

HEALTH CARE LAW: A SURVEY OF 1996 DEVELOPMENTS

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INTRODUCTION

This Survey of developments for the 1996 Survey period covers the various aspects of the rapidly expanding and changing area of health care law. This Survey focuses on specific areas of health law that are likely to have the broadest impact on practitioners in the health care area. The Survey is not intended to be a comprehensive or complete discussion of all changes in this field; rather, it is intended to be a summary of important activities in the areas of provider liability, Medicare and Medicaid reimbursement, physician-assisted suicide, patient rights, tax exemptions, antitrust, and employment.

I. HEALTH CARE PROVIDER LIABILITY

During the Survey period, the Indiana judiciary decided several significant cases relating to liability of health care providers. The issues addressed in the cases varied widely, ranging from the status of a physician with respect to hospitals and non-patient third parties to proper service of process upon health care providers following the rendition of an opinion by a medical review panel formed pursuant to the Indiana Medical Malpractice Act.¹

A. Judicial Decisions

1. *Apparent Agency Between Hospital and Non-Employed Physicians.*—In *Sword v. NKC Hospitals, Inc.*,² the Indiana Court of Appeals addressed whether a hospital could be held vicariously liable for the alleged negligence of a non-employed physician on its medical staff. While in labor with her first child at Norton Hospital in Louisville, Kentucky, Ms. Sword received an epidural anesthetic from Dr. Luna.³

Following delivery of a healthy child, Ms. Sword experienced headaches, sensitivity to light and loud noises, and numbness in her back. The Swords brought suit against Norton Hospital for the alleged negligence of Dr. Luna in administering the epidural.⁴ After the trial court held that hospitals are not liable

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1. IND. CODE §§ 27-12-1-1 to -18-2 (1993 & Supp. 1996). The term, “Act,” or, “Malpractice Act,” as used throughout this section of the Survey refers to the Indiana Medical Malpractice Act.

2. 661 N.E.2d 10 (Ind. Ct. App. 1996), *trans. granted*, (Ind. Oct. 7, 1996).

3. *Id.* at 11. It was undisputed that Dr. Luna was not an employee of Norton Hospital but was, rather, an independent contractor on the hospital’s medical staff.

4. *Id.* Norton Hospital, a Kentucky hospital, apparently was not a qualified health care

for the negligence of independent contracting physicians on the medical staff,⁵ the Swords appealed.

The Swords urged the court of appeals to adopt either the theory of ostensible agency⁶ or the theory of agency by estoppel⁷ to render the hospital liable for Dr. Luna's acts. The court, however, declined to adopt either of the restatement theories and held that the Swords could state a claim against Norton Hospital under the existing Indiana law of apparent agency.⁸ Thus, according to the court of appeals:

[H]ospitals may be held liable for the negligence of their apparent agents, notwithstanding the fact that the agents are independent contractors. For a hospital to be held liable for the negligence of a health care professional under the doctrine of apparent agency, a plaintiff must show that the hospital acted or communicated directly or indirectly to a patient in such a manner that would lead a reasonable person to conclude that the health care professional who was alleged to be negligent was an employee or agent of the hospital, and that the plaintiff justifiably acted in reliance upon the conduct of the hospital, consistent with ordinary care and prudence. A hospital is not liable for the plaintiff's injuries if the plaintiff knew, or should have known, that the allegedly negligent health care professional is an independent contractor.⁹

The court of appeals traced the origin of the rule that a hospital could not be

provider under the Indiana Medical Malpractice Act. *See* IND. CODE § 27-12-3-2 (1993). Thus, the case apparently was not subject to the procedural requirements of the Act and was brought directly in court. IND. CODE §§ 27-12-10-1 to -26 (1993). *See infra* notes 36-38 and accompanying text.

5. *Sword*, 661 N.E.2d at 12 (citing *Interman v. Baker*, 15 N.E.2d 365 (Ind. 1938); *South Bend Osteopathic Hosp., Inc. v. Phillips*, 411 N.E.2d 387 (Ind. Ct. App. 1980); *Ross v. Schubert*, 388 N.E.2d 623 (Ind. App. 1979); *Hoover v. Protestant Deaconess Hosp.*, 133 N.E.2d 864 (Ind. App. 1956); *Fowler v. Norways Sanitorium*, 42 N.E.2d 415 (Ind. App. 1942).

6.

One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

RESTATEMENT (SECOND) OF TORTS § 429 (1965).

7.

One who represents that another is a servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

RESTATEMENT (SECOND) OF AGENCY § 267 (1958).

8. *Sword*, 661 N.E.2d at 12.

9. *Id.* at 15 (footnote omitted).

held liable for the negligence of non-employed physicians to *Interman v. Baker*.¹⁰ According to the court, *Interman* “concluded that because hospitals could not practice medicine under Indiana law, no patient could reasonably conclude that those who were practicing medicine in hospitals were the hospitals’ employees.”¹¹ In formulating the new rule, the court noted that judicial decisions and statutory changes subsequent to *Interman* had essentially eroded the foundation upon which the decision rested. Specifically, the court noted in *Sloan v. Metro Health Council*,¹² that the *Interman* rule had eroded over time, thus making the rule no longer viable.¹³ In addition, the court observed that, under the Indiana Professional Corporations Statute,¹⁴ corporate entities such as hospitals could be held liable for the negligent acts of employees.¹⁵ “Thus, the rationale of *Interman*—that patients could not reasonably conclude that doctors are agents or servants of the hospitals in which they practice because hospitals cannot practice medicine—is now without foundation in law or policy.”¹⁶

In *Sword*, the court of appeals noted that the Swords must establish that they justifiably acted in reliance upon some representation, direct or indirect, of Norton Hospital that an agency relationship existed between the hospital and Dr. Luna.¹⁷ The Swords presented evidence of various advertisements made by the hospital regarding its expertise in caring for maternity patients, the most relevant of which provided that the hospital offered:

[I]nstant access to the specialized equipment and facilities, as well as to physician specialists in every area of pediatric medicine and surgery. Every maternity patient has a private room *and the full availability of a special anesthesiology team, experienced and dedicated exclusively to OB patients*.¹⁸

The court of appeals determined that genuine issues of material fact existed. The court of appeals, therefore, reversed and remanded the decision with orders to consider all circumstances and evidence presented.¹⁹

Nonetheless, Judge Rucker, in his dissenting opinion, argued that in the absence of the right to control which typically attends an employer-employee relationship, it was inappropriate to make the hospital vicariously liable for the acts of an independent contracting physician on the medical staff.²⁰ Although he acknowledged that a hospital may be responsible for the acts of a physician

10. 15 N.E.2d 365 (Ind. 1938).

11. *Sword*, 661 N.E.2d at 14.

12. 516 N.E.2d 1104 (Ind. Ct. App. 1987).

13. *Sword*, 661 N.E.2d at 14.

14. IND. CODE §§ 23-1.5-1-1 to -5-2 (1993).

15. *Sword*, 661 N.E.2d at 14.

16. *Id.*

17. *Id.* at 15.

18. *Id.* (emphasis in original).

19. *Id.* at 16.

20. *Id.* at 17 (Rucker, J., dissenting).

rendering medical care on hospital premises, Judge Rucker stated, "that is so only where the physician is an employee of the hospital and the hospital is aware that the care the physician is providing has deviated from normal practice."²¹ Because there was no dispute that Dr. Luna was not an employee of the hospital, Judge Rucker concluded that, under the law of Indiana, Dr. Luna's negligence as an independent contractor could not be imputed to the hospital.²²

The Indiana Supreme Court granted the hospital's petition for transfer on October 7, 1996, and heard oral arguments on the issues on November 26, 1996. Thus, the bench and bar must await the final disposition of this important case.

2. *The Scope and Extent of the Health Care Provider's Duty.*—The Indiana Court of Appeals decided two cases²³ during the Survey period relating to a health care provider's status with respect to certain classes of individuals who alleged liability on the part of the providers for claimed injuries.

The second case decided during the Survey period which related to the duty of a health care provider was *Dixon v. Siwy*.²⁴ In 1987, Debra Dixon, received breast implants with which she subsequently developed complications.²⁵ Dixon was examined and ultimately underwent a surgical procedure described as a "left breast closed-capsular rupture" at Wishard Memorial Hospital.²⁶ Dr. Janet Turkle, a resident in Wishard's plastic surgery program, was the physician who examined Dixon and performed the surgical procedure.²⁷

Following her examination by Dr. Turkle, but before the performance of the surgical procedure, Dixon signed a "Consent and Pre-Operative Note" in which she consented to the operation "by Siwy, M.D., or members of the medical staff and personnel of Wishard Memorial Hospital."²⁸ Dr. Siwy was a member of the faculty at Wishard Hospital in the plastic surgery program; however, she did not consult on the case or participate in the recommendation or performance of the surgical procedure.²⁹ Dr. Siwy's name appeared on the consent form as a result of the "common practice at Wishard for residents, who were already certified in

21. *Id.* at 18 (Rucker, J., dissenting) (citing *Weaver v. Robinson*, 627 N.E.2d 442 (Ind. Ct. App. 1993), *disapproved on other grounds*, *Kennedy v. Murphy*, 659 N.E.2d 506 (Ind. 1995)).

22. *Id.* (Rucker, J., dissenting).

23. One of which, *Cram v. Howell*, 662 N.E.2d 678 (Ind. Ct. App. 1996), *vacated and rev'd*, 680 N.E.2d 1096 (Ind. 1997), was subsequently overturned by the Indiana Supreme Court.

24. 661 N.E.2d 600 (Ind. Ct. App. 1996).

25. *Id.* at 602.

26. *Id.*

27. *Id.*

28. *Id.* The Consent and Pre-Operative Note provided in part as follows:

I (we) hereby request and consent to the performance of the following operation or procedure on the patient by Siwy, M.D., or members of the medical staff and personnel of Wishard Memorial Hospital . . . [left breast closed-capsular rupture] . . . I acknowledge that I have had an opportunity to discuss with Turkle, M.D., the operation or procedure . . . and risks and possible complications

Id.

29. *Id.*

general surgery, to simply fill in the name of a doctor on the faculty in that space, whether or not that particular doctor had in fact been consulted.”³⁰

Dixon filed a proposed medical malpractice complaint with the Indiana Department of Insurance pursuant to the Indiana Medical Malpractice Act³¹ naming Dr. Turkle, Dr. Siwy and Wishard Hospital as defendants and alleged that they had committed medical negligence.³² Upon Dr. Siwy’s filing of a motion for preliminary determination of law³³ in the trial court, the trial court granted the motion and dismissed the proposed complaint as to her.³⁴

On appeal, Dixon argued initially that the trial court lacked jurisdiction to entertain Dr. Siwy’s motion to dismiss.³⁵ The court of appeals acknowledged that in medical malpractice cases the jurisdiction³⁶ of the trial court is limited; they have no jurisdiction “to rule preliminarily upon any . . . issue of law or fact preserved for a written opinion by the medical review panel.”³⁷ The court further observed, however, that “the trial court does have jurisdiction, before the medical

30. *Id.*

31. IND. CODE §§ 27-12-1-1 to -18-2 (1993 & Supp. 1996).

32. *Dixon*, 661 N.E.2d at 602.

33. IND. CODE § 27-12-11-1 (1993).

34. *Id.* at 602-03.

35. Dr. Siwy’s motion to dismiss was brought under Trial Rule 12(B)(6). The court of appeals addressed sua sponte whether the trial court properly treated Dr. Siwy’s motion under Trial Rule 12(B)(6) or whether the motion should have been converted to a motion for summary judgment pursuant to Trial Rule 12(B)(8). *Id.* at 603. Because Dr. Siwy supported her motion to dismiss with the submission of her deposition testimony, the court of appeals determined that the trial court erred in not considering the motion as one for summary judgment under Trial Rule 56. *Id.* The court of appeals, however, deemed the error to be harmless because Dixon was given ample opportunity to present material external to the pleadings and, in fact, submitted such material in the form of Dixon’s affidavit. *Id.* at 604. The court of appeals, therefore, treated the appeal as if it came from a grant of summary judgment by the trial court. *Id.* at 605.

36. Although not germane to the case, the court of appeals presented an excellent discussion of the distinction between subject matter jurisdiction and a court’s jurisdiction over a particular case in the context of motions for preliminary determinations of law. *Dixon*, 661 N.E.2d at 605 n.10. Generally, a medical malpractice action against a qualified health care provider may not be brought into court before the patient’s complaint is presented to a properly formed medical review panel and the panel has issued an opinion. *See* IND. CODE § 27-12-8-4 (1993). However, a trial court has limited jurisdiction to determine certain preliminary issues prior to the panel’s issuance of an opinion. *See id.* § 27-12-11-1. The court of appeals concluded:

[A]n otherwise competent court has subject matter jurisdiction over medical malpractice cases prior to the issuance of the review board’s opinion. However, the review board must issue its opinion before the court acquires jurisdiction *over a particular case*, except for the preliminary matters which the court may consider, pursuant to IC 27-12-11-1(a), prior to the issuance of the review board’s opinion.

Dixon, 661 N.E.2d at 606 n.10.

37. *Dixon*, 661 N.E.2d at 605 (quoting *Santiago v. Kilmer*, 605 N.E.2d 237, 240 (Ind. Ct. App. 1992)).

review panel has expressed its opinion, to rule upon issues not requiring expert opinion which can be preliminarily determined under Trial Rule 12.”³⁸

The court of appeals viewed Dr. Siwy’s motion to dismiss as a request for a determination of whether a physician-patient relationship ever existed between Dixon and Dr. Siwy. The court held that such a determination is a legal question that may be preliminarily determined under Trial Rule 12.³⁹ Therefore, the court found that the trial court had jurisdiction to consider Dr. Siwy’s motion to dismiss.⁴⁰

With respect to the merits of the motion to dismiss, Dixon argued that a physician-patient relationship arose between her and Dr. Siwy despite the fact that Dr. Siwy had no involvement in her medical care. She claimed that Dr. Siwy was aware of the practice at Wishard Hospital of residents placing the name of a faculty member on the consent form whether or not the faculty member had consulted on the case.⁴¹ Therefore, Dixon argued that a physician-patient relationship and the associated duty arose between her and Dr. Siwy at the time Dixon executed the consent form.⁴²

The court of appeals rejected Dixon’s argument stating “no authority exists for the proposition that a physician-patient relationship may be established without the physician performing some affirmative act with regard to the patient and without the physician’s knowledge.”⁴³ The court of appeals concluded that, in the absence of any evidence indicating a physician-patient relationship, there could be no liability on Dr. Siwy’s behalf for the allegedly negligent care Dixon received.⁴⁴ The trial court’s entry of judgment in favor of Dr. Siwy was, therefore, affirmed.⁴⁵

3. *Statutory Construction of the Indiana Medical Malpractice Act.*—Several cases were decided during the Survey period in which the Indiana courts construed various provisions of the Indiana Medical Malpractice Act.⁴⁶ Under Indiana law, medical malpractice claims against a qualified health care provider are governed by the Malpractice Act.⁴⁷ A health care provider’s qualification under the Act, however, is purely voluntary.⁴⁸ If a health care provider chooses to qualify under the Malpractice Act, the provider, or the provider’s insurance carrier, is required to file proof of financial responsibility with the Indiana Department of Insurance and pay a surcharge to the patient’s compensation fund.⁴⁹ Upon qualification, a

38. *Id.* at 606 (citing *Griffith v. Jones*, 602 N.E.2d 107 (Ind. 1992)). *See also* *Johnson v. Padilla*, 433 N.E.2d 393 (Ind. Ct. App. 1982)).

39. *Id.* at 606-07.

40. *Id.*

41. *Id.* at 607.

42. *See id.* at 606.

43. *Id.* at 607.

44. *Id.* at 608.

45. *Id.*

46. IND. CODE §§ 27-12-1-1 to -18-2 (1993 & Supp. 1996).

47. *See id.* § 27-12-3-1 (1993).

48. *See id.*

49. *Id.* § 27-12-3-2.

health care provider's liability is limited to \$100,000 per occurrence of medical malpractice.⁵⁰ In the event a patient's damages exceed \$100,000, the patient may seek additional compensation from the patient's compensation fund up to a maximum statutory limit of \$750,000.⁵¹ Moreover, with few exceptions, a claim for medical negligence against a qualified health care provider may not be brought as an initial matter in court.⁵² Instead, the claim must first be filed with the Indiana Department of Insurance and be presented to a medical review panel for an opinion issued in accordance with the Malpractice Act.⁵³

In *Comer v. Gohil*,⁵⁴ the Indiana Court of Appeals interpreted a provision⁵⁵ of the Malpractice Act relating to the tolling of the medical malpractice statute of limitations⁵⁶ upon the filing of a proposed complaint with the Indiana Department of Insurance. In *Comer*, Dr. Gohil performed surgery on Comer to remove a needle from the patient's foot.⁵⁷ After the operation, Comer continued to experience pain and discomfort in her foot. She later consulted with a second physician who determined that Dr. Gohil had failed to remove the entire needle from Comer's foot.⁵⁸ Comer filed a proposed complaint before the Indiana Department of Insurance in accordance with the Medical Malpractice Act and a complaint in the Howard Superior Court.⁵⁹ Comer filed her proposed complaint with the Indiana Department of Insurance by certified mail; however, insufficient postage was affixed to the mailing. At the time the proposed complaint was refiled by certified mail with proper postage, the two-year medical malpractice statute of limitations had expired.⁶⁰

Dr. Gohil initiated a separate action in the Marion Superior Court seeking a declaratory judgment that Comer's claim for medical malpractice was barred for her failure to file a proposed complaint with the Department of Insurance within the applicable statute of limitations.⁶¹ Dr. Gohil also sought dismissal of Comer's

50. *See id.* § 27-12-14-3(b).

51. *See id.* § 27-12-14-3(a), (c).

52. *See id.* § 27-12-8-4.

53. *See id.*

54. 664 N.E.2d 389 (Ind. Ct. App. 1996).

55. IND. CODE § 27-12-7-3 (1993).

56. *Id.* § 27-12-7-1. The statute of limitations contained in the Medical Malpractice Act is an occurrence statute which provides in pertinent part:

A claim, whether in contract or tort, may not be brought against a health care provider based upon professional services or health care that was provided or that should have been provided unless the claim is filed within two (2) years after the date of the alleged act, omission, or neglect, except that a minor less than six (6) years of age has until the minor's eighth birthday to file.

Id. § 27-12-7-1(b).

57. *Comer*, 664 N.E.2d at 391.

58. *Id.*

59. *Id.* at 390.

60. *Id.* *See* IND. CODE § 27-12-7-1(b) (1993).

61. *Comer*, 664 N.E.2d at 390.

complaint in the Howard Superior Court on the same theory.⁶² Both courts ultimately held in Dr. Gohil's favor.⁶³

After the Howard Superior Court dismissed Comer's complaint, Comer appealed,⁶⁴ contending initially that the filing of her proposed complaint with the Indiana Department of Insurance was effective despite the fact that she failed to affix proper postage to the mailing.⁶⁵ The court of appeals noted that, under the Indiana Code,⁶⁶ "[a] proposed medical malpractice complaint is considered filed *when mailed* by certified mail to the Commissioner of the Department of Insurance,"⁶⁷ and that upon filing the proposed complaint the statute of limitations is tolled until ninety days following the claimant's receipt of the medical review panel opinion.⁶⁸ The court further noted, however, that the payment of proper postage "was a matter wholly in Comer's hands,"⁶⁹ and consequently held that Comer's original proposed complaint had not been "filed" for purposes of the Indiana Code.⁷⁰ Comer's medical malpractice action before the Indiana Department of Insurance was, therefore, barred by the statute of limitations.⁷¹

Comer attempted to avoid the statute of limitations by arguing that the statute was tolled by the doctrine of fraudulent concealment.⁷² Comer did not discover Dr. Gohil's alleged negligence until she consulted with a second physician. Comer contended that, because she properly filed her proposed complaint within the two-year statute of limitations period following the discovery of Dr. Gohil's negligence, her proposed complaint was timely filed.⁷³

The court of appeals rejected Comer's argument on the basis that, even assuming the doctrine of fraudulent concealment applied, it did not provide two full years from the date of discovery of the alleged medical negligence in which to file a claim.⁷⁴ "Instead, the law imposes the responsibility upon the plaintiff to institute her action within a reasonable time after discovering the alleged malpractice."⁷⁵ The court of appeals held that the twenty-one-month delay between Comer's discovery of Dr. Gohil's negligence and the proper filing of the proposed complaint was unreasonable and, thus, the doctrine of fraudulent concealment did not operate to save Comer's claim before the Department of

62. *Id.*

63. *Id.* at 390-91.

64. *Id.* Comer appealed both the ruling of the Marion Superior Court and the ruling of the Howard Superior Court, and the two lawsuits were consolidated for purposes of the appeal.

65. *Id.* at 391.

66. IND. CODE § 27-12-7-3 (1993).

67. *Comer*, 664 N.E.2d at 391 (emphasis in original).

68. *Id.*

69. *Id.* at 392.

70. IND. CODE § 27-12-7-3.

71. *Comer*, 664 N.E.2d at 392.

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

Insurance.⁷⁶

The court of appeals, however, reversed the dismissal. Under Indiana Trial Rule 15, the court of appeals observed that a party may file an amended pleading once, as a matter of right and without permission of the court, when no responsive pleading has been filed.⁷⁷ Further, such an amendment relates back to the date of the original pleading.⁷⁸ Because Comer's amended complaint sought damages in an amount of \$15,000 or less, Comer was not required to file a proposed complaint with the Indiana Department of Insurance.⁷⁹ Further, because Comer's amended complaint related back to the date of the original complaint filed in the Howard Superior Court, it was not subject to dismissal.⁸⁰

In *Gleason v. Bush*,⁸¹ the Indiana Court of Appeals addressed the requirement of the Malpractice Act that a medical review panel issue its expert opinion within 180 days following the selection of the last member of the panel.⁸²

The plaintiff, Lester Gleason, filed a proposed complaint for medical malpractice against the health care providers who treated him for a broken arm.⁸³ Selection of the medical review panel was completed on February 21, 1994.⁸⁴ In accordance with statute, the medical review panel's opinion was required to be issued within 180 days which was on or before August 22, 1994.⁸⁵ The lawyer chairman of the panel established a submission schedule which made the plaintiff's submission due on or before April 7, 1994.⁸⁶ After requesting two unopposed thirty-day enlargements of time to submit evidence to the panel, Gleason's counsel sent correspondence to the panel chairman requesting a third enlargement of time to submit evidence until an affidavit could be received from the plaintiff.⁸⁷ The August 22, 1994, time limit for issuance of the panel opinion expired without further correspondence from the parties.⁸⁸

The health care providers subsequently filed motions to dismiss the plaintiff's proposed complaint for failure to comply with the 180-day time limit of the

76. *Id.*

77. *Id.* at 393 (citing IND. TR. R. 15(A)).

78. *Id.* (citing IND. TR. R. 15(C)).

79. *Id.* See IND. CODE § 27-12-8-6 (1993).

80. See *Comer*, 664 N.E.2d at 393. The court of appeals concluded that neither Dr. Gohil's motion to dismiss the original Howard County complaint nor the filing of the separate action in the Marion Superior Court constituted the filing of a responsive pleading for purposes of Trial Rule 15. *Id.* at 393 n. 2. In addition, the court of appeals opined that, even if Comer was required to seek leave of the trial court to file her amended complaint, it would have been an abuse of discretion for the trial court to have denied the amendment of the complaint. *Id.*

81. 664 N.E.2d 1183 (Ind. Ct. App. 1996).

82. IND. CODE § 27-12-10-13(a) (1993).

83. *Gleason*, 664 N.E.2d at 1184.

84. *Id.*

85. See *id.*

86. *Id.*

87. *Id.*

88. *Id.*

Malpractice Act.⁸⁹ During the hearing held on the motions to dismiss, Gleason argued that he had good cause for not making his submission to the medical review panel within the required time limit.⁹⁰ Specifically, Gleason presented evidence that he was a twenty-year-old male living solely on Social Security disability benefits due to disability occasioned by the medical malpractice committed by the defendants.⁹¹ In addition, Gleason presented evidence that he had insufficient financial means to maintain personal telephone service or personal transportation and that he had changed mailing addresses approximately three times during the previous nine months.⁹² For these reasons, Gleason argued that he had good cause in failing to submit the affidavit needed by his counsel to complete the submission of evidence to the medical review panel.⁹³ The trial court rejected Gleason's arguments and granted the motions to dismiss.⁹⁴

On appeal, the Indiana Court of Appeals rejected any notion that the 180-day time limit constituted a statute of limitation stating:

We hold today that the Act's 180-day time frame, alone, is neither a statute of limitation, nor the functional equivalent of a statute of limitation. Therefore, if a panel should be unable to comply with IC 27-12-10-13(a) because of plaintiff's failure to make a timely submission, that does not automatically trigger the imposition of sanctions on either parties or panel members. Instead [under IC 27-12-10-13(b)], the panel must submit an explanation to the commissioner explaining the delay and attempt to expedite the process in a reasonable manner. The defendant may seek dismissal or other sanction by initiating a court action pursuant to IC 27-12-10-14.⁹⁵

The court of appeals acknowledged that it is within the trial court's discretion to fashion appropriate sanctions, including dismissal of the proposed complaint, when the parties or panel members are dilatory in complying with the time limitations established by the Malpractice Act.⁹⁶ The court further noted, however, that a trial court may not impose sanctions when the offending party or panel member establishes good cause for failure to comply with the requirements of the Act.⁹⁷ On the record before it, the court of appeals was unable to discern whether the trial court dismissed the proposed complaint on the basis of a proper exercise of discretion on a finding that Gleason had failed to establish good cause for his failure to submit evidence to the panel or on the erroneous belief that the Malpractice Act mandated dismissal upon the expiration of the 180-day time

89. *Id.* at 1185.

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.* at 1187 (citation omitted).

96. *Id.*

97. *Id.*

requirement for the issuance of a medical review panel opinion.⁹⁸ The court of appeals, therefore, remanded the case to the trial court for determination of whether Gleason established good cause for failure to make a timely submission to the medical review panel.⁹⁹

4. *Service of Legal Process Following the Issuance of a Medical Review Panel Opinion.*—Upon completion of the medical review panel process before the Indiana Department of Insurance, an injured patient may bring suit in a court of law notwithstanding that the medical review panel may have concluded that the health care providers complied with the appropriate standard of care.¹⁰⁰ In *Bonaventura v. Leech*,¹⁰¹ the Indiana Court of Appeals addressed the issue of whether a plaintiff in a medical malpractice action must serve process upon counsel for the health care provider following completion of the action before the Indiana Department of Insurance to properly initiate a medical malpractice action in a court of law.

In *Bonaventura*, the plaintiffs filed a proposed complaint before the Indiana Department of Insurance against various health care providers alleging medical negligence.¹⁰² Following the issuance of a medical review panel opinion unanimously finding that the health care providers had failed to comply with the appropriate standard of care, the plaintiffs filed a complaint against the health care providers in Lake Superior Court.¹⁰³ The trial court granted a default judgment in favor of the plaintiffs when none of the health care providers responded to the complaint.¹⁰⁴ The health care providers moved the court to set aside the default judgment pursuant to Indiana Trial Rule 60(B) because plaintiffs had failed to serve the summons and complaint upon the attorneys who represented the health care providers in the action before the Indiana Department of Insurance.¹⁰⁵ The trial court denied the motions.¹⁰⁶

98. *Id.*

99. *Id.* The *Gleason* court was quick to note that “[o]ur holding does not depart from our previous decisions . . . and nothing in this opinion should serve as support for parties or panel members who are dilatory in upholding the letter and spirit of the [M]alpractice Act.” *Id.* Another case decided during the Survey period which addressed the 180-day time limit and the consequences of a plaintiff’s failure to submit evidence to the medical review panel was *Jones v. Wasserman*, 656 N.E.2d 1195 (Ind. Ct. App. 1995). In *Jones*, the Indiana Court of Appeals upheld the trial court’s dismissal of a patient’s proposed complaint finding that the trial court had properly exercised its discretion following a hearing in which the plaintiff was given an opportunity to explain his failure to comply with the time requirement of the Act. *Id.* at 1197.

100. IND. CODE § 27-12-8-1 (1993). Although the opinion of the medical review panel is not conclusive on the issue of liability, the Malpractice Act expressly provides for the admissibility of the panel opinion in any subsequent action brought in a court of law. *See id.* § 27-12-10-23.

101. 670 N.E.2d 123 (Ind. Ct. App. 1996).

102. *Id.* at 124.

103. *Id.*

104. *Id.*

105. *Id.* at 125.

106. *Id.* at 124-25.

On appeal, the health care providers argued that, because the medical negligence action filed in the Lake Superior Court was merely a continuation of the medical review panel proceeding before the Indiana Department of Insurance, the lawyers appearing on behalf of the health care providers before the Indiana Department of Insurance were entitled to notice of the summons and complaint.¹⁰⁷ The court of appeals held that the obligation to serve a party's attorney arises only upon the filing of an appearance on behalf of the party by the attorney.¹⁰⁸ Because there had been no appearance entered on behalf of the health care providers before the Lake Superior Court, the plaintiffs had no obligation to serve counsel on behalf of the health care providers.¹⁰⁹

In support of their contention that the action filed in Lake Superior Court was a mere continuation of the proceedings before the medical review panel, the health care providers noted that submission of a claim of medical negligence to a medical review panel was a condition precedent to the filing of a complaint in a court of law under the Malpractice Act and that the Act specifically provides that the opinion of the medical review panel is admissible in a subsequent court action.¹¹⁰ According to the health care providers, the statutory interrelationship of the two proceedings via the Malpractice Act was sufficient to render the court action filed after the medical review panel process merely a continuation of that process rather than a separate action for purposes of service of process.¹¹¹

The court of appeals rejected the arguments of the health care providers. The court observed that the action filed in the Lake Superior Court could not be considered as a review or appeal of the medical review panel opinion since neither the trial court nor a jury had authority to alter or invalidate the opinion issued by the medical review panel.¹¹² Further, the court noted that the record failed to demonstrate that the health care providers or their counsel had been misled or that the status of the case had been misrepresented by the plaintiffs or their counsel.¹¹³ Although the court acknowledged the statutory interrelationship between the two proceedings, the court concluded:

Under the statutory scheme, initiation of a legal proceeding for medical negligence is a separate action from the medical review panel process. Thus, for purposes of service of process, the attorneys who appeared before the medical review panel are not entitled to notice upon the commencement of a civil suit for medical negligence.¹¹⁴

The court of appeals, therefore, affirmed the trial court's denial of the motions of

107. *Id.*

108. *Id.* See IND. TR. R. 5(B).

109. See *Bonaventura*, 670 N.E.2d at 124-25.

110. *Id.*

111. *Id.* at 126.

112. *Id.* at 125.

113. *Id.* at 126.

114. *Id.*

the health care providers to set aside the default judgments entered against them.¹¹⁵

II. REIMBURSEMENT: PUBLIC AND PRIVATE—JUDICIAL DECISIONS

A. Medicaid Reimbursement To Providers

The changes made to the Medicaid reimbursement methodology in January 1994, led to litigation brought by Methodist Hospitals of Gary, Indiana and five physicians “contending that the new rules were invalid.”¹¹⁶ Prior to 1994, “Indiana reimbursed providers for outpatient services at the provider’s customary billing amount, but not to exceed 100% of the provider’s actual cost.”¹¹⁷ The new approach pays all providers in the State the same amount for the same service.¹¹⁸ Outpatient services are divided into nine categories, and Medicaid pays each provider the sum of 50% of the Medicare rate for that service and 50% of the statewide median amount paid for that service in 1992.¹¹⁹ Consequently, providers with higher than average costs are disadvantaged under this new system. The hospital claimed that the new outpatient rules would cost the hospitals \$1 million per year compared with the former method. The issue on appeal is whether Indiana’s rules comply with federal law,¹²⁰ which requires that every state Medicaid plan must assure that payments “are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”¹²¹

According to plaintiffs, to ensure that every Medicaid recipient can find all essential care nearby, federal law requires comprehensive studies prior to any change in the state’s plan of reimbursement. The court noted that “plaintiff’s demand is nothing less than a complete description of supply and demand schedules for every medical specialty in every part of the state, so that before changing reimbursement rates, a state knows exactly what effect the new rate will have on the demand for, and supply of, medical care.”¹²² “[I]t is exceptionally difficult to determine demand and supply schedules for a single product. Doing this for the entire medical segment of the economy would be more than difficult; it would be impossible.”¹²³

In its conclusion, the court states that neither the language of the federal statute, nor any implementing regulation, “requires a state to conduct studies in advance of every modification.”¹²⁴ Rather, it requires states “to produce a result,

115. *Id.* at 128.

116. *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1027 (7th Cir. 1996).

117. *Id.* at 1027.

118. *Id.*

119. *Id.*

120. 42 U.S.C. § 1396a(30)(A) (1994).

121. *Methodist Hosps., Inc.*, 91 F.3d at 1029. *See* 42 U.S.C. § 1396a(30)(A).

122. *Methodist Hosps., Inc.*, 91 F.3d at 1030.

123. *Id.*

124. *Id.*

not to employ any particular methodology for getting there.”¹²⁵

B. Anti-Kickback Issues Related To Medicare and Medicaid

This Survey period has seen significant activity with regard to judicial interpretation of the Medicare/Medicaid Anti-Kickback statute.¹²⁶ As was reported in the 1995 Health Law Survey, health care providers received favorable news from the case of *Hanlester Network v. Shalala*.¹²⁷ *Hanlester* created a difficult burden for prosecutors to meet when attempting to demonstrate that a defendant's conduct under the Anti-Kickback statute was “knowing and willful.”¹²⁸ The Ninth Circuit construed the words “knowing and willful” as requiring the defendants to (1) know that the statute prohibits offering or paying remuneration to reduce referrals, and (2) engage in the prohibited conduct with a specific intent to disobey the law.¹²⁹ Thus, the Ninth Circuit found that knowledge of the illegality was required for a willful violation of the statute.¹³⁰ The holding narrowed the previous authority on this issue, *United States v. Greber*.¹³¹ In *Greber*, the Third Circuit Court of Appeals held that if one purpose of the payment is to induce referrals, then the statute is violated.¹³² *Hanlester* provided health care providers with much needed guidance. However, the *Hanlester* decision has not been fully accepted by other courts. To the contrary, three courts have recently addressed the language of the Anti-Kickback statute and have rejected aspects of the *Hanlester* case.

In *United States v. Neufeld*,¹³³ a federal district court in Ohio held that there is no requirement that a defendant must know that his or her conduct is illegal under the law. Rather, the proper interpretation simply requires “a purpose or willingness to commit the act.”¹³⁴ Further, the court noted that when a physician performs a service for monies received, if any one purpose of the arrangement is to induce referrals, then the law has been violated.¹³⁵

125. The court also considered Indiana's argument that it was entitled to attorney's fees and affirmed the district court's denial of this request. See 42 U.S.C. § 1988 (1994).

126. *Id.* § 1320a-7b(b). The Anti-Kickback statute provides, subject to exceptions, “whoever knowingly and willfully offers, pays, solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly in cash or kind,” in return for or to induce the referral of patients or business for which payment may be made in whole or in part by Medicare, Medicaid, or certain other state health programs is guilty of a felony. *Id.* Violation of the statute can result in a fine of up to \$25,000 or imprisonment for up to five years, or both. See *id.*

127. 51 F.3d 1390 (9th Cir. 1995).

128. *Id.*

129. *Id.* at 1399.

130. *Id.*

131. 760 F.2d 68 (3d Cir. 1985).

132. *Id.* at 72.

133. 908 F. Supp. 491 (S.D. Ohio 1995).

134. *Id.* at 495.

135. *Id.*

The case of *Medical Development Network, Inc. v. Professional Respiratory Care/Home Medical Equipment Services, Inc.*,¹³⁶ addresses the application of the Anti-Kickback statute to arrangements with entities other than health care providers, specifically a commission-based payment arrangement. The *Medical Development* court held that the Anti-Kickback statute does not apply only to health care providers, but rather, decided that any arrangement within the contemplation of the statute will suffice.¹³⁷ The court specifically rejected the two-tiered approach to the interpretation of the words “knowingly and willingly” in the *Hanlester* decision.¹³⁸ The court stated that the statute is directed at punishment of those who perform specific acts and does not require that one engage in the prohibited conduct with the specific intent to violate the statute.¹³⁹

A third case, *United States v. Jain*,¹⁴⁰ addressed the mens rea standard applicable to a physician who is convicted of violating the Anti-Kickback law for receiving payments from a psychiatric hospital for referring patients to that hospital. The court upheld the district court’s jury instruction that the word “willfully” means the defendant knew his conduct was unjustifiable and wrongful and that “good faith” was a defense to the charge.¹⁴¹ Thus, under this court’s interpretation, the standard for conviction under the Anti-Kickback statute requires that the defendant know that his conduct is wrong, but not that it is in violation of the law itself.

C. Determining Responsible Parties For Reimbursement

Two cases from this Survey period are significant in terms of defining the parties who are and are not responsible for the payment of health care costs. The Indiana Court of Appeals in *St. Mary’s Medical Center v. Warrick County*¹⁴² held that a hospital was entitled to be reimbursed by the county sheriff for the cost of medical services provided to a prisoner under the county sheriff’s control. In *St. Mary’s*, while a the prisoner was incarcerated and awaiting court proceedings, he attempted suicide. He was treated at Warrick Hospital, but was later transferred to *St. Mary’s Medical Center* when he required services not available at Warrick Hospital. The county sheriff paid Warrick Hospital for the care rendered to the prisoner at the hospital, but refused to pay *St. Mary’s* for the medical services it had provided.

St. Mary’s contended that the county sheriff had a duty to pay for the hospital care that it provided while the prisoner was in the custody and control of the county sheriff. The sheriff responded that *St. Mary’s* was obligated, yet failed, to seek payment from the Department of Public Welfare pursuant to the Hospital

136. 673 So. 2d 565 (Fla. Dist. Ct. App. 1996).

137. *Id.* at 567.

138. *Id.*

139. *Id.*

140. 93 F.3d 436 (8th Cir. 1996).

141. *Id.* at 441.

142. 671 N.E.2d 929 (Ind. Ct. App. 1996).

Care for the Indigent Act (HCI),¹⁴³ rather than seeking payment from the sheriff. The HCI program is intended to make cost-free emergency care readily available to indigent persons who suffer serious physical injury.¹⁴⁴ Further, Indiana law requires hospitals to provide patients with information regarding HCI eligibility and benefits if “the hospital has reason to believe that the patient may be indigent.”¹⁴⁵ Thus, the court considered whether the prisoner’s status as a jail inmate who had attempted suicide supports the inference that St. Mary’s had reason to believe that the prisoner may have been indigent.

The court held that because St. Mary’s was not obligated to seek HCI benefits, as it had no reason to believe that the prisoner “may” have been indigent, the county sheriff is responsible for the cost of medical services provided to the prisoner. Finally, the court added the caveat that “where a hospital is placed on actual or inquiry notice that a prisoner may be indigent, the HCI statute applies, and the hospital is not relieved of its responsibility to seek HCI benefits merely because a Sheriff has a duty to pay for a prisoner’s medical care.”¹⁴⁶

In *Bryant v. Mutual Hospital Services*, the Indiana Court of Appeals protected a parent or guardian from liability for the cost of medical services provided to a minor under certain circumstances.¹⁴⁷ In *Bryant*, a grandmother (hereinafter “Mother”) adopted her granddaughter (hereinafter “Daughter”). Daughter subsequently ran away from home and was later the subject of multiple delinquency proceedings and had a child out-of-wedlock. Daughter was then placed in foster care, from which she ran away. She was then arrested and placed in a youth shelter. The hospital treated Daughter on numerous occasions for both venereal disease and depression. Hospital, in turn, sued Mother for the amounts owed to the hospital for such treatment. The trial court entered judgment in favor of the hospital, and Mother appealed.¹⁴⁸

Although the appeals court noted that, under certain circumstances, Indiana law implies a promise by a parent/guardian to pay for necessities furnished to a minor child/ward, where a parent/guardian is willing and ready to make suitable provision for the child, the parent is not liable for the necessities furnished by others without its consent.¹⁴⁹ Further, the court held that when an adequately supported minor child reaches the age of discretion and abandons the parent’s/guardian’s home, he no longer has the right to bind the parent for his necessities.¹⁵⁰ In its analysis, the court considered the fact that Daughter had abandoned her mother’s home to escape parental discipline, and the medical

143. IND. CODE §§ 12-16-3-1 to -4 (1993).

144. *Id.* § 12-16-3-1. This section delineates the medical criteria an individual must satisfy to qualify for HCI benefits.

145. *Id.* § 12-16-3-4.

146. *St. Mary’s Med. Ctr.*, 671 N.E.2d at 933.

147. 669 N.E.2d 427 (Ind. Ct. App. 1996). This case has come to be known as the “Wayward Ward” case.

148. *Id.*

149. *Id.*

150. *Id.*

services had been necessary due to her refusal to submit to the reasonable restraints imposed by her mother.¹⁵¹ Accordingly, the court found that Mother was not liable for the provision of medical services to Daughter.¹⁵²

III. CHANGES TO HMO STATUTE

Effective July 1, 1996, Senate Enrolled Act 378¹⁵³ made several important changes to Indiana law regarding regulation of health maintenance organizations (HMO).¹⁵⁴ The statute allows entities owned in whole or part by health care providers to become a "participating provider" under HMO law that permits physician hospital organizations and other organizations with multiple ownership to be eligible to participate fully in providing health services for an HMO.¹⁵⁵ The Act also provides that a participating provider may contract with another health care provider to provide health services to enrollees of an HMO with neither provider being required to obtain a certificate of authority from the Indiana Department of Insurance (IDI).¹⁵⁶

In a substantial modification of the methodology to compute an HMO's net worth to comport with the requirement of the general HMO law, the Act now permits inclusion of value attributable to medical equipment. The value of these assets may be included within total assets if:

- (1) owned by the HMO and not subject to lien, claim or encumbrance;
- (2) used, at least in part, to treat, diagnose, or care for HMO enrollees;
- (3) the equipment has an initial cost of at least three thousand dollars (\$3,000.00);
- (4) the equipment has a useful life of at least two (2) years; or
- (5) More than thirty percent (30%) of the total HMO net units consists of medical equipment.¹⁵⁷

Net worth of an HMO may include without limit the value of owned data processing equipment used in HMO operations if it is not subject to any lien, claim or encumbrance.¹⁵⁸

A. Anti "Gag Orders" and Primary Care Providers

Senate Enrolled Act became law on July 1, 1996, and prohibits inclusion of

151. *Id.* at 430.

152. *Id.*

153. Act of Mar. 18, 1994, § 25, 1994 Ind. Acts 552, 578-641 (codified as amended at IND. CODE §§ 27-13-1-1 to -35-1 (Supp. 1996)).

154. An HMO "is a person that undertakes to provide or arrange for the delivery of health care services on a prepaid basis, except enrollee responsibility for copayments or deductibles." IND. CODE § 27-13-1-19 (Supp. 1996).

155. *Id.* § 27-13-1-28(b).

156. *Id.* § 27-13-2-2(b).

157. *Id.* § 27-13-12-1(c)(1).

158. *Id.* § 27-13-12-1(c)(2).

certain provisions in managed health care contracts. HMO and preferred provider organizations (PPO) participating health care provider agreements may not preclude providers from disclosing to enrollees information regarding financial incentives given to providers and treatment options available, even if not covered under the enrollee's policy or contract. A health care provider may not be penalized by an insurer or an HMO for disclosing information regarding incentives or treatment options.¹⁵⁹ The law also allows women enrollees to select specialists in obstetrics and gynecology as the primary care physician under a managed care contract.

B. Regulation of Telemedicine

House Enrolled Act 1274, which became effective July 1, 1996, provides that treatment or diagnostic services provided to patients in Indiana when transmitted through electronic communication on a regular, routine basis, or pursuant to an agreement to provide such services, constitutes the practice of medicine requiring an Indiana medical license.¹⁶⁰ An Indiana license is not required for a non-resident physician rendering treatment or diagnostic services if such services constitute a second opinion or are in follow-up to care rendered to a patient originally treated outside of Indiana.¹⁶¹

C. Expiration of Certificate of Need

Since 1987, Indiana has had in place a form of a certificate of need (CON) program requiring approval for the construction, addition or conversion of beds for use as comprehensive care beds in a comprehensive care facility.¹⁶² However, licensed hospitals¹⁶³ were permitted to convert up to fifty acute care beds to comprehensive care beds without the necessity of a CON.¹⁶⁴ The statute which required a CON expired on July 1, 1996.¹⁶⁵ Consequently, since July 1, 1996, a CON has not been required for the construction, addition or conversion of beds to comprehensive care use.

D. Transferability of Health Insurance Programs

The Federal Health Insurance Portability and Accountability Act ("Act")

159. *Id.* §§ 27-8-11-4.5, 27-13-15-1(a)(2), (3).

160. *Id.* § 25-22.5-1-1.1(a)(4).

161. *See id.*

162. A comprehensive care facility is a health facility licensed under IND. CODE § 16-28-2-1 (1993) and which is certified for participation in a state or a federal reimbursement program including Title XVII or Title XIX of the Social Security Act (42 U.S.C. §§ 1395-1395ccc (1994 & Supp. I. 1995) and *id.* §§ 1396-1396u).

163. Hospitals are licensed pursuant to IND. CODE § 16-21-2-2 (1993).

164. IND. CODE § 16-29-3-2 (1993).

165. *Id.* § 16-29-1-16 (Supp. 1996).

became effective August 21, 1996.¹⁶⁶ The Act is designed to remove barriers to employees changing jobs and retaining health insurance coverage and will likely require substantial revisions to many group health plans and employer benefits policies. The statute created a new part of the Employee Retirement and Income Security Act of 1974 (ERISA),¹⁶⁷ which generally applies to any welfare benefit plan that provides medical coverage to employees or their dependents whether directly or indirectly.

The principal insurance requirements of the Act are the establishment of minimum eligibility criteria whereby an individual who provides a certificate of previous coverage must be enrolled into a new employer's group health insurance plan. The prior coverage is considered creditable coverage unless that coverage is followed by at least a sixty-three day period of non-coverage. Group health plans are required by the Act to provide written certification of creditable coverage when an individual ceases to be covered under a plan.

Pre-existing condition exclusions may be imposed upon an individual under a new health plan only if: (i) the exclusion relates to a condition treated or received six months prior to the proposed enrollment date; (ii) the exclusion does not exceed twelve months after enrollment (eighteen months in the instance of a late enrollee); and (iii) the period of exclusion is licensed by the length of any immediately preceding period of creditable coverage (excluding waiting periods).¹⁶⁸ Pregnancy and genetic predisposition may not be considered as pre-existing conditions.¹⁶⁹ Children new to a family and enrolled within thirty days of arrival also may not be subjected to pre-existing condition exclusions.¹⁷⁰

The Act does not apply to all plans, employers or benefits and excludes from its requirements coverage for accident or disability income insurance, supplements to liability insurance, liability insurance including general and automobile coverage, worker's compensation coverage, automobile medical coverage, credit only insurance and coverage for on-site medical clinics.¹⁷¹ The Act will likely change most employer health plans throughout the country.

E. House Enrolled Act 1075

During the 1996 legislative session, the Indiana General Assembly passed legislation concerning insurance and HMO coverage for postpartum hospital stays. The legislation, House Enrolled Act 1075,¹⁷² was a response to the practice of certain health insurance companies and HMOs of denying payment on behalf of enrollees for in-hospital care received by a mother and newborn more than twenty-

166. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

167. 29 U.S.C.A. §§ 1181-1191(c) (West Supp. 1997).

168. *Id.* § 1181(a).

169. *Id.* § 1181(b)(1)(B), (d)(3).

170. *Id.* § 1181(d)(1).

171. *Id.* § 1191b(c)(1).

172. IND. CODE §§ 27-8-24-1 to -5 (Supp. 1996).

four hours after an uncomplicated vaginal birth, and more than forty-eight hours after an uncomplicated cesarean birth. Effective July 1, 1996, the new legislation requires various types of insurance policies and HMO contracts that provide maternity benefits to cover a postpartum stay in the hospital that is of a duration consistent with the minimum postpartum hospital stay guidelines published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their *Guidance for Parental Care*.¹⁷³ Simply stated, these guidelines provide for a minimum forty-eight hour postpartum stay at a hospital in the event of an uncomplicated vaginal birth, and a minimum seventy-two hour postpartum stay in the event of an uncomplicated cesarean delivery. The legislation allows health insurance policies and HMO contracts to provide coverage for shorter period of time, but only if the mother's physician determines that further inpatient care is not necessary for the mother or the newborn child, and the policy or contract authorizes at least one at-home post-delivery care visit to be conducted not later than forty-eight hours following the mother's and newborn's discharge from the hospital.

IV. ADMINISTRATIVE ACTIVITY

A. *Reimbursement For Teaching Physician*

On December 8, 1995, the Health Care Financing Administration (HCFA) promulgated new regulations¹⁷⁴ establishing criteria for billing by teaching physicians involved in residency programs. These regulations went into effect July 1, 1996.

Under the new regulations, the general rule is that if a resident participates in a service furnished in a teaching setting, the teaching physician must be "physically present" during the provision of the key portion of the service or procedure in order for it to be billable to Medicare.¹⁷⁵ As a result, teaching physicians must be present during the portion of the services that determine the level of services to be billed. For example, in cases of complex or high-risk surgical procedures, the teaching physician must be present during all critical portions of the surgery in order for the teaching physician's professional services to be billed.¹⁷⁶

The presence of the teaching physician during the key portion of this service or procedure must be documented. This documentation requirement can be satisfied by notes in the medical records made by a physician, resident or nurse. However, in the case of evaluation and management procedures, the teaching

173. *Id.* § 27-8-24-4.

174. 42 C.F.R. § 415.172(a) (1996).

175. *Id.*

176. *See id.* § 415.172(a)(1). The new regulations eliminate the requirements that the attending physician physically examine the patient, that the attending physician be recognized by the patient's personal physician, and that one physician be the attending physician for an entire inpatient episode.

physician must personally document his participation by a notation in the medical record.

B. Reimbursement For Medical Devices

HCFA also promulgated new regulations concerning Medicare coverage for medical devices subject to the FDA's Investigational Device Exemption (IDE). Effective November 1, 1995, nonexperimental/investigational devices are covered by Medicare subject to the usual Medicare criteria and relevant FDA protocol restrictions.¹⁷⁷ The new rule is designed to allow greater Medicare beneficiary access to leading edge technology and respond to a mandate that federal agencies streamline regulations and be more customer oriented.

The key to the new regulation is a classification process conducted by the FDA which places devices into three (3) classes and two (2) different categories. Quarterly, HCFA will announce IDE categorizations and device eligibility for coverage. Providers may use this guidance to determine if a device may be covered. However, the devices used in a hospital must satisfy the protocol procedures and other Medicare requirements. Moreover, HCFA has indicated that Medicare beneficiaries will not have to pay for the use of non-covered devices where the beneficiary was not informed that the device is not covered.

C. Reimbursement To Out Of State Provider

In November 1996, a Final Agency Order¹⁷⁸ from FSSA overturned a favorable decision by an administrative law judge requiring OMPP to reimburse the Children's Hospital of Philadelphia in excess of \$180,000. This matter arose when conjoined (siamese) twins born to Indiana resident parents were admitted to the Hospital to have a surgical separation procedure performed.

Under the Indiana law in force at the time of the twins' admission, Indiana Medicaid reimbursement for out-of-state hospitals was to be in "accordance with the reimbursement methodology of the provider's state."¹⁷⁹ Midway through the subsequent hospital stay of 296 days, reimbursement for out-of-state providers who participate in the Indiana Medicaid program was changed by passage of a new code,¹⁸⁰ whereby out-of-state providers were assigned a rate of \$601 per day.

The OMPP argued at the administrative hearing that the Hospital had orally agreed to a \$997 per diem reimbursement rate, which would require the Hospital to absorb \$180,000 more than what would have been required under either states' laws. The ALJ found for the Hospital, however, FSSA overturned this decision on appeal. Children's Hospital of Philadelphia has filed a petition for judicial review of FSSA's decision under the Administrative Orders and Procedures Act.

177. *Id.* § 405.201-215, -.753, -.877; § 411.15, -.406 (1996).

178. Children's Hosp., No. L9410-180 (Ind. FSSA May 13, 1996) (final agency order).

179. IND. ADMIN. CODE tit. 405, r. 1-7-4(c)(7) (1992).

180. *Id.* r. 1-10-4 (1993).

D. *New Anti-Kickback Safe Harbors*

Under a final rule issued by the Department of Health and Human Services Office of Inspector General (OIG), three (3) existing "safe harbor" regulations under the Medicare/Medicaid Anti-Kickback legislation were revised.¹⁸¹ Such safe harbors are intended to protect from prosecution certain conduct by health care providers and managed care plans.¹⁸²

These safe harbors clarify existing safe harbors in the areas of waivers of co-payments and deductibles, incentives of to enrollees, and price reductions offered by providers to health plans.

V. HEALTH CARE PROVIDERS/PATIENT RIGHTS—JUDICIAL DECISIONS

A. *Physician-Assisted Suicide*

Recently, the U.S. Supreme Court upheld state authority to criminalize physician-assisted suicide.¹⁸³ These decisions are discussed by Professor Rosalie Berger Levinson in this issue.¹⁸⁴

Besides the two Supreme Court decisions, an additional case of interest is *Kevorkian v. Arnett*.¹⁸⁵ This case held that competent adult patients have a fundamental substantive due process right to physician assisted suicide and struck down the California statute criminalizing the physician-assisted suicide.¹⁸⁶ Although claims for both due process and equal protection were made in this case, the court upheld only the due process claim and did not address the equal protection claim at this time.

B. *Emergency Medical Treatment and Active Labor Act*

The Fourth Circuit recently issued an opinion clarifying utilization of the Emergency Medical Treatment and Active Labor Act (EMTALA).¹⁸⁷ In *Bryan v.*

181. 42 U.S.C. § 1320a-7b(b) (1994). *See supra* note 126.

182. In an effort to alleviate the concern of prosecution under the Anti-Kickback statute, the OIG has issued various "safe harbor" regulations which set forth standards and guidelines that, if met, allow specific business arrangements and payment practices not to be treated as a criminal offense under the statute. There is no affirmative obligation to meet any safe harbor, as the safe harbors are designed only to provide a means through which individuals and entities can be assured that their arrangements are immune from potential criminal and administrative sanctions under this law. *See* 42 C.F.R. § 1001.952 (1996). If a practice does not fall within a safe harbor, it has precisely the same legal risk that it had before the safe harbor was promulgated.

183. *Vacco v. Quill*, 117 S. Ct. 2293 (1997); *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

184. Rosalie Berger Levinson, *State and Federal Constitutional Law Developments*, 30 IND. L. REV. 965, 987-89 (1997).

185. 939 F. Supp. 725 (C.D. Cal 1996).

186. *Id.* at 731.

187. 42 U.S.C. § 1395dd (1994).

Rectors and Visitors of the University of Virginia,¹⁸⁸ the Fourth Circuit answered a number of questions with respect to ongoing treatment obligations of a hospital under EMTALA and also attempted to explain its previous decision, *In re Baby K*.¹⁸⁹

Cindy Bryan, as administratrix of the Estate of Shirley Robertson, brought an action against the University of Virginia under EMTALA. The complaint alleged that the hospital violated EMTALA when, having treated Mrs. Robertson for an emergency medical condition for twelve days, determined that no further efforts to prevent her death would be made. Mrs. Robertson died eight days later. The hospital received direction from the family of Mrs. Robertson to take all necessary measures to “keep her alive and trust in God’s wisdom,”¹⁹⁰ but the hospital refused to follow the direction of the family and entered a Do Not Resuscitate order. The district court dismissed the action and held that once the patient was admitted to the hospital, the hospital’s obligations are covered by state tort law and not EMTALA. In her appeal, Ms. Bryan contended that the hospital has an ongoing responsibility to continuously “stabilize” the condition of the patient no matter how long the treatment is required to maintain that condition. Subsection (b)(1) of EMTALA provides:

If an individual . . . comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

- (A) . . . for such further medical examination such treatment as may be required to stabilize the medical condition, or
- (B) for transfer of the individual to another medical facility¹⁹¹

The appellant argued that if a hospital “accepts a patient with an emergency medical condition either by admission or transfer and continues stabilizing treatment for any period of time, whether it be one hour, one week or twelve days, and then refuses such stabilizing treatment, such refusal of stabilizing treatment without transfer violates EMTALA.”¹⁹² The court of appeals rejected Bryan’s argument stating, “Under this interpretation, every presentation of an emergency patient to a hospital covered by EMTALA obligates the hospital to do much more than merely provide immediate, emergency stabilizing treatment with appropriate follow-up.”¹⁹³

Recognizing that EMTALA is a limited “anti-dumping” statute and not a federal malpractice statute, the court refused to extend its reading to require hospitals to provide treatment to patients indefinitely. Citing Congressional intent for EMTALA,¹⁹⁴ the court held that,

188. 95 F.3d 349 (4th Cir. 1996).

189. 16 F.3d 590 (4th Cir. 1994).

190. *Bryan*, 95 F.3d at 350.

191. 42 U.S.C. § 1395dd(b)(1) (1994)).

192. *Bryan*, 95 F.3d at 350.

193. *Id.* at 351.

194. In its opinion, the court quotes the Congressional Record including remarks by Senators

[O]nce EMTALA has met that purpose of ensuring that a hospital undertakes stabilizing treatment for a patient who arrives with an emergency medical condition, that patient's care becomes the legal responsibility of the hospital and the treating physicians. And, the legal adequacy of that care is then governed not by EMTALA but by the state malpractice law that everyone agrees EMTALA was not intended to preempt.¹⁹⁵

The appellant, in this case, attempted to rely on the Fourth Circuit's previous conclusion in the case, *In re Baby K*. The hospital sought declaratory judgment stating that the prevailing standard of care for anencephalic infants should provide the standard for its compliance with EMTALA's requirement of stabilization of the patient's respiratory distress. The Fourth Circuit rejected that contention, holding that EMTALA's stabilization requirement focused upon the patient's emergency medical condition, not her general medical condition. In *Baby K*, the requirement was to provide stabilizing treatment of the condition of respiratory distress, without regard to the fact that the patient was anencephalic or to the appropriate standard of care for that general condition. The court reiterated that the holding in *Baby K* did not present the issue of "temporal duration of that obligation, and certainly did not hold that it was of indefinite duration."¹⁹⁶ The court made no ruling on any potential medical malpractice cause of action against the hospital; rather, held that the conduct of the hospital did not violate EMTALA.

C. Abortion Law

In *A Women's Choice-East Side Women's Clinic v. Newman*,¹⁹⁷ the Indiana Supreme Court held that the medical emergency provision applicable to Indiana's abortion statute,¹⁹⁸ permits dispensing with the informed consent requirements when the attending physician concludes, based on his/her medical judgment and in good faith, that medical complications in the patient's pregnancy indicate the necessity of a therapeutic abortion.

Because the slate upon which the court was required to write concerning this issue was "not merely clean, but spotless,"¹⁹⁹ the court looked to other jurisdictions for guidance, but found none. Indiana's abortion law defines "medical emergency" as

a condition that, on the basis of the attending physician's good faith clinical judgment, complicates the medical condition of a pregnant

Durenberger, Kennedy, Dole, Baucus, Heinz and Proxmire, emphasizing that the source of EMTALA was a widely reported scandal on emergency rooms increasingly dumping indigent patients from one hospital to the next while the patient's emergency condition worsened. *Id.*

195. *Id.*

196. *Id.* at 352.

197. 671 N.E.2d 104 (Ind. 1996).

198. IND. CODE §§ 16-34-2-1 to -7 (1993 & Supp. 1996).

199. *A Women's Choice-East Side Women's Clinic*, 671 N.E.2d at 107.

woman so that it necessitates the immediate termination of her pregnancy to avert her death or for which a delay would create serious risk of substantial and irreversible impairment of a major bodily function.²⁰⁰

If such a medical emergency exists, the requirement to obtain consent of the pregnant woman is abrogated.

In consideration of the first question, whether the abortion statute excuses compliance with Indiana's informed consent law when such compliance *would pose a significant threat to the life or health of the woman*, the court concluded that a doctor's regard for all relevant factors pertaining to a woman's health is implicit in the term "clinical judgment." If the diagnosis "indicates that an abortion is medically necessary, then the physician may perform it without delay."²⁰¹ The court also stated that a positive provision for immunity is not necessary to shield a physician from prosecution on the basis of professional judgment.

In response to the second question, whether the medical emergency exception excuses compliance with the informed consent laws when such compliance *threatens to cause severe but temporary physical health problems for the woman*, the court held that the statute allows only death or substantial and irreversible impairment to excuse compliance with its informed consent provisions.²⁰² Because temporary problems pass and are not ordinarily of such severity that they necessitate treatment by abortion, they are not covered by the exception.²⁰³

To the third question, whether compliance with the statute's informed consent provisions may be excused when compliance *threatens to cause the woman severe psychological harm*, the court responded that persons who suffer mental health injuries are often substantially and irreversibly disabled. A physician treating a woman faced with this risk may be excused from compliance with the informed consent requirements when the physician concludes, through good faith clinical judgment, that an abortion is medically indicated.²⁰⁴

The Indiana Supreme Court's broad interpretation of the medical emergency exception, allowing physicians to dispense with the informed consent requirements in certain instances, is significant in that Indiana is the first state to define the medical emergency exception. According to this decision, physicians are now provided with immunity for dispensing with informed consent requirements when there is a significant threat to the life, health, or psychological well-being of the woman. Physicians may not, however, dispense with the informed consent requirements when compliance with such requirements threatens to cause severe, but temporary physical health problems for the woman.

200. IND. CODE § 16-18-2-223.5 (Supp. 1996).

201. *A Women's Choice-East Side Women's Clinic*, 671 N.E.2d at 109.

202. *Id.*

203. *See id.* at 111.

204. *Id.*

VI. TAX ISSUES: TAXPAYER BILL OF RIGHTS

From a federal perspective, one of the most significant developments during the last Survey period is the Taxpayer Bill of Rights 2²⁰⁵ (“The Act”) which presents new tax planning challenges for exempt hospitals, integrated delivery systems, and for physicians and others who deal with such entities. The Act provides for a series of penalty excise taxes where exempt organizations (i) pay unreasonable compensation to individuals that are in a position to substantially influence the organization; (ii) pay compensation based in whole or in part on the revenues of the organization in a manner that results in private inurement; or (iii) enter into agreements that result in them paying more for assets than such assets are worth or selling assets for less than they are worth.²⁰⁶ Significantly, the Act imposes these taxes on both the recipient of such improper payment and on the person(s) in the tax exempt organization who participated in the transaction, not on the organization itself.²⁰⁷

The significance of the Act is emphasized by the retroactive application of the penalty provisions, more commonly referred to as the “intermediate sanctions.”²⁰⁸ Prior to this Act, revocation of the tax exempt status of an organization was the only sanction available to the IRS in connection with prohibited transactions. The new legislation now allows the IRS to take less dramatic measures raising additional revenue.

In a recent change of position, the IRS increased flexibility for substantial physician representation on the governing boards of tax exempt Integrated Delivery Networks (IDN). The new “facts and circumstances” approach will replace the highly criticized 20% safe harbor rule, which restricted the number of financially interested physicians to 20% of the Board. The IRS decided to ease the guidelines as it has become more comfortable with IDNs and their operations.

The current view of the IRS for newly created organizations is to allow physicians and other individuals with a financial interest to constitute up to 49% of the Board. The remaining 51% representation is to come from the community. The purpose of the community Board members, according to the IRS, is to demonstrate that the organization operates to promote the health of the community as a whole and not to benefit private individuals. The IRS also requires a proper conflict of interest policy covering the transactions of financially interested individuals of all organizations in the health care system.

VII. ANTITRUST ISSUES

A. *Judicial Developments—Market Definitions*

During this Survey, the courts have continued to grapple with definitions of

205. Pub. L. No. 104-168, §§ 1311-1314, 110 Stat. 1452, 1475-81 (1996).

206. I.R.C. § 4958(c) (West Supp. 1997).

207. *Id.* § 4958(a).

208. The intermediate sanctions are applicable to transactions entered into after September 14, 1995.

both the relevant product and geographic markets in the area of antitrust. In late 1995, two federal courts rejected the government's use of traditional antitrust analysis to describe the geographic markets narrowly. The new view supported inference that an injury to competition was likely to result from hospital mergers and looked instead to where patients could reasonably turn for inpatient hospital services.

In *United States v. Mercy Health Services*,²⁰⁹ the U.S. District Court for the Northern District of Iowa denied the U.S. Department of Justice's (DOJ) efforts to obtain an injunction to block the partnership of two Dubuque, Iowa, hospitals—Mercy Health Services and Finley Hospital. The DOJ alleged that the proposed partnership would substantially lessen competition for acute inpatient hospital services in a geographic area consisting of Dubuque County and the surrounding area. However, the court rejected this proposed definition of the particular market, stating that the government's proposed geographic market rested too heavily on past market conditions and made invalid assumptions as to the reactions of third-party payors and patients to price changes. Instead, the court found that the Dubuque hospitals compete for inpatient admissions with other "regional" hospitals located seventy to one hundred miles away.²¹⁰ Thus, the geographic market had to include these hospitals. In such a large market, the hospitals had too little a share of the market to raise antitrust concerns. Therefore, the court concluded that the merger of the only two hospitals in Dubuque County would not be anti-competitive. Subsequently, the two hospitals abandoned their merger plans. The Eighth Circuit concluded that the case had become moot and vacated the district court's decision.

In a similar case, *FTC v. Freeman Hospital*,²¹¹ the FTC sought a preliminary injunction to prevent a merger of two hospitals in Joplin, Missouri. The Eighth Circuit affirmed the district court's denial of the injunction, because the FTC failed to meet its burden of proving a relevant geographic market. Similar to the court's decision in *Mercy Health Services*, the Eighth Circuit held that the FTC was required to present evidence addressing the critical question of where consumers of acute care inpatient hospital services could practically turn for alternative sources of such services should the hospitals' merger be consummated and Joplin hospital prices become anti-competitive.

The court found that the FTC failed to produce such evidence. The evidence produced by the FTC to support its proposed geographic market—Joplin, Missouri and areas located within a twenty-seven mile radius of the city—consisted primarily of an analysis illustrating current patient flow into and out of the three hospitals located in Joplin. The court found that this analysis gave a static, rather than a dynamic, picture of the acute care market in Joplin and the surrounding area.

Like most hospital merger cases, the *Mercy Health Services* and *Freeman Hospital* decisions turned on the definition of the market; both hospitals prevailed

209. 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997).

210. *Id.* at 972.

211. 69 F.3d 260 (8th Cir. 1995).

by attacking the traditional geographic market premise on which the government relied. The courts' broad definition of the geographic market in both Joplin, Missouri, and Dubuque, Iowa, allowed both hospitals to overcome challenges launched by the FTC and the DOJ. Nonetheless, at least one court has rejected the dynamic market analysis utilized in Joplin and Dubuque in favor of a more traditional geographic market definition.

In September 1996, the U.S. District Court for the Western District of Michigan denied FTC's request for a preliminary injunction to help the proposed merger of two Michigan hospitals.²¹² The FTC challenged the proposed merger of two Grand Rapids hospitals—Butterworth Health Corporation and Blodgett Memorial Medical Center—on the ground that it would have the effect of substantially lessening competition contrary to section 7 of the Clayton Act.²¹³ The court found the proposed merger lawful despite the fact that they would control 47% to 65% of the general acute care inpatient services in the surrounding area and 65% to 70% of the primary care inpatient services in Grand Rapids.

The *Butterworth* court's analysis of the relevant market is a departure from the norm in that the government alleged a second, less extensive product market.²¹⁴ The court was satisfied that the FTC had adequately established that general acute care inpatient hospital services and primary care inpatient services were relevant product markets.

The *Butterworth* court took a different approach from the *Mercy Health Services* and *Freeman Hospital* decisions, which defined broad geographic markets and defeated government challenges to hospital mergers. Specifically, the court accepted the FTC's definition of the relevant geographic market for general acute care inpatient hospital services as Grand Rapids and the area encompassed within its thirty mile radius. With respect to the primary care inpatient hospital services, the relevant market was determined to be the immediate Grand Rapids area because of the unwillingness of patients to travel significant distances to receive primary care inpatient services.²¹⁵

Although the FTC successfully established a *prima facie* case that the proposed merger would violate section 7 of the Clayton Act, the defendant successfully rebutted this *prima facie* case with evidence that the proposed merger was not likely to cause anti-competitive effects.²¹⁶ The court's reliance on several

212. *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996).

213. 15 U.S.C. § 18 (1994).

214. The FTC identified two alternative product markets in which the merged entity would possess substantial market power: (i) general acute care inpatient services, the traditional product market for hospital mergers; and (ii) primary care inpatient hospital services, including "basic or less complex services available at most general acute care hospitals." *Butterworth*, 946 F. Supp. at 1290.

215. *See id.* at 1293.

216. In reaching its decision, the court was cognizant not only of antitrust policy, but of competing public policies as well. Specifically, the court considered empirical proof that higher hospital concentration in Michigan was actually associated with lower non-profit hospital prices. Moreover, the court was persuaded that the involvement of prominent community and business

non-economic, non-traditional defenses suggests that a presumption of anti-competitive effects when there exists high market concentration in the relevant market may not always be appropriate.

On November 18, 1996, the FTC issued an administrative complaint challenging the proposed merger as anti-competitive. In addition, the FTC announced that it will appeal the district court's decision to deny FTC's request for a preliminary injunction.

B. Administrative Developments

One area of particular concern in the health care industry over the past few years has been the application of "rule of reason" analysis to collective conduct by partially integrated provider groups. On August 28, 1996, the DOJ and the FTC issued revised Antitrust Enforcement Guidelines for the health care industry which address this issue. Where provider integration through a network is likely to produce significant efficiencies, any agreement on price "reasonably necessary" to accomplish the venture's procompetitive benefits will be analyzed under the rule of reason according to the revisions to Statements 8 and 9, dealing with physician network joint ventures and multiprovider networks respectively.²¹⁷ The Agencies indicated that their revisions were made in response to evolving market arrangements involving joint activity by health care providers and the agencies' additional experience with evaluating the competitive impact of joint provider activity.

The previous version of Statement 8, dealing with physician network joint ventures, issued in September 1993, provided an antitrust "safety zone" for integrated physician networks that jointly marketed physician services and collectively agreed on the prices at which their services would be offered to payors. The safety zone applied to exclusive and non-exclusive non-integrated networks that included fewer than 20% or 30%, respectively, of the physicians in any physician specialty with active hospital staff privileges who practice in the relevant geographic market. The safety zone only explicitly recognized, however, two acceptable forms of integration—capitation and significant risk withholds.

The revised Statement 8 retains the 20% and 30% size thresholds for exclusive and non-exclusive networks, but provides an expanded discussion of what constitutes "integration" for purposes of antitrust analysis. The revised Statement 8 recognizes that financial integration can be accomplished by physician networks that share substantial financial risk via capitation, risk withholds, percentage of premium or percentage of revenue payment methodologies, global pricing or

leaders on the Boards of both hospitals, who have demonstrated a genuine commitment to serve the Greater Grand Rapids community by using profits to increase health care quality, could be expected to bring accountability to price structuring. *Id.* at 1298. Finally, the court relied heavily on the non-profit status of the hospitals, as well as the fact that hospitals were in the business of saving lives, in reaching its conclusion. *Id.* at 1296.

217. FEDERAL TRADE COMM'N & U.S. DEP'T OF JUSTICE, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996).

substantial financial award/penalties based on group performance in meeting predetermined utilization targets. The Agencies further acknowledge that new types of risk sharing arrangements may develop and encourage networks to take advantage of the Agencies' expedited business review and advisory opinion procedures when evaluating new risk-sharing models. Further, Statement 8 contemplates that physician network joint ventures that do not involve substantial financial risk-sharing, and therefore do not fall within the antitrust safety zone, may nonetheless demonstrate that the venture will produce sufficient efficiencies to avoid antitrust concern.

Statement 9, first issued in September 1994, describes the general antitrust analysis for multiprovider networks. Statement 9 provides that multiprovider networks, comprised of competing providers, that engage in joint pricing will be evaluated under the rule of reason if they share substantial financial risk through capitation, risk withholds, percentage of premium or percentage of revenue payment methodologies, global pricing or substantial financial awards/penalties based on group performance and meeting utilization targets. As with physician networks, the Agencies acknowledge that significant efficiencies may be achieved in some multiprovider networks through agreements by competing providers to share substantial financial risk for services provided through the network.

Statement 9 also acknowledges that multiprovider networks that do not involve sharing of substantial financial risk may be sufficiently integrated to demonstrate sufficient desired efficiencies to avoid per se treatment under the antitrust laws. Finally, this statement contemplates that an agreement between competitors on service allocation or specialization which is "reasonably necessary" for the network to realize significant procompetitive benefits would be subject to the rule of reason analysis.

VIII. LABOR/EMPLOYMENT

A. Administrative Developments: OSHA Issues Workplace Violence Guidelines for Health Care Workers

On March 14, 1996, the Occupational Safety and Health Administration (OSHA) published guidelines for preventing workplace violence in health care and social service workplaces.²¹⁸ The guidelines were published in response to the increasing safety and health hazards presented by recurring violence in health care settings. OSHA has stated that there is an underreporting of violent activities reflecting a lack of institutional reporting policies, employee beliefs that reporting will not benefit them, and employee fears that employers believe assaults and other forms of violence are the result of employee negligence or poor job performance. In order to reduce the risk of workplace violence, OSHA recommends that all health care facilities review the guidelines in conjunction with existing policies.

218. OCCUPATIONAL SAFETY & HEALTH ADMIN., PREVENTING WORKPLACE VIOLENCE IN HEALTH CARE AND SOCIAL SERVICE WORKPLACES, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION GUIDELINES (1996).

In the guidelines, OSHA identifies several risk factors which mandate a review of workplace violence policies and response plans. According to OSHA, the risk of violence in the health care setting has increased due to several factors which include the increased prevalence of handguns and other weapons in hospitals, along with the increased targeting of hospitals, clinics, and pharmacies as sources of drugs. In addition to these concerns, OSHA has also cited the following as contributing factors to the rise in workplace violence: low staffing levels during times of specific increased activity; isolated work with clients during examination or treatment; solo work, often in remote locations; and lack of training of staff in recognizing and managing escalating hostile and abusive behavior.

The voluntary OSHA guidelines are published in order to assist all health care employers in determining what actions can be taken to reduce the risk of workplace violence. The guidelines include policy recommendations and practical suggestions to help prevent and mitigate the effect of workplace violence through the implementation of effective security devices and administrative work practices.

*B. Judicial Decisions: Physician Lease Agreements May
Constitute Employment Relationship*

Recently, a U.S. District Court for the Southern District of Indiana ruled that a physician's landlord/tenant arrangement may constitute an employer/employee relationship for purposes of determining liability under federal employment discrimination laws. In *Mukhtar v. Castleton Service Corp.*,²¹⁹ the court expanded federal employment discrimination laws when they held that a business relationship intended to be one of principal/independent contractor for landlord/tenant will constitute an employer/employee relationship for purposes of federal employment discrimination laws if enough of the indicia of an employment relationship exists.²²⁰ This case mandates a reexamination of all principal/independent contractor and landlord/tenant relationships to examine employment tax liabilities and to avoid coverage by federal and state employment laws.

In *Mukhtar*, the landlord, Castleton Service Corporation (CSC), owned and operated an immediate care facility ("Clinic").²²¹ Several physicians practiced at the Clinic, including the tenant, Dr. Mukhtar. Dr. Mukhtar leased the premises for his "non-exclusive use."²²² He agreed not to alter the Clinic and to use it only as an immediate care facility.

CSC provided and maintained the medical equipment and supplies at the Clinic and provided and paid for all utilities. CSC also staffed the Clinic with nurses and other technical and clerical staff. Although these individuals were

219. 920 F. Supp. 934 (S.D. Ind. 1996).

220. *Id.* at 938.

221. *Id.* at 936.

222. *Id.*

employees of CSC, they were also under the supervision of the tenants and other practicing physicians with regard to all professional duties. CSC indemnified Dr. Mukhtar for any payroll tax obligations for these individuals.

With regard to payment, the contract required CSC to provide all business and management services²²³ and CSC received as rent, a percentage of Dr. Mukhtar's gross annual charges to patients. The amount received by Dr. Mukhtar was treated as "non-employee compensation" for tax purposes and was reported on IRS Form 1099.²²⁴ The IRS audited this lease arrangement and did not object to CSC's failure to withhold employee taxes from these payments.²²⁵

Dr. Mukhtar worked at the Clinic as a licensed physician for several years. After CSC terminated the parties' contractual relationship, Dr. Mukhtar sued CSC for violation of the Age Discrimination and Employment Act (ADEA). CSC contended that it had a landlord/tenant relationship with Dr. Mukhtar rather than an employment relationship. CSC argued that the ADEA, which applies solely to discrimination of employment, did not apply to its relationship with Dr. Mukhtar. The district court disagreed with CSC finding that key elements of an employment relationship existed.

The district court acknowledged that, where a statute's definition of "employee" is not helpful, various factors developed by previous court decisions must be considered when classifying workers as employees.²²⁶ Because varying amounts of weight are placed on these factors, depending on the facts or circumstances of each case, the status of an individual cannot be decided simply because a majority of factors favor one classification over another. Although no one factor is outcome determinative, the district court indicated that all factors can be summarized into one general inquiry: Does the alleged "employer" control the individual performing these services?²²⁷

Given the fact-specific analysis adopted by the district court, "principals" and "landlords" may no longer assume that they are free to terminate contractual relationships of "independent contractor" or "lessee" physicians without the potential of employment discrimination liability. Principals and landlords must now ensure that they do not exercise control over when, where, and how the physicians do their work to such a degree that their arrangement will constitute an employer/employee relationship. If an employment relationship exists, then the termination must be viewed in light of the various State and Federal employment discrimination laws.

CONCLUSION

The Survey period has indeed been an interesting, and in some cases an unsettling one. Increased regulation and enforcement challenge providers seeking

223. *Id.* at 937.

224. *Id.*

225. *Id.*

226. *Id.* at 940.

227. *Id.* at 939.

to deliver services of higher quality with expectations of decreased reimbursement. Agencies such as the Department of Justice and Federal Trade Commission are being forced by judicial decisions to reconfigure previously held principles which benefits providers while the IRS has provided legislation to impose new sanctions against providers and individuals within the health care industry. It is an opportune time for members of the bar to step forward and assist their health care clients in a manner that allows the clients to concentrate on the delivery of a highly valued service which benefits the communities in which the care is provided.

