HEALTHCARE**LEGAL**NEWS

July 12, 2012 • Volume 2, Number 6

IN THIS ISSUE

Supreme Court To Hear FTC Challenge To Georgia Hospital Merger

Healthcare Information Technology News
Impact Of The Supreme Court's Decision On Healthcare Information Technology

Tax News
Internal Revenue Service Issues Proposed Regulations For Tax-Exempt Hospitals

Healthcare Intellectual Property News
Naming Your Business Or Product: What You Don't Know Can Get You Sued

DW HEALTHCARE TEAM - NEWS & SUCCESS STORIES

Ralph Levy, Jr. wrote *Beware the Bundle: Medicare Announces Pilot Program for Bundled Payments to Providers*, which appeared in Journal of Health Care Compliance, May - June 2012.

SUPREME COURT TO HEAR FTC CHALLENGE TO GEORGIA HOSPITAL MERGER

By: James M. Burns, a member in Dickinson Wright's Washington D.C. office, who can be reached at 202.659.6945 or JMBurns@dickinsonwright.com

On June 25, the United States Supreme Court granted a request by the Federal Trade Commission (FTC) for review of the 11th Circuit's decision in *Federal Trade Commission v. Phoebe Putney Health System*. This case involves the FTC's failed attempt to enjoin the merger of two southwest Georgia hospitals – Phoebe Putney and Palmyra Medical Center – on competitive grounds, and raises significant antitrust immunity issues.

Significantly, as explained in the FTC's petition for certiorari, the Eleventh Circuit rejected its claim despite agreeing with the FTC that the transaction would likely lessen competition for hospital services in Albany County. In reaching this rather surprising result, the Eleventh Circuit held that regardless of its potential competitive implications, the transaction was immune from FTC challenge based upon the "State Action Doctrine," a state sovereignty principle that immunizes state entities from the antitrust laws when they act pursuant to a "clearly articulated state policy" to replace competition with regulation. The State Action Doctrine is implicated in this case because the local Hospital Authority was nominally the purchaser in the transaction (using Phoebe Putney funds to pay Palmyra and then agreeing to lease Palmyra to Phoebe Putney for a dollar a year for 40 years). *For additional details on the background of the case, please see the article by L. Pahl Zinn and Christian G. Ohanian in the February, 2012 issue of this Newsletter.*

By taking the case, the Supreme Court will resolve a split among the Circuits concerning what constitutes a "clearly articulated and affirmatively expressed" state policy to displace competition, as is required to trigger the application of the State Action Doctrine.

When this case is argued, the FTC will cite rulings in the Fifth, Sixth, Ninth and Tenth Circuits and will contend that a state must create a regulatory structure that unambiguously displaces "unfettered business freedom" with regulation for the State Action Doctrine to apply, and that a position of "neutrality" with respect to competition is insufficient. Specifically, the FTC will argue that because "Georgia has no affirmative policy of using hospital authorities to facilitate the acquisition of monopoly power by private entities,

as occurred here," the requirements of the State Action Doctrine have not been met.

In contrast, Phoebe Putney will likely contend that the Eleventh Circuit's ruling that the "clear articulation" test is satisfied whenever anticompetitive conduct is a "foreseeable result" of state legislation is the proper standard. As a result, the hospital system will agree with the lower court's conclusion that the legislation that created the hospital authority and that authorized it to acquire and lease hospitals made the acquisition a "foreseeable" occurrence, one that is outside the scope of FTC challenge even if potentially harmful to competition.

As the FTC noted in its petition, "the application of the state action doctrine to public hospitals is a recurring issue salient to communities across the nation, and ensuring robust competition among hospitals is an important part of the response to the fiscal challenges presented by health care costs". As such, the Supreme Court's decision in this case will likely be of great interest next term, and once decided could have a far-reaching impact.

HEALTHCARE INFORMATION TECHNOLOGY NEWS

IMPACT OF THE SUPREME COURT'S DECISION ON HEALTHCARE INFORMATION TECHNOLOGY

By Tatiana Melnik, an associate in Dickinson Wright's Ann Arbor office, who can be reached at 734.623.1713 or tmelnik@dickinsonwright.com

On June 28, 2012, the United States Supreme Court ruled on the constitutionality of the Patient Protection and Affordable Care Act of 2010 (ACA) when it decided *National Federation of Independent Business v. Sebelius*. The case focused on two issues: (i) the individual mandate, which requires that all U.S. citizens or legal residents have health insurance or pay a penalty, and (ii) the Medicaid expansion, which provides for additional funding of the expansion of state sponsored Medicaid programs using federal matching funds if the expanded programs meet certain requirements.

As to the first issue, the Supreme Court upheld the individual mandate under the Taxing Clause of the U.S. Constitution, finding that the "shared responsibility payment" looks like a tax, acts like a tax and therefore must be a tax. The Supreme Court discounted the "penalty" label and concluded that "magic words or labels" do not change the practical operation of the provision.

With respect to the second issue, the Supreme Court struck down the Medicaid expansion under the Spending Clause of the U.S. Constitution, reasoning that while Congress can use its power to grant federal funds to states so long as the states meet certain conditions, Congress cannot compel states to regulate. The Supreme Court noted that Medicaid spending accounts for more than 20% of the average state's total budget and that federal funds cover 50% - 83% of these costs. As a result, the Supreme Court reasoned that threatening to withdraw all previously committed Medicaid funds if a state chooses not to expand its Medicaid program is akin to "a gun to the head". The Court's decision means that Congress can condition payment to a state of the new funds allocated for Medicaid expansion on that state's willingness to expand its program, but that the state's existing Medicaid funds cannot be jeopardized.

It is helpful to remember that this decision involved the Patient Protection and Affordable Care Act (ACA). Two Healthcare IT-related initiatives, payments to encourage the use of electronic health records (called by some Meaningful Use funds) and the restrictions on use of patient healthcare information that are contained in the Health Information Technology for Economic and Clinical Health Act (HITECH), are part of the American Recovery and Reinvestment Act of 2009 (ARRA), a different statute than the ACA. Therefore, even if the Supreme Court had struck down the ACA in its entirety, payments for Meaningful Use and HITECH restrictions would still continue in effect.

Nonetheless, when the Supreme Court upheld the ACA, numerous healthcare IT provisions contained in the ACA will continue in effect, including those related to Accountable Care Organizations (which look to Meaningful Use), numerous quality improvement provisions, and various grants to help organizations transition to and incorporate healthcare information technology.

TAX NEWS

INTERNAL REVENUE SERVICE ISSUES PROPOSED REGULATIONS FOR TAX-EXEMPT HOSPITALS

By John T. Schuring, an associate in Dickinson Wright's Grand Rapids office, who can be reached at 616.458.6753 or jschuring@dickinsonwright.com

The Internal Revenue Service (IRS) and the Treasury Department recently proposed regulations that will affect charitable hospital organizations. The Patient Protection and Affordable Care Act (ACA) added §501(r) to the Internal Revenue Code, which imposes certain requirements for tax-exempt hospitals to obtain and retain their tax-exempt status. Under this provision, for example, hospital organizations must conduct a community health needs assessment at least once every three years and adopt an implementation program to meet the identified needs.

In addition, hospital organizations must adopt a written financial assistance policy (FAP) that establishes eligibility criteria for free or discounted care, including how any unpaid charges will be collected as well as a written policy relating to emergency medical care that outlines requirements to provide care for emergency medical care regardless of eligibility under the FAP. The Proposed Regulations provide guidance on compliance with certain of the §501(r) requirements:

- Clarification on which entities must meet the §501(r) requirements in order to obtain or retain tax exemption.
- Descriptions of the information that a hospital facility must include in its FAP and the methods a hospital facility must use to widely publicize that policy.

- Descriptions of what a hospital facility must include in its emergency medical care policy.
- How the hospital facility can determine the maximum amount that can be charged for emergency or other medically necessary care provided to individuals who are eligible for assistance under its FAP, which cannot be "more than the amounts generally billed to individuals who have insurance covering such care".
- Details on what are considered to be "extraordinary collections actions" and the reasonable efforts a hospital must take to determine whether a patient is eligible for its FAP before it can engage in extraordinary collections actions.

If a hospital or hospital system fails to comply with the requirements of §501(r), its tax-exempt status will be subject to revocation. In addition, for certain violations, additional taxes and/or penalties might apply. For example, if a charitable hospital fails to conduct a timely community health needs assessment as required by §501(r), it is subject to a penalty of $50,000 (excise tax). The Proposed Regulations contain a placeholder for details as to the consequences of failure to comply with the requirements to adopt and comply with an FAP and an emergency medical care policy.

HEALTHCARE INTELLECTUAL PROPERTY NEWS

NAMING YOUR BUSINESS OR PRODUCT: WHAT YOU DON'T KNOW CAN GET YOU SUED

By John C. Blattner, a member in Dickinson Wright's Ann Arbor office, who can be reached at 734.623.1698 or jblattner@dickinsonwright.com

When UnitedHealth Group Incorporated of Minnesota selected "UnitedHealthOne" as the umbrella brand for its individual health insurance policies, it almost certainly did not anticipate being dragged into an expensive trademark infringement lawsuit.

But that is exactly what happened.

UnitedHealth expended a considerable amount of time, energy, and money in selecting its name. During 2007 and 2008, it worked with a consultant who conducted a detailed branding audit, competitive analysis, market segmentation, and brand identity analysis. The results of this elaborate analysis suggested a variety of possible names. UnitedHealth narrowed the list to four, and asked its consultant to conduct focus groups in several U.S. cities. "UnitedHealthOne" ultimately emerged as the consensus favorite. In all, UnitedHealth spent more than $900,000 in the process of selecting and launching the "UnitedHealthOne" brand.

Apparently, the one thing UnitedHealth didn't do was ask a trademark attorney to conduct a risk analysis of the numerous trademarks owned by third parties that were mentioned in the brand consultant's 600-page report. One of these was the registered trademark "HealthONE," owned by HealthONE of Denver, Inc., which operates hospitals in Colorado and surrounding states.

By the time UnitedHealth received a cease-and-desist letter from the Denver healthcare company in 2008, it probably felt it was too late to turn back in light of the amount spent. As a result, in 2010, HealthONE filed a federal lawsuit in Denver against UnitedHealth alleging infringement of the "HealthONE" trademark.

In January of this year, UnitedHealth filed a motion for summary judgment, asking the court to rule that HealthONE's infringement claims could not be sustained. On May 30, 2012, the court denied the motion. So the litigation will continue.

It is not unusual for businesses to put together committees and hire consultants to help select new product names. They use internet search engines to see what names are already in use. They check with the appropriate agencies to see what corporate names are already registered in their state. All this is well and good. But as demonstrated by the UnitedHealth Group case (and many others), it's not enough. Any naming project should include a comprehensive clearance search and risk analysis by a competent trademark attorney – and it should be done before it's too late to pursue alternatives if one of the candidates doesn't pan out. Failure to do so can be an expensive mistake – one for which UnitedHealth is still paying.

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