# HOOPER LUNDY & BOOKMAN, INC.

HEALTH LAW PERSPECTIVES

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## AB 1889 Preempted By NLRA

On September 16, a Federal District Court issued an Order granting in part plaintiffs' motion for summary judgment in *Chamber of Commerce of the United States et al. v. Lockyer, et al.*

The case involves the legal challenge of AB 1889 (Cedillo), a state law that prohibits the use of state funds to "assist, promote, or deter" union organizing. AB 1889 was sponsored by the unions and is intended to strip employers, including long-term care providers and acute care hospitals, of their protected rights under the National Labor Relations Act (NLRA).

AB 1889 required state agencies, including the Department of Health Services (DHS), to obtain a certification from private employers who accept state funds that the employer will comply with the provisions of AB 1889. In February, DHS began distributing certification forms to be signed and returned by participating long-term care providers. The certification packets instructed providers to sign and return the certification forms within 45-days or face termination from the Medi-Cal program. In response to this enforcement activity, a number of interested associations joined together to challenge AB 1889 in court.

The associational plaintiffs in this action are: the U.S. Chamber of Commerce (as the lead plaintiff), California Chamber of Commerce, California Manufacturers and Technology Association, Employers Group, California Association of Health Facilities, California Healthcare Association, and California Association of Homes and Services for the Aging. In addition to the associational-plaintiffs, there are seven skilled nursing facilities named in the law suit. The defendants include Attorney General Bill Lockyer, Diana Bonta (Director of DHS), and Frank Vanacore (Chief of DHS Audit, Review & Analysis Divison). The intervenor in this action is the AFL-CIO.

There have been a number of judicial prosecutions of long term care providers under the law which have been undertaken by California Attorney General Bill Lockyer and the unions. More have been threatened to other long term care providers and acute care hospitals.

The September 16 Order holds that AB 1889 is preempted by the NLRA as it applies to employers who are either: (1) recipients of state grant funds, (2) employers conducting business on state property, or, (3) employers who receive more than $10,000 in a calendar year due to participation in a state program. This last section covers the vast majority of skilled nursing facilities, intermediate care facilities, ICF-DDs and any other health care providers that participate

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in the Medi-Cal program. Interestingly, the court declined to address the remaining substantive arguments related to AB 1889's alleged violation of the U.S. and California Constitutions, or the claim that AB 1889 is preempted by the Medicaid Act.

The Order, however, denied plaintiffs' motion for summary judgment in part based on lack of standing as to the portions of the statute that apply to employers who: (1) are state contractors, (2) are performing work on a service contract, (3) receive $50,000 or more pursuant to a state contract, or (4) are a public employer.

Finally, the court did not grant either of the defendants' or the intervenor's cross-motions for summary judgment. The intervenor had only requested summary judgment as it applied to the sections of AB 1889 relating to public employers. As public employers are government entities and are not governed by the NLRA, preemption on this basis could not be granted.

Because the Order grants summary judgment for only part of the claims brought by the plaintiffs, this is not considered a final judgment that can be immediately appealed to the 9th Circuit Court of Appeal. However, this is a clear victory for long term care facilities and other health care providers that are covered by AB 1889, by virtue of their participation in the Medi-Cal program.

*HLB attorneys Mark Reagan and Mark Johnson represented the plaintiffs in this action. For additional information, please contact them at (415) 875-8500.*

## Statute of Limitations Tolled in Civil Rights Case

The U.S. Ninth Circuit Court of Appeals has ruled that the statute of limitations for a medical laboratory's federal suit against state officials was tolled while the lab pursued various actions in state court (*Azer;Doctor's Medical Laboratory v. Connell,* No. 01-55359).

The civil rights action was filed by Doctor's Medical Laboratory against State Controller Kathleen Connell and other state officials after Connell withheld $3 million in Medi-Cal payments from the lab as part of a Medi-Cal fraud investigation the controller's office was conducting at the time.

A Los Angeles federal district court dismissed the case on the grounds that it was barred by a one year statute of limitations. On appeal, the Ninth Circuit reversed the district court's decision and remanded the case for further proceedings.

"We are pleased with the headway we have been able to make with regard to civil rights actions," said HLB Attorney Patric Hooper, who represented the lab in this case. "This is the second favorable decision we have received recently from the Ninth Circuit in a Medicaid civil rights action involving a fraud investigation."

In addition, the firm has also recently filed a similar suit in Los Angeles District Court on behalf of a physician. As with the laboratory case, this case challenges the authority of an individual state employee to impose sanctions against a provider.

*For more information, please contact Mr. Hooper at (310) 551-8165.*

On November 21, 2002, Hooper, Lundy & Bookman will be conducting a half-day seminar entitled: "The Next Generation Of IPAs And Medical Groups: Is Capitation Too Risky?"

IPA insolvencies, increasing reserve requirements, and low capitation rates are causing a number of medical groups and IPAs to reconsider their heavy dependence on capitation. This seminar will explore the feasibility of converting some or all of an IPA's capitated business to fee-for-service, or developing new methods to reduce risk in a capitated environment. The issues to be addressed include:

- Market trends;
- How health plans will respond to efforts to contract on a reduced risk basis;
- How to restructure an IPA to negotiate fee-for-service payments;
- Recent FTC rulings and antitrust concerns;
- The role of IPA management companies; and
- Joint venture opportunities with general acute care hospitals.

The speakers will include members of the firm, as well as Steve Valentine, a principal of The Camden Group, and Noah Rosenberg, a principal with Rosenberg and Kaplan.

The seminar should be of interest to medical groups, IPAs and general acute care hospitals. The seminar is scheduled from 8:30 a.m. to 12:00 p.m. at the Century Plaza Hotel, in Los Angeles. If you are interested in attending, please contact Susan Nakashima at (310) 551-8118.

# Employers Should Review Health Plans' Status as HIPAA 'Covered Entities'

By Elspeth K. Delaney, Esq.

By now everyone knows that HIPAA applies to how to treat patient information, but did you know it may apply to your employees' health information too? This means that if your group health plan meets the definition of a "covered entity," you need to consider how the health plan is going to comply with the transaction, security and privacy requirements of HIPAA (discussed below).

HIPAA applies to "covered entities," which are health care providers, plans and clearinghouses. Although most of us do not think of employee health benefit plans as a "health plan," under HIPAA they are just that. An employer-sponsored group health plan, whether insured or self-insured, is likely a "covered entity" if it has 50 or more participants or is administered by an entity other than the employer.

**Transaction Codes**

Under HIPAA, a covered entity must transact billing, claims, enrollment, disenrollment and certain other administrative and financial transactions using specified code sets. The deadline for compliance was October 15, 2002 for most covered entities and October 15, 2003 for "small health plans." However, covered entities (other than small health plans) may apply for a one-year extension by completing a simple extension form, which can be found at http://www.cms.hhs.gov/hipaa/hipaa2/ascaform.asp.

To determine whether your employer-sponsored group health plan is a "small health plan," you will need to calculate the plan's annual receipts. A "small health plan" is a plan with annual receipts of $5 million or less. The Centers for Medicare and Medicaid Services (CMS) has provided guidance on how to calculate "receipts." CMS states that for health plans that report receipts to the IRS, "receipts" means "total income" (or in the case of a sole proprietorship, "gross income") plus "cost of goods sold," as these terms are defined on the IRS' federal tax return forms. Therefore, if you file tax returns, you should consult with your accountant to determine whether your group health plan is a "small health plan."

For employee health plans that do not file tax returns (such as ERISA group plans that are exempt from filing), CMS states that you should "use proxy measures to determine annual receipts." Fully insured health plans should use the amount of total premiums that they paid for health insurance benefits during the plan's last full fiscal year. Self-insured plans, both funded and unfunded, should use the total amount paid for health care claims by the employer, plan sponsor or benefit fund, as applicable, on behalf of the plan during the plan's last full fiscal year. Each health plan (medical, dental, vision, etc.) should be calculated separately.

If you are a small health plan, you do not need to file an extension; if you are not a small health plan, you should have filed an extension or begun transacting billing and other covered transactions using the specified code sets by October 15, 2002.

**Security & Privacy**

The security regulations under HIPAA have not yet been finalized, but are expected by the end of this year. Once they are finalized, covered entities will have approximately 12 months to come into compliance. Still, it is a good idea when implementing the privacy requirements, to also implement security measures, which can later be updated when the final regulations are issued.

Most of the requirements under the Privacy Regulations that are applicable to health care providers, are also applicable to covered health plans, including requirements: (1) to provide written notice of its privacy practices; (2) to obtain authorizations to use and disclose protected health information other than for treatment, payment or healthcare operations; (3) to disclosure the minimum information necessary to accomplish the intended purpose of the disclosure; (4) to afford covered individuals with certain rights regarding their health information (such as amendment and accountings); and (5) to meet certain administrative requirements, such as, the appointment of a privacy official and implementing appropriate policies and procedures.

Many of the privacy regulation requirements are reduced if a group health plan provides health benefits solely through an insurance contract with a

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health insurance issuer or HMO, and does not create or receive protected health information other than summary health information or information on whether an individual is participating in the group health plan, is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan. "Summary information" is information that may be individually identifiable health information, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and which has been "de-identified" except for the employee's five digit zip code. If possible, an employer may wish to examine whether it can change its operations to fit into this definition, in order to reduce the administrative burdens associated with the privacy regulation requirements. For example, group health plans that meet this definition do not need to provide employees with a notice of privacy practices.

An employer should also note that the privacy regulations apply only to protected health information and not all records an employer holds. For example, "employment records" regarding worker's compensation or on the job injuries may not be covered.

*For questions, please contact us: in Los Angeles, Elspeth Delaney and Daron Tooch at (310) 551-8111; in San Francisco, Pam Riley at (415) 875-8507 .*

# CALENDAR

**November 8** HLB Attorney Patric Hooper participates in the Legal Updates panel at the California Clinical Laboratory Association Annual Conference, Westgate Hotel, San Diego.



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