

## Implications of Recent Union Shake-up On Health Care Employers

The recent news that the Teamsters, the Service Employees International Union (SEIU), and perhaps additional members of the recently named "Change to Win Coalition" are withdrawing from the AFL-CIO may have significant implications — especially in the near-term — on hospitals, pharmaceutical companies, and others serving the ill, injured or infirm. Implications could include intensified organizational efforts by the withdrawing unions and, perhaps, competition — between one or more unions remaining in the AFL-CIO and one or more of the withdrawing unions — for the right to represent workers in those industries.

The reason for the split in organized labor may be explained partly by the egos and desires for power of AFL-CIO President John Sweeney and his allies and those of SEIU President Andy Stern. More important, perhaps, Mr. Sweeney and those in his camp seemingly believe that the key to expanding labor's influence is to devote more of its dues income to lobbying and supporting liberal political candidates, whereas Mr. Stern and his camp apparently think those dollars are better spent in union organizing campaigns. For the present at least, the two camps are evidently incompatible.

Some observers believe the split will weaken organized labor and that employers will benefit as a result. While this may be true, employers in the health care industry should be cautious not to assume that a weakened organized labor result is inevitable. In the near future, employers such as hospitals, pharmaceutical companies and long-term care providers may instead face an even more intense organizing effort directed towards their employees by the SEIU, the Teamsters, and others than has previously occurred. By the same token, unions remaining in the AFL-CIO may be expected to create worker distractions as those unions aggressively endeavor to sign up new members as well as to unseat incumbent dissidents. *(continued on p.2)*

### UNION COMPETITION FOR NURSES

In 2004, representatives from the California Nurses Association (CNA) traveled to Chicago to meet with nurses at Cook County Hospital as well as other institutions that negotiate with the Illinois Nurses Association (INA). The INA, an affiliate of the American Nurses Association and the AFL-CIO, had represented the nurses at Cook County Hospital for approximately forty years. Many nurses expressed dissatisfaction with the last contract negotiated by INA, which expired in November 2004.

After a three-day vote, it was announced on May 13, 2005 that the registered nurses had voted 955 to 487 to replace the INA with the CNA. This resulted in approximately 1,800 nurses joining the National Nurses Organizing Committee (NNOC), the CNA's national organizing arm.

Although the CNA may not be the nation's largest union, it has been aggressively pursuing nurses in other states. The CNA is often competing against the Service Employees International Union, which has 80,000 registered nurses among its 900,000 health care members, and the United American Nurses, a union affiliated with the American Nurses Association and the AFL-CIO, which represents 104,000 registered nurses.

Thus far, nurses in 40 states have signed on to join the NNOC. According to the NNOC, the reason is that most of these nurses want a union that only represents nurses and speaks directly to issues such as patient advocacy, workplace safety and improving the health care system. The NNOC has been successful at attracting nurses due to its promotion of the recently enacted legislation in California limiting the number of hospital patients per nurse. As the NNOC expands its representation into other states, other jurisdictions should expect increased lobbying efforts for similar legislation and initiatives. Such active competition among unions for nurse representation could, however, dilute each union's overall nurse representation and therefore weaken each union's ability to effectuate their respective agendas.

### IN THIS ISSUE

Implications of Recent Union Shake-up on Health Care Employers	cover
Union Competition for Nurses	sidebar
Pay-For-Performance Programs Growing	p.2
OIG Proposes Safe Harbor	p.3
Drug Manufacturers Allowed to Subtract Medicaid Rebates ...	p.3
OIG Publishes Supplemental Compliance Program Guidelines ...	p.4

The dissident unions will be seeking to expand their membership exponentially in the near term in order to prove that their split with the AFL-CIO was justified. Unfortunately, the primary way in which unions seek to attract new members is to propagandize workers with assertions that their pay, benefits and/or working conditions are woefully inadequate. As a result, health care employers can expect to hear concern regarding their supposed unfair treatment of their workers.

For non-unionized health care employers, the key to avoiding deteriorating labor relations at this critical juncture will continue to be: (a) providing workers with compensation and benefits so that they feel they do not need a collective bargaining representative, and (b) implementing good employee relationship strategies. Unionized health care employers may want to avoid becoming involved in contests among unions warring with each other for workers' support.

### **Pay-For-Performance Programs Growing**

The Medicare Payment Advisory Commission (Commission) recently issued a report to Congress recommending that Medicare begin paying physicians and other providers based on their performance. In its report, the Commission recommended that as much as 2% of all Medicare payments should be placed in a pool to reward the best performers, a scenario that would reduce reimbursements for those that do not perform well. Currently doctors are scheduled to receive a pay cut averaging about 5% a year for the next 7 years beginning in 2006.

There appears to be strong interest among lawmakers in both parties to incorporate pay-for-performance (P4P) programs into Medicare. A Senate Bill (S.1356) would create P4P programs under Medicare for providers including doctors. Under this bill, providers would be paid an additional 1% to 2% for meeting quality standards or improving the care they offer. Yet, even if Congress does not adopt P4P legislation, the Centers for Medicare and Medicaid Systems (CMS) has indicated that P4P initiatives will nevertheless be adopted administratively through CMS demonstration projects.

In February, for example, CMS announced a national demonstration project involving 10 large medical groups whose combined total of more than 5,000 doctors treat approximately 200,000 Medicare recipients. This demonstration project, which began on April 1, 2005, provides bonuses of up to 5% of an annual performance target, in addition to fee-for-service reimbursements, based on 32 quality indicators such as blood pressure management, beta-blocker therapy and colorectal cancer screenings. Performance targets for physician groups, which will be calculated annually, will be based on the amount of Medicare savings and how well the groups perform on the quality measures.

CMS also launched a Hospital Quality Initiative, linking payment to 10 quality measures. About 94% of all hospitals eligible for the program are now participating. Similarly, in the Premier Hospital Quality Incentive Demonstration, CMS is collecting data on 34 quality measures related to five clinical conditions at about 300 hospitals, rewarding a 2% bonus to top performers.

These programs and demonstration projects are just the latest in a string of similar programs developed in recent years by CMS which, along with private insurance companies and employers, believes that such financial incentives will eventually save the government and private payors billions of dollars and dramatically reduce unnecessary hospitalizations.

Currently, it is estimated that anywhere from 84 to 105 P4P initiatives are in existence throughout the country, covering about 104 plans and more than 39 million patients. These P4P initiatives are dramatically changing health plan designs, participating provider agreements, and executive and physician compensation plans. They also raise a number of legal issues in terms of how quality indicators are measured and P4P plans are implemented.

## OIG Proposes Safe Harbor

Public health centers were created to provide community-based health care services in underserved areas and to special, medically underserved populations such as migrant workers, the homeless and public housing residents. These health centers are funded with federal Public Health Services (PHS) grants. These health centers are often sought out or offered opportunities to enter into arrangements with hospitals or health care providers and suppliers to enhance or improve patient care consistent with the PHS mission. Providers and suppliers were concerned that such arrangements may be suspect under the Medicare anti-kickback statute, because public health centers are often in a position to refer patients covered by federal health programs, such as Medicaid.

In the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Congress mandated that the Office of the Inspector General (OIG), develop a safe harbor for public health centers. Specifically, the MMA required the OIG to promulgate a Medicare anti-kickback statute safe harbor to exclude remuneration between public health centers and health care suppliers, so long as the remuneration contributes to the public health center's ability to maintain or increase the availability or enhance the quality of services provided to the medically underserved population by the health center.

On July 1, 2005, the OIG published proposed standards for an anti-kickback safe harbor that would protect certain financial arrangements between public health centers and other health care providers and suppliers.

The proposed safe harbor requires that any arrangement: (i) provide the benefit directly to the public health center and not to the individual or entity providing the remuneration; (ii) should not limit patients' freedom to choose services from any provider or supplier; and (iii) should not improperly steer clinical decisions based on financial interests. Whether or not the proposed safe harbor will be enacted as currently worded remains unclear.

## Drug Manufacturers Allowed to Subtract Medicaid Rebates From Gross Receipts Under New IRS Ruling

The Internal Revenue Service recently issued Revenue Ruling 2005-28, 2005-19 IRB, which holds that Medicaid rebates paid by drug manufacturers to state agencies should be considered purchase price adjustments that are subtracted from gross receipts in determining gross income, rather than ordinary and necessary business expenses deductible from gross income.

The Omnibus Budget Reconciliation Act of 1990 (Act) established a Medicaid rebate program designed to reduce the costs of drugs paid for by Medicaid. Under the Act, drug manufacturers desiring to gain access to the Medicaid funded segment of the drug market must sign a rebate agreement with the U.S. Department of Health and Human Services (the Rebate Agreement). The Rebate Agreement requires the manufacturer to rebate, directly to each state Medicaid agency, a portion of the price paid by the agency to retailers for covered outpatient drugs provided to Medicaid beneficiaries. Typically, a drug manufacturer will sell a prescription drug to a wholesaler that, in turn, sells it to a retail pharmacy. The pharmacy will then dispense the medication to a Medicaid beneficiary and file a reimbursement claim with the state Medicaid agency. If the agency approves the claim, it will reimburse the pharmacy for the prescription drug provided to the Medicaid beneficiary and the manufacturer will pay a rebate to the agency pursuant to the Rebate Agreement.

A manufacturer's gross income is its total sales, minus the cost of goods sold, plus any income from investments and from incidental and outside sources or operations. A manufacturer can generally deduct ordinary and necessary business expenses from its gross income. However, Internal Revenue Code §162(c)(3) denies any deduction for any rebate made by a provider of services, supplier, physician or other person who furnishes items or services for which payment is, or may be, made under the Social Security Act, or paid out of federal funds, in whole or in part, under a state plan approved under such Act, if the rebate is made in connection with the furnishing of such items or services or the making or receipt of such payments. As a result of this deduction denial, a drug manufacturer would receive no tax benefit from paying rebates under the Rebate Agreement unless such rebates were treated as purchase price adjustments that would reduce gross receipts.

**ATLANTA**

One Peachtree Pointe  
1545 Peachtree Street, N.E., Suite 700  
Atlanta, Georgia 30309-2401  
404-885-1500  
404-892-7056 fax

**BOSTON**

Two Seaport Lane, Suite 300  
Boston, Massachusetts 02210-2028  
617-946-4800  
617-946-4801 fax

**CHICAGO**

55 East Monroe Street, Suite 4200  
Chicago, Illinois 60603-5803  
312-346-8000  
312-269-8869 fax

**HOUSTON**

700 Louisiana Street, Suite 3700  
Houston, Texas 77002-2797  
713-225-2300  
713-225-2340 fax

**LOS ANGELES**

One Century Plaza  
2029 Century Park East, Suite 3300  
Los Angeles, California 90067-3063  
310-277-7200  
310-201-5219 fax

**NEW YORK**

1270 Avenue of the Americas, Suite 2500  
New York, New York 10020-1801  
212-218-5500  
212-218-5526 fax

**SACRAMENTO**

400 Capitol Mall, Suite 2350  
Sacramento, California 95814-4428  
916-448-0159  
916-558-4839 fax

**SAN FRANCISCO**

560 Mission Street, Suite 3100  
San Francisco, California 94105  
415-397-2823  
415-397-8549 fax

**WASHINGTON, D.C.**

815 Connecticut Avenue, N.W., Suite 500  
Washington, D.C. 20006-4004  
202-463-2400  
202-828-5393 fax

**BRUSSELS**

Boulevard du Souverain 280  
1160 Brussels, Belgium  
(32)(2) 647 60 25  
(32)(2) 640 70 71 fax

Revenue Ruling 2005-28 concludes that Medicaid rebates are made with the purpose of reaching an agreed upon net selling price for the drugs and is negotiated and agreed to before the sale by the manufacturer occurs. In determining the income from the sale of the drugs, the amount realized is based on the actual price for which the drugs are sold, and not a greater price for which the drugs could have been sold. Accordingly, under the Ruling, Medicaid rebates paid by drug manufacturers should be treated as purchase price adjustments that are subtracted from gross receipts when determining the manufacturer's gross income. This Revenue Ruling could significantly affect how many drug companies state and report their earnings.

**OIG Publishes Supplemental Compliance Program Guidance for Hospitals**

On January 27, 2005, the Office of Inspector General (OIG) of the Department of Health and Human Services issued an updated, supplemental voluntary compliance program guidance for hospitals. The original compliance program guidance was issued in 1998. The purpose of the original compliance program guidance was to assist hospitals in complying with the rules and regulations for participation in Medicare, Medicaid and other Federal health care programs. Specifically, the original guidance focused on how hospitals could design effective voluntary compliance programs.

The OIG developed the supplemental compliance program guidance after soliciting public comment. The OIG received a large number of comments with respect to fraud and abuse risk areas. Accordingly, the supplemental compliance program guidance focuses on measuring and improving the effectiveness of existing compliance efforts and identifies additional fraud and abuse risk areas for hospitals.

The specific risk areas discussed in the supplement include: (i) billing under the outpatient prospective payment system; (ii) the physician self-referral law; (iii) the Federal anti-kickback statute; (iv) relationships between hospitals and physicians; (v) relationships between hospitals and other providers; (vi) joint ventures; (vii) practitioner recruitment; and (viii) the furnishing of substandard care.

The guidance also identifies practical measures hospitals can use to gauge the effectiveness of their compliance programs. The OIG has urged each hospital to review its existing compliance plans and adopt changes to such plans and methods of enforcement in light of this supplemental guidance.

---

This newsletter is a periodical publication of Seyfarth Shaw LLP and should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and you are urged to consult a lawyer concerning your own situation and any specific legal questions you may have.

For further information about any of the issues in this newsletter, please contact Deborah Gordon, Chair of the Health Care Practice Group, at [dgordon@seyfarth.com](mailto:dgordon@seyfarth.com).