



HEALTH LAW INSTITUTE NEWSLETTER

Monitoring the pulse of health law

SPRING COLLOQUIUM 2006

Please join us for our upcoming **Spring Colloquium!** Each month, scholars, judges, practitioners, and community leaders from around the country share their research and answer questions. For more information, please contact Michele Goodwin at (312) 362-5269.

Genetic and Medical Experimentation in the Aftermath of the Holocaust

Distinguished guest speaker, Patricia Heberer, will discuss Nazi human medical experimentation and the protocols derived in the aftermath.

Speaker: Patricia Heberer, Historian, U.S. Holocaust Museum

Date: January 25, 2006

Time: TBA

Location: TBA

Superbabies: The Use and Abuse of Children in Medical Testing

Date: February 15, 2006

Time: TBA

Location: TBA

Study Abroad: The Utilization of 3rd World Markets for Medical Experimentation

Date: March 15, 2006

Time: TBA

Location: TBA

Whose Agenda Matters Most?: Fiduciary Responsibilities of Physicians and Medical Professionals

Date: April 19, 2006

Time: TBA

Location: TBA

Healthcare at a Wal-mart Near You

By Amy Vandenbroucke

Feeling sick but don't want the hassle of visiting your physician? A new option is rapidly becoming available to you. Across the U.S. a growing number of convenience medical clinics staffed by nurse practitioners ("NPs") are being located in supermarkets, discount retail chains, malls, corporate offices and pharmacies. Many corporations liken this arrangement to renting space to other services, such as Starbucks, banks and dry cleaners, to improve customer service. These clinics, designed to treat minor everyday ailments, offer basic primary care services from immunizations and tests to treatments for common infections. Common services and treatments include urinary tract infections, bronchitis, pink eye, strep throat cultures or rapid strep tests, ear infections, screening for high blood pressure, cholesterol and glucose checks, school inoculations, meningitis vaccines, tetanus and flu shots. However, the clinics will treat neither chronic conditions, such as hyperten-

sion, asthma, and diabetes, nor children younger than eighteen months.

NPs can practice independently in twenty-seven states, while other states require NPs to have a supervisory relationship with a physician. Regardless, NPs generally work with area physicians who are board certified in family practice, pediatric or emergency care in case they have questions or problems. Some clinics have required, irrespective of state law, that all clinics have a physician consultant, generally one on-call physician for every five NPs who are on the job. NPs can prescribe antibiotics for common infections; however, they are unable to prescribe medications for on-going conditions, such as birth control pills, antidepressants, and cholesterol-lowering drugs.

The number of clinics is rising as people pay an increasing share of their own healthcare costs because of reduced insurance coverage by many employers or higher co-payments. *Continued on page 4*

Gainsharing

By Adam Hitchcock

In federal fiscal year 2004, acute-care hospitals lost \$2.4 billion on their most common Medicare-covered services. Hospitals are finding there are fewer and fewer places to save money. The fundamental misalignment of economic incentives makes it harder for hospitals to cut costs—doctors consume hospital resources, such as medical devices and supplies, and the hospital pays for the consumption. Physicians control eighty percent of hospital costs. For hospitals to realize true savings they are going to have to enlist physicians in the effort.

What if it were possible for doctors to cut costs while maintaining the current

level of patient care? This situation is known as gainsharing. Gainsharing creates incentives for the doctor to be efficient without compromising high quality care. It is an attempt to change doctor behavior that results in inappropriate or wasteful use of medical supplies. Hospitals do this by identifying areas of wasteful and unnecessary spending and then calculating the amount of spending that could safely be reduced by the doctors over one year in that area. Under such an agreement hospitals will equally divide the savings realized with the doctors in the identified areas. Cardiac care has been identified as a starting point for gainsharing.

Continued on page 4

NEWS OF INTEREST

Federal Judge Voids Suburban Chicago Hospital Merger

By Ameer Lakhani

Federal Trade Commission (“FTC”) Chief Administrative Law Judge Stephen McGuire has ruled that the merger of two hospitals in the northern suburbs of Chicago led to unfair price hikes and violated the Clayton Antitrust Act in a landmark decision that could lead to similar challenges of mergers across the country. The ruling ordered the undoing of the 2000 merger of Evanston Northwestern Healthcare (“ENH”) and Highland Park Hospital. ENH is the parent of Evanston Hospital in Evanston, Glenbrook Hospital in Glenview, and Highland Park Hospital.

The FTC filed a complaint in 2004 due to the fact that Evanston Hospital increased its prices, leading to a fifty percent or more increase in certain instances and a price increase of nearly two hundred percent for in-patient care. “ENH was able to raise its prices far above price increases to other comparable hospitals as a result of the transaction,” the FTC said in a statement. The price increases started the year after the merger and continued in 2002 and 2003, McGuire said. Attorneys for ENH, however, said the price increases were used to renovate the facilities and make more than \$120 million in improvements to Highland Park Hospital.

ENH plans to appeal the ruling. The case is considered a landmark for federal antitrust lawyers who view the challenge as a chance for the federal government to take an aggressive stance toward hospital mergers. This appeal will be watched nationally by hospitals, health insurers, and employers. Consequently, the case may prove to be invaluable to the hospital industry by providing an in-depth examination of the competitive and antitrust issues raised by hospital mergers. □

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HEALTH LAW INSTITUTE NEWSLETTER

The DePaul Health Law Institute Newsletter is published bi-monthly during the academic year by the Health Law Institute at DePaul University College of Law, 25 East Jackson Boulevard, Chicago, IL 60604. Please send subscription requests and address corrections to the above address, c/o Michele Goodwin. The Newsletter is also available at: www.law.depaul.edu/health

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California Seeks to Prohibit Use of Children as Medical Interpreters

By Kendra Gray

Using children as medical interpreters is common in states such as California, which is home to millions of non-English speaking residents. Children are often the only people available to speak for their parents, but an increasing number of studies have shown the potentially lethal consequences of incorrect translations. That danger has motivated health care regulators and members of the California assembly to seek an end to the practice.

In November of 2005, the California Department of Managed Health Care will hold public hearings on draft regulations that would prevent children from interpreting at private hospitals, physicians' offices and clinics, although the rules would not apply in emergencies. If approved, California would be the first state to implement such a wide prohibition. Other states have restric-

tions, but none have gone as far as California's proposal. Leland Yee, a California assemblyman, is also sponsoring a bill that would prevent children from translating for their parents at public hospitals and any clinic that receives public money.

Those who support a ban on child interpreters say children lack the emotional maturity and vocabulary to serve as effective interpreters. Many times children are the first family member to learn of a serious illness and must deliver the bad news, which is a huge responsibility. In addition, according to a 2003 study published in the American Academy of Pediatrics, two of every three mistranslations have clinical consequences. Although there are definite problems with allowing children to serve as interpreters for their parents, finding substitutes will not be easy. California already has a chronic shortage of medical interpreters.

Continued on page 6

Patent Rights and Production Capacity: Why Drug Companies May Play a Key Role in Determining the Size of a Bird Flu Pandemic

By Hillary Ahle

In a move originally intended to aid impoverished nations in obtaining essential drugs at a more affordable price, the World Trade Organization (WTO) in 2001 granted governments "compulsory licensing rights" to waive foreign drug patents in a public health crisis [1]. Effectively, in a public health emergency, the new WTO rules allow governments to waive foreign patents and produce generic copies of medicines domestically. Under these rules, however, a country must first seek to reach an agreement with the license holder [2].

Recently, Roche, a Swiss pharmaceutical giant, has been in the hotseat regarding its monopoly over the production and marketing of Tamiflu, an antiviral drug thought to be our first line of defense in combating bird flu [3]. In the case of a bird flu pandemic, these WTO rules may allow countries to begin their own production of a generic version of Tamiflu so as to avoid the projected drug shortage that could prove deadly.

The head of Roche's pharmaceutical division, William M. Burns, has stated that the company intends to increase annual production capacity to 300 million courses of treatment within the year, which is a substantial increase from its production of 55 million courses in 2005 [4]. In an effort to assuage fears that Roche may not be able to meet the demand for Tamiflu in the case of a pandemic, Mr. Burns responded, "This is a capacity significantly larger than the cumulative number of orders we have" [5].

The World Health Organization (WHO) recommends that countries stockpile enough antivirals for at least a quarter of their populations [6]. Amid the hoarding and stockpiling of Roche's Tamiflu and in anticipation of a bird flu pandemic, the governments of several countries have encouraged Roche to extend licensing to other manufacturers before the health crisis hits [7]. But even if Roche were to grant licenses to other companies (it

has reportedly received licensing inquiries from over 150 companies), Roche suggests it may take a newcomer up to three years to be able to start production of Tamiflu [8]. Currently, Roche says the manufacturing process takes between six and eight months once the materials are in hand. Further, Roche's production of Tamiflu depends on a Chinese spice, star anise, which is in limited supply.

Nevertheless, Roche has stated that it will narrow the list of possible licensees to less than the current eight serious offers by the end of November [9]. Further, Roche has decreased the price of Tamiflu for less-developed countries, as identified by the World Bank, and Roche is in talks with Vietnam to provide the country with the finished active ingredients for Tamiflu in hopes that local companies may be able to encapsulate the treatments more cheaply [10]. □

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NEWS OF INTEREST

Gainsharing *continued from page one*

Savings could be achieved by having doctors only open packaged supplies as needed and by using supply items that are just as effective but cost less than those previously used.

The government has expressed concerns about negative results that may occur under gainsharing agreements. There is a fear that in an attempt to cut costs doctors would reduce the quality of care for patients. The government also worries that gainsharing agreements could be structured in a way that reward doctors for making referrals to the gainsharing group. Another concern is that the doctors will treat healthy patients and send less healthy patients to a hospital without gainsharing – an action known as cherry picking.

To address these and other concerns, it is necessary for any gainsharing agreement to have safeguards. Safeguards are put in place to assure that the financial benefits are achieved without a reduction in the quality of care. Safeguards that have appealed to the Office of the Inspector General of the Department of Health and Human Services (“OIG”) are the following: use of credible medical support, implementation of guards and caps to prevent cherry picking, limiting the amount of savings that can be achieved so that patient safety is not compromised, providing written disclosure to the patient, distributing financial awards to a

group of doctors on a per capita basis, not allowing gainsharing to reward referrals, limiting savings to specific groups of actions, and limiting agreement duration to one year.

Even with safeguards in place gainsharing is not in use because the OIG has said it would be in direct violation of the federal anti-kickback statute, and the possibility also exists that the arrangement would jeopardize non-profit tax status. It is this appearance of illegality that has hampered adoption of gainsharing.

However, recent OIG advisory opinions have added to the legitimacy of gainsharing. These opinions gave tacit approval to a select few gainsharing agreements that had the appropriate safeguards in place. These opinions said that the agreements were in violation of federal law but the OIG would not impose sanctions because the safeguards addressed the OIG’s concerns. These approvals should not be viewed as general endorsements of gainsharing. The advisory opinions were fact-specific and involved a small number of agreements.

The OIG opinions highlight the need for legislative action. Legislative action allowing gainsharing could speed up its adoption. Congress will not take any action on gainsharing this year but it is possible this issue could be addressed in the future. □

*The author would like to thank Neil Olderman, Esq. for his assistance with this article.

Healthcare at a Wal-mart Near You *continued from page one*

Clinics are also an option for those with little or no health insurance. A visit to a clinic costs under \$60, while a typical visit to a physician costs \$110 and a trip to the emergency room can cost over \$300. The majority of clinics do not currently accept, nor plan to accept, insurance.

While the clinics are designed to increase patient access to care and avoid clogging primary physicians’ waiting rooms, these clinics acknowledge that they are not a substitute for an established physician-patient relationship or for hospital emergency rooms. The clinics are promoted as “complements” or “adjuncts” to a patient’s primary care system. Towards this end, these clinics monitor their patients and, to avoid regular customers, refer repeat patients, or patients showing signs of chronic disease, to primary-care physicians. Most NPs have the authority to turn customers away.

Beyond offering quick medical care, clinics offer customers longer hours and the flexibility of just showing up, rather than scheduling an appointment. People can shop if the NP is busy; many clinics offer pagers, which allows customers to shop until there is an opening at the clinic. Additionally, some clinics post their services and prices, like a café menu, for all customers to view.

Physicians are divided about this new alternative to their own offices. Some welcome the idea and view the clinics as a chance to shift their focus from common colds to more pressing concerns, such as difficult to treat blood pressure. Because clinics handle the simpler cases, physicians have time to devote to bigger issues. Other physicians are concerned about a lack of communi-

cation with the clinic about patients. Additionally, some wonder if the concept of bringing fast-food efficiency into healthcare is a good idea. While it may increase access to patient care, it may decrease the quality of healthcare being offered. The president of the American Medical Association pointed out that “serious illnesses sometimes present with simple symptoms. A cough might be something as simple as a cold or something as serious as congestive heart failure. The ability to ferret out the twenty percent of serious illnesses that present with simple symptoms is what we went to medical school for.” Nevertheless, NPs currently can treat a cough and offer antibiotics. There are issues of medical malpractice that need to be worked out with respect to clinics.

Several companies have announced their plans for medical clinics. Wal-mart Stores Inc., the largest retailer to rent space to medical clinics, said that 12 clinics will open in existing Wal-Mart Supercenters by the end of January 2006, including the three currently open in Arkansas, Indiana and Oklahoma. The four clinics planned for Florida will have board-certified physicians staffing them instead of NPs. CVS Corp. said that it hopes to have 60 clinics in operation soon. Target Corp., Osco Drug, Rite Aid Corp., Cub Foods and Brooks Eckerd Pharmacy have also announced plans to open clinics in the coming months. □

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Washington Adopts Strict Ban Against Smoking

By Courtney Quilter

The state of Washington recently passed one of the most controversial proposals to ban smoking in both public places and workplaces throughout the state. Initiative 901 prohibits smoking within twenty-five feet of doors, windows, and vents in public places such as bars, restaurants, clubs, bowling alleys, and non-tribal casinos. While other state bans exempt some businesses, such as bars, private clubs, card rooms, and cigar lounges, Initiative 901 is the most strict due to its twenty-five-foot rule.

Under the smoking ban, businesses in Washington can obtain waivers from the twenty-five-foot zone if they can show that the smoke will not permeate the business. Local health departments will enforce the ban against businesses by imposing fines or license restrictions, while local law enforcement agencies are responsible for enforcing the ban against individuals. People who violate the ban are subject to a \$100 fine.

Initiative 901 was primarily sponsored by organizations in the health care field with the American Cancer Society contributing \$521,000 of the \$1.38 million campaign. Agencies enforcing the ban, such as the Tobacco Prevention Program for Public Health in Seattle & King County, have stated that they are more interested in clean air than in handing out fines. Officials have said that their main goal is education before enforcement of the ban.

While the ban was met with some opposition, many smokers stated that they felt the ban should pass. Although some smokers expressed a desire for a few underground places which would allow smoking, others viewed the ban positively. For individuals who were looking for a way to quit, Initiative 901 provided the perfect reason, since smoking in public places will now be against the law. □

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Overweight Americans Banned From Suing Their Way to Good Health

By Valerie Smith

On October 21, 2005, in a 307-119 vote [1], the United States House of Representatives passed the Personal Responsibility in Food Consumption Act of 2005, commonly known as the "Cheeseburger Bill" [2]. The Cheeseburger Bill ("Bill") stems from a class action lawsuit, *Pelman ex rel. Pelman v. McDonald's Corp.*, brought by two teenagers from New York who accused McDonald's of causing them to become obese [3]. The Bill seeks to ban class action obesity lawsuits against producers and sellers of fast food and manufacturers of non-alcoholic beverages. Although fast food manufacturers would appear to benefit most from the Bill, the Bill would also protect grocery stores, restaurants and even hot dog vendors. Congress found that the food and beverage industry is a significant part of the national economy and, therefore, should be protected from frivolous lawsuits [4].

In support of the Bill, many Republican representatives argued that fast food and "mom and pop" restaurants should not take the blame for the public's poor eating choices and lack of exercise [5]. Some representatives also voiced concerns that allowing litigation against the food industry would harm the economy, causing increases in the cost of eating out. Proponents of the Bill recognized that obesity among children has doubled in the past three decades, but believe that Americans should accept personal responsibility for their health.

The Bill's sponsor, Florida Representative Ric Keller, R-Florida, said the legislation focuses on, "common sense and personal responsibility" [6]. Many House Democrats opposed the Bill, arguing that it would allow companies to do whatever they want without liability. Other opponents of the Bill included the Center for Science in the Public Interest and the Physicians Committee for Responsible Medicine. These organizations blame "Big Food" corporations for the nation's obesity problem [7]; a perspective that gained increased recognition the day before the Bill was passed, presumably due to a study that revealed that poor diet and lack of exercise caused 4,000 deaths in 2000, which was a thirty-three percent jump from 1990 [8].

In opposition to the Bill, Representative James McGovern, D-Mass, stated, "It protects an industry that doesn't need to be protected at this particular point and we're dealing with a problem that doesn't exist. The problem that does exist is that we have an obesity problem in this country" [9]. Other critics argued that the Bill would not attempt to combat the obesity problem because it would not encourage healthier lifestyles, but instead would only please the industries promoting the consumption of unhealthy food. The opposition further expressed the necessity of courts to decide the outcome of the lawsuits, not Congress.

The Bill faces an uncertain future in the Senate, which has historically blocked measures that protect specific industries. Although the Senate may not support the Bill, twenty-one states, including Illinois, have followed the lead of the House in passing similar legislation [10]. □

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CASE NOTES

Lockyer v. R.J. Reynolds, No. S121009, 2005 WL 3489460 (Cal. 2005)

By Erin Wetherille

In early October, the California Supreme Court heard arguments on a challenge by R.J. Reynolds Tobacco Co. to a state law preventing cigarette companies from giving free tobacco samples to adults. The company sued, after it was fined \$14.8 million six years ago for handing out free cigarettes to 15,000 adults at six public events.

The tobacco company focused its arguments on claims that the 1969 Federal Cigarette Labeling and Advertising Act ("Act") preempts the state law and, therefore, they may give free tobacco to adults. The Act bans cigarette advertisements from television and radio, but also notes that states should not interfere with cigarette advertising. The company also argued that a loophole in California's law allowed for the company's conduct, and at least one of the seven justices agreed. Another part of the dispute centered on language of the state law which allows free distribution at public events if minors are not present. Attorneys for R.J. Reynolds argued that, even if the state law is not preempted, it only prohibits minors from entering an area where free cigarette distribution is taking place. The state attorney general's office

argued that minors must be barred from the entire event.

Health groups such as the California Medical Association and the American Medical Association submitted court briefs in support of upholding the law, citing how tobacco use is the nation's single most preventable cause of premature death and disease. Business groups sided with R.J. Reynolds, noting that states should not govern areas already controlled by the federal government. At least 17 states and the District of Columbia have laws regulating the distribution of free tobacco.

States are allowed to adopt their own laws if they do not conflict with federal mandates. California attorneys in the case argued that the states are already free to oversee tobacco distribution by imposing taxes, prohibiting sales to minors, and controlling who can sell tobacco.

The U.S. Supreme Court has not yet directly addressed this issue. As such, this case is likely to be appealed to the U.S. Supreme Court regardless of the outcome at the state level. The California Supreme Court issues decisions within 90 days of oral arguments. □

Tomczak v. Ingalls Mem'l Hosp., 834 N.E.2d 549 (Ill. 2005)

By Erin Wetherille

On August 17, 2005, the Illinois Appellate Court of the First Circuit held that emergency room triage times, treatment times, and triage acuity designations of non-party patients are discoverable in a medical malpractice lawsuit. Special administrators of an emergency room patient's estate brought a wrongful death and survival action against the Ingalls Memorial Hospital and several physicians as a result of the patient's treatment in the emergency room.

During discovery, the plaintiffs requested information from non-party patients who were in the emergency room on the night that the victim died, regarding their time in the treatment area, the time each was examined, and the triage acuity designation for each patient. The hospital claimed this information was protected by HIPAA and appealed when the circuit court ordered them to provide the information. The appellate court disagreed with that argument, noting that although the physician-patient privilege provides some protection to the medical records of non-party patients, it does not protect "time-data" that was sought

by the plaintiffs. Such information is not necessary for physicians' treatment of the patient nor does it relate to a patient's medical condition or diagnosis; it merely describes the patient's condition when he or she is first treated.

The hospital then argued that another HIPAA regulation, 45 C.F.R. §164512(e)(1), required the trial court to issue a protective order before it could order disclosure of the requested information. The court disagreed, finding the regulation only applies to "protected health information" that either identifies the individual or could reasonably be used to identify the individual. The court determined the requested information here fell outside that category; therefore, the trial court was not required to issue the protective order.

Finally, the appellate court held that the circuit court did not abuse its discretion by ordering the hospital to comply with the discovery request, because the information requested was material and relevant to the claims. □

Medical Interpreters *continued from page three*

The new rules proposed by the state Department of Managed Health Care would require private health plans to provide patients with trained, adult interpreters, which could take effect as early as March 2006. The California Association of Health Plans estimates that translating medical materials and hiring professional interpreters could cost as much as \$15 million. The estimated \$15 million does not take into account the cost of Leland Yee's bill for public clinics and hospitals.

There will be much debate over who will pay for these ad-

ditional services. Hospitals and physicians are extremely concerned about the additional costs. Some physicians are worried they will be forced to stop treating non-English speaking immigrants due to the cost of hiring professional interpreters. There are also people who oppose the ban, not because of the increased costs, but because they feel children should be able to translate for their parents, if that is what the family wants. □

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Daniel v. Am. Bd. of Emergency Med.*, 428 F. 3d 408 (2nd Cir. 2005)By Dayna Vidas*

A group of 175 named and 14,000 other emergency medicine physicians joined together in a class action suit against the American Board of Emergency Medicine ("ABEM"), the Council of Emergency Medicine Residency Directors ("CORD"), along with twenty-eight hospitals operating residency programs in emergency medicine, and various individuals who were at some time associated with the ABEM, CORD, and hospitals. The physicians alleged that the defendants conspired to restrain trade in connection with the practice of emergency medicine by monopolizing emergency medicine, and in doing so violated the Sherman Act. The plaintiffs alleged that the ABEM certification requirements were purposely designed to limit the emergency physicians with that accreditation so that these ABEM certified physicians could dominate the market, harming their competition. ABEM only allowed physicians who had completed a residency program in emergency medicine, and in turn, caused an artificial shortage of such certified physicians. ABEM certification was not required by states, but plaintiffs argued that some

hospitals restricted hiring based on such certification or paid substantially more to ABEM physicians. Plaintiffs sought to temporarily restore the practice track as an alternative to the residency requirement so that they could qualify for the ABEM exam. The United States District Court for the Western District of New York dismissed the complaint for lack of antitrust standing, and the plaintiffs appealed to the Second Circuit. The Second Circuit concluded that the Western District of New York lacked personal jurisdiction and venue, but that transferring to another jurisdiction would not be necessary because the complaint lacked antitrust standing. The Second Circuit further held that plaintiffs did not sustain an antitrust injury because they argue that ABEM physicians command super-competitive remuneration and they are injured by the inability to do the same. A dissenting opinion argued that plaintiffs had sufficiently alleged an antitrust violation and injury because the non-ABEM physicians were unreasonably restrained from competing against ABEM physicians. □

Pharmaceutical Care Management Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005)By Ameer Lakhani*

The U.S. Court of Appeals for the First Circuit in Boston affirmed a lower court's ruling that the Maine prescription drug law, the Unfair Prescription Drug Practices Act, requires greater transparency in business dealings by the pharmacy-benefits managers ("PBM") in the state was constitutional.

The Pharmaceutical Care Management Association, the plaintiff, argued that Maine's Unfair Prescription Drug Practices Act was unconstitutional and could end up harming consumers because benefit managers use confidential information to get drug companies to compete with each other by lowering their prices. The lawsuit claimed that the law was preempted by federal law, specifically by the Employee Retirement Income Security Act of

1974, and would amount to a regulatory taking of trade secrets and revenues, as well as violate due process, freedom of speech, and the Commerce Clause of the Constitution.

Supporters of the law view it as a means to promote transparency by giving health plan clients access to information about discounts, drug-switching programs and any conflicts of interest that involve benefit managers. The Unfair Prescription Drug Practices Act has disclosure requirements for all financial benefits that a PBM obtains from a pharmaceutical-related company.

In response to the appellate court's decision, the Pharmaceutical Care Management Association said it will continue to oppose similar legislation in other states. □

Viola v. Cal. Dept. of Managed Health Care*, No. B174455, 2005 WL 2496423 (Cal. Ct. App. 2005)By Malcolm "Skip" Harsch*

In October 2005, the California Court of Appeals ruled that binding arbitration provisions in health service plans provide a forum for resolving disputes and are expressly approved by the California Legislature.

The plaintiffs applied for a small business plan group services agreement to provide health insurance coverage for its employees. The Department of Managed Health Care ("Department") responded with a plan that contained a mandatory, binding arbitration clause and refused to negotiate an alternative to binding arbitration. The plaintiffs rejected this plan and the Department refused to issue a policy for health care to the plaintiffs.

The plaintiffs claimed that their constitutional right to a jury trial was violated by health care service plans offered by their employers that contained mandatory, binding arbitration clauses. They contended that the Department should not have approved

these clauses. The California trial court concluded that the plaintiffs had no cause of action against the Department because there was no constitutional right to medical insurance through a health care service plan and because the plaintiffs were not compelled to participate in the plan.

On appeal plaintiffs contended that the Department must disapprove any plan that requires disputes to be resolved by binding arbitration because such a requirement is an unconstitutional waiver of the right to a jury trial and not in compliance with the Knox-Keene Act ("Act"). Under the Act, a health care employer submits a service plan and the Department must approve a health service plan unless the contract, disclosure form, or coverage is not in compliance with the Act. The court found no authority in either the federal or state constitutions to support this claim. □



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ANNOUNCEMENTS

SAVE THE DATE!

The DEPAUL JOURNAL OF HEALTH CARE LAW
presents its annual Symposium

*The Forefront of Biotechnology & Public Health:
Shaping a New Direction for the Debate of Morals in Medicine*

Friday, March 10 and Saturday, March 11, 2006
DePaul University, Lincoln Park Campus

The Symposium will provide a forum for debate on issues such as Assisted Reproductive Technology, Stem Cell Research, and Pharmaceutical Markets. In addition to these plenary sessions, the DePaul Journal of Health Care Law would like to invite scholars, professionals, and students to speak in an open forum of discussion on current health law issues. Interested speakers should contact Anne Brown at (312) 362-5634 or abrown25@students.depaul.edu