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Fall 1997

ILLINOIS SUPREME COURT HOLDS CORPORATE PRACTICE OF MEDICINE DOCTRINE INAPPLICABLE TO LICENSED HOSPITALS

Holding that the prohibition against the corporate practice of medicine does not apply to licensed hospitals that seek to directly employ physicians, the Illinois Supreme Court has reversed the circuit court and appellate court decisions in *Berlin v. Sarah Bush Lincoln Health Center*. This much-anticipated decision sheds new light on the application of the corporate practice of medicine doctrine in the state of Illinois.

Developed in the 1930s as a reaction against the salaried

employment of physicians, the corporate practice of medicine doctrine ("Corporate Practice Doctrine") prohibits corporations from practicing medicine. In Illinois, the courts have inferred the Corporate Practice Doctrine from several sections of the Illinois Medical Practice Act (the "Act"), which is codified at 225 ILL. COMP. STAT. ANN. §§ 60/1, 60/3, 60/49, 60/50 (West 1997). The Act prohibits any person from practicing medicine without a valid license to do so and imposes criminal and civil penalties on persons or entities that engage in activities that constitute the practice of medicine under the Act. 225 ILL. COMP. STAT. ANN. §§ 60/3, 60/49, 60/50 (West 1997). Since corporations cannot obtain medical licenses, the Corporate Practice Doctrine holds that corporations cannot practice medicine. Accordingly, absent specific statutory authorization, the corporate employment of physicians is illegal because the acts of the physicians are attributable to the corporate employer, which cannot hold a medical license.

Several public policy justifications underlie the Corporate Practice Doctrine. First, it has been argued that corporations will vitiate the professional judgment of their employee physicians. In addition, corporate employment allegedly divides the physician's loyalty between the patient and the profit-making employer. Finally, corporate employment of physicians allegedly leads to the commercialization of the medical profession.

The supreme court of Illinois first addressed the Corporate Practice Doctrine in *Dr. Allison, Dentist, Inc. v. Allison*, 196 N.E. 799 (Ill. 1935), in which it held that a corporation could not practice a profession because it could not meet the qualifications for licensing, which included having such human characteristics as honesty and loyalty. The same court addressed the issue again one year later in *People v. United Medical Service, Inc.*, 200 N.E. 157 (Ill. 1936), in which it again held that a corporation was prohibited from practicing medicine.

Recently, the Illinois Supreme Court revisited the Corporate Practice Doctrine in *Berlin v. Sarah Bush Lincoln Health Center*, 1997 WL 656548 (Ill. Oct. 23, 1997). In this long-awaited decision, the state's highest court has departed from established precedent in holding that the Corporate Practice Doctrine does not apply to licensed hospitals.

The *Berlin* case arose out of a 1992 employment agreement between Richard Berlin, Jr., M.D., and Sarah Bush Lincoln Health Center ("Hospital"). The five-year contract included a restrictive covenant that prohibited Dr. Berlin from providing health services within a 50-mile radius of the Hospital for a period of two years after the contract's termination. In 1994, Dr. Berlin terminated the employment agreement and began working for a clinic that was located one mile from the Hospital. Believing that Dr. Berlin's actions violated the restrictive covenant in the employment agreement, the Hospital sought a preliminary injunction to stop Dr. Berlin from working at the clinic.

The circuit court granted the Hospital's request and enjoined Dr. Berlin from working for any competing health care provider within a 50-mile radius of the Hospital. Arguing that the employment agreement violated the Corporate Practice Doctrine, Dr. Berlin filed a complaint for declaratory judgment and a motion for summary judgment to have the restrictive covenant declared unenforceable. Relying on *Kerner v. United Medical Service, Inc.*, 200 N.E. 157 (Ill. 1936), the circuit court held that the Hospital, by hiring Dr. Berlin to practice medicine as an employee, violated the Corporate Practice Doctrine. Accordingly, the circuit court voided the employment agreement.

Upon review, the appellate court for the fourth district agreed with the circuit court's decision. The appellate court pointed to the supreme court's holdings in *Dr. Allison* and *Kerner* as binding authority that the Corporate Practice Doctrine applies to non-profit hospitals. Further, the court reasoned, the Illinois legislature had chosen to provide very limited and specific exceptions to the Corporate Practice Doctrine, and none of those exceptions applied to hospitals. While acknowledging that the health care industry has changed considerably since the Corporate Practice Doctrine was first established, and that compelling public policy considerations might favor the employment of physicians by nonprofit hospitals, the appellate court concluded it was bound by the rule of *stare decisis* to stand by established precedent. The court also concluded that any decision to exempt hospitals from the Corporate Practice Doctrine should come only from the legislature. The appellate court thus categorically denied the Hospital's argument that the Corporate Practice Doctrine does not apply to nonprofit hospitals. Subsequently, the Illinois Supreme Court granted the

Hospital's petition for an appeal.

In its review of the *Berlin* case, the Illinois Supreme Court stated that the central issue on appeal was whether the Corporate Practice Doctrine prohibits licensed hospitals from employing physicians to provide medical services. In a 5-2 opinion written by Justice John L. Nickels, the Illinois Supreme Court reversed the decisions of the lower courts by holding that the Corporate Practice Doctrine does not prohibit licensed hospitals from employing physicians to provide medical services.

In its analysis, the supreme court opined that "prior to the instant action, apparently no Illinois court has applied the corporate practice of medicine rule set out in [*Kerner*] or specifically addressed the issue of whether licensed hospitals are prohibited from employing physicians." *Berlin*, 1997 WL 656548 at *6. The supreme court looked to other jurisdictions to see how other courts applied the Corporate Practice Doctrine to hospitals. The supreme court found that, given the important role of hospitals in the delivery of health care, numerous jurisdictions have recognized either statutory or judicial exceptions to the Corporate Practice Doctrine so as to allow hospitals to employ physicians. Basically, the supreme court explained, other jurisdictions have used one of three approaches to justify the Corporate Practice Doctrine's inapplicability to hospitals.

Under the first approach, certain states have refused to adopt the Corporate Practice Doctrine when interpreting their respective state medical practice acts. Under this approach, hospitals which employ physicians do not practice medicine, but merely make treatment available. Under the second approach, the courts of some jurisdictions have ruled that the Corporate Practice Doctrine is inapplicable to nonprofit hospitals and health associations. In justifying this approach, these courts have reasoned that the public policy arguments underlying the Corporate Practice Doctrine do not apply when physicians are employed by charitable organizations. Under the third approach, some state courts have ruled that the Corporate Practice Doctrine does not apply to hospitals which employ physicians because hospitals are authorized by laws other than the state medical practice act to provide medical treatment to patients.

In its ruling, the *Berlin* court found the rationale of the

second and third approaches persuasive. The court began its analysis by distinguishing *Berlin* from existing Corporate Practice Doctrine case law (e.g., *Kerner*, *United Medical Service*). According to the court, such precedent did not specifically address the employment of physicians by hospitals, nor did these cases involve corporations licensed to provide health care services to the public.

Turning its attention to the instant case, the supreme court held that Illinois' Medical Practice Act does not expressly prohibit the corporate employment of physicians, but rather the Corporate Practice Doctrine was inferred from the general policies underlying the Medical Practice Act. While the Corporate Practice Doctrine's prohibition is appropriate where a corporation is not licensed to provide health care services, the court argued that the Corporate Practice Doctrine is inapplicable to those corporations appropriately licensed to render health care services. The supreme court stated that statutes such as the state's Hospital Licensing Act authorize (and sometimes require) Illinois hospitals to provide medical services. To provide such medical services, the court held that licensed hospitals have implied statutory authorization to employ physicians. In this regard, the court saw no reason to distinguish between for-profit and nonprofit hospitals because, in the court's opinion, the statutes authorizing licensed hospitals to provide medical services made no such distinction.

The *Berlin* court also found that the public policy concerns underlying the Corporate Practice Doctrine are inapplicable to licensed hospitals in today's health care industry. In the court's opinion, extensive changes in the health care industry (e.g., the emergence of health maintenance organizations) have lessened the concern over the commercialization of the medical profession. In addition, the court found that the concern for lay control over professional judgment is alleviated in a licensed hospital because a separate medical staff is responsible for the quality of medical care delivered in the facility. In addition, the court noted that licensed hospitals have an independent duty to provide for a patient's health and welfare. Therefore, the *Berlin* court found that the employment of physicians by licensed hospitals would not compromise patient care. Given the foregoing, the *Berlin* Court held that "a duly-licensed hospital possesses the legislative authority to practice medicine by means of its staff of licensed physicians and is excepted from the

operation of the corporate practice of medicine doctrine."

Applying its holding to the case at bar, the Illinois Supreme Court held that the employment agreement between the Hospital and Dr. Berlin was not unenforceable merely because the Hospital is a corporate entity. The court thus reversed the decisions below to award summary judgment to Dr. Berlin, and the case was subsequently remanded back to the circuit court for further proceedings.

Practical Application

In sum, the Illinois Supreme Court has ruled that the corporate practice of medicine doctrine is inapplicable to licensed hospitals. As a result of the *Berlin* decision, Illinois hospitals (whether for-profit or nonprofit) may directly offer physician services. With the ability to directly employ physicians, a hospital may be able to afford itself greater protection against health care facilities that desire to lure its physicians away.

The *Berlin* decision has left various questions unanswered, however. For instance, must a licensed hospital be the direct employer of physicians, or may it *indirectly* employ physicians through a related entity? Is *Berlin* applicable to a licensed hospital that employs physicians but is controlled by a non-hospital entity? What is *Berlin's* effect on the applicability of the Corporate Practice Doctrine on non-hospital entities (*e.g.*, PHOs, HMOs) that employ physicians? For the answers to these and other questions, health care providers and institutions must wait for further guidance from the Illinois courts or legislature.

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Courts Decide That "Deselected" Network Providers Have Right to Fair Procedure

The future ability of health plans to fully regulate their provider networks may be substantially curtailed in the wake of recent court decisions and legislative initiatives. Courts in at least two states have found that health care providers have some right to due process or fundamental fairness in determinations regarding termination or deselection by a health plan, even if the contract between

the parties allows for termination without cause. The decisions, along with pending legislation in several states, reflect an emerging trend in health care legislation aimed at protecting patient and physician rights in the age of managed care.

The California Case

In *Potvin v. Metropolitan Life Insurance Co.*, 63 Cal. Rptr. 2d 202 (Cal. Ct. App. 1997), California's Second District Court of Appeals held that a physician must be provided certain due process protections before an insurance company can remove him from the insurer's network of providers. The *Potvin* court held that California's common law right to fair procedure overrides any provision in the contract allowing for termination without cause.

Louis E. Potvin, a licensed physician with a 30-year-old practice in California, entered into a 1990 agreement with two California-based health care networks managed by Metropolitan Life Insurance Co. The agreement contained a commonly used provision allowing either party to terminate the agreement, with or without cause, upon 30 days' written notice. Two years later Metropolitan terminated the agreement without cause. After several written inquiries by Dr. Potvin to find out why he had been deselected, Metropolitan responded that his malpractice history did not meet its standards. Dr. Potvin responded with a detailed summary of his malpractice history, and he requested a formal hearing to discuss his deselection. Metropolitan declined, and Potvin filed suit.

The trial court granted summary judgment in favor of Metropolitan. Potvin appealed, claiming that he had established the defendant's liability as a matter of law, based on the evidence that he was denied his common law right to fair procedure. He further contended that the defendant had violated its duty under Section 805 of California's Business and Professional Code to provide him with notice and a hearing prior to terminating the agreement.

In overruling the trial court, the appellate court held that summary judgment on the due process issue was not appropriate, but declined to find that Potvin had established Metropolitan's liability as a matter of law. Citing as precedent *Delta Dental Plan of California v.*

Banasky, 27 Cal. App. 4th 1598 (Cal. Ct. App. 1994), and *Ambrosino v. Metropolitan Life Insurance Co.*, 899 F. Supp. 438 (N.D. Cal. 1995), the court explained that California's common law right to fair procedure applies to a health plan's decision to terminate a provider's participation in the plan and overrides any termination without cause provision. *Delta Dental Plan* involved a dental plan's internal review policies regarding fees to be paid to participating dentists, while *Ambrosino* involved a podiatrist who entered into an agreement similar to Dr. Potvin's and was later terminated without cause.

Based on *Delta Dental Plan* and *Ambrosino*, the court found that, notwithstanding the "without cause" termination provision in the contract, Dr. Potvin indeed had a common law right to fair procedure, including the right not to be terminated from membership on a provider panel for reasons which were "arbitrary, capricious, and/or contrary to public policy." The fair procedure requirement is warranted, the court reasoned, because insurance companies and managed care entities control substantial economic interests of a physician's practice through their ability to select and deselect providers for their networks.

The court concluded, however, that while Dr. Potvin was denied proper notice or an opportunity to be heard, there was at least a triable issue of fact as to whether his deselection was arbitrary, capricious, or contrary to public policy as a matter of law, since Metropolitan's decision may have been supported by Dr. Potvin's malpractice history. Therefore, summary judgment was inappropriate. The court also disagreed with Dr. Potvin's claim that the defendant violated its duty under the California Business and Professional Code to provide him with formal notice and a hearing, finding that the provision did not apply to insurers. *Potvin v. Metropolitan Life Insurance Co.*, 63 Cal. Rptr. 2d 202, 212 (Cal. Ct. App. 1997).

Potvin is viewed as the first decision by a California court that expressly recognizes a physician's right to fair procedure. Historically, managed care companies have justified their selection and deselection of providers as business decisions. After *Potvin*, deselection may still remain a business decision; however, such decisions now may be subject to certain due process limitations. Moreover, "termination without cause" provisions may carry little, if any, weight against a provider's challenge to a termination decision.

The *Potvin* court's decision did not specify what type of procedure would satisfy a physician's common law right to fairness, however. California case law suggests the state's fair procedure requirements may be rather minimal, perhaps requiring only a written statement of the reason for termination and an opportunity for the physician to respond either in writing or through an informal hearing process.

On July 30, 1997, the Supreme Court of California granted Metropolitan's petition for review. *Potvin v. Metropolitan Life Insurance Co.*, 941 P.2d 1121 (Cal. 1997). The state's supreme court has yet to issue its ruling on the case. Regardless of the final outcome, however, the ability of managed care organizations ("MCOs") to terminate providers without cause may be curtailed in the future. Legislation is pending in California that would prohibit plans from including "without cause" termination provisions in their contracts with providers.

The New Jersey Case

Soon after the *Potvin* decision, a federal district court in New Jersey held that psychologists dropped from an MCO's provider network could proceed with their claims that their termination violated public policy and the state's common law doctrine of fundamental fairness. *New Jersey Psychological Ass'n v. MCC Behavioral Care, Inc.*, No. 96-3080 (D.N.J. Sept. 15, 1997).

The defendant, MCC, is an MCO for mental health and substance abuse services. The plaintiff, a professional organization of New Jersey psychologists, claimed that several of its members were improperly terminated as providers by MCC. Plaintiff alleged that defendant's termination decision violated public policy and fundamental fairness requirements, among other things, and that MCC had disguised its termination as "without cause" to avoid the scrutiny that a for-cause termination would generate. Plaintiff claimed its member psychologists were terminated after MCC determined that the treatment plans that the psychologists recommended to their patients were not "managed care compatible," and that such determination by MCC impinged on the psychologists' ability to exercise their best professional judgment in the treatment of patients.

The district court analogized the plaintiff's public policy

claim to a wrongful discharge claim recognized by the New Jersey Supreme Court in *Pierce v. Ortho Pharmaceutical Corp.*, 84 N.J. 58 (1980). Although the state's highest court has never addressed the issue with regard to MCOs and their network providers, the district court found the instant case to be analogous to the granting of hospital staff privileges to physicians and noted that the state has a strong public policy against hospitals' "arbitrarily foreclosing otherwise qualified doctors from their staffs." This policy interest was found to require a fairness hearing before a hospital could terminate a provider's contract, or in the managed care context, before termination of a provider's contract. The court noted that the privilege to participate in a managed care network could be critical to a doctor's ability to practice his profession, and that termination of such a privilege could have serious economic consequences for that practice.

The court further found that New Jersey courts have recognized a right to "fundamental fairness" in determinations regarding hospital privileges, and that such a right therefore extends to determinations regarding network provider contracts.

Additionally, the court noted that regulations recently adopted by the New Jersey Department of Health provide that utilization management determinations by MCOs must be based on "written clinical criteria and protocols developed with involvement from practicing physicians and other licensed health care providers within the network." N.J. ADMIN. CODE tit. 8, § 38-8.1 (1996). The regulations further provide that all determinations to deny or limit medical treatment must be rendered by a physician and not by non-physician employees of the MCO.

Practical Application

The *Potvin* and *MCC* decisions reflect a trend toward greater recognition of the rights of physicians and patients participating in the managed care system. In addition to these and other similar cases across the country, various state legislatures are enacting laws designed to regulate MCOs, safeguard physicians' rights, and improve patients' access to health care.

For example, the New Jersey legislature recently enacted a managed care reform law, the New Jersey Health Care Quality Act ("NJHCQA"). Signed into law on August 7,

1997, the NJHCQA adds new protections for HMO subscribers and health care providers alike. Under the NJHCQA, HMOs are required to give their enrollees greater choice in selecting providers by offering a point-of-service option. The NJHCQA also contains a prohibition on "gag clauses" and has provisions to minimize the impact of financial incentives on a physician's professional judgement.

This spring, the Illinois legislature contemplated managed care reform when it considered the Managed Care Reform Act, 1997 Ill. H.B. 606 ("H.B. 606"). Although H.B. 606 passed the Illinois House in April, it has yet to come to a vote in the Senate (*see* article on Illinois managed care reform in this issue). If passed, H.B. 606 would require health plans to disclose, among other things, descriptions of coverage provisions and explanations of subscribers' financial responsibility for payment of premiums and other charges. H.B. 606 would also ban health plans from terminating or refusing to renew a provider's contract because the provider advocated, filed a complaint, or appealed a decision on behalf of a patient. In addition, in all cases where a plan decides to terminate its contract with a health care professional, the act would require the plan to provide written reasons for contract termination or nonrenewal.

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NEW LAWS FOR ILLINOIS HEALTH CARE EMPLOYERS

The Illinois Health Care Workers Background Check Act, which requires health-care employers to initiate a criminal record check on applicants and employees with duties involving direct patient care, has been amended effective January 1, 1998 to include additional criminal convictions for which a covered individual must be disqualified unless a waiver is granted by the state licensing agency. (Enclosed please find lists of each of the disqualifying criminal convictions). However, the amendment does not require an additional criminal background check on employees for whom checks were initiated during 1996 or 1997. Another amendment enables an employee suspended because of an inaccurate background check to recover backpay for the suspension period if the employer

is the cause of the inaccuracy.

Also, the Illinois Medical Patient Rights Act has been amended effective January 1, 1998 to require that identification badges be worn by health-care facility employees and volunteers (including students) who examine or treat patients or residents. The badge must disclose the wearer's first name, licensure status if any, and staff position.

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INDUSTRY GROUPS AND LEGISLATORS DIVIDED OVER STATE LICENSURE REQUIREMENTS FOR TELEMEDICINE

Illinois Passes Law Requiring State Licensure of Telemedicine Practitioners

Beginning January 1, 1998, physicians in other states engaging in the practice of telemedicine within Illinois will be required to obtain Illinois medical licenses before consulting directly with patients in this state. Illinois' new telemedicine law amends the state's Medical Practice Act (the "Act") to require licensure of an out-of-state practitioner engaged in medical practice within Illinois. 225 ILL. COMP. STAT. § 60/49.5 (West 1997). The amendment defines telemedicine as the performance of any activity that would constitute the practice of medicine as defined in the Act, "including, but not limited to, rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois, by a person located outside the state of Illinois relying upon transmission of individual patient information by telephonic, electronic, or other means of communication from within this state." A person who engages in the practice of telemedicine without being licensed under the Act would be subject to criminal and civil penalties.

The statute provides an exception for "periodic consultations" between a licensed Illinois physician and an out-of-state physician, although it does not define the term "periodic consultations." The Act also exempts: (1) second opinions provided to physicians licensed in Illinois; and (2) diagnosis of or treatment to an Illinois patient following treatment in another state where the provider is

licensed to practice medicine.

With the passage of its new legislation, Illinois joins a growing number of states which have adopted state licensure requirements for out-of-state physicians who engage in the in-state practice of telemedicine. These recent actions have fueled a growing debate over whether such telemedicine licensure requirements help promote high medical standards or instead hinder the delivery of care to those in need.

Telemedicine: Background and Development

Rapid advances in technology and the changing landscape of health care access and delivery have focused increased attention on the practice of telemedicine. Generally, "telemedicine" is defined as the use of telecommunications in medical consultation, diagnosis, or treatment. The practice of telemedicine can be as basic as transmitting medical records and images over a computerized network, or as futuristic as robot-controlled surgery. Examples of telemedical services already in widespread use include the use of interactive video and telephone conferencing, imaging networks, and facsimile transmissions. Sophisticated new developments include the use of cardiac telemetry by emergency response teams, transmission of electrocardiogram data over telephone lines, and satellite transmission of x-rays, photographs, and other medical information.

With these advances, the practice of telemedicine may expand access to health care services and medical expertise, as well as reduce the costs associated with serving isolated populations (*e.g.*, rural and homebound patients). In the managed care industry, in particular, telemedicine can help promote cost-effective health care delivery by allowing managed care organizations to operate "telephone triage" centers staffed by physicians or nurses who render "medical necessity" and treatment coverage determinations to network providers. Practitioners also benefit from this technology, as telemedicine can link physicians in rural, isolated areas with specialty consultants at leading medical centers.

Legal Issues: State Licensure Requirements

From a legal perspective, telemedicine raises a number of issues, including physician licensure, medical malpractice

liability, and electronic access to confidential patient records. Because telemedicine allows physicians to practice medicine over long distances, one of the issues of major concern to lawmakers and practitioners is how the various states will reconcile telemedicine with the traditional system of physician licensure.

Licensing of physicians is governed at the state level. Each state, through its medical practice act, requires a physician to have a license issued by that state's medical board in order to practice medicine in that state. The traditional system of state-by-state physician licensing poses potentially significant barriers to telemedical practitioners, since the practice of telemedicine frequently involves physicians in one state consulting with physicians or patients in another state. In this respect, state-by-state licensing requirements could have the practical effect of stopping telemedicine practices at state borders.

A physician with a valid medical license in one state can usually obtain a second license in another state through a process called "endorsement." However, this process can be time consuming, costly, and confusing because each state has its own set of requirements for licensure. Nevertheless, it is illegal to practice medicine in a state without having a license issued by that state. Thus, to avoid criminal and civil sanctions for the unauthorized practice of medicine, telemedicine practitioners must first determine what constitutes the practice of medicine in a particular state before engaging in telemedicine in that state. A typical state medical practice act will define the "practice of medicine" to include treating, rendering diagnoses and opinions, writing prescriptions, and performing surgery. Many states have traditionally allowed an exception for consultations between physicians in different states without requiring out-of-state physicians to be licensed.

With the practice of telemedicine becoming more prevalent, some states are amending their state licensure requirements to narrow the consultation exception and/or require full licensure of out-of-state physicians who practice telemedicine in-state. States that have already passed such legislation include Arizona, Connecticut, Texas, Florida, Kansas, Nevada, Massachusetts, New Mexico, South Dakota, Indiana, and, most recently, Illinois.

Common provisions of these amendments make "regular" or "ongoing" provision of medical services subject to the state licensure requirement. For example, Indiana expanded its definition of the practice of medicine to include providing diagnostic services to a person in Indiana "through electronic communications" and "on a regular, routine and non-episodic basis." IND. CODE. ANN. § 25-22.5-1-2(a)(4) (Michie 1996). Like the Illinois statute, however, the Indiana statute has retained an exception for periodic consultations between practitioners.

A number of government and industry groups are grappling with the telemedical licensure issue with differing viewpoints and approaches. Some organizations, such as the Center for Telemedicine Law ("CTL"), are pushing for a federally coordinated uniform interstate licensure system for telemedicine practitioners. The CTL, a non-profit agency supported by various medical and legal groups, contends that state-by-state licensing requirements impose unnecessary barriers and conflicting requirements on physicians and restrict access to high-quality health care. The CTL has voiced concern that new state laws appear to restrict a number of long-standing types of consultation agreements by exempting only "periodic" consultations or consultations between physicians of the same specialty.

In contrast, the American Medical Association ("AMA") favors state-by-state licensure and has called on states and their medical boards to develop full licensure requirements for telemedicine practitioners. Voicing the fear of many physicians, the AMA contends that telemedicine practice undermines community medicine because practitioners not fully licensed to practice in a state would be competing with in-state physicians who are required to be fully licensed. Other groups, such as the Federation of State Medical Boards ("FSMB"), support the idea of special "limited" licenses for telemedicine. FSMB, which last year drafted model legislation for limited telemedicine licensure, has said that national licensure standards may result in imposing the "lowest standard" and remove each state's ability to regulate the medical profession according to the needs of its population.

Several states have authorized "limited" or "special purpose" licenses for telemedicine practitioners. Colorado, for example, permits an out-of-state physician to practice telemedicine in Colorado on no more than 12 cases per

year. California updated its licensure law last year to authorize the state medical board to develop regulations for a registration program for out-of-state physicians. Other states, including Illinois, permit "emergency" exemptions from licensing for out-of-state physicians who assist in emergencies. *See e.g.*, 225 ILL. COMP. STAT. § 60/3 (West 1997).

The federal government has also taken notice of the telemedicine licensure issue. The interstate nature of telemedicine allows the federal government to wield more influence in an area traditionally reserved for states' rights. The Telecommunications Reform Act of 1996 established the Joint Working Group on Telemedicine ("JWGT") and charged it with assessing the role of the federal government in telemedicine and exploring ways to overcome barriers to the use of telemedical technology. In its report to Congress submitted on January 31 of this year, JWGT was noncommittal as to whether traditional state licensure imposed unnecessary barriers to the growth of telemedicine, or whether state licensure should be preempted by federal regulation. Instead, the report called for studies of alternative approaches to licensing at the state level.

Practical Application

The phenomenal growth and interstate nature of telemedicine has focused increased attention on the traditional state-by-state licensure system for the medical profession. While some groups urge that uniform national licensure standards for telemedicine would help to resolve the licensure issue, others are calling for individual states to enact their own telemedical licensure requirements. As the debate continues, an increasing number of states are passing laws aimed at regulating the practice of telemedicine within their borders. The practical effect and long-term impact of these new laws on the growth of telemedical technology remains to be seen. Even in states which have not amended their statutes, varying state definitions about what constitutes the practice of medicine complicate the issue of whether certain procedures or transmissions fall within a particular state's definition. As sophisticated new technologies continue to emerge, the risk of the unauthorized practice of medicine may inhibit broad and progressive uses of telemedicine. Given telemedicine's potential to improve health care access and to reduce the cost of health care delivery, health care

providers, industry groups, and legislators should focus on resolving issues such as licensure in order to facilitate the future growth and effectiveness of telemedical services.

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MEDICAID MANAGED CARE IN ILLINOIS AFFECTED BY RATE CUTS, FEDERAL BALANCED BUDGET ACT

State Cuts Pay to HMOs

Faced with substantial reductions in reimbursement rates and the uncertain direction of Illinois' voluntary Medicaid managed care program, several health maintenance organizations ("HMOs") have opted to cut back or discontinue their Medicaid business with the state.

The Illinois Department of Public Aid ("IDPA") announced in June 1997 that it would cut by 12% the amount the state pays HMOs for treatment of Medicaid patients in fiscal year 1998. Illinois Governor Jim Edgar approved the plan, which would reduce the monthly per-enrollee reimbursement cap from \$113 to \$99.42. Within days of the announcement, Humana Health Care Plans announced that it was terminating its Medicaid contracts with 450 private practice physicians in Illinois. Two other HMOs, Unity HMO of Illinois, Inc. and Maxicare Health Plans of the Midwest, withdrew their 1998 contract bids, citing the rate cuts and continuing uncertainty about the future of Medicaid managed care in Illinois.

IDPA subsequently amended its plan, increasing the average per-member, per-month reimbursement rate for all Medicaid HMOs to \$103.47. In addition, the deadline for HMOs to withdraw bids has been extended through November in order to continue contract negotiations with the eight HMOs remaining in the program and two others which have submitted bids. Current contracts expire on October 31, 1998.

IDPA has defended the rate cuts, saying the lower rates are set at a level that is actuarially sound and will improve the long-term viability of the state's Medicaid program.

MediPlan Plus Reconsidered in Light of BBA

As Medicaid HMO contract negotiations continue, the state is reconsidering plans to implement its Section 1115 waiver program, the MediPlan Plus Program ("MPP"). Under MPP, virtually all of Illinois' Medicaid recipients would be required to be enrolled in managed care plans, or to select a primary physician to oversee their care. Medicaid recipients who failed to make that choice within a designated time frame would be automatically enrolled in a managed care plan. The Illinois legislature approved the program in 1994, but the Health Care Financing Administration ("HCFA") did not approve the program until 1996. The program has yet to begin operation due to numerous changes and extensive review required by HCFA of all materials used in implementing the program.

As of November 11, 1997, the IDPA had yet to issue a formal decision regarding the fate of MPP. Rather than rolling out MPP as planned, it is possible the state may develop a new mechanism to implement managed care by amending Illinois' state plan. Authorized under the federal Balanced Budget Act ("BBA"), implementing managed care via a state plan amendment would require far less federal regulation and oversight. Signed into legislation by President Clinton on August 5, 1997, the BBA allows states to establish mandatory managed care for Medicaid recipients and affords greater flexibility in implementing such programs than the Section 1115 waiver process entails (*see* the special Balanced Budget Act of 1997 insert to this newsletter).

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EXPLANATION OF IRS GUIDANCE ON PHYSICIAN RECRUITMENT INCENTIVES

Physician recruitment arrangements by tax-exempt hospitals are subject to scrutiny by the Internal Revenue Service ("IRS") because they potentially violate the prohibitions against private inurement and private benefit found in Section 501(c)(3) of the Internal Revenue Code ("Code") and corresponding Treasury Regulations. Prior to now, little formal guidance existed to assist tax-exempt hospitals seeking to attract new physicians with recruitment incentives. While Section 333.3 of the Audit Guidelines for Tax-Exempt Hospitals and the Hermann Hospital Recruitment Guidelines have served as useful

predictors of how the IRS might evaluate certain physician incentive arrangements, until Revenue Ruling 97-21 ("Rev. Rul. 97-21"), no legally binding authority on the issue had been promulgated.

Rev. Rul. 97-21 Provides Precedential Authority

Rev. Rul. 97-21 provides the first legally binding guidance on how tax-exempt hospitals may incentivize physicians to join their staffs or to provide medical services to the community. Largely consistent with the proposed revenue ruling announced in 1995, Rev. Rul. 97-21 is generally viewed as favorable to hospitals in terms of allowing flexibility in recruitment arrangements that are well-documented and meet certain criteria. In delineating the range of permissible physician recruitment arrangements, Rev. Rul. 97-21 outlines the standards of review for such activities and applies that analysis to five specific fact situations.

In four of the five scenarios, the IRS determined that the hospitals did not violate the requirements of Section 501 (c)(3) of the Code because the physician recruitment activities: (1) furthered the hospital's charitable purposes; (2) did not result in inurement; (3) did not cause the hospitals to serve a private, rather than public, purpose; and (4) were assumed to be lawful for purposes of the ruling. In addition, in each of the four acceptable scenarios, the arrangements were negotiated at arm's length and approved by the Hospital's board of directors ("Board"), a committee appointed by the Board to approve contracts with hospital medical staff, or the officer designated by the Board to enter into a contract. The agreements also were in accordance with the physician recruitment guidelines established and regularly reviewed by the hospital's Board, and the hospital did not provide any recruitment incentives other than those set forth in the written agreement. In the fifth scenario, however, the hospital was found to be in violation of the exemption requirements because its recruitment arrangement led to a criminal conviction under the federal anti-kickback laws.

In each of the scenarios described in Rev. Rul. 97-21, the hospitals have been recognized as tax-exempt and operate in accordance with the standards for exemption under the Code. Additionally, the physicians recruited are deemed not to have substantial influence over the affairs of the hospitals that are recruiting them and, therefore, are not

disqualified persons as defined in Section 4958 of the Code. Nor do they have any personal or private interest in the activities of the organization that would subject them to the Section 501(c)(3) proscription on inurement.

Situation 1. A rural hospital located in a county designated as a Health Professional Shortage Area ("HPSA") recruits an obstetrician/gynecologist to become a member of its staff and establish full-time practice in its service area. Under a written agreement negotiated at arm's length which meets the recruitment guidelines established by the hospital's Board, the hospital provides a recruitment package in which it agrees to pay the physician a signing bonus (of an unspecified amount), cover his professional liability insurance premium for a "limited period," provide office space at below market rent for a limited number of years, guarantee a mortgage on a home in the area, and provide start-up financial assistance pursuant to a properly documented loan agreement. In this scenario, the loan agreement bears "reasonable terms," which presumably include a commercially reasonable interest rate on the loan, as well as a reasonable repayment schedule. The agreement is approved by a committee appointed by the hospital's Board and authorized to approve contracts with medical staff members.

Situation 2. The hospital in this scenario is located in an economically depressed inner city neighborhood. Its community needs assessment indicates that a shortage of pediatricians in the service area exists and that Medicaid patients are having difficulty obtaining pediatric services. The hospital recruits a physician to relocate to the city, open a full-time pediatric practice in the hospital's service area, become a member of the hospital's medical staff, and treat a reasonable number of Medicaid patients. Pursuant to a written agreement negotiated at arm's length and approved by the hospital's Board, the hospital reimburses the physician for "moving expenses" (as that term is defined in Section 217(b) of the Code), as well as his professional liability "tail" coverage for his former practice. The hospital also guarantees the physician's private practice net income for a limited number of years if the physician practices full time in the hospital's service area and does not generate a certain level of net income.

Situation 3. The hospital, located in an economically depressed inner city neighborhood, conducts a community needs assessment that indicates a shortage of obstetricians

willing to treat indigent patients. The hospital enters into an agreement with an obstetrician who is already a member of the hospital's medical staff to treat a reasonable number of Medicaid and charity care patients for one year. The hospital in return agrees to reimburse the physician for that year's professional liability insurance premium. The agreement is in writing and is consistent with physician recruitment guidelines established by the hospital's Board. It is approved by the officer designated by the hospital's Board to enter contracts with medical staff members.

Situation 4. A hospital located in a medium-to-large metropolitan area requires a minimum of four diagnostic radiologists to ensure adequate coverage and quality care for its radiology department. Two of the four diagnostic radiologists are leaving, and the hospital institutes a search for two replacements. It determines that one of the qualified candidates is a physician who is on the staff of another hospital in the same city, at which hospital the physician provides radiology services for patients but does not refer any patients to that or any other hospital in the city. The hospital recruits the physician to join its medical staff and provide coverage for its radiology department. Under an agreement negotiated at arm's length and approved by the hospital's Board, the hospital guarantees the physician's private practice net income for the first few years that the physician is a member of the hospital's medical staff and provides coverage for its radiology department.

Situation 5. A hospital in a medium-to-large city has engaged in physician recruitment activities that result in its being found guilty of knowingly and willfully violating the Medicare and Medicaid anti-kickback statute, 42 U.S.C.A. § 1320a-7b (1997). The conviction is based on recruitment incentives offered by the hospital which constituted payments for referrals.

Analysis

Rev. Rul. 97-21 states that in order to meet the requirements for maintaining tax-exempt status under Section 501(c)(3) of the Code, a hospital that provides recruitment incentives must do so in a manner that does not violate the "operational" test of Section 1.501(c)(3)-1 of the Treasury Regulations. Whether the operational test is met is determined based on all relevant facts and

circumstances, including dollar amounts and duration of incentives.

A somewhat different analysis applies when a tax-exempt hospital recruits a physician for its medical staff to provide services to the surrounding community, but not necessarily on behalf of the organization. Rev. Rul. 97-21 outlines four basic criteria which must be met in these situations:

- ⚡ *Furtherance of Exempt Purpose.* The hospital may not engage in substantial activities that do not further its exempt purposes. All recruitment activities must be reasonably related to the accomplishment of those purposes.
- ⚡ *Inurement.* The hospital must not engage in activities that result in inurement of its net earnings to a private shareholder or individual.
- ⚡ *Private Benefit.* The hospital may not engage in substantial activities that cause it to be operated for the benefit of a private rather than a public interest so that it has a substantial nonexempt purpose.
- ⚡ *Legality.* The hospital may not engage in substantial unlawful activities.

Rev. Rul. 97-21 does not specifically state what factors the IRS will consider in deciding if the above criteria are met. One may discern from Rev. Rul. 97-21, however, that the following considerations will play an integral role in the IRS' future decisions in the area of physician recruitment by hospitals.

About Vedder Price

Vedder, Price, Kaufman & Kammholz is a national, full service law firm with approximately 180 attorneys in Chicago, New York City and Livingston, New Jersey. Vedder Price provides a broad range of services to its health care clients, including:

- ⚡ Federal and state regulatory counseling on tax-exemption, Medicare/Medicaid, antitrust, fraud and abuse/Stark legislation, Certificate of Need, licensure, corporate practice of medicine and other issues;
- ⚡ Development of managed care

Demonstrated Community Need

In all four of the permitted scenarios, the hospitals presented objective evidence of a need for the recruited physicians' services, whether through a government study, designation as an HPSA or the hospital's own community needs assessment. In each situation, this objective showing of community need was a key factor in the IRS determination that the recruitment arrangements furthered the hospitals' charitable purposes, and that they were reasonable in light of the benefits derived by the hospital.

Documentation and Approval Criteria

- organizations and other strategic health care arrangements;
- ✦ Structuring of corporate networks, mergers, affiliations and acquisitions, including purchases and sales of practices and institutions;
- ✦ Comprehensive counseling to professional health care associations and medical specialty societies;
- ✦ Counseling in connection with implementation of strategic initiatives by health care entities, such as primary care satellite programs, physician recruitment and retention initiatives, and program development in emerging areas such as home health and outpatient mental health;
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In each scenario laid out in Rev. Rul. 97-21, the physician recruitment agreement is in writing, negotiated at arm's length, and approved by the hospital governing Board or by a committee or designated officer according to policy established and reviewed by the Board. The agreements are also in accordance with the physician recruitment guidelines established and regularly reviewed by the hospital's Board. In all four permitted situations, the hospital does not provide any recruitment incentives other than those set forth in the written agreement.

Recruitment Incentives

In Rev. Rul. 97-21, the IRS approved of a number of specific incentives in its ruling on the facts presented. Those incentives included: signing bonuses; payment of malpractice insurance premiums for a limited time period; subsidized office rent for a limited period; home mortgage guaranty; reimbursement of moving expenses; reimbursement of malpractice "tail" coverage; private practice net income guaranty for a limited time period; and start-up financial assistance in the form of a loan that is properly documented and bears so-called "reasonable terms" (e.g., a commercially reasonable interest rate). Thus, the ruling suggests that hospitals may utilize a variety of incentives to attract needed providers to the area.

The ruling does not claim to be an exclusive list of permitted incentives, or that these incentives will be appropriate in every fact situation. Nor does it necessarily imply that the incentives may be unlimited in duration or amount. Rather, the IRS has indicated that the ruling is intended as general guidance on physician recruitment arrangements and that the reasonableness of a particular arrangement, including dollar amounts and durations of incentives, would depend on all relevant facts and circumstances.

Cross-Town and Staff Physician Recruitment

Rev. Rul. 97-21 distinguishes between physicians who are recruited from outside the hospital's service area, those who are already on the hospital's staff, and those on the staff of another local area hospital. This differentiation could be read to imply that more relaxed standards might apply to incentives offered to physicians already on staff, as in Situation 3, and to "cross-town" recruitment

incentives provided to physicians who already practice at other institutions in the hospital's service area, as in Situation 4.

Income Guarantees

The use of salary surveys is permitted as a means to support the reasonableness of the net income guarantees in Rev. Rul. 97-21. For example, under the private practice income guarantees used in Situations 2 and 4, the ruling notes that the amount of the net income guarantee fell "within the range reflected in regional or national surveys regarding incomes earned by physicians in the same specialty."

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Undue Influence

Rev. Rul. 97-21 states that the physicians involved in the first four Situations "do not have substantial influence over the affairs of the hospitals that are recruiting them."

Accordingly, under Rev. Rul. 97-21, these physicians are not "disqualified persons" (as that term is defined in Section 4958(f)(1) of the Code), nor do these physicians have any personal or private interest in the activities of the hospitals that would subject them to the inurement proscription of Section 501(c)(3) of the Code. This applies even to Situation 3, where the physician was already on staff at the recruiting hospital and therefore would have been considered an insider based on prior guidance from the IRS.

Practical Application of Rev. Rul. 97-21

Although Rev. Rul. 97-21 is precedential authority, health care organizations must exercise care in their reliance on the IRS' latest pronouncement on physician recruitment agreements. Health care entities other than hospitals rely on Rev. Rul. 97-21 at their peril. For that matter, even hospitals should view Rev. Rul. 97-21 with circumspection. To the extent practical, hospitals seeking to rely on Rev. Rul. 97-21 should evidence circumstances substantially similar to one of the first four factual situations discussed above.

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ILLINOIS LEGISLATIVE UPDATE

A number of health care-related bills were passed by the Illinois General Assembly in its spring 1997 legislative session and signed by Governor Jim Edgar this summer.

Despite passage of several important measures, one of the major topics of debate during the legislative session remains unsettled — managed care reform. After the Illinois House of Representatives passed a comprehensive managed care reform bill, the Illinois Senate chose not to take action on the matter until fall at the earliest. Illinois' efforts toward managed care reform and the proposed legislation are detailed in another article in this issue. The following is a summary of some key measures that passed.

Right of Conscience and Surrogacy Acts Amended

H.B. 725 (P.A. 90-246) extends Illinois' Right of Conscience Act ("Conscience Act"), 745 ILL. COMP. STAT. § 70/1 (West 1997), to health maintenance organizations ("HMOs"), insurance companies, and other managed care providers. The Conscience Act exempts from liability and prohibits discrimination against all health care facilities and personnel that refuse to permit or provide health care services which are contrary to their consciences. For purposes of the Conscience Act, a health care facility's conscience is found in its articles of incorporation, bylaws, and other governing documents. The amendment, signed by Governor Edgar on July 29, 1997 and effective January 1, 1998, extends the Conscience Act's protection to managed care entities, insurance companies, and other health care payors. It also expands the definition of "health care facility" to include laboratory or diagnostic centers and physician organizations and associations.

H.B. 725 creates three new sections of the Conscience Act addressing the rights of health care payors. Section 11.2 provides that no health care payor or any person or entity that owns, operates, or manages a health care payor may be held civilly or criminally liable for refusal to pay for or arrange payment for health care services that violate the payor's conscience as documented in its governing documents. Similarly, Section 11.3 prohibits discrimination in licensing against such health care payors. All other forms of discrimination against health care payors are also unlawful under this section, including

discrimination in granting of authorizations, aid, assistance, benefits, or other privileges, and granting authorization to expand, improve, or create a health care payor. Section 11.4 makes it unlawful to deny any form of aid, assistance, grant, or benefits to a health care payor that would otherwise be entitled to the aid because the payor refuses to pay for or arrange payment for health care services that are contrary to that payor's conscience.

H.B. 725 also amends the state's Health Care Surrogate Act ("Surrogate Act"), 755 ILL. COMP. STAT. § 40/1 (West 1997), to significantly expand the authority of a health care surrogate to make medical treatment decisions on behalf of a patient with no decision-making capability, even if the patient does not have a qualifying condition.

Previously, the Surrogate Act allowed for surrogate decision-making only in decisions of whether to forgo life-sustaining treatment in cases where the patient was suffering from a "qualifying condition," defined as a terminal illness, permanent unconsciousness, or an incurable or irreversible condition, as determined and certified in writing by the attending physician.

The amendment to the Surrogate Act does not significantly alter the provisions for end-of-life decisions, in that it still requires a qualifying condition for surrogate decision-making to forgo life-sustaining treatment. The bill provides, however, that health care surrogates may make decisions regarding all other medical treatment for individuals who lack decisional capacity, with no judicial scrutiny or involvement, regardless of whether the individual has a qualifying condition.

Licensing Required for Telemedicine Practitioners

S.B. 314 (P.A. 90-99) amends the state's Medical Practice Act, 225 Ill. Comp. Stat. §§ 60/160/63 (West 1997), to require Illinois physician licensure of out-of-state practitioners who engage in the practice of telemedicine within Illinois. Signed by Governor Edgar on July 11, 1997 and effective January 1, 1998, the bill defines "telemedicine" as the performance of any activities that would constitute the practice of medicine under the Medical Practice Act, including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois, by a person outside the state relying upon transmission of patient information by

telephonic, electronic, or other means of communication. The bill excludes the following from the definition: (1) periodic consultations between an Illinois physician and a person outside the state; (2) a second opinion provided to an Illinois physician; and (3) diagnosis or treatment of an Illinois patient following treatment in another state in which the provider is licensed to practice medicine. (*See* related article this issue.)

Illinois Nursing Act

H.B. 1076 (P.A. 90-248) extends the sunset date of the Illinois Nursing Act (the "Act"), 225 ILL. COMP. STAT. §§ 65/165/49 (West 1997), to 2008. The bill also amends the Act to include a definition of "registered professional nursing practice" which recognizes the expanded role of nursing as a profession which entails diagnosis, "promotion, maintenance and restoration of health," and the teaching and supervision of nursing students.

The definition clarifies nurses' authority to delegate and supervise unlicensed assistive personnel such as nurse's aides, attendants, and orderlies. Prior to this provision, it was often assumed that unlicensed personnel were under the supervision of the institution. State regulation provides, however, that the supervising nurse, not the institution, is responsible for unlicensed assistive personnel.

The bill establishes a task force to study the roles and responsibilities of unlicensed assistive personnel to determine if there is a need for regulation of such personnel by the Illinois Department of Professional Regulation. The eleven-member task force is to report its findings and recommendations to the Governor by January 1, 1999. Some in the nursing profession question the need for state regulation of unlicensed assistive personnel, as regulation would entail establishing a scope of practice for such personnel. Concerns have been raised that the scopes of practice could be expanded over time to create higher levels of responsibility for auxiliary workers who have traditionally been under the supervision and direction of nurses.

Another amendment to the Act calls for the establishment of a professional assistance program by January 1, 1999. The program will provide treatment for nurses whose ability to perform their job duties is compromised by

substance abuse or addiction.

One important measure in the bill which did not pass, however, was the establishment of a licensure category for advance practice registered nurses ("APRNs"). The APRN matter was deferred for further discussion and negotiations during the next legislative session.

Post-Mastectomy Care Bill

Signed by Governor Edgar on June 10, 1997, H.B. 1881 (P.A. 90-07) amends the Illinois Insurance Code, 215 ILL. COMP. STAT. §§ 5/15/5 (West 1997), to require insurers to provide inpatient coverage following a mastectomy. The bill allows the attending physician to determine the duration of the hospital stay, based on an individualized evaluation of the patient and coverage for and availability of a post-discharge physician office visit or in-home nurse visit in the first 48 hours after discharge.

The bill also reduces the age at which insurance companies must provide coverage for annual mammograms from 50 years to 40 years and requires coverage for annual cervical or Pap smear tests and prostate-specific antigen tests.

Nursing Home Retention and Discharge Guidelines for Medicaid Patients

S.B. 444 (P.A. 90-310) amends the Nursing Home Care Act, 210 ILL. COMP. STAT. §§ to 45/1-131 (West 1997), to establish conditions for when a nursing home may discharge a resident if the resident switches from being a private pay patient to being a Medicaid patient upon the exhaustion of personal financial resources. The bill provides that facilities with distinct-part units may refuse to retain a resident in the noncertified parts of the facility if the person is unable to pay for care without Medicaid. The refusal to retain the resident must be in writing, and a written explanation of the facility's policy must be given to the resident at the time of admission and upon contract renewal. The bill was signed by Governor Edgar on August 1, 1997, and went into effect that day.

HIPAA Brings State into Compliance with Federal Law

S.B. 802 (P.A. 90-30) creates the Health Insurance

Portability and Accountability Act ("HIPAA") and brings the state into compliance with the federal HIPAA of 1996, commonly known as Kennedy-Kassebaum. Signed by Governor Edgar on June 26 and effective July 1, 1997, the bill provides that persons who have previously been covered under group health insurance must always be eligible for health insurance, if they have no more than a 63-day break in coverage. The bill also limits exclusion of coverage for pre-existing conditions to one year.

Genetic Information Privacy Act

H.B. 8 (P.A. 90-25) creates the Genetic Information Privacy Act, which limits the use of genetic information by insurers and employers. Signed by Governor Edgar on June 26, 1997, the bill takes effect January 1, 1998. Under the new law, all information derived from genetic testing is confidential and cannot be released without the patient's consent. No consent is required, however, for release of genetic information to legal authorities conducting an investigation or prosecution.

HMO Provision of Outpatient Services to Children

H.B. 1565 (P.A. 90-316) amends the state's Health Maintenance Organization Act, 215 ILL. COMP. STAT. §§ 65/165/6 (West 1997), to authorize HMOs to make basic outpatient preventive and primary care services available to children under the age of 19 who are otherwise unable to obtain health care benefits.

This amendment parallels a similar provision in the Balanced Budget Act of 1997 which enacted a number of federal Medicare/Medicaid reforms. The new provision establishes an entitlement program under which states will receive federal funds to be used to provide health coverage to low-income children in rural areas. The bill was signed by Governor Edgar on August 14, 1997, effective that day.

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