MESSAGE FROM THE CHAIR

by Mary Ellen Nepps

There is a scene in the movie As Good As It Gets where Helen Hunt's character learns how her HMO has been cutting corners on her son's health care. Her outburst about "blood-sucking HMO's" (expletives deleted) met with thunderous applause in theaters everywhere. An innocuous response to a humorous line or a manifestation of a potentially powerful backlash to managed care? The vigorous applause left no doubt in my mind.

From where do such strong sentiments stem and are they justified? Managed care had been heralded as the solution to a health care industry gone out of control. There can be no doubt that managed care has succeeded in cutting much waste and many of the costs of health care delivery. What is troublesome, however, is that in many instances it has cut corners on care as well. The electronic and print media is replete with managed care horror stories. For every story reported by the media, there are dozens more told privately by consumers everywhere.

The evidence suggests that the response of the public and health care providers alike already has moved far beyond movie theater applause. And as with many complex issues, the battle lines are being drawn in the legal arena.

Physicians frustrated at having their hands tied in providing quality care have taken the extraordinary step of asking the courts to allow them to form collective bargaining units for the purpose of negotiating with managed care organizations. Health care providers and the public alike are waging court battles to whittle away at the ERISA preemption which has long shielded managed care organizations from medical malpractice claims to the extent that treatment decisions could be characterized as "denial of benefit claims" under ERISA. A decision is expected any day.

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Legislative Update

by Carol Snyder

The Senate Public Health and Welfare Committee and the Senate Appropriations Committee have approved Senate Bill 100, the Quality Health Care Protection Act. Sen. Tim Murphy, R-Allegheny, prime sponsor of the bill, offered an omnibus amendment in the Public Health and Welfare Committee that would set standards for managed care plans in areas such as patient access to health care services, disclosure of information about coverage and restrictions on providers. As this issue of the Health Care Law Newsletter was going to press, S.B. 100 was ready for full Senate action in March.

The bill would prohibit managed care provider contracts from including gag clauses that restrict a provider's ability to discuss with patients treatment options that are costly or not covered by the plan. It would ban the use of financial incentives for providers to withheld medically appropriate treatment.

Managed care plans would be required to cover emergency care around the clock and provide procedures that allow subscribers to get emergency care out of the normal service area. Emergency care would have to be covered for a condition if the patient had reason to

Carol Snyder is director of the Pennsylvania Nurses Association Legislative Program.

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believe it was serious or life-threatening.

Women would be ensured direct access to the services of obstetricians and gynecologists, and the disabled would be able to obtain direct access to specialist services as a result of the bill.

The bill allows enrollees to continue to see their provider for at least 60 days after a managed care plan terminates its contract with that provider.

Other provisions specify that managed care plans provide all plan information to enrollees and prospective enrollees in clear, understandable language. The bill establishes confidentiality requirements for managed care subscribers' medical records to ensure they are secure and available to him or her in a timely fashion.

from the Pennsylvania Supreme Court in the case of *Papas v. Asbel* where a delay in transfer to another facility for definitive treatment for a spinal cord lesion precipitated by a patient's HMO resulted in paralysis. The transferring hospital joined the HMO as a third party defendant and is now challenging the HMO's reliance on ERISA preemption to shield it from liability.

Often health care providers themselves become the object of the public's frustration with the fallout from managed care. Indeed, it has been suggested that the recent rash of multi-million dollar verdicts in medical malpractice cases is symptomatic of this phenomenon. Comments from jurors leave little room for doubt.

In response to HMO restrictions on care, the legislature has also deemed it necessary to step in and legislate the quantity if not the quality of care. For instance, the Pennsylvania legislature has mandated a minimum postpartum hospital stay in response to adverse outcomes stemming from insurance-driven maximum stays of twenty-four hours or less for postpartum patients.

Will the legislative and legal efforts and an angry populace restore balance to the equation of quality and cost in health care or are the goals of health care providers and health care insurers so mutually exclusive as to defy such balance? Perhaps. What is clear, however, is that the two are on an inevitable collision course the outcome of which is far from certain. For our respective clients as well as for ourselves as consumers of health care, we as lawyers should not merely be the beneficiaries of the problem but the architects of solutions.
Viability of Medicare PSOs Not Yet Clear

by Daniel B. Vukmer, Esq.

The 1997 Balanced Budget Act ("Act") contains legislation that has long been sought after by medical groups, hospitals, and their representative associations, such as the AMA and AHA — provisions allowing Provider Sponsored Organizations ("PSOs") to participate directly in Medicare managed care programs. Unfortunately, the legislation passes on many of the difficult issues, which would otherwise determine the viability of this strategy, and has left the Department of Health to clarify the qualifications for participation.

PSOs are generally defined as a group of affiliated medical providers which can offer a wider range of services or even their own health care benefits plan. Coverage can include traditional fee-for-service arrangements or services under capitated, risk-assuming payment arrangements. One advantage to providers is that they can organize collectively into a PSO, provide their own administrative services and thereby receive both administrative and professional payments from Medicare that would otherwise be unbundled and partially absorbed by the health care networks and administrators such as HMOs. Good in theory, but if the PSOs are to serve the same function as HMOs then they must be willing to accept compensation on a risk-assuming basis, as opposed to a fee-for-service basis.

In order to assume risk, many states, such as Pennsylvania, have required that these entities be financially able to absorb the downside risk to protect patients. Accordingly, state licensing statutes for PSOs contain minimum net and surplus capital solvency requirements. Many other states have no such statutes, thus requiring the PSOs to submit to HMO solvency standards. In either case, the solvency standards are prohibitive for all but the largest players. For this reason, the AMA and other organizations have lobbied for new federal solvency requirements that would be less burdensome and thus allow a wider range of potential PSO participants in federal managed care programs.

The Act was intended to allow PSOs the same opportunity to participate in Medicare risk-assuming managed care contracts as was previously afforded only to federally qualified HMOs. Logically, this would require a leveling of the playing field with respect to solvency standards. Although the Act allows PSOs to participate in the Medicare+Choice program and authorizes the Department of Health to waive the state solvency requirements, the circumstances under which these waivers will be issued are unclear. Moreover, the waivers, even if granted, make long-term planning difficult because they are valid for only three years. After expiration of the waiver, the PSOs will have to meet either state or federal solvency requirements; unfortunately, there are no federal solvency requirements. The legislature has simply directed the Department of Health to propose interim standards by April 1, 1998. As of October 22, 1997, the negotiated rulemaking committee has reached "tentative concurrence" on "proposed ground rules" for procedural matters but has made no progress on the substantive issues.

As one might imagine, the introduction of Medicare PSOs into the healthcare market will undoubtedly rile traditional insurers who are already facing increased competition. Insurers will want the solvency requirements to be somewhat more stringent to reduce potential competitors. On the other hand, providers are naturally pushing for reduced solvency requirements to increase competition and, according to theory, reduce costs to patients and the government. As an example of this tension, and why rulemaking will be difficult, is the current argument over whether hard assets will be counted when satisfying the solvency requirements. Insurers are generally in favor of only liquid assets counting toward the requirements while providers want to include the value of hard assets such as hospitals, clinics and equipment. The Act requires that the rulemaking committee consider the National Association of Insurance Commissioners' framework for solvency requirements — this framework considers only liquid assets as reserves. Such arguments are certain to continue well into 1998.

In addition to the unknown solvency requirements, the Act fails to include a concise definition of the term "PSO." It is not clear whether independent contractual relationships between providers will suffice to create a PSO or whether traditional corporate governance, stock ownership or partnership rules will be applied. The statute requires that entities provide a "substantial portion" of their Medicare services themselves or through "affiliated providers." This question may be resolved when regulations further define the terms "substantial portion" and "affiliated providers." We will have to wait to see whether the Department opts to provide clarification on these issues in 1998.

The inclusion of PSOs into federal managed care programs is surely a step in the right direction. However, it cannot yet be determined whether this provides a viable alternative for providers until the participation and solvency requirements are clarified.

Daniel B. Vukmer is a practitioner with Houston Harbaugh, P.C., a Pittsburgh law firm, which specializes in the healthcare sector.
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Beware the Medical Review Committee — for Participating Providers

By Rodney A. Beard, Esq.

Pennsylvania law currently prevents a doctor or other medical service provider aggrieved by an adverse determination of a professional health corporation's dispute review committee from seeking court review of the determination unless the provider can claim some form of fraud, misconduct, or egregious unfairness in the committee's procedures. Joseph P. Rudolph, M.D. v. Pa. Blue Shield, 451 Pa. Super. 300, 679 A.2d 805 (1996). In that case, Dr. Rudolph and other participating physicians filed a claim with Pa. Blue Shield for additional reimbursement due for services rendered to subscribers of the health corporation. Blue Shield's medical review committee determined that Dr. Rudolph actually had overbilled for services, and owed $26,005 back to Blue Shield.

After exhausting the internal review procedures without relief, Dr. Rudolph filed a separate court action which went to arbitration. The panel of physician arbitrators decided that Blue Shield owed $75,000 in additional reimbursement. Blue Shield appealed the decision on grounds that Dr. Rudolph's group had no right to pursue the separate court case; their exclusive remedy was through the health corporation's medical review committee. The Pennsylvania Superior Court agreed with Blue Shield and held that as long as Blue Shield's procedures were "constitutionally adequate," the doctor had no right to challenge them in court.

Prior to this case, the law was that "[A] doctor can always seek review of an unfavorable Medical Review Committee decision . . . in the appropriate state court . . ." See Pa. Blue Shield v. Com., Dept of Health, 93 Pa. Cmwlth. 1, at 13-14, 500 A.2d 1244, at 1250 (1985). The upshot of the Rudolph decision is to make the professional health corporation's medical review committee the "court of last resort" on questions of reimbursement absent fraud or blatant misconduct. The case has been appealed to the Pennsylvania Supreme Court, but no decision has yet been rendered.

The Pa. Supreme Court recently decided a case involving peer review of a doctor participating with a health maintenance organization organized under the individual practice association structural model established under the Health Maintenance Organization Act, 40 P.S. § 1551, et seq. McClellan v. HMO of Pa., 546 Pa. 463, 686 A.2d 801 (1996). Although the case involved discovery of peer review records in litigation, it sheds light on the Supreme Court's approach to statutory interpretation of the relevant legislation. When the Supreme Court reviews the Health Services Plan Corporations Act, 40 P.S. § 6301, et seq. at issue in the Rudolph case, it is likely the Court will take a very literal interpretation that the only dispute resolution procedure is as "prescribed in the bylaws of the professional health service corporation." See 40 P.S. § 6324 (c).

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Rodney A. Beard practices law in State College, where he counsel physicians and other medical providers.
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A Guide to Pennsylvania Hospital Systems and Networks

by Bartley R. Simera, Esq.

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