the date the affidavit is signed.<sup>35</sup>

Representative William Archer (R-Texas) and Senator Jon Kyl (R-Arizona) have introduced legislation that would abolish the two-year moratorium on Medicare participation and allow providers to contract with beneficiaries on a claim-by-claim basis.<sup>36</sup> Proponents of the legislation argue that the two-year prohibition limits patient choice and would actually limit access to health care by further restricting the number of physicians who treat Medicare beneficiaries.<sup>37</sup> On the other hand, critics charge that eliminating the two-year exclusion would effectively create a two-tiered system for Medicare services.<sup>38</sup> Individuals with lower incomes would have less access to physicians than those with higher incomes because physicians could simply choose to contract with patients who could pay more for their services.<sup>39</sup>

### C. *The False Claims Act*

In an interesting case arising under the False Claims Act ("FCA"),<sup>40</sup> the Fifth Circuit Court of Appeals held in October of 1997 that providers who falsify certifications of compliance with Medicare regulations face potential liability under the FCA.<sup>41</sup> Relator James Thompson brought a qui tam action against Columbia/HCA alleging Medicare fraud.<sup>42</sup> Thompson alleged that Columbia violated the FCA by submitting Medicare

---

34. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4507(a), 111 Stat. 251, 439-41 (1997).

35. See *id.* § 4507(a), Ill. Stat. at 440.

36. See *CBO Says Contracting Change Could Increase Fraud But Impact Uncertain*, Health Care Daily (BNA), Nov. 3, 1997 available in LEXIS, BNA Library, BNAHLT File.

37. See *Contracting Provision in Budget Law Called a 'Flaw' and Invasion of Privacy*, Health Care Daily (BNA), Nov. 5, 1997 available in LEXIS, BNA Library, BNAHLT File.

38. See *id.*

39. See *Administration, Members of Congress Air Views on Private Contracting Proposals*, Health Care Daily (BNA), Feb. 28, 1998 available in LEXIS, BNA Library, BNAHLT File.

40. 42 U.S.C. § 3729 (1997).

41. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899 (5th Cir. 1997).

42. See *id.* at 900.

claims for services rendered in violation of the Medicare anti-kickback statute and the Stark laws.<sup>43</sup> The district court dismissed Thompson's complaint for failure to state a claim under Rule 12(b)(6) of the Federal Rules of Civil Procedure,<sup>44</sup> and the Fifth Circuit Court of Appeals held that claims for services rendered in violation of a statute do not necessarily constitute a false or fraudulent claim under the FCA.<sup>45</sup>

More importantly, however, the Fifth Circuit also held that the FCA applies in cases in which false representations are employed to obtain government privileges or services.<sup>46</sup> Therefore, when the government requires certified compliance with a statute or regulation as a condition of payment, a false claim is submitted if a claimant falsely certifies compliance with those regulations.<sup>47</sup> This holding may validate Thompson's second allegation that a condition of Columbia's participation in the Medicare program was the certification in annual cost reports that the services identified in those reports were provided in compliance with the laws and regulations relating to the provision of federal health care services.<sup>48</sup> Thompson argued that because Columbia violated the Medicare anti-kickback statute and the Stark laws, Columbia's certifications of compliance on its annual cost reports were false and amounted to a false claim under the FCA.<sup>49</sup>

Columbia argued that because Medicare claims are typically submitted shortly after furnishing services, certification of compliance in annual cost reports was not a prerequisite to Medicare payments.<sup>50</sup> Thompson retorted that certification of compliance in the annual cost reports is a prerequisite to payment because retention of Medicare payments received prior to the submission of annual cost reports is conditioned upon the certification of compliance contained in those reports.<sup>51</sup> The Fifth Circuit was unable to determine from the record the extent to which certifications of compliance in annual cost reports constituted a prerequisite to Medicare payment and remanded the

---

43. See *id.* at 901.

44. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 938 F. Supp. 399 (S.D. Tex. 1996).

45. See *Thompson*, 125 F.3d at 902.

46. See *id.* at 903.

47. See *id.* at 902.

48. See *id.*

49. See *id.*

50. See *id.*

51. See *id.*



case to the district court with instructions to make this determination.<sup>52</sup> The court also instructed the district court to consider Thompson's assertion that claims for services rendered in violation of the Stark laws are also false and fraudulent claims under the FCA.<sup>53</sup> Thompson argued that because Stark expressly prohibits payment for services rendered in violation of its terms, such claims are necessarily false and fraudulent under the FCA.<sup>54</sup>

This case has caused a great deal of concern in the provider community because it suggests that simple errors contained in annual cost reports could lead to substantial liability under the FCA. The Fifth Circuit denied a subsequent motion for rehearing,<sup>55</sup> and the case is currently pending before the district court.

## II. ANTITRUST

1997 was an interesting, though relatively quiet, year on the antitrust front, with mergers receiving most of the attention. During 1997, the Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") employed innovative theories to challenge hospital mergers;<sup>56</sup> two for-profit titans battled over a physician group merger in Mississippi,<sup>57</sup> and the DOJ and FTC issued revisions to section IV of their Horizontal Merger Guidelines.<sup>58</sup>

### A. Hospital Mergers

At the beginning of 1997, industry analysts suggested that the enforcement agencies' success in stopping potentially anticompetitive hospital mergers in 1997 would be predicted by the final disposition of the *FTC v. Butterworth Health Corp.* case.<sup>59</sup> Indeed, the FTC's defeat in *Butterworth* was indicative of the Agencies' continued lack of success in challenging hospital

---

52. See *id.*

53. See *id.* at 903.

54. See *id.*

55. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 1998 U.S. App. Lexis 2050 (5th Cir. 1998).

56. See Jeffrey M. Teske, *Antitrust Update 1* (Oct. 17, 1997) (unpublished update, distributed with materials from Illinois Association of Healthcare Attorneys Fifteenth Annual Health Law Symposium, on file with author).

57. See *id.* at 6.

58. See *id.* at 10.

59. See *Outlook '97*, 6 Health L. Rep. (BNA) 1, 4 (Jan. 2, 1997) (citing *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff'd*, 7 Trade Reg. Rep. (CCH) ¶ 71,863 (6th Cir. July 7, 1997)).

mergers. The *Butterworth* case arose out of the FTC's objection to the proposed merger of the two largest hospitals in Grand Rapids, Michigan.<sup>60</sup> The FTC attempted to enjoin the merger by asserting that the merger would "substantially lessen competition" in violation of Section 7 of the Clayton Act.<sup>61</sup>

To make a *prima facie* case under Section 7 of the Clayton Act, the FTC must show that a proposed merger will produce an entity that controls an undue percentage share of the relevant market and will result in a significant increase in the entity's concentration of power in the market.<sup>62</sup> The relevant market consists of two separate components, the product market and the geographic market.<sup>63</sup>

In *Butterworth*, the FTC attempted to utilize an innovative definition of the product market. Faced with difficulties created by a broader geographic market analysis in two previous cases,<sup>64</sup> the FTC defined two relevant product markets in *Butterworth*: the typical "acute inpatient hospital care" market and the more narrow "primary care inpatient hospital services" market.<sup>65</sup> The FTC established its *prima facie* case by convincing the court to accept both proffered product market definitions and by showing that the concentration levels resulting from the proposed merger were potentially anticompetitive.<sup>66</sup>

By successfully establishing its *prima facie* case, the FTC created a presumption that the proposed merger would create an entity that controlled an undue percentage share of the two relevant markets.<sup>67</sup> The district court, however, held that the defendants successfully rebutted the presumption of anticompetitiveness,<sup>68</sup> and the Sixth Circuit Court of Appeals affirmed the district court in a short, unpublished *per curiam* opinion.<sup>69</sup> Therefore, although the court adopted the FTC's market

---

60. See *Butterworth Health Corp.*, 946 F. Supp. at 1286.

61. See *Outlook '97*, *supra* note 59, at 6.

62. See *Butterworth Health Corp.*, 946 F. Supp. at 1289.

63. See *id.* at 1290.

64. See *Teske*, *supra* note 56, at 2 (citing *FTC v. Freeman Hosp.*, 69 F.3d 260 (8th Cir. 1995), and *United States v. Mercy Health Services*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated*, 1997-1 Trade Cases (CCH) ¶ 71,729 (8th Cir. 1997)).

65. See *Butterworth Health Corp.*, 946 F. Supp. at 1290.

66. See *id.* at 1294.

67. See *id.*

68. See *id.* at 1302.

69. See *FTC v. Butterworth Health Corp.*, 7 Trade Reg. Rep. (CCH) ¶ 71,863 (6th Cir. July 7, 1997).

definition, the agency's effort to enjoin the merger proved unsuccessful.

After the Sixth Circuit's affirmative ruling, the FTC threatened to proceed with an administrative challenge to the merger. This tactic elicited an interesting congressional response.<sup>70</sup> There was an attempt in Congress to attach a rider to the appropriations bill governing the FTC's funding that would have explicitly prohibited any spending on an administrative challenge in the *Butterworth case*.<sup>71</sup> When the proposed budgetary restriction came before the Senate, the Senate Judiciary Committee held hearings on the issue.<sup>72</sup> These hearings raised several interesting issues, including the fairness of the enforcement agencies' ability to challenge proposed mergers both judicially and administratively.<sup>73</sup> Soon after the hearings ended, the FTC backed away from an administrative challenge.<sup>74</sup>

The DOJ also used an innovative product market definition in *United States v. Long Island Jewish Medical Center*.<sup>75</sup> This case concerned the DOJ's objection to the proposed merger of two large hospitals near New York City.<sup>76</sup> The DOJ argued that the relevant product market consisted of "the bundle of acute inpatient services provided by anchor hospitals to managed care plans."<sup>77</sup> The DOJ asserted that the two hospitals attempting to merge, North Shore Manhasset and Long Island Jewish Medical Center, were competing to be the "anchor" hospital that served Queens and Nassau counties in any managed care plan's hospital network.<sup>78</sup> The agency asserted that anchor hospitals are those "having prestigious reputations, broad ranging and highly sophisticated services, and high quality medical staffs."<sup>79</sup>

The district court rejected the government's approach, holding that its proffered product market definition was unduly restrictive and that it did not comport with the typical product market definition used in other cases, namely "general acute in-

---

70. See Teske, *supra* note 56, at 4.

71. See *id.*

72. See *id.*

73. See *id.*

74. See *id.*

75. *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121 (E.D.N.Y. 1997).

76. See *id.* at 123.

77. See *id.* at 137.

78. See *id.* at 137-38.

79. See *id.*

patient services.”<sup>80</sup> The court also noted that the government failed to establish that the acute inpatient services produced at the “anchor hospitals” were unique and would support a separate relevant product market.<sup>81</sup>

### B. Physician Groups

In addition to hospital mergers, physician group mergers also drew attention in 1997. The most noteworthy item in this area came from a battle between Columbia/HCA and Quorum Health Group in Mississippi.

In *HTI Health Services, Inc. v. Quorum Health Group, Inc.*,<sup>82</sup> Columbia Vicksburg Medical Center, a subsidiary of Columbia/HCA, challenged the proposed merger of the two largest physician clinics in Vicksburg, Mississippi.<sup>83</sup> Quorum was the indirect majority shareholder of River Region Medical Corporation (“RRMC”), and the proposed merger would have made the two physician groups shareholders of RRMC.<sup>84</sup> In its complaint, Columbia first argued that the proposed merger would violate Section 7 of the Clayton Act by substantially lessening competition in Vicksburg’s physician, hospital, and managed care markets.<sup>85</sup> Second, Columbia claimed that Quorum violated Section 2 of the Sherman Act by conspiring to monopolize Vicksburg’s physician and hospital services with “the specific intent of making Vicksburg a one hospital town.”<sup>86</sup>

Columbia asserted two main arguments to support its Clayton Act claim. Relying on the hospital merger cases, Columbia first argued that the merger would create excessively high post-merger market shares and thus should be presumed illegal under Section 7 of the Clayton Act.<sup>87</sup> The district court, however, distinguished the hospital merger cases by noting that the extensive regulation of hospitals creates a significant barrier to entry for new competitors that does not exist in the Vicksburg physician marketplace.<sup>88</sup> Columbia also argued that the physi-

---

80. *See id.*

81. *See id.*

82. *HTI Health Services, Inc. v. Quorum Health Group, Inc.*, 960 F. Supp. 1104 (S.D. Miss. 1997).

83. *See id.*

84. *See id.* at 1108.

85. *See id.* at 1110.

86. *See id.*

87. *See id.* at 1133.

88. *See id.*

cians would direct patients to the Quorum-owned Parkview hospital rather than the Columbia-owned Vicksburg Medical Center.<sup>89</sup> The court dismissed this claim, holding that patients choose their own hospitals based on religious preference and proximity to their physicians' offices.<sup>90</sup>

In its Sherman Act claim, Columbia asserted that Quorum representatives had expressed their desire to unify the Vicksburg medical community and essentially create a "one-hospital town."<sup>91</sup> The court also rejected this claim, finding that the challenged merger was not the product of a concerted effort to monopolize.<sup>92</sup> Rather, the court held that the merger was "the natural byproduct of a rapidly evolving medical services market."<sup>93</sup>

The *HTI* decision indicates that because the barriers to entering the physician services market are typically lower than those for the hospital inpatient services product market, the government may be required to show more significant post-merger market share concentrations to warrant the finding of an anti-trust violation. If the physician group merger trend persists, the development of this area should continue generating interest in the future.

### C. Revision of Merger Guidelines

Another noteworthy merger development in 1997 was the issuance of revisions to section IV of the DOJ and the FTC's Horizontal Merger Guidelines.<sup>94</sup> The revision deals with the efficiencies created by mergers,<sup>95</sup> and the new guidelines clearly indicate that the agencies will focus on "merger-specific" efficiencies.<sup>96</sup> Specifically, the revision requires entities to substantiate efficiency claims in a manner that allows the agencies to

---

89. *See id.* at 1136.

90. *See id.* at 1137.

91. *See id.* at 1139.

92. *See id.* at 1140.

93. *See id.* at 1144.

94. *See Teske, supra* note 56, at 10.

95. "Efficiency" is a shorthand term for the economic principle of "allocative efficiency," which is the optimal allocation of societal resources producing maximum benefit to the consumer. *See* Kenneth Laurence, *Antitrust Laws and Health Care Providers - Identifying and Reducing Antitrust Risks of Cooperative and Competitive Activities*, C557 ALI-ABA 301, 444 (1990).

96. *See Teske, supra* note 56, at 10 (stating that merger specific efficiencies are those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished without it).

reasonably verify the likelihood and magnitude of each asserted efficiency, how and when each would be achieved, how each would enhance the merged firm's ability and incentive to compete, and why each one would be merger-specific.<sup>97</sup>

### III. TAXATION ISSUES

Though some significant legislation was passed, tax-exempt health care organizations will likely remember 1997 for the lack of guidance provided by the Internal Revenue Service ("IRS"). Specifically, while Congress repealed the \$150 million bond cap on certain non-hospital bonds<sup>98</sup> and the IRS issued a revenue ruling regarding physician recruitment,<sup>99</sup> the IRS did not issue long-awaited guidance on intermediate sanctions and did not issue guidance on whole-hospital joint ventures until March 4, 1998.<sup>100</sup>

#### A. Joint Ventures

In an attempt to penetrate new markets, for-profit hospital chains have been acquiring, merging with, or entering into joint ventures with tax-exempt hospitals.<sup>101</sup> In a typical whole-hospital joint venture, the tax-exempt organization contributes all or nearly all of its assets to the joint venture entity in return for a partnership interest. The for-profit entity also typically contributes assets or cash to the joint venture entity and receives a partnership interest.<sup>102</sup> The joint venture entity then operates the hospital assets.<sup>103</sup> Although the last two Treasury-IRS business plans have made issuance of guidance on whole-hospital joint ventures a priority, the IRS did not issue specific guidelines until March 4, 1998.<sup>104</sup> Therefore, anxiety about potentially jeopard-

---

97. *See id.*

98. *See* Steven B. Kite & Robert L. Capizzi, *\$150 Million Non-Hospital Bond Limitation Eliminated for New Capital Expenditures*, 6 Health L. Rep. (BNA) 1287 (Aug. 14, 1997).

99. *See* Rev. Rul. 97-21, 1997-18 I.R.B.

100. *See* Rev. Rul. 98-15, 1998-12 I.R.B.

101. *See* T.J. Sullivan, *Tax-Exemption Developments 1* (Oct. 17, 1997) (unpublished update, distributed with materials from Illinois Association of Healthcare Attorneys Fifteenth Annual Health Law Symposium, on file with author).

102. *See id.*

103. *See id.*

104. *See id.*

izing the tax-exempt status of an exempt partner was a major concern in 1997.<sup>105</sup>

Before the official guidelines were issued, the Exempt Organizations Division (“EOD”) of the IRS dropped hints in 1997 about the agency’s position on this issue.<sup>106</sup> Speaking at the National Symposium on Health Care Enforcement, Marcus Owens, the director of the EOD, advised practitioners to take a close look at the Service’s unfavorable exemption ruling in *Redlands Surgical Services v. Commissioner*.<sup>107</sup> *Redlands* involved a joint venture between a for-profit hospital and a tax-exempt hospital system. The tax-exempt system created a subsidiary to hold a partnership interest in a surgery center.<sup>108</sup> The Service denied the subsidiary exempt status, because a charitable entity did not have a “meaningful ability” to control the partnership and the surgical center did not operate in a charitable manner.<sup>109</sup>

Commentators have noted that the facts in *Redlands* are similar to a whole-hospital joint venture situation,<sup>110</sup> and the Service’s denial letter provides insight into how the agency is likely to address whole-hospital joint ventures.<sup>111</sup> The issue of “control” was central to the Service’s analysis in *Redlands*, because the subsidiary assumed the liability of a general partner without possessing the commensurate ability to control the partnership.<sup>112</sup> This decision is consistent with other cases in which the Service has addressed ventures between tax-exempt and for-profit entities.<sup>113</sup> In *Plumstead Theatre Society, Inc. v. Commissioner*,<sup>114</sup> for example, the IRS granted exemption because the exempt organization controlled the joint venture.<sup>115</sup> In *Housing Pioneers, Inc. v. Commissioner*,<sup>116</sup> however, an exemption was

---

105. See *id.*; see also Carolyn D. Wright & Fred Stokeld, *IRS Cheated EOS on Guidance in 1997; Here’s Hoping for a Better ‘98*, 78 TAX NOTES 33, 34 (1998).

106. *Precedential Guidance, Federal Court Actions Among ‘Coming Attractions,’ IRS Official Says*, Health Care Daily (BNA) Feb. 26, 1998, available in LEXIS, BNA Library, BNAHLT File.

107. *Redlands Surgical Services v. Commissioner*, No. 11025-97 (T.C. 1997).

108. See Carolyn D. Wright & Fred Stokeld, *IRS Officials Exempt Bond Compliance Projects*, 77 TAX NOTES 660, 661 (1997).

109. See Carolyn D. Wright, *Sullivan: IRS Denial Letter Offers Clues For Whole Hospital J/Vs*, EXEMPT. ORG TAX REV., Dec. 1997, at 186, 186.

110. See Wright & Stokeld, *supra* note 108, at 660.

111. See Wright, *supra* note 109, at 186.

112. See *id.*

113. See Wright & Stokeld, *supra* note 108, at 660.

114. 74 T.C. 1324 (1980).

115. See *id.*

116. T.C.M. (RIA) ¶ 93, 120 at 527 (1993).

denied because the charitable organization did not exercise significant control over the joint venture.<sup>117</sup>

The recently promulgated Revenue Ruling 98-15 seems to comport with the Service's stance in *Redlands*.<sup>118</sup> The main issue continues to be control. Revenue Ruling 98-15 presents two different scenarios setting forth radically different methods of operation for a limited liability company ("LLC") resulting from a whole-hospital joint venture.<sup>119</sup> In the first scenario, the nonprofit entity retains control.<sup>120</sup> For example, the governing documents mandate that three of the LLC's five governing board members are chosen by the nonprofit partner and that the hospital owned by the LLC be operated in a manner that furthers charitable purposes.<sup>121</sup> The Service said that this arrangement properly demonstrated that the nonprofit entity maintained control over changes in activities, disposition of assets, and renewal of management contracts.<sup>122</sup> Therefore, the nonprofit partner could ensure that the LLC was used to further charitable purposes, and tax-exempt status would be allowed for the LLC.

The second scenario presents a circumstance in which the for-profit entity retains substantial control, and the joint venture would not be granted tax-exempt status. In this example, the LLC's governing board is composed of three nonprofit appointees and three for-profit appointees.<sup>123</sup> Furthermore, the firm providing management services is a wholly-owned subsidiary of the for-profit entity.<sup>124</sup> Finally, under the second scenario, the LLC's governing documents provide that the LLC's governing board needs only a majority vote to approve annual budgets, earnings distributions, and selection of important executives.<sup>125</sup> The Service noted that the governing documents under these facts lack a "binding obligation" for the LLC to operate in a charitable manner.<sup>126</sup> The Service also emphasized that the nonprofit partner in this example would be unable to "initiate programs" within the LLC to address new health needs without the

---

117. *See id.* at 532.

118. *See Wright & Stokeld, supra* note 108, at 660.

119. *See Rev. Rul. 98-15, 1998-12 I.R.B. 6.*

120. *See id.*

121. *See id.*

122. *See id.* at 9.

123. *See id.* at 7.

124. *See id.*

125. *See id.*

126. *See id.* at 9.



agreement from at least one appointee of the for-profit partner.<sup>127</sup> Therefore, just as the Service stressed in *Redlands*, the nonprofit partner must retain substantial control over an entity created through a joint venture with a for-profit partner to ensure that the nonprofit partner retains its tax exempt status.

### B. Intermediate Sanctions

The IRS also failed to issue long-awaited guidance on the intermediate sanction authority created by the Taxpayer Bill of Rights 2 in 1996.<sup>128</sup> Internal Revenue Code ("IRC") section 4958 imposes a penalty excise tax on a "disqualified person" who improperly benefits from an "excess benefit transaction" with a not-for-profit section 501(c)(3) health care organization or a section 501(c)(4) tax-exempt health maintenance organization.<sup>129</sup> Intermediate sanction authority is significant because it gives the IRS the ability to punish violations of the tax-exemption laws without revoking an organization's tax-exempt status.

The IRC recognizes two types of "disqualified persons" against whom intermediate sanctions can be levied: "insiders" who benefit from the transaction and "organizational managers" who knowingly participate in the improper transaction.<sup>130</sup> "Insiders" are individuals who are or who have recently been in a position to exercise substantial influence over the tax-exempt organization.<sup>131</sup> "Organizational managers" are officers, directors, trustees, or any other individuals with similar powers or responsibilities.<sup>132</sup> Though official regulations are still pending, a House of Representatives Ways and Means Committee report on intermediate sanctions stated that, as a general proposition, physicians would only be classified as "insiders" if they exercise "substantial control" over the tax-exempt organization.<sup>133</sup>

A recent decision by the United States Tax Court may provide further insight into the way courts will define "disqualified persons" under IRC section 4958. In *United Cancer Council v.*

---

127. See *id.*

128. See Taxpayer Bill of Rights 2, Pub. L. No. 104-168, §§ 1311-14, 110 Stat. 1452, 1475-81 (codified as amended in scattered sections of 29 U.S.C. (1996)).

129. See I.R.C. § 4958(a)(1) (West 1998).

130. See I.R.C. § 4958(f) (West 1998).

131. See I.R.C. § 4958(f)(1) (West 1998).

132. See I.R.C. § 4958(f)(2) (West 1998).

133. H.R. REP. NO. 104-506, at 58 (1996), reprinted in 1996 U.S.C.C.A.N. 1143, 1181.

*Commissioner*,<sup>134</sup> the court ruled that an outside fundraising firm was an insider for purposes of the IRC private inurement prohibition, because an agreement between the fundraising firm and the tax-exempt entity gave the firm the ability to exercise significant control over the charity's financial dealings.<sup>135</sup> As a result of this decision, commentators have speculated that control or the ability to influence the tax-exempt organization will be central to the determination of disqualified persons subject to intermediate sanctions under section 4958.<sup>136</sup>

Although the IRS has promised the public that it will be "reasonable" in its intermediate sanction enforcement, industry experts urge tax-exempt health care organizations to take proactive steps to avoid future problems.<sup>137</sup> For example, institutions have been advised to implement risk management programs to identify potentially disqualified persons and to review all transactions and documents to ensure that they will not be considered "excess benefit transactions."<sup>138</sup> Finally, institutions should implement a conflicts of interest policy that ensures that all compensation arrangements and financial transactions with disqualified persons are reasonable.<sup>139</sup>

### C. Physician Recruitment

In 1997, the IRS did provide some guidance with respect to physician recruitment incentives. Revenue Ruling 97-21 addressed the issue of whether a tax-exempt hospital violates the requirements for exemption if it provides incentives for physicians to join its medical staff or to provide medical services to the community.<sup>140</sup> The ruling contains five fact scenarios, only one of which was held to imperil the hospital's tax-exempt status.<sup>141</sup>

The ruling indicated that the hospital's required showing depends upon whether the hospital is recruiting the physician to provide services for the hospital or merely to provide services

134. 109 T.C. 17 (1997).

135. See Alison Bennett, *Cancer Charity's Loss of Exemption Carries Great Significance for EOS, Practitioners Say*, 6 Health L. Rep. (BNA) 1884, 1885 (Dec. 11, 1997).

136. See *id.*

137. See Fred Stokeld, *Get Ready for Intermediate Sanctions, McGovern Tells Exempts*, EXEMPT ORG. TAX REV., Nov. 1997, at 200, 200.

138. See *id.*

139. See *id.* at 201.

140. See Rev. Rul. 97-21, 1997-18 I.R.B. 8; see also Wright & Stokeld, *supra* note 105 at 34.

141. See Rev. Rul. 97-21, 1997-18 I.R.B. 8, 9.

on the physician's own behalf in the community served by the hospital.<sup>142</sup> If a hospital recruits a physician to perform services for or on behalf of the organization, the hospital must show that the remuneration paid to the physician is reasonable compared with the services performed.<sup>143</sup> Furthermore, all benefits conferred to the physician, including employment incentives, must be included in the remuneration calculation.<sup>144</sup>

In contrast, if the physician being recruited will provide services to the community, but not necessarily for or on behalf of the organization, the exempt hospital's recruitment efforts must meet four requirements. First, the tax-exempt entity may not substantially engage in activities that do not further the hospital's exempt purposes or that do not bear a reasonable relationship to the accomplishment of those purposes. Second, the tax-exempt entity must not engage in activities that result in the inurement of the hospital's net earnings to private individuals. Third, the tax-exempt entity may not engage in any substantial activity that causes it to be operated for the benefit of a private interest. Finally, the tax-exempt entity may not engage in any substantial unlawful activity.<sup>145</sup>

Revenue Ruling 97-21 appears to be good news for hospitals. The Service seems to indicate that hospitals may provide significant recruitment incentives, as long as they are reasonable. For example, the Revenue Ruling approves compensation packages that included signing bonuses, payment of professional liability insurance premiums for a limited time, payment of professional liability insurance for a physician's former practice, provision of office space in a hospital-owned building at below-market rates for a limited period of time, moving expenses, and a guarantee of a minimum level of private practice income for a limited period of time.<sup>146</sup> The Ruling also indicates that compensation packages must be in writing, negotiated at arms' length, and in conformity with guidelines established by the hospital's board of directors.<sup>147</sup> Finally, the Ruling suggests that remuneration packages are presumed to be reasonable if they reflect regional

---

142. See *id.* at 10.

143. See Wright & Stokeld, *supra* note 105, at 34.

144. See Kelcy M. Whitman & Lee A. Morton, *IRS Provides Guidance on Physician Recruitment by Hospitals*, 28 TAX ADVISER 546, 546 (1997).

145. See *id.*

146. See Rev. Rul. 97-21, 1997-18 I.R.B. 8.

147. See *id.*

or national surveys regarding income earned by physicians in the same specialty.<sup>148</sup>

#### D. Repeal of the \$150 Million Bond Cap

Since the Tax Reform Act of 1986,<sup>149</sup> section 501(c)(3) organizations have been prohibited from being the beneficiaries of more than \$150 million in principal amount of tax-exempt bonds used to finance non-hospital facilities during specified test periods.<sup>150</sup> Section 222 of the Taxpayer Relief Act of 1997 repealed the \$150 million cap with respect to bonds issued after August 5, 1997, as long as at least 95% of the proceeds from the issue are used to finance capital expenditures incurred after that date.<sup>151</sup>

Although the Taxpayer Relief Act certainly benefits section 501(c)(3) organizations that finance non-hospital facilities after the enactment date, it does not address some significant problems created by the \$150 million cap. Currently, for example, the non-hospital bonds of organizations under common management or control are aggregated for purposes of the \$150 million limit, and the new Act does not change this provision.<sup>152</sup> Furthermore, the Taxpayer Relief Act does not apply to outstanding tax-exempt bonds.<sup>153</sup> Therefore, not more than five percent of the net proceeds of a bond issue can be used to finance working capital, costs of issuance, pre-enactment date capital expenditures, and interest that is not capitalized.<sup>154</sup> The Act also does not apply to bonds issued to refund tax-exempt or taxable non-hospital bonds that were used to finance capital expenditures incurred prior to the enactment date.<sup>155</sup> Thus, while the Act will certainly provide a major benefit to many section 501(c)(3) organizations in the future, it does not eradicate the problems created by the initial bond cap, and further Congressional or regulatory action may be needed.

---

148. *See id.* at 8-9.

149. Tax Reform Act of 1986, Pub. L. No. 99-514, § 1313(c), 100 Stat. 2085, 2663-64 (1986).

150. *See* Kite & Capizzi, *supra* note 98, at 1287.

151. *See* Taxpayer Relief Act of 1997, Pub. L. No. 105-34, § 222, 111 Stat. 788, 818 (1997) (adding I.R.C. § 145(b)(5)).

152. *See* Kite & Capizzi, *supra* note 98, at 1287.

153. *See id.*

154. *See id.*

155. *See id.*

#### IV. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

1997 was business as usual in the complex and convoluted world of ERISA. The statute, which was originally passed to "protect . . . participants in employee benefit plans and their beneficiaries,"<sup>156</sup> has yet to be amended to address the realities of the health care industry in the 1990s. Through its broad preemption provisions, ERISA continues to allow certain insurers to avoid extracontractual and consequential damages by preempting state law and permitting beneficiaries to recover only the benefits due under their health plans.

In 1997, the U. S. Supreme Court issued three preemption decisions, but it is unlikely that they will provide much clarity for lower courts struggling with the scope of ERISA's preemption provisions and attempting to formulate a standardized analytical approach to preemption cases. Lower courts began testing the limits of ERISA's alternative civil enforcement provisions in 1997 and continued to appeal for congressional action to realign ERISA's original intent with the realities of the current health care market.

##### A. U.S. Supreme Court Decisions

The U.S. Supreme Court decided four ERISA cases in 1997, three of which focused on ERISA's preemption clause.<sup>157</sup> Since ERISA's enactment, the Court has struggled with ERISA preemption in sixteen cases.<sup>158</sup> With limited exceptions, section 514 of ERISA generally preempts any state law that "relates to" ERISA-covered employee benefit plans.<sup>159</sup> This preemption provision effectively shields some insurance plans from liability under state law by removing actions to federal court and limiting recovery to the amount that would have been paid had services been rendered.<sup>160</sup>

In the first preemption case, *California Division of Labor Standards Enforcement v. Dillingham Construction*,<sup>161</sup> a unani-

---

156. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001(b) (1994).

157. See Susan M. Kayser, *The Pre-emption Problem*, CONN. L. TRIB., July 21, 1997, available in LEXIS, News Library, CURNWS File.

158. See *id.*

159. See Pub. L. No. 93-406, § 514, 88 Stat. 829, 897 (1974) (codified as amended at 29 U.S.C. § 1144 (1994)).

160. See Kayser, *supra* note 157.

161. 117 S. Ct. 832 (1997).

mous Court ruled that ERISA did not preempt California's journeyman prevailing wage law, because the state law does not "make reference" to ERISA plans.<sup>162</sup> In the second, *Boggs v. Boggs*,<sup>163</sup> a sharply divided Court held that Louisiana's community property law conflicted with ERISA and was therefore preempted.<sup>164</sup> In the Court's final preemption case of 1997, *De Buono v. NYSA-ILA Medical and Clinical Services Fund*,<sup>165</sup> trustees of a trust fund established to administer an ERISA plan sought a declaration that ERISA preempted a New York State tax on the gross receipts of health care facilities operated by the fund.<sup>166</sup> In a seven-to-two opinion, the Court held that the "relate to" language in ERISA's preemption clause was not intended to supplant state law and that a hospital operated by an ERISA plan is subject to the same laws as other hospitals.<sup>167</sup>

These three preemption cases afforded the Court an opportunity to clarify some of the longstanding problems created by ERISA, but the opinions failed to provide lower courts with meaningful guidance on the scope of the preemption clause or the appropriate method of preemption analysis.<sup>168</sup> In *De Buono* and *California Division of Labor Standards*, the two cases in which the Court held that the state laws were not preempted, the majority opinions emphasized that the state laws at issue dealt with matters traditionally left within the purview of the states.<sup>169</sup> The testamentary transfer in *Boggs*, however, also dealt with issues traditionally left to the state.<sup>170</sup> Furthermore, the analysis employed in *De Buono* and *California Division of Labor Standards* focused on the extent to which the state laws at issue "related to" an ERISA plan.<sup>171</sup> In *Boggs*, however, the Court did not use a "relate to" analysis; it simply determined that the state law conflicted with ERISA and was, therefore,

---

162. *See id.* at 842 (reasoning that ERISA did not preempt the prevailing wage law because the law functions irrespective of ERISA's existence and does not "have a connection with" or "relate to" ERISA plans).

163. 117 S. Ct. 1754 (1997).

164. *See id.* at 1763 (ruling that a deceased wife's testamentary transfer to her children of her community property interest in her husband's undistributed retirement benefits is preempted by ERISA).

165. 117 S. Ct. 1747 (1997).

166. *See id.* at 1749.

167. *See id.* at 1752.

168. *See Kayser, supra* note 157.

169. *See id.*

170. *See id.* (Justice Breyer noted in his dissent that property rights and probate matters "are also areas of traditional and important state concern").

171. *See id.*

preempted.<sup>172</sup> With this paucity of guidance, variance among the lower courts is destined to proliferate, and the Court certainly will be faced with more ERISA preemption issues in the near future.

### B. *Managed Care - Breach of Fiduciary Duty*

As the Supreme Court continued to struggle with ERISA preemption, lower courts began testing the limits of ERISA's civil enforcement provisions. For example, in September, the Massachusetts Superior Court ruled in *Nascimento v. Harvard Community Health Plan, Inc.*,<sup>173</sup> that ERISA did not preempt a patient's state law claims of medical malpractice against her physician and HMO. The court held that most of the patient's claims<sup>174</sup> did not "relate to" an ERISA plan, because reference to the plan was not necessary to resolve claims as to whether the patient's care was consistent with the care an average, qualified practitioner would have provided.<sup>175</sup>

*Nascimento* was one of eight cases in which the U.S. Department of Labor filed amicus briefs contending that ERISA should not preempt state law medical malpractice claims regarding an HMO's alleged misconduct in the delivery of medical care.<sup>176</sup> The Department argued that malpractice law does not mandate the structure or administration of benefit plans but simply sets forth liability for actions taken by corporate entities engaged in the business of arranging and delivering medical care for a fee.<sup>177</sup>

Another important case in this area was *Shea v. Esensten*.<sup>178</sup> In *Shea*, the decedent suffered from chest pains and requested that his primary physician refer him to a specialist.<sup>179</sup> The physician convinced Mr. Shea that he did not need a referral, and Mr. Shea subsequently died.<sup>180</sup> Mr. Shea was unaware that his

---

172. See *Boggs v. Boggs*, 117 S. Ct. 1754, 1763 (1997).

173. No. 94-2534 (Mass. Super. Ct. Sept. 26, 1997).

174. See *Benefit Plan Law Does Not Supersede Claims of Medical Malpractice by HMO*, Health Care Daily (BNA), Nov. 5, 1997, available in LEXIS, BNA Library, BNAHLT File.

175. See *id.*

176. See *id.*

177. See *id.*

178. 107 F.3d 625 (8th Cir. 1997).

179. See *id.* at 626.

180. See *id.*

HMO's contract with its preferred doctors created financial incentives designed to minimize referrals.<sup>181</sup>

Mr. Shea's widow initially brought a wrongful death action in Minnesota state court. The HMO removed the case to federal court by successfully arguing that ERISA preempted her state law claim.<sup>182</sup> Mrs. Shea amended her complaint and alleged that the HMO's undisclosed efforts to reduce referrals violated its fiduciary duties under ERISA.<sup>183</sup> The Eighth Circuit agreed and held that an HMO's failure to disclose financial incentives not to refer patients to a specialist gave rise to a cause of action for breach of fiduciary duty.<sup>184</sup> Although the court did not specify the types of available damages, this case illustrates the backlash against managed care plans, particularly in light of the protection these plans have received from ERISA preemption in the past.

### C. *A Plea for Congressional Action*

Courts have desperately attempted to take equitable action in ERISA preemption cases, but the broad preemption language often forces them to shield the arrangers and payers of health care from the legitimate state law claims of wronged beneficiaries by removing the claims to federal court. In *Bast v. Prudential Insurance Company*,<sup>185</sup> for example, the beneficiary, Mrs. Bast, was diagnosed with breast cancer in 1990 and underwent a left modified radical mastectomy.<sup>186</sup> In August, 1991, she was diagnosed with "secondary malignancy neo-lung," and her oncologist determined that her only chance for survival was a procedure known as HDC/ABMT, which uses high doses of chemotherapy in conjunction with a bone marrow transplant.<sup>187</sup> Prudential first denied coverage for the removal of Mrs. Bast's bone marrow for processing and storage, and then denied coverage for the bone marrow transplant because the company considered the procedure to be "investigational or experimental."<sup>188</sup> Six months after her initial request for treatment, and three

---

181. *See id.* at 627.

182. *See id.*

183. *See id.*

184. *See id.* at 629.

185. No. 97-35429 (9th Cir., appellants' brief filed Sept. 2, 1997).

186. *See Family Argues Against ERISA Preemption in Suit Over Transplant Coverage*, HEALTH L. LITIG. REP., Oct. 1997, at 9.

187. *See id.*

188. *See id.*



months after the recommended period for receiving the treatment, a letter from Mrs. Bast's attorney convinced Prudential to approve the procedure.<sup>189</sup> Unfortunately, by this time, Mrs. Bast's cancer had metastasized into her brain, and she was no longer eligible for the procedure.<sup>190</sup> She passed away in January, 1993.<sup>191</sup>

Mrs. Bast's family sued Prudential, and during the trial in Washington state federal district court, Prudential admitted that it acted in bad faith by initially delaying authorization for the procedure and denying coverage for the bone marrow transplant.<sup>192</sup> However, the district court granted Prudential's motion for summary judgment and dismissed the case with prejudice, holding that ERISA allows recovery only for the cost of the requested treatment.<sup>193</sup> The case is currently on appeal before the Ninth Circuit Court of Appeals.

Another case, *Andrews-Clarke v. Travelers Insurance Company*,<sup>194</sup> illustrates the frustrations experienced by courts faced with the unjust and absurd consequences of ERISA's preemption clause. In *Andrews-Clarke*, the insured was admitted to a hospital for alcohol detoxification.<sup>195</sup> Although the insurance policy provided for one thirty-day rehabilitation program per year, the insurance company's utilization review agent, Mr. Greenspring, only approved a five-day stay.<sup>196</sup> After this brief stay, the insured resumed drinking and then admitted himself to another hospital.<sup>197</sup> This time, the utilization review agent only authorized an eight-day inpatient stay.<sup>198</sup> After his second hospitalization, the insured ingested large quantities of drugs and alcohol and attempted suicide.<sup>199</sup> Mr. Greenspring would not authorize payment for a court-ordered rehabilitation program in a private facility, so the insured was sent to a correctional facility where he received little treatment and was sexually abused

---

189. *See id.*

190. *See id.*

191. *See id.*

192. *See id.*

193. *See Amicus Claims Establishing a Trust Is Appropriate ERISA Remedy*, MANAGED CARE LITIG. REP., Oct. 24, 1997, at 5.

194. 984 F. Supp. 49 (D. Mass. 1997).

195. *See Court's ERISA Preemption Ruling Fuels Fire for New Claims Rules*, MANAGED CARE WEEK, Nov. 24, 1997, at 24.

196. *See id.*

197. *See id.*

198. *See id.*

199. *See id.*

by another inmate.<sup>200</sup> After his release from the correctional facility, the insured committed suicide.<sup>201</sup>

The decedent's wife sued the insurance company for breach of contract and several other state law claims. The lawsuit was removed to federal court, and because the court held that the claims "related to" an ERISA plan, the Massachusetts district court was forced to dismiss the claims.<sup>202</sup> In a passionate opinion, Judge Young noted that when ERISA was enacted, most disputes between insurance companies and beneficiaries arose when the insurance company denied reimbursement for health care the beneficiary had already received.<sup>203</sup> In today's era of managed care, however, a denial of coverage often translates into a denial of needed health care, and ERISA effectively shields insurers from liability stemming from the denial.

Judge Young also chastised Congress for not amending ERISA to reflect the current state of modern health care.<sup>204</sup> The judge concluded the opinion by writing:

Although the alleged conduct of Travelers and Greenspring in this case is extraordinarily troubling, even more disturbing to this court is the failure of Congress to amend a statute that, due to the changing realities of the modern health care system, has gone conspicuously awry from its original intent.

Does anyone care?

Do you?<sup>205</sup>

Perhaps someone is listening. Currently, three separate bills are percolating through Congress which would make significant changes to ERISA. Two of the bills would end ERISA preemption with respect to state causes of action for personal injury or wrongful death,<sup>206</sup> and the third would make managed care group health plans accountable for the failure to provide health benefits due to improper cost-driven policy decisions.<sup>207</sup>

## V. CONCLUSION

In 1997, the individuals driving the health care industry's development (consumers, providers, payors, and attorneys) contin-

---

200. *See id.*

201. *See id.*

202. *See Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 52 (D. Mass 1997).

203. *See id.* at 58.

204. *See id.* at 53.

205. *See id.* at 65.

206. *See H.R. 1415*, 105th Cong. (1997); *S. 644*, 105th Cong. (1997).

207. *See H.R. 1749*, 105th Cong. (1997).

ued their attempt to strike that elusive balance between optimal care and optimal price. An industry that is awash in money and regulation naturally tends towards rapid evolution, and 1998 will undoubtedly bring new statutes, new regulations, new interpretations, and new challenges. So, stay tuned, health care enthusiasts, because the ride is far from over.