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As Y2K Problems Begin, Legislation May Limit Suits

By Robert S. Greenberger
Staff Reporter of The Wall Street Journal

SEATTLE—Michael Verna, a California lawyer, is warning a group of technicians about the dangers ahead if they don't get the glitches out of their companies' computers by the end of the year.

"A courtroom may seem foreign to you people sitting here today, but in a few years, you could be sitting in a witness chair," he tells two dozen nervous techies gathered in a nondescript hotel conference room here. "This isn't like the asbestos manufacturers or even the breast-implant makers," he adds, referring to two of the billion-dollar legal actions of the past decade. "This will be across the board. It will involve everybody."

Michael Verna

It certainly will involve lots of lawyers, including firms such as Mr. Verna's that are focusing on Year 2000 computer problems. And that worries some lawmakers back in the other Washington. The Republican-led Congress is working on legislation to head off an expected avalanche of Y2K lawsuits by limiting damage awards and encouraging quick settlements. The House approved the bill Wednesday, which could spur Senate action soon.

Technical problems loom after Jan. 1, 2000, when computers read the "00" in the date field of the programs they are running and some of them determine that it means 1900, fouling up everything from VCRs to sensitive medical devices. But political problems associated with Y2K have already begun.

The White House is being squeezed by two wealthy Democratic constituencies. On one side are trial lawyers, major party campaign contributors who are unhappy with dollar limits on lawsuits. On the other side are high-tech companies that want to limit their legal liabilities. The Clinton administration, which says it wants to work with Congress on the measure, has indicated that the president would veto the bill if it limits consumers' rights.

The trial lawyers have carried the fight to the Senate, whose rules make it easier than in the House to block legislation. Meanwhile, Virginia Rep. Tom Davis, chairman of the National Republican Congressional Committee, sees Y2K worries as a potential rallying point—and funding source—for the GOP. He travels to Silicon Valley today to attend campaign fund-raisers this weekend.

Here in Seattle, Mr. Verna is explaining how writing internal memos or careless e-mail could hurt a firm in a Y2K lawsuit. Loretta Pirozzi of Data Dimensions Inc., a consulting firm, complains that most bosses aren't budgeting enough money to fix the problems. A knowing chuckle sweeps the room. Mr. Verna warns that memos on such budget disputes become smoking guns in court.

"What can we do?" asks another woman.

"Have lawyers show you how to protect your documents, for one thing," he says. "By the way," he adds, "that isn't a sales pitch."

But, of course, it is. Bowles & Verna, a 21-member firm in Walnut Creek, Calif., has a Y2K game plan. It starts with seminars that help develop new clients. The millennium itself will usher in the "failure-litigation phase" of court fights. And in about five years, just when it seems like everyone has sued everyone else, comes the "insurance-coverage phase," when companies go after their insurers to pay some of their Y2K losses.

"You want to be on the leading edge of the tort of the millennium," Mr. Verna says.

Bowles & Verna's journey to 2000 began almost by chance, in 1997, while Kenneth Jones, then a third-year law student, was playing a computer football game. His wife, Sandy, was telling him that people were stocking up on canned goods and bottled water for the expected chaos of Y2K. At that moment, Mr. Jones recalls, he had an epiphany.

A new area of law, involving future failures due to Y2K bugs, was being born, and Mr. Jones, a law student comfortable with technology, was perfectly positioned for it. He also was headed for a job at Bowles & Verna, where he had been a summer law clerk. "I decided the firm could be the experts. They just needed to cross the technological barrier and learn how to talk tech," he says.

Kenneth Jones

With Mr. Verna's strong encouragement, the 28-year-old Mr. Jones prodded his colleagues, giving some of the firm's techno-challenged lawyers a book, "Year 2000 Solutions for Dummies." Gradually, the firm formed a Y2K team. All it lacked was a client. Then, late last year, Mr. Jones's friend Tom Johnson, a Walnut Creek swimming coach, went shopping for a laptop computer—and Bowles & Verna found its first Y2K lawsuit.

Mr. Johnson was upset because most of the retailers where he shopped neglected to tell him that some of their laptops weren't Y2K-ready. But with no apparent injury to Mr. Johnson, the firm needed a legal theory. California's Unfair Business Practices Act came to the rescue. The statute permits citizen lawsuits on behalf of the people of the state to stop unfair or deceptive business practices. And so Mr. Johnson is suing about half a dozen retailers for injunctive relief to require disclosure for Y2K compliance, but not for damages. And, under the state law, Bowles & Verna would collect attorney's fees.

But more important, the firm enhances its image as a hard-nosed litigator. "We, of course, hope and expect that we will both be successful [in the lawsuit] and be recognized for our efforts in this case," says Mr. Verna.

The novel approach of suing before damages occur is the kind of action that lawmakers are trying to discourage. The legislation Congress is working on would do that by giving defendants 30 days to fix a potential Y2K problem before a lawsuit may begin, and then give the retailer or manufacturer an additional 60 days if it agrees to fix the problem.

If a lawsuit is filed, the House bill would limit the amount of punitive damages against small businesses to either three times the amount of actual damage or $250,000, whichever is less. For businesses with more than 50 employees, the limit on punitive damages would be either three times actual damages or $250,000, whichever is greater. With some prodding from the trial lawyers, the Senate version was changed to eliminate the cap on punitive damages against large businesses.

Of course, what makes the prospect of Y2K lawsuits so strange is that any of Mr. Verna's clients could be a plaintiff in one action and a defendant in another. "Switch-hitting isn't a bad thing. It makes me a better lawyer," he says.

As the two-hour Seattle session ends, Mr. Verna issues his final warning: "Be careful out there. You're not just dealing with a technical problem, you're dealing with a legal problem. One day you may have to answer some questions from a person like me."

Medicare Tests of Competitive Bidding Rile HMOs Fearing a Drop in Payments

By LAURIE MCGINLEY
Staff Reporter of THE WALL STREET JOURNAL

The health-care industry loves to say Medicare should act more like a business. But now that the program is trying to adopt private-sector strategies, many in the industry are squawking.

Consider Medicare's efforts to try out alternative payment schemes for health-maintenance organizations. Currently, HMOs are paid according to a complicated formula set by Congress. But the 1997 Balanced Budget Act directed Medicare to experiment with competitive bidding to see if it would be a cheaper, more efficient way of reimbursing HMOs for caring for the elderly.

As a first step, federal advisers to Medicare selected Phoenix and Kansas City as sites for pilot projects for competitive bidding. Under the plan, Medicare HMOs must submit bids indicating how much they would accept from the government for each patient. Even though the effort has barely started, one result is in: The HMOs are unhappy.

In Phoenix, where 40% of seniors are enrolled in HMOs, health plans and local officials have been demanding the project be delayed at least a year or killed outright. In Kansas City, where HMOs have a smaller chunk of the seniors' market, health plans have been unenthusiastic but less vocal. At a meeting in Detroit yesterday, federal advisers to Medicare rejected the Phoenix requests, but agreed to allow a delay of as long as three months, until next April, for implementing the pilot projects in the two cities.

In opposing the projects, the Phoenix health plans argue that the market already is highly competitive because senior citizens have a number of HMOs to choose from, all offering generous benefits. The competitive bidding process, they claim, would drive down their federal payments, forcing them to charge seniors premiums or reduce benefits. "We think our customers are being penalized and told, 'We will use you as an experiment in an effort to figure out how to continue to cut Medicare,'" says Gay Ann Williams, executive director of the Arizona Association of Health Plans.

A similar flap involves medical equipment. Currently, Medicare sets prices for a wide range of durable medical equipment, including wheelchairs and hospital beds. To simplify the byzantine system and save money, the program launched a competitive-bidding demonstration project in Polk County, Fla. Supplies are to be selected on price and quality.

But the Florida Association of Medical Equipment Services, an Orlando group that represents equipment suppliers, says the bidding process inevitably will reduce prices and hurt small suppliers. The group sued to block the effort but was recently rebuffed by a federal judge.

The Health Care Financing Administration, which runs Medicare, has long been urged by the health-care establishment, as well as Congress and health analysts, to become a savvier buyer. But the industry opposition to competitive bidding shows how hard it is to make fundamental changes in the federal health program for 39 million elderly and disabled. The Medicare system is due to run out of money by 2015, and both Congress and the Clinton administration are weighing alternatives to overhaul the program.

The bottom line, says Ira Loss, senior vice president at Washington Analysis, an equities-research firm, is that Medicare providers are "interested in the free market only if it means the government is getting away from bothering them. But when it comes to the government actually forcing them to compete for business, they are unhappy about it."

HMO officials vehemently dispute that. Karen Ignagni, president of the American Association of Health Plans, which represents HMOs, says the government's bidding procedure is flawed—"a jury-rigged proposal masquerading as free-market competition." She says the bidding process isn't fair, because it doesn't include Medicare's traditional fee-for-service program, so that HMOs would bear the brunt of any payment reductions.

No matter what the fate of the pilot projects, HMO officials are determined to prevent competitive bidding from being used on a national scale. The industry says any reduction in payments to health plans will roil the HMO market, which already is grappling with reductions in federal reimbursements. Some believe the competitive bidding could cause more HMOs to drop out of Medicare. Instead, HMOs want Medicare to stop spending more on patients in the traditional fee-for-service program than on those in HMOs. Such a move, though, would force people in the traditional program to pay more for their care, Medicare officials say.

The contretemps is occurring even as there is widespread agreement that Medicare's reimbursement system is cumbersome. Some government studies, moreover, have suggested Medicare has overpaid HMOs and medical-equipment suppliers. "Who benefits from competitive bidding?" asks Robert Reischauer, a senior fellow with the Brookings Institution and a member of the advisory board on competitive bidding. "The taxpayer. But the taxpayer doesn't always have a voice in this."

In Phoenix, where 155,000 senior citizens are enrolled in HMOs, the health plans have enlisted an array of allies, including the Chamber of Commerce, doctors and beneficiaries. They all believe the current system works fine: HMOs offer generous benefit packages that include prescription-drug coverage—and no supplemental premium.

In a recent letter to HCFA Administrator Nancy-Ann DeParle, the entire Arizona congressional delegation warned that competitive bidding "would only disrupt a market in which competition is already vigorous, costs are low and participation is high." The lawmakers have signaled they may block the project by legislation.

Such resistance irks those who believe Medicare badly needs to experiment with new cost-containment tools, including increased competition among health plans. Given the debate over Medicare, "this is the kind of demonstration that is directly relevant and should be conducted to give Congress information about what way the program should go," says Robert Berenson, a top HCFA official.

In 1996 and 1997, the HCFA was forced to abandon HMO bidding projects in Baltimore and Denver because of industry opposition.

Here's how competitive bidding would work: No matter what they bid, all HMOs would be permitted to take part in Medicare, as they generally are now. The government would then calculate a median of all the submitted bids and pay every HMO that amount. The health plans are worried that such a system would further reduce their reimbursements, forcing them to either charge a premium or reduce benefits, making them less competitive. HCFA officials say that benefits won't decline but acknowledge some patients may have to pay premiums for services they now get for free.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administratio

The Administrator
Washington, D.C. 20201

MAY 6 1999

The Honorable John McCain
United States Senate
Washington, D.C. 20510

Dear Senator McCain:

Thank you for your letter regarding the Health Care Financing Administration's (HCFA's) plans to implement the Competitive Pricing Demonstration in Phoenix as designated by the Competitive Pricing Advisory Committee (CPAC). As you know, the Competitive Pricing Committee was created by Congress in the Balanced Budget Act of 1997 to recommend the design, structure, and sites for the Competitive Pricing Demonstration.

According to the statute, the goals of this demonstration project are to use market-based pricing to reimburse Medicare managed care plans in selected metropolitan statistical areas (MSAs) throughout the United States in order to determine the impact on the price and quality of services provided by participating Medicare+Choice (M+C) plans, as well as to understand the effect on beneficiaries, health care plans, and providers. The CPAC, a national panel of experts, chaired by Mr. James Cubbin, the Executive Director of the General Motors Health Care Initiative, identified protecting beneficiaries and setting fair rules for the marketplace as additional objectives to meet as CPAC designed the demonstration and selected sites for demonstration implementation.

The CPAC was Congressionally mandated to select at least four, and up to seven, sites in order to test market-based pricing in different areas of this country. At least one of those sites must be in a rural area. In order to design this demonstration and make its initial site selections, the CPAC held a series of meetings during 1998 which were open to the public and announced in the Federal Register. With regard to selecting sites, the CPAC engaged in a deliberative and an objective process to identify appropriate locations for implementing the demonstration.

Before examining specific locations, committee members identified the relevant factors for reviewing sites: current Medicare payment in the community; Medicare health maintenance organization (HMO) market share; commercial market share of health plans in the community; number of Medicare beneficiaries in the community; proximity to other managed care market areas; and the extent of recent Medicare managed care non-renewals in the area. For its initial selections, CPAC members believed it was important to select locations that had relatively high Medicare capitation rates, but that

varied in their level of managed care penetration so the effects of competition in different market settings could be evaluated.

While CPAC was interested in selecting relatively high payment areas, payment was not the only factor it thought was important to consider. However, as one of its initial steps, the Committee decided to select the top 100 MSAs in the United States, in terms of Medicare managed care payment before considering other factors. The extremely large MSAs were excluded by the Committee because the potential impact would be inconsistent with the concept of a demonstration where new ideas are tested on a scale that is sufficient to provide meaningful results.

The relevant factors were applied to all MSAs in the United States, and a list of nine potential sites was produced. These criteria and additional detailed information on beneficiary counseling resources, the extent of Medicaid managed care activity, hospital and physician supply characteristics, and overall health plan performance and financial status were used to select the first two demonstration sites. Kansas City was selected to represent an emerging market and Phoenix to represent a mature managed care market.

In you letter, you compare the Congressional Research Service's recent analysis of the mean national monthly Medicare HMO per beneficiary payment rate to the Maricopa County mean rate. The CPAC, however, did not base its analyses on average payment rates. In fact average payment rates per beneficiary can be misleading because the small number of extremely high payment rate areas, such as Miami and Los Angeles, skew the overall results. Therefore, the CPAC considered the county payment rates within each MSA weighted by the number of beneficiaries in each county to determine payment rates for each MSA. The Phoenix MSA ranked number 72 out of a total of 319 MSAs, with number one being the highest payment rate. The rate for Phoenix, utilizing this methodology, was $490 while the national median was $424. Our consultants have updated the payment rates for Plan Year 2000, using this same methodology, with substantially the same results.

Consistent with its Congressional mandate, the CPAC left many important decisions up to the Phoenix Area Advisory Committee (AAC), the local panel of experts, so that individuals familiar with the local market, as well as those representing all the stakeholders, could make these decisions. For example, the AAC will develop the standard benefit package consistent with CPAC guidelines on which all participating plans must bid, and it will determine the method for setting the Medicare contribution that will be used for this demonstration site.

We share your concern about protecting beneficiaries in rural areas. However, the Phoenix MSA does not include any rural areas. Therefore, such areas should not be adversely affected by the implementation of the demonstration in the two selected sites.

As you note, the first AAC meeting was held in Phoenix on March 31. While continuing to make crucial implementation decisions for this demonstration site, the AAC voted to recommend to CPAC and to Congress to delay implementation for a year. Your letter also urges that the CPAC and HCFA consider the decision to go forward with a Competitive Pricing Demonstration in Phoenix. We welcome suggestions from the AAC, as well as other members of the local community and will forward any recommendations to the CPAC for considerideration during its May 13 meeting in Detroit. We will follow the recommendations of the CPAC as we have throughout this process.

The CPAC has already considered whether to delay implementation of this demonstration for another year at the same meeting at which it selected Phoenix and Kansas City as the initial demonstration sites. The CPAC voted not to delay implementation in view of the statutory requirements to conduct this demonstration and the importance of this demonstration project to the future of Medicare reform.

HCFA and CPAC share your concerns about the regulatory burden on M+C plans. To that end, the plans will not be required to submit adjusted community rating (ACR) proposals as all other M+C plans will be required to do by July 1. Instead, a plan's bid submission will replace the need for ACR submission. In addition, plans will not be required to break down the various components of their bids.

I hope this letter addresses the concerns that you and your colleagues have expressed. I have offered to meet with you and other members of the Arizona delegation to discuss your concerns in greater detail, and indeed, we held one such meeting on April 27. I would be happy to meet again in the future, as I look forward to working with you to strengthen the Medicare program. A similar letter is also being sent to the co-signers of your letter.

Sincerely,

Nancy-Ann Min DeParle
Administrator