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Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS

Affordable Care Act Implementation

ACA Enrollment Continues to Rise as 2015 Open Enrollment Deadline Approaches

On February 4, CMS announced that nearly 7.5 million people have signed up for coverage on the federal exchange, with an additional 2.4 million people signing up for plans or being automatically enrolled through state exchanges, for a total of 9.9 million people. This exceeds the 7 million people who signed up in the first open enrollment period.

Taxpayers Face Challenges as New ACA-Related Provisions Come into Effect

This tax season, taxpayers are grappling with the effects of the Affordable Care Act for the first time. Taxpayers who did not have insurance coverage in effect throughout 2014 are required to pay a penalty or claim an exemption from coverage. Taxpayers who received subsidized coverage through the health insurance marketplace must complete a form to reconcile the subsidies they received with those to which they were entitled. Taxpayers who had full-year minimum essential coverage have it the easiest; the only additional task is to check a box on Line 61 of Form 1040. However, there is little guidance available for taxpayers to determine whether or not their employer-provided coverage was affordable and adequate for 2014.

Taxpayers who did not have full year coverage and claim an exemption from the coverage requirement for some or all of 2014 must complete Form 8965. The calculations for claiming an exemption can become quite complicated for those claiming an exemption because the lowest-cost health care coverage available through his/her employer-sponsored plan was unaffordable, or for individuals not eligible for employer coverage.

Taxpayers who received subsidized coverage through the health insurance marketplace must complete Form 8962 to claim their premium tax credit and to reconcile any advance payments of the premium tax credit that reduced their monthly premiums. When a taxpayer signs up for subsidized health insurance through the marketplace, the subsidy is based on his or her estimated income for the calendar year. The difference between estimated and actual income is reconciled on Form 8962, with the result that taxpayers who overestimated their income receive additional premium tax credit and those who underestimated their income repay the portion of the premium tax credit to which they were ultimately not entitled. This calculation is also quite complicated because, among other challenges, the amount of credit for

which a taxpayer is eligible is defined in relation to the monthly premium for the second lowest-cost silver plan that would have covered the taxpayer and his/her family, and this can be difficult to determine.

Other Federal Developments

President Releases FY 2016 Budget Proposal

On February 2, the Obama Administration released its proposed federal budget for FY 2016. Below is a summary of the key provisions:

- Medicare Delivery and Payment Reforms: The proposed FY 2016 budget includes a package of Medicare legislative proposals estimated to save $423.1 billion over 10 years. Highlights include:
    - Repeal the Sustainable Growth Rate (SGR) formula used to update the Medicare physician fee schedule and replace it with reforms contained in recent legislation.
    - Allow CMS to assign more Medicare fee-for-service beneficiaries to Federally Qualified Health Centers and Rural Health Clinics that participate in an Accountable Care Organization (ACO) under the Medicare Shared Savings Program, and expand the basis for beneficiary assignment for ACOs to include nurse practitioners, physician assistants, and clinical nurse specialists.
    - Eliminate the 190-day lifetime limit on inpatient psychiatric facility services.
    - Reduce Medicare coverage of bad debts from 65% in most cases to 25% over three years starting in 2016.
    - Exclude radiation therapy, therapy services, advanced imaging, and anatomic pathology services from the in-office ancillary services exception to the Stark law, except in cases where a practice is “clinically integrated” and demonstrates cost containment, as defined by the Secretary of HHS.
    - Reduce critical access hospital (CAH) reimbursement to 100% of costs and limit CAH designation eligibility for hospitals within 10 miles of another hospital.
- Major Program Integrity Provisions
    - Expand funding for the Health Care Fraud and Abuse Control program, the Medicaid Integrity Program, and Medicaid Fraud Control Units, and other HHS program integrity efforts.
    - Expand the current authority to exclude individuals and entities from federal health programs if they are affiliated with a sanctioned entity by closing a “loophole” that allows an officer, managing employee, or owner of a sanctioned entity to avoid exclusion by resigning his or her position or divesting his or her ownership; and extending the exclusion authority to entities affiliated with a sanctioned entity.
    - Authorize civil monetary penalties for providers who do not update enrollment records.

  - The budget includes several provisions to reform the Medicare appeals process, including allowing HHS to retain a portion of Recovery Audit Contractor recoveries to fund related appeals; increasing the minimum amount in controversy required for Administrative Law Judge adjudication; allowing the Office of Medicare Hearings and Appeals to use attorney adjudicators for certain claims; establishing expedited OMHA procedures for claims with no material fact in dispute; remanding an appeal to the first level of review when new documentary evidence is submitted into the administrative record at the second level of appeal or above; and authorizing the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques

- Increased funding for the OIG: The proposed budget includes an increase of $80 million from the OIG's FY 2015 allocation. This will allow the OIG to focus on vulnerabilities and risk areas within HHS, such as the health insurance marketplaces, the management and administration of grants and contracts from HHS and payment accuracy within the federal health-care programs.

HHS Announces Payment and Delivery Reform

On January 26, HHS Secretary, Silvia Burwell, wrote a perspective piece in the New England Journal of Medicine outlining the Obama Administration's efforts to reduce total Medicare and Medicaid spending. Secretary Burwell explained that HHS intends to focus its energies on augmenting reform in three ways: using incentives to motivate higher-value care, by increasingly tying payment to value through alternative payment models; changing the way care is delivered through greater teamwork and integration, more effective coordination of providers across settings, and greater attention by providers to population health; and harnessing the power of information to improve care for patients. HHS has set a goal of having 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018. In addition, HHS has set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction programs.

Medicare Overpaid $4.6 Million to Hospitals for Clinic Visits

On January 13, the OIG released a report in which it found that CMS made $4.6 million in incorrect payments in calendar year 2012 to hospitals for established patients' clinic visits. The Medicare payment for clinic visits depends on whether the patient is identified as "new" or "established" at a particular hospital. If the patient has a hospital medical record that was created within the past 3 years, that patient is considered an established patient at the hospital.

Of the 110 randomly sampled line items that the OIG audited, only one was correct. Hospitals told the OIG that the incorrect codes were the result of staff making clerical and programming errors as well as not understanding Medicare policy for billing patient clinic visits. The OIG recommends that CMS, in conjunction with Medicare Administrative Contractors (MACs), recover incorrect overpayments identified in the audit, and resolve the remaining line items for the overall sample for patient clinic visit payments and recover the $4.6 million in incorrect payments. CMS agreed with the first recommendation and partially concurred with the second.

Meaningful Use Updates

Proposed Stage 3 Meaningful Use Rule Sent to White House Office of Management and Budget (OMB)

In early January, HHS confirmed that it sent a proposed rule implementing Stage 3 of Meaningful Use to the OMB. Although the proposed rule itself is not yet public, HHS has indicated that the rule will focus on advanced use of electronic health record (EHR) technology to promote improved outcomes for patients, and it proposes changes to the reporting period, timelines, and structure of the program, including providing a single definition of meaningful use. HHS has explained that these changes "will provide a flexible, yet, clearer framework to ensure future sustainability of the EHR program and reduce confusion stemming from multiple stage requirements." In the notice to the OMB, HHS also says that it is working with the Office of the National Coordinator for Health Information Technology (ONC) to ensure that the Stage 3 meaningful use definition coordinates with the standards and certification requirements being proposed, and that there is sufficient time to upgrade and implement these changes. Stage 3 is scheduled to begin in 2017. The rule could be published in the Federal Register at any time.

CMS Intends to Modify Requirements for Meaningful Use

On January 29, CMS announced that it intends to issue a new rule that would "update" the Medicare and Medicaid EHR incentive programs, and shorten the attesting reporting period in 2015 from one-year to 90 days in order to "accommodate" these changes. The new rule, expected this spring, is in direct response to provider concerns about software implementation, information exchange readiness and other related concerns. Specifically, CMS is considered proposals to:

- Realign hospital EHR reporting periods to the calendar year to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other CMS quality programs
- Modify other aspects of the program to match long-term goals, reduce complexity, and lessen providers' reporting burdens
- Shorten the EHR reporting period in 2015 to 90 days to accommodate these changes

This rule would be separate from the proposed rule implementing Stage 3 of the Meaningful Use program.

OCR Launches Updated Breach Portal

The HHS Office for Civil Rights (OCR) recently launched an updated version of the portal covered entities must use to notify OCR regarding a breach of unsecured protected health information under 45 C.F.R. § 164.408. While the previous version of the breach portal consisted of a single web page where the user could input the information to be included in the report, the updated breach portal utilizes a new format in which the user inputs the information in successive stages. The updated portal also adapts to the information provided. For example, if a business associate is completing the form, the fields will change. The updated portal is available here: https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true. The deadline for reporting 2014 breaches affecting fewer than 500 individuals is March 2, 2015.

OIG Reviews Medicare's Oversight of Compounded Pharmaceuticals Used in Hospitals

On January 21, the OIG issued another report examining the safety of compounded sterile preparations (CSPs) used in hospitals, in response to a 2012 meningitis outbreak caused by contaminated

injections. The report assesses the extent to which Medicare's oversight of hospitals addresses 55 practices for recommended practices for CSP oversight in acute-care hospitals recommended by various expert guidelines. While CMS and the four CMS-approved hospital accreditors addressed most of the recommended CSP-related practices at least some of the time, the OIG identified certain gaps, particularly with regard to review of hospital contracts with stand-alone compounding pharmacies. The OIG also questioned the human capital available by oversight entities to thoroughly review hospitals' preparation and use of CSPs, and the adequacy of surveyor training related to compounding. The OIG recommends that CMS: (1) ensure that hospital surveyors receive training on standards from nationally recognized organizations related to safe compounding practices; and (2) amend its interpretive guidelines to address hospitals' contracts with standalone compounding pharmacies. CMS concurred with the recommendations.

OIG Says Hospital Compliance Reviews Are a Critical Component of Provider Education

In a January 15 letter to the American Hospital Association (AHA), the OIG responded to the AHA's criticisms about its hospital compliance reviews. In November 2014, the AHA sent a letter to the OIG urging it to stop conducting hospital compliance reviews and extrapolating the findings of audits citing numerous legal problems with the extrapolation method. In response, the OIG says the "reviews have served an important role in highlighting vulnerabilities in hospital billing and returning improper payments to the Medicare Trust Fund." In addition, the reviews "are a critical component of educating providers about how to identify and remediate risk areas in billing Medicare." The OIG hopes hospitals will use the reviews to reduce the number of Medicare billing errors in the future and strengthen compliance.

CMS Further Extends Enrollment Moratoria on Some Home Health Agencies and Ambulance Suppliers

On January 29, CMS announced that it would extend for another six months the temporary moratoria on enrollment of new ambulance suppliers and home health agencies in specific parts of the country, including Florida, Illinois, Michigan, Texas, Pennsylvania and New Jersey. CMS said it consulted with the OIG and the Department of Justice and they agreed that a significant potential for fraud, waste and abuse continues to exist in these geographic areas. We first reported on the moratoria in February 2014. Existing providers and suppliers in these areas can continue to provide and bill for services, but no new provider or supplier applications will be approved during the moratoria. We originally reported on the moratoria in February 2014, and they were extended in the summer of 2014.

OIG Issues Advisory Opinion Regarding Providing Free Items in Maternal Health Program

On January 26, the OIG issued an advisory opinion in which it concluded that an existing arrangement in which a provider offers free diapers and play yards in to women in connection with offering medical services through a state-run maternal health program would not result in the imposition of administrative sanctions or monetary penalties. Under the arrangement, Medicaid beneficiaries who are eligible for the maternal health program can receive one free pack of diapers during their initial consultation with the provider regarding participation in the program. The beneficiaries are not required to enroll in the program or select the provider for their medical services. If a beneficiary decides to enroll in the program and selects the provider for medical services, she can receive one free pack of diapers per provider visit. To receive a play yard, beneficiaries are required to enroll in the maternal health program, select the provider for their medical services and complete 10 visits. The total aggregate value of diapers for each beneficiary is below $50 and the play yards cost $50.

The OIG concluded that the arrangement is not subject to any sanctions because the value of the diapers is minimal, and the free diapers and play yards meet the preventive care exception to the civil

monetary penalties statute. The preventive care exception exempts any incentives that are provided to beneficiaries to induce them to seek preventive care from being classified as remuneration.

STATE DEVELOPMENTS

New Requirements for Board of Medicine Licensees

The Board of Medicine held a public hearing on February 4, 2015 on proposed rules governing two new requirements for physicians to renew their licenses. All licensees authorized to prescribe Schedule II, III and/or IV controlled substances must register with the Prescription Drug Monitoring Program (PDMP) before license renewal. Instructions for registering have been sent by email to all current licensees. Licensees who have a New Hampshire practice location will also be required to complete the New Hampshire Division of Public Health's Licensure Survey (NHPH survey). The survey, which should take between 5 and 15 minutes to complete, captures information about the supply and capacity of physicians and physician assistants to be used in conducting statewide healthcare workforce assessments and provider shortage designations and in anticipating and responding to health workforce shortages. Information about the survey is included with the licensee's license renewal information. It was reported at the hearing that 895 physicians have already completed the survey. Under the proposed rules, failure to register with the PDMP or complete the NHPH survey will constitute professional misconduct and will be grounds for discipline.

Implementation of New Hampshire Law Allowing for Medical Marijuana Continues

Fourteen nonprofit organizations applied to operate medical marijuana alternative treatment centers in New Hampshire before the application deadline on January 28, 2015. Under the existing law, the state is permitted to license four alternative treatment centers, though there is a bill before the legislature to allow for additional satellite locations. The state has advised that it will publicly announce the four selected applicants ten days after they are chosen. It is expected that the state will begin accepting applications from patients who qualify to use therapeutic cannabis approximately six weeks prior to the expected opening date of the first alternative treatment center. Several bills related to medical marijuana have been introduced in this legislative session. We will be reporting on those bills as they progress through the legislative process.

NH Immunization Registry Meets Yet Another Obstacle

New Hampshire remains the only state in the country without an immunization registry. Last spring the state entered into a contract with an outside vendor to set up the registry and HHS began the rulemaking process with the intention of launching the registry in February. The rulemaking process stalled when opposition expressed concern about the "opt-out" provision and how the decision to opt out of the registry would be tracked and reported. Some believe the registry should track and report a person's decision to opt out of the registry while others believe that even keeping a record of the decision to opt-out compromises privacy. Advocates on both sides of the debate are working to resolve the issues while balancing the public health and privacy concerns.

Anthem Reports Major Data Breach

Anthem, the largest insurer in New Hampshire has reported that it is the victim of a sophisticated cyber-attack which compromised that data of its members, likely including the 290,000 members in New Hampshire. The information accessed includes member names, health ID numbers, Social Security numbers, dates of birth, addresses, telephone numbers, email addresses and employment information, including income data. At this point, it appears no credit card or personal health information was accessed. All impacted Anthem members will be enrolled in identity repair services and will be provided information about how to enroll in free credit monitoring.

Reminder : Annual Reports to the Secretary of State Due by April 1, 2015

Just a reminder that corporations, limited liability companies, limited liability partnerships and certain other business entities must file annual reports with the Secretary of State by April 1, 2015 in order to avoid late filing penalties. The link to file the annual report is http://www.sos.nh.gov/corporate/annualreport/.

The Legislative Session is Underway

The 2015 Legislative Session continues. We are monitoring the following bills:

- HB 117: This bill proposing to add physician assistants to the providers able to prescribe therapeutic cannabis was voted **Inexpedient to Legislate** by the House Health and Human Services Committee (16-0).

- HB 129: This bill mandates certain facilities and services accept donations of unused prescription drugs. Current law allows voluntary acceptance of such donations. It was voted **Inexpedient to Legislate** by the House Health and Human Services Committee (16-0).

- HB 151: Establishes a committee to study end-of-life decisions. It is introduced and referred to the Judiciary Committee.

- HB 164: Require the Department of Health and Human Services to begin processing applications for registry identification cards not later than July 25, 2015. Voted **Inexpedient to Legislate** by the House Health and Human Services Committee (18-0).

- HB 165: Clarifies the definition of "qualifying medical condition for the therapeutic use of cannabis to allow that certain diagnoses meet the definition whether or not the patient suffered the listed effects. Voted **Inexpedient to Legislate** by the House Health and Human Services Committee (17-1).

- HB 202: Repeals the authority of registered nurses from dispensing non-controlled prescription drugs in clinics operated by or under contract with the Department of Health and Human Services or in clinics of nonprofit family planning agencies. Introduced and referred to House Health and Human Services Committee.

- HB 271: This bill exempts from the provisions of the Controlled Drug Act a health care professional or other person who prescribes, dispenses, distributes, or stores an opioid antagonist, or who administers it to an individual suffering from an apparent opioid-related overdose. Introduced and referred to House Health and Human Services Committee.

- HB 326: This bill clarifies certain membership positions on the board of registration of medical technicians by adding registered or certified health care providers to the list of those who can serve on the Board. Introduced and referred to Executive Departments and Administration.

- HB 330: This bill establishes an oversight commission for medical cost transparency to monitor and further develop the NH HealthCost Internet website. There is a proposed amendment changing the composition of the commission. Voted **Ought to Pass with Amendment** by House Health and Human Services Committee (18-0).

- HB 337: This bill declares that if a patient admitted to a facility is not of sound mind as determined by a physician or a court, the wishes of the patient's immediate family or guardian shall take precedence over the provisions of the patients' bill of rights. Introduced and referred to House Health and Human Services Committee.

- HB 389-FN: This bill repeals the certificate of need moratorium on nursing home and rehabilitation beds. Introduced and referred to House Health and Human Services Committee.

- HB 410: This bill repeals the law prohibiting the sale of purchase of parts under the uniform anatomical gift act. Introduced and referred to Executive Departments and Administration.

- HB 413-FN: This bill establishes the governing board of polysomnographic technologists within the allied health professionals, defines the practice of polysomnography, and requires licensure of persons engaged in the practice. Introduced and referred to Executive Departments and Administration.

- HB 422-FN: This bill allows physician assistants to certify death certificates and to authorize involuntary commitment and voluntary admission to state institutions. Introduced and referred to House Health and Human Services Committee.

- HB 477- FN: This bill changes the weekly compensation for temporary total disability, permanent total disability, and temporary partial and permanent partial disability. This bill also requires the Labor Commissioner to establish medical payment schedules. Introduced and referred to House Labor, Industrial and Rehabilitative Services Committee.

- HB 484: This bill modifies definitions, adds requirements for members appointed to the Board of Nursing and adds exemptions from licensure for administration of medications by assistive personnel and for attendant care services. Introduced and referred to Executive Departments and Administration.

- HB 508: This bill establishes a procedure for the dissolution of the New Hampshire medical malpractice Joint Underwriting Association. Introduced to House Judiciary Committee. Vacated from Judiciary and referred to House Committee on Commerce and Consumer Affairs.

- HB 548: This bill establishes the federally-facilitated health exchange as the health exchange for New Hampshire. Introduced to House Committee on Commerce and Consumer Affairs. (See extended discussion below.)

- HB 564-FN: This bill declares that a managed care health benefit plan offering prescription drug benefits shall not require prior authorization for certain drugs used to treat mental illness. Introduced and referred to House Health and Human Services Committee.

- HB 593-FN: This bill permits qualifying patients and registered caregivers to cultivate cannabis for therapeutic use. Introduced and referred to House Health and Human Services Committee.

- HB 600-FN: This bill requires employers to provide paid sick leave for employees. Introduced and referred to House Labor, Industrial and Rehabilitative Services Committee.

- HB 628-FN: This bill declares that any facility licensed under RSA -151 may provide employment information to any other facility regarding an employee or prospective employee if the information is provided in good faith. The facility, its directors and employees will be immune from civil liability for providing the information unless the information provided is proven to be false and was provided with knowledge of its falsity. Introduced and referred to House Health and Human Services Committee.

- HB 670-FN: This bill prohibits discrimination against health care providers who conscientiously object to participating in any health care service. Introduced and referred to House Health and Human Services Committee.

- HB 686-FN: This bill establishes a single payer health system for New Hampshire. Introduced and referred to House Health and Human Services Committee, sent to subcommittee.

- SB 7: This bill requires the joint health care reform oversight committee to provide oversight, policy direction and recommendations for legislation regarding implementation of managed care and the NH Health Protection Plan. Introduced and referred to Senate Health and Human Services Committee.

- SB 23: This bill allows certain advanced practice registered nurses to authorize involuntary commitment and voluntary admission to state institutions. Introduced and referred to Senate Health and Human Services Committee.

- SB 36: This bill allows pharmacies to dispense oral contraceptives to persons 18 years of age or older without a prescription. Voted **Inexpedient to Legislate** by Senate Commerce Committee (5-0).

- SB 45: This bill requires an injured worker and his or her health care provider to enter into an opioid treatment agreement outlining the procedures for opioid use under workers' compensation. Introduced and referred the Senate Commerce Committee.

- SB 84: This bill clarifies when it is appropriate to use telemedicine in practitioner-patient medical circumstances. Under this bill a practitioner shall not prescribe controlled drugs, Schedule II-IV, by means of telemedicine. Voted **Ought to Pass** by Senate Health and Human Services Committee.

- SB 108-FN: This bill make changes to the law governing the reporting of health care associated infections including expanding the list of facilities with a reporting requirement to include end-stage renal dialysis centers, nursing and other residential care facilities and assisted living residences. It is requested by the Department of Health and Human Services. Introduced and referred to Senate Health and Human Services Committee.

- SB 112: This bill requires Medicaid coverage under RSA-420-J to cover telemedicine services. Introduced and referred to Senate Health and Human Services Committee.

- SB 130: This bill establishes an opt out option for participation in the immunization registry. It is requested by the Department of Health and Human Services. Introduced and referred to Senate Health and Human Services Committee.

- SB 133-FN: This bill requires certain encrypted health care information collected by the insurance department to be available to the public upon request to the Department of Health and Human Services under certain circumstances. Introduced and referred to Senate Commerce Committee.

- SB 176: This bill declares that primary care providers providing direct primary care pursuant to a primary care agreement are not subject to the insurance laws, provided certain conditions are met. Introduced and referred to Senate Commerce Committee.

Proposed House Bill 548 Would Formally Establish the Federally-Facilitated Health Insurance Marketplace as the State's Health Benefit Exchange, and Would Ensure Continued Eligibility of New Hampshire Citizens for Premium Tax Credits and Cost-Sharing Reductions

The House Commerce and Consumer Affairs Committee is currently considering a bill that would repeal existing law prohibiting a state-based health insurance exchange in favor of an affirmative provision establishing the federally-facilitated health insurance marketplace as the state's exchange. The law would also permit state agencies or departments to perform any exchange functions necessary to ensure continued eligibility of New Hampshire citizens for premium tax credits and cost-sharing reductions.

The bill is a pre-emptive strike in case the Supreme Court interprets the Affordable Care Act to prohibit the federal government from giving premium tax credits to families who purchase health insurance on a federally-facilitated marketplace as opposed to state-created marketplace. As discussed in past legal updates, the Supreme Court has agreed to hear a legal challenge to the IRS regulation making premium tax credits available to users of the federal marketplaces. A decision in the case, *King v. Burwell*, is expected in June. The challengers argue that because section 36B of the Affordable Care Act provides for the award of premium subsidies to taxpayers enrolled "through an Exchange established by the State" under section 1311 of the ACA, the IRS overstepped its authority in promulgating a regulation permitting users of both state and federal marketplaces to obtain premium subsidies.

By enacting a law "establishing" the federally facilitated marketplace as the health benefit exchange for New Hampshire pursuant to section 1311 of the ACA, the New Hampshire bill's sponsors presumably hope to inoculate New Hampshire residents from the effects of the upcoming Supreme Court decision were it to deny tax credits to all but users of a health insurance exchange established by a State.

EMPLOYMENT LAW DEVELOPMENTS

Equal Pay Laws Took Effect on January 1

Several new provisions of RSA chapter 275 took effect, which protect employees from pay discrimination. These changes include:

- Pursuant to RSA 275:37, employers are prohibited from discriminating between employees on the basis of sex by paying employees of one sex at a rate less than the rate paid to employees of the other sex for work that requires equal skill, effort and responsibility, and is performed under similar working conditions, except where such variation in the rate of

payment is based upon a market difference in seniority, experience, training, skill, ability or difference in duties and services performed.

- A new statute, RSA 275:38-a, prohibits an employer from discharging or discriminating, in any manner, against any employee because he or she raises concerns relating to the equal pay requirements or has discussed his or her wages or those of another employee. This provision does not, however, apply to an employee who has access to wage information of other employees as part of his or her essential job functions and discloses that information to other employees, unless the disclosure is in response to a complaint or charge or in furtherance of an investigation.

- Another new section, RSA 275-:41-b, prohibits employers from requiring as a condition of employment that an employee refrain from disclosing the amount of his or her wages or sign a waiver that purports to deny the employee the right to disclose the amount of his or her wages.

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Cinde Warmington, Clara Dietel, and Benjamin Siracusa Hillman contributed to this month's Legal Update.

BIOS

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