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Health Care Update

National News

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Accountable Care Organizations– An Increasingly Likely Model

The healthcare reform debate has focused heavily on establishing Accountable Care Organizations (ACOs). ACOs are designed to be provider-based organizations focused on improving quality while reducing (or slowing) spending. If such quality and cost benchmarks are met, the ACO receives shared savings from payers. This type of approach has been implemented in programs such as the Medicare Physician Group Practice Demonstration. The ACO approach incorporates steps such as wellness programs, coordination of care, disease management, and other programs that focus on outcomes. The key features are local accountability, shared savings, and performance measurement. An ACO can encompass a wide variety of potential provider collaborations; however the unifying theme is accountability for overall care and efficiency. Current examples are integrated delivery systems, physician-hospital organizations, or physician networks. However, pending final healthcare reform legislation, certain design elements will be important to consider. For example, the form, scope and governance of the entity will need to be well defined. Similarly, investment in infrastructure, technology and data will be critical to capture and report on quality and efficiency measures. ACOs are receiving significant attention in the healthcare reform debate and are a likely model to be adopted.

Northern District of Illinois Denies Class Certification in Reed v. Advocate et al. (N.D. Ill. Sept. 28, 2009)

Background and Issues: On June 20, 2006, class-action lawsuits were filed on behalf of nurses in four cities – Memphis, San Antonio, Albany and Chicago. The complaints filed were nearly identical in substance and alleged that hospitals and hospital systems in each of the jurisdictions conspired to suppress nurse wages in violation of Section 1 of the Sherman Act. Another virtually identical case was filed in Detroit a few months later. The defendants in this, the Chicago, case are Advocate Healthcare, Resurrection Healthcare, University of Chicago Hospital and NorthShore University HealthSystem. The complaint has two counts. Count one alleges an agreement to suppress nurse wages. Count two alleges an agreement to exchange nurse wage information and that the effect of that exchange is to suppress nurse wages. The estimated size of the proposed class is 19,000. After extensive discovery, plaintiffs moved to certify the alleged class. The defendants opposed class certification principally on the grounds that injury in fact (antitrust impact) and damages could not be shown on a classwide basis with common proof, and therefore the requirements of Rule 23(b)(3) of the Federal Rules of Civil Procedure cannot be satisfied.

Key Facts: To sustain their burden under Rule 23(b)(3), plaintiffs principally relied on the declarations of their expert, Professor Gordon Rausser. To show that class members would have suffered wage suppression as a result of the alleged conspiracy, Prof. Rausser performed what he referred to as his “wedge” analysis, an empirical analysis designed to show the amount of the average wage suppression suffered by all nurses in the putative class. Through his model, Prof. Rausser estimated that the average wage suppression for nurses in the putative class was approximately 11.3%. Prof. Rausser also performed a multiple regression analysis to confirm that the common impact experienced through the alleged wage suppression would not be overshadowed by individual wage variation among the nurses.

Defendants’ expert, Prof. Robert Willig, criticized many of Prof. Rausser’s opinions. Prof. Willig said that the wedge analysis had serious methodological errors, and when those errors were corrected, the alleged wedge and the wage suppression disappeared. More fundamentally, the wedge only attempts to measure average wage suppression. According to Prof. Willig, even if one assumes that the average wage was reduced by the alleged conspiracy, that does not mean that all members of the proposed class suffered a reduced wage or that any reduction for an individual nurse could be calculated in a formulaic way by common proof. Prof. Willig also criticized Prof. Rausser’s regressions as being too imprecise and unreliable, leaving a wide range of explained variations in nurse wages.

Resolution: Judge Grady agreed with the defendants and denied plaintiffs motion for class certification. According to Judge Grady, plaintiffs did not meet their burden of demonstrating that antitrust impact or the amount of damages could be shown on a classwide basis with common proof. Prof. Rausser’s reliance upon average wages resulted in a fundamental flaw in his approach. Measuring an average base wage suppression does not indicate whether each putative class member suffered harm from the alleged conspiracy. Thus, it is not a methodology that can determine impact with respect to each class member. Judge Grady also agreed that Prof. Rausser’s regression models were too imprecise to avoid the need for individualized hearings on impact and damages.

Significance: Judge Grady expressly rejected the plaintiffs’ argument that at the class certification stage, plaintiffs are not obligated to demonstrate that Prof. Rausser’s analysis works; they merely are required to show that the model is workable. Judge Grady noted that the essence of plaintiffs’ argument is that the court should not subject the expert’s models to rigorous analysis, which is contrary to law. In so doing, Judge Grady’s decision follows a growing body of law that requires plaintiffs attempting to achieve class certification to do more than hire a competent expert who proposes to use accepted econometric models, such as regression analyses. As Judge Grady noted, “The critical issue is not whether Dr. Rausser’s techniques are generally accepted; it is whether they are appropriate when applied to the facts and data in *this* case.”

IRS Issues Governance Check Sheet for Public Charities Governance Practices

On December 9, 2009, the Internal Revenue Service (IRS) posted on its website (www.irs.gov) a "Governance Check Sheet" and a related "Governance Project Guide Sheet for Completing the Project Check Sheet." The posting states that the Check Sheet will be used by IRS' Exempt Organizations Examination agents to capture data about governance practices and the related internal controls of organizations being examined. These Check Sheets will apply to examinations of public charities after September 2009. The data generated from these Check Sheets will be included in a long-term study to gain a better understanding of the intersection between the governance practices and tax compliance of tax-exempt organizations. IRS asserts that good governance is important to increase the likelihood that tax exempt organizations will comply with the tax law, protect their charitable assets and thereby best serve their charitable beneficiaries.

The Governance Check Sheet lists information that the examining agent will seek from tax exempt organizations in the following areas: (1) governing body and management, (2) compensation, (3) organizational control, (4) conflict of interest, (5) financial oversight, and (6) document retention. The questions in the Check Sheet go far beyond those in IRS Form 990 and will require the IRS Examination agents to probe deeply into the practices and procedures of the organizations being examined. Public charities would be well advised to modify their practices and procedures as necessary to conform to the standards implied in the Check Sheet, because those charities with many "wrong" answers are more likely to be subject to intensive audit.

Genetic Information Nondiscrimination Act

The employment provisions in Title II of the Genetic Information Nondiscrimination Act (GINA), became effective November 21, 2009. Final regulations are expected to issue in the near future. Seyfarth Shaw submitted comments to the proposed regulations, which are available at: *http://www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480970cf1*.

GINA regulates the acquisition, treatment and disclosure of genetic information, and prohibits employment discrimination based on genetic information. Preliminarily, GINA broadly defines "genetic information" to include information about the genetic testing of, as well as the manifestation of a disease or disorder in, an individual and his or her family members (including dependents, or first, second, third or fourth-degree relative). GINA may be distinguished from the Americans With Disabilities Act, as amended, as GINA regulates conditions that have not yet manifested (i.e., asymptomatic conditions).

GINA prohibits employers from collecting genetic information. However, there are a few important exceptions to this rule. For example, GINA includes a "water-cooler" exception protecting employers where genetic information is inadvertently acquired. This exception would apply where a supervisor unintentionally overhears a conversation between employees where genetic information is disclosed. GINA also permits genetic information to be collected in various other circumstances, such as where: an employer offers genetic services through a voluntary wellness program; genetic information is disclosed in the course of complying with the Family Medical Leave Act or similar state laws; and where an employer purchases commercially available documents containing genetic information. GINA also requires employers to treat genetic information as confidential. Genetic information may not be maintained in personnel files and only may be disclosed under limited circumstances, such as in response to a court order.

In addition, GINA forbids employers from considering genetic information in making employment decisions. For example, GINA prevents an employer from refusing to hire an applicant based on its belief that she is likely to develop breast cancer because it knows her mother had that condition. The procedures and remedies of Title VII of the Civil Rights Act of 1964 apply to

claims under GINA, although GINA does not presently provide a cause of action for disparate impact claims. Notably, many states already have enacted statutes that are similar to GINA, and GINA does not preempt those statutes.

Employers must promptly get into compliance with GINA. In the immediate future, employers should: (i) post the updated "Equal Employment Opportunity It's the Law" poster referencing GINA's prohibitions; (ii) update anti-discrimination policies; (iii) segregate genetic information from personnel files; and (iv) omit genetic information (again, this includes family medical history) from post-offer, pre-employment healthy history and other employment-related examinations.

Hospital Social Networking

Hospitals and healthcare systems are now fully engaged in the social networking phenomenon. Despite many healthcare systems' historically risk averse cultural orientations, and their tendency to rely on the most authoritative sources for information, hospitals increasingly are breaking out of this mold with their use of social media. Many now depend on social networking sources, such as LinkedIn Groups, Facebook, and Twitter, to attract and assess candidates for employment, to enhance their brand, and to build employee and patient loyalty. This is perhaps no surprise, considering the studies that show that all age groups (including 60% of people age 55 and over, and a still higher percentage of all other age groups over 15) are comfortable with, and are regularly using, social media. The fastest growing segment of social network users are women between 35 and 64—a demographic that describes a significant percentage of healthcare decisionmakers.

Responding to this reality, hospitals and healthcare systems now regularly tout their success stories on YouTube; they use social networks to increase donations, education, and evangelism and to empower their employees, stakeholders, and advocates; and they sponsor groups that enable patients to easily spread the word about their experiences at the hospital. This year, several hundred healthcare systems used YouTube, Twitter, Facebook or blogging to interactively deliver messaging. Some established vibrant online communities where employees and patients regularly congregate and exchange ideas. Many captured newsworthy moments, provided health tips, or responded to requests for health information, by "tweeting" on Twitter. Hiring employers used LinkedIn Healthcare Groups to identify applicants and place targeted job advertisements. The most successful of these social network users identified the value of a strong partnership between their marketing and staffing functions, and plenty of hospitals quickly learned that their YouTube accounts and Facebook Groups were vastly more successful at branding important initiatives, and attracting traffic, than were their traditional websites. By developing tools that enable immediate interactions with patients and employees, several healthcare systems were uniquely poised to effectively respond, in real time, to what others were posting about them on the web.

Before leaping into the fray, however, healthcare systems and hospitals are well-advised to develop a comprehensive strategy, and sound policies, to govern how social media should be appropriately used. After all, the risks associated with social networks are varied and can include such claims as discrimination and harassment, privacy and stored communications violations, negligence, defamation, intellectual property infringement, off-the-clock work by non-exempt employees, and violations of HIPAA or the National Labor Relations Act. As just one example, a hospital in the Southwest fired two employees who posted pictures of patients' injuries on MySpace. The parties disputed whether the infraction identified the patients in a way that would constitute a HIPAA violation, but the hospital relied on a violation of its policy on cellphone use to support the termination and defend against invasion of privacy claims.

While three quarters of managers believe that social networking sites may put their brand or reputation at risk, less than twenty percent of employers have specific risk mitigation policies in place. For some organizations, operational considerations and management's unwillingness to buy-in to social networking strategies may place hurdles in the path. But even in organizations where social networking tools are embraced, an entity's ability to carefully control content and

effectively manage distribution will dictate success. Hospitals should work with legal counsel to create and distribute policies that specifically address how social networking works within the hospital's communications and other programs. These policies also should cover all aspects of the employment relationship: pre-employment considerations (such as anti-discrimination, because employers may gain access to information through social networks that would not otherwise be available from more traditional hiring tools); disciplinary issues during employment (such as prohibiting the posting of patient information, and mandating anti-harassment and respectful language); and post-employment considerations (such as whether to prohibit "recommendations" on LinkedIn, for example, to avoid inconsistent messaging regarding an employee terminated for performance reasons). Of course, all employers must define clear goals for their social media programs (including who they want to reach, why, and how they will measure success), and must incorporate specific training and monitoring programs to ensure their social networking policies are understood and enforced.

Form 990 and Management Agreements

As tax exempt health institutions begin reporting in accordance with the recently revised IRS Form 990, it is important to note a new requirement related to disclosure of management/ service contracts with private entities. Specifically, if an exempt organization has received tax-exempt financing, there are strict requirements related to arrangements with persons or entities providing management services and utilizing assets financed with tax-exempt funds. Under the new Form 990, exempt organizations with outstanding tax-exempt bonds must annually report the percentage of such "private use" of bond-financed property, and whether agreements with private parties related to such property comply with the applicable safe harbor.

IRS Revenue Procedure 97-13 provides a safe harbor for permitted service contracts. Compensation must be reasonable and may not be based in whole or in part on net profits attributable to the operation of the bond-financed assets. The structure of the fee to be paid to the service provider must also be specified in advance and based on such structure, the agreement is limited to the potential term and termination notices. Eligible service contracts, which may involve management, service or incentive payments, result in "private use" of bond-financed property to the extent that compensation for services rendered is based on a share of net profits from the facility's operation and/or the private services rendered involve a portion or any function of a facility financed with exempt funds. Although employment agreements are explicitly excluded from the definition of a service contract, potential agreements include contracts for professional services, medical directors, teaching, food service, on-call coverage and facility or department management.

In most cases, an exempt organization may be able to amend a non-compliant agreement in order to satisfy the safe harbor. In the alternative, there is a 5% private use or "bad money" allowance related to the financed property, to the extent the exempt organization has not already used some portion of that allowance. The exempt organization may also reallocate bond proceeds to alternative uses, or allocate taxable debt or the organization's own funds, to finance the otherwise non-qualified assets or use. Finally, in the absence of other alternatives, it may be necessary to take other remedial action to preserve the tax-exempt status of the bonds, and such action may include redeeming or defeasing a portion of the bonds which is allocable to the property used in connection with a non-compliant agreement.

Exempt organizations must assess their method for determining what property has been financed with tax-exempt bonds and carefully review and confirm that "service contracts" comply with the applicable safe harbors. The organization must also take steps to properly report such compliance on Form 990.

The Health Care Team continues to monitor the various health care reform debates and pending legislation. We will provide further information once something is passed.

Health Care Team Contact List

Transactional/Regulatory/Non-Profit:

Name	Phone	Email
Mark W. Coffin	(713) 225-1337	mcoffin@seyfarth.com
Michel J. Feldman	(312) 460-5613	mfeldman@seyfarth.com
Neal T. Goldstein	(312) 460-5536	ngoldstein@seyfarth.com
Deborah C. Gordon	(312) 460-5620	dgordon@seyfarth.com
Janessa Griffin	(312) 460-5926	jgriffin@seyfarth.com
Alvin L. Kruse	(312) 460-5824	akruse@seyfarth.com
Nathaniel Sack	(312) 460-5645	nsack@seyfarth.com
Thomas B. Shapira	(312) 460-5538	tshapira@seyfarth.com

Labor & Employment:

Name	Phone	Email
James Baird	(312) 460-5806	jbaird@seyfarth.com
Edward W. Bergmann	(312) 460-5807	ebergmann@seyfarth.com
Joseph Damato	(202) 828-5354	jdamato@seyfarth.com
Joan E. Gale	(312) 460-5862	jgale@seyfarth.com
Timothy F. Haley	(312) 460-5506	thaley@seyfarth.com
Gary S. Kaplan	(312) 460-5871	gkaplan@seyfarth.com
Mark A. Lies II	(312) 460-5877	mlies@seyfarth.com
Kristin McGurn	(617) 946-4858	kmcgurn@seyfarth.com
Ellen E. McLaughlin	(312) 460-5887	emclaughlin@seyfarth.com
Gerald L. Pauling II	(312) 460-5561	gpauling@seyfarth.com
Keith A. Reed	(312) 460-5838	kreed@seyfarth.com
Scott Schaefers	(312) 460-5647	sschaefers@seyfarth.com
William P. Schurgin	(312) 460-5899	wschurgin@seyfarth.com
Brian M. Stolzenbach	(312) 460-5551	bstolzenbach@seyfarth.com

Litigation:

Name	Phone	Email
Paul E. Freehling	(312) 460-5618	pfreehling@seyfarth.com
Christopher A. Garcia	(312) 460-5950	cgarcia@seyfarth.com
Molly Joyce	(312) 460-5628	mjoyce@seyfarth.com
Bart A. Lazar	(312) 460-5986	blazar@seyfarth.com
Ronald L. Lipinski	(312) 460-5879	rlipinski@seyfarth.com

Benefits:

Name	Phone	Email
Eugene Jacobs	(312) 460-5818	ejacobs@seyfarth.com
Mary K. Samsa	(312) 460-5873	msamsa@seyfarth.com

Recent Speeches and Publications

"Board of Director and Compliance Responsibilities" presented by **Thomas Shapira** and **Deborah Gordon** to the University HealthSystem Consortium, October 2009

"On Syndicated Loans and Their Potential New Importance in Healthcare" written by **Deborah Gordon** for American Health Lawyers Association, Business Law and Practice Governance Group

"The Brave New World of 403(b) Plans: Issue Spotting for the Future" breakfast briefing by **Mary Samsa** with Mesirow Financial

"Healthcare Employers Targeted in Wage and Hour Class Actions" webinar moderated by **Joan Gale** and **Deborah Gordon**

"Family Medical Leave Act and Related Laws" presentation by **Joan Gale** to Metropolitan Chicago HealthCare Council

"Employee Free Choice Act and Healthcare" presentation by **Kristin McGurn**, with the Massachusetts Hospital Association and Denterlein Worldwide

"Health Care Industry Corporate Campaigns," presentation by **William Schurgin**, at the US Chamber of Commence Conference in Washington, D.C.

"Medicare II: Stark Law," course taught by **Neal Goldstein**, Curriculum Committee, Loyola University of Chicago School of Law, Beazley Institute for Health Law and Policy

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