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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

***DHHS Predicts 10 Million Will Have Enrolled in and be Paying for Health Insurance Marketplace Coverage by End of 2016***

On October 15, the U.S. Department of Health and Human Services announced that the Department expects 10 million individuals to be enrolled and paying for coverage on health insurance marketplaces by the end of 2016. While a significant majority of the expected enrollees would be based on renewals of existing coverage, approximately one-third would be uninsured individuals joining the marketplace for the first time.

The DHHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) conducted a demographic analysis of uninsured individuals who are likely eligible for marketplace coverage. By the end of the open enrollment period on January 31, 2016, ASPE expects that between 11 and 14.1 million individuals will have selected plans through the health insurance marketplaces for coverage in 2016, though not all of the individuals who select plans will be enrolled and paying for coverage at the end of 2016. Additionally, ASPE found that of the 10.5 million uninsured Americans who are eligible for enrollment in a marketplace plan, almost half are between the ages of 18 and 34, almost 40 percent are living with incomes between 139 and 250 percent of the federal poverty level, and more than a third are people of color.

***Federal Agencies Issue New FAQs for ACA Preventive Services and Wellness Programs***

On October 23, several federal departments issued a joint set of FAQs providing guidance on the implementation of specific ACA preventive services and wellness programs. Several of the FAQs deal with lactation counseling, and make clear that health plans and issuers must provide a list of lactation counseling providers within their networks; may impose cost-sharing for lactation counseling provided out-of-network only if there are in-network providers who can also provide such services; may not limit coverage for lactation counseling to services provided on an inpatient basis; and must extend coverage for lactation support services without cost sharing for the duration of breastfeeding.

Plans and issuers (except for grandfathered plans) must cover, without cost-sharing, screening for obesity in adults. They may not apply a general exclusion for weight management services. Services performed in connection with a preventive (screening) colonoscopy must be covered with no cost-sharing, including any required advance consultation with a specialist that is determined by the attending provider to be medically appropriate (for example, to determine if the patient is healthy enough for the procedure),

and any pathology exam on a polyp biopsy.

In addition, the FAQs clarify that women found to be at increased risk for breast cancer using a screening tool designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation must receive coverage without cost sharing for genetic counseling, and, if indicated, testing for harmful BRCA mutations.

Finally, the FAQs clarify that non-financial incentives, such as gift cards that are given to participants who adhere to wellness programs, are subject to wellness program regulations.

***Benchmark Marketplace Plans and Premium Tax Credits Are Increasing an Average of 5.1 Percent in New Hampshire in 2016***

On October 26, the U.S. Department of Health and Human Services (DHHS) issued the results of an analysis of the cost of marketplace plans for coverage for 2016. According to DHHS, nearly 8 out of 10 returning consumers will be able to purchase a plan on the marketplace for less than $100 a month after tax credits. The average rate increase for the benchmark plan (the second lowest cost silver plan available in any particular region or state) on the federal marketplace is 5.1 percent in New Hampshire and 7.5 percent nationally. Premium tax credits, which are tied to the benchmark plan, will increase accordingly. Because of those subsidies, premium increases for most enrollees will be in the single digits. DHHS also reminded enrollees that even for those already enrolled, shopping around during open enrollment is likely to result in lower-cost coverage for the following year.

***GAO Reports More "Decoy" Applicants Approved for Marketplace Subsidies***

On October 23, an official with the Government Accountability Office (GAO) testified in a congressional hearing regarding the continued vulnerability to fraud of marketplace eligibility and enrollment procedures. According to the official, GAO employees posing as fictitious applicants for health insurance earlier this year were approved for subsidies and issued health insurance coverage in ten out of ten attempts, even though they used phony social security numbers and fictitious employers. Seven out of eight attempts to enroll in Medicaid using fictitious identities were similarly successful.

***Minuteman's Rate Hikes Are Lower than Anticipated***

On October 13, Minuteman Health announced that its rate increases for individual and family plans in New Hampshire will increase between 5 and 9 percent in 2016, much lower than its earlier projection of 42 to 51 percent. Minuteman blames the rate increase on the move of the Medicaid expansion population from Medicaid coverage to state-paid marketplace coverage through the Premium Assistance Program beginning January 2016, noting that in the absence of that change, it would have expected to decrease its rates modestly for 2016.

***Supreme Court Will Review ACA Contraception Opt-Out for Religious Non-Profit Organizations***

On November 6, the Supreme Court of the United States announced that it would once again review the constitutionality of the Affordable Care Act's requirement that insurance plans cover certain contraceptives. The Court agreed to hear seven different cases on this topic; in each case, non-profit entities have argued that the mandate is in violation of their rights under the Religious Freedom Restoration Act (RFRA). In last summer's decision in *Hobby Lobby*, the Supreme Court found that the mandate was in violation of the rights of certain closely-held for-profit entities under RFRA, at least where there was no available opt-out mechanism.

Under current law, houses of worship such as churches, synagogues, and mosques are explicitly exempt from the requirement to provide coverage for contraception, and do not need to file any paperwork to opt-out. Religious non-profit organizations, as well as closely-held for-profit entities following the *Hobby Lobby* decision, can opt-out, but must avail themselves of an accommodation process through which they notify the government of their objections, triggering the provision of coverage by a third party organization instead. The Court will decide whether this accommodation process satisfies the test of RFRA, which requires that if a law places a substantial burden on an individual or organization's exercise of religion, the government must utilize the "least restrictive" means of accomplishing its goal. The Court's decision in *Hobby Lobby* identified the accommodation mechanism by which religious non-profit entities could opt-out, which was not then available to for-profit entities, as a potential less restrictive alternative, though the question of whether the accommodation process itself qualifies as the "least restrictive" means and hence is lawful under RFRA was not decided by the Court.

## Other Federal Developments

### *CMS Issues 2016 Physician Fee Schedule Final Rule*

On October 30, the Centers for Medicare and Medicaid Services (CMS) issued the 2016 Physician Fee Schedule final rule. The final rule, which is effective for services rendered on or after January 1, 2016 finalizes changes to several of the quality reporting initiatives associated with Physician Fee Schedule payments including the Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier (Value Modifier) and the Electronic Health Record (EHR) Incentive Program. Among other changes, the Final Rule includes new codes for the separate payment for advance-care planning services, modifications to and clarifications of the Stark physician self-referral law and changes to the supervision requirements for billing "incident to" services.

The changes to the quality reporting initiatives follow the repeal of the Sustainable Growth Rate formula and the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and reflect the overall movement towards the implementation of the Merit-based Incentive Payment System (MIPS) payment based on quality outcomes rather than fee-for-service payments.

The new codes for advance-care planning are intended to recognize the additional time it takes practitioners to engage in end-of-life planning discussions with patients and their families. The rule also finalizes reimbursement for advance-care planning when included in the "Annual Wellness Visit" covered by Medicare.

The rule introduces two new exceptions to Stark law. The first allows hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) to pay physicians to recruit non-physician practitioners (NPPs). The exception requires the NPP to be employed by the physician or the physician's practice that is receiving remuneration, and that the NPP's services remain primarily limited to primary care and mental health services. The second exception allows for timesharing of space, equipment, and other resources between a provider and a physician. Control of these resources cannot be relinquished entirely to a physician from a provider, but rather the arrangement must only allow for the use of such resources. The rule also makes a number of compliance clarifications, namely that the writing requirement for many exceptions can be satisfied with a collection of documents; that expired leasing and personal services arrangements may continue indefinitely on the same terms if otherwise compliant; that a 90-day grace period to collect missing signatures on documentation will be allowed; and that a hospital and physician are not considered to have a financial relationship if the physician provides services in the hospital, but they both bill

independently.

***U.S. District Court Strikes Down Interpretative Rule related to 340B Orphan Drug Exclusion***

On October 14, the U.S. District Court for the District of Columbia (Court) struck down an interpretative rule on the 340B orphan drug exclusion finding it to be contrary to the plain language of the statute. Section 340B of the Public Health Services Act requires manufacturers who participate in Medicaid to sell "covered outpatient drugs" to certain health care entities at a reduced price established by a statutory formula. The 340B program is administered by the Health Resources Services Administration (HRSA). The Orphan Drug Act provides special status to drugs or biologicals that are used to treat rare diseases in an effort to reduce the costs of bringing such drugs to market and provide financial incentives to pharmaceutical companies to develop such drugs. Under the Affordable Care Act (ACA), drugs designated under the ODA as orphan drugs are excluded from the definition of "covered outpatient drugs" and, therefore, are not subject to 340B.

In May 2014, the Court invalidated final rule issued by HRSA that narrowed the exclusion of orphan drugs from the 340B program exclusion to apply only when the drug is used to treat the rare disease or condition finding that HRSA lacked the statutory authority to issue such a rule. In response to that decision, HRSA issued an interpretative rule that included the same provision as the previously invalidated final rule. The Pharmaceutical Research and Manufacturers of America (PhRMA) challenged the interpretive rule and prevailed as the Court found that the rule conflicted with the plain language of the statute.

The American Hospital Associated responded to the ruling stating that it "will reduce access to critical services and treatment for some of the most vulnerable patients in society."

***CMS Will Permit Alternate Exclusions Under EHR Final Rule***

On October 21, the Centers for Medicare and Medicaid Services (CMS) responded to a Frequently Asked Question by stating that it will allow alternate exclusions to the public health reporting objective in 2015 under the Electronic Health Records (EHR) final rule released earlier in October. Noting that it did not intend to inadvertently penalize providers for their inability to meet measures that were not required under the previous stages of meaningful use, CMS advised that it will allow eligible professionals scheduled to be in Stage 1 to attest to one public health measure instead of two and will allow eligible hospitals or critical access hospitals to attest to two measures instead of three. Additionally, CMS said that it would allow providers to claim an alternate exclusion for a measure if the provider did not intend to attest to the equivalent prior objective consistent with CMS policy for other objectives and measures.

***CMS Issues Report on RAC Activity***

In a report issued on October 15, the Centers for Medicare and Medicaid Services (CMS) said that for fiscal year 2014, Recovery Audit Contractors (RACs) identified and corrected over 1.1 million claims containing improper payments totaling $2.57 billion, with $2.39 billion in in overpayments collected and $173.1 million in underpayments repaid to providers. After accounting for the costs of the RAC program, the net return of funds to the Medicare Trust Fund was in excess of $1.6 billion. The number of corrections was decreased from previous years, a fact that CMS attributed in part to the prohibition of RACs to review inpatient hospital patient statuses on claims dating on or after October 1, 2013 due to the controversial "two-midnight" rule and the "probe and educate" process implemented in response.

***OMB is Reviewing Final Rule on Requirement to Return Medicare Overpayments***

On October 21, the Office of Management and Budget (OMB) received for review the long awaited

final rule on reporting and returning Medicare overpayments within 60 days of identification. The proposed rule which was published in February 2012 raised great concern among providers. The rule would implement Section 6402(a) of the ACA, which requires that an overpayment be reported and refunded no later than 60 days after identification or cost report submission. While a final rule must ordinarily be issued within 3 years after issuance of the proposed rule, the Centers for Medicare and Medicaid Services (CMS) announced in February 2015 that it was extending the publication timeline by one year due to the rule's complexity and the scope of the comments it received. Additionally, CMS reminded all stakeholders that even without the final regulation, they are still subject to existing statutory requirements and could face False Claims Act liability, Civil Monetary Penalties Law liability, and exclusion from Federal health programs due to failure to report and return overpayments.

***Congress Reaches Budget Deal***

On October 30, the Senate approved a budget deal that raises the Federal debt ceiling through March 2017 by a vote of 64-35. The budget agreement includes a number of health care related provisions. One such provision establishes "site neutral" payments for "new" off-campus hospital outpatient departments. Instead of being reimbursed at a higher rate as they have been under the outpatient prospective payment system (OPPS), any provider-based off-campus hospital outpatient department that executes a provider agreement subsequent to the budget measure's enactment would be reimbursed under either the Ambulatory Surgical Centers PPS or the Medicare Physician Fee Schedule. The American Hospital Association (AHA) cautioned that the site neutral payment provision could hamper access to health care. However the American College of Physicians expressed support for the change indicating that '[t]he policy is a positive step forward in addressing inappropriate and wasteful payment disparities for identical clinical services provided in different healthcare settings."

The budget agreement also contained a provision that would continue the 2% sequestration of Medicare payments through 2025. The National Rural Health Association and the Federation of American Hospitals expressed disappointment at the continuing sequestration, citing the recent increase in rural hospital closures and the unfavorable treatment of hospitals which are shouldering a disproportionate share of the burden.

***CMS Finalizes Medicaid Equal Access Provisions***

On October 29, the Centers for Medicare and Medicaid Services (CMS) issued a final rule with comment period intended to ensure adequate access to services for all Medicaid beneficiaries. The Medicaid statute requires states to provide coverage to certain groups of individuals and sets forth certain minimum coverage benefits. Under the statute, States are required to ensure that payments to providers are "sufficient to enlist enough providers so that care and services are available under the plan at least to the same extent that such care and services are available to the general population in the geographic area." CMS has not previously regulated an approach to guide states in making this assessment which has led to confusion and litigation over payment rates and also, in some cases, to access problems for beneficiaries.

Earlier this year, the Supreme Court decided the case of Armstrong v. Exceptional Child Center, Inc. 135 S.Ct. 1378 (2015) finding that the Medicaid statute does not provide a private right of action to providers to force states to comply with the requirement to make sufficient payment. CMS had issued its proposed rule years before the Supreme Court decision but, in light of that decision, now recognizes the need to strengthen its review and enforcement capabilities. The final rule provides for "a transparent data-driven process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with [the Social Security Act]. " The rule requires

states to provide an access monitoring review plan detailing their consideration of enrollee needs, the availability of care and providers, and the utilization of services. States will be required to utilize data elements and other information in order to ensure access to mandatory and optional services; to establish new procedures to review the effects of proposed rate reductions and payment restructuring on beneficiary access; and to implement ongoing access monitoring reviews of key services as well as additional services when necessary.

CMS has issued the rule with comment period in order to solicit feedback from stakeholders about which core measures, thresholds, and appeals processes would provide additional information or approaches that would be helpful in ensuring that Medicaid beneficiaries have access to care. The effective date of the rule and the deadline for submission of comments is January 4, 2016.

***OIG & CMS Publish Final Rule Extending Fraud Waivers for ACOs In Medicare Shared Savings Program***

On October 29, the U.S. Department of Health and Human Services Office of Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS) published a final rule extending waivers of Federal fraud and abuse laws for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). The rule, effective October 29, finalizes five waivers of the Stark Physician Self-Referral Law, the Anti-Kickback Statute, and the Civil Monetary Penalties Law provision relating to beneficiary inducements related to the MSSP. The 5 waivers are as follows:

- An ACO "pre-participation" waiver of the Stark Law and Anti-Kickback Statute that applies to ACO-related startup arrangements in anticipation of participating in the Shared Savings Program;
- An "ACO participation" waiver of the Stark Law and Anti-Kickback Statute that applies broadly to ACO-related arrangements during the ACO's participation in Shared Savings Program and for a specified time thereafter;
- A "shared savings distributions" waiver of the Stark Law and Anti-Kickback Statute that applies to distributions and uses of shared savings payments earned under the Shared Savings Program;
- A "compliance with the physician self-referral law" waiver of the Anti-Kickback Statute for ACO arrangements that implicate the Stark Law and satisfy the requirements of an existing exception; and
- A "patient incentive" waiver of the Beneficiary Inducements Civil Monetary Penalties and the Anti-Kickback Statute for medically related incentives offered by ACOs under the Shared Savings Program to beneficiaries to encourage preventative care.

CMS and OIG assert that the waivers, which have been available since November 2011, have been adequately protecting beneficiaries and Federal health programs while promoting innovation within the MSSP.

The final rule does not extend waivers of the Civil Monetary Penalties law relating to "gain-sharing" arrangements, as the enactment of MACRA has eliminated the need for this waiver provision by narrowing the prohibition on the payment of physicians to induce them to reduce or limit services to cover only medically necessary services.

***OIG Modifies Two Previously Issued Advisory Opinions***

On November 2, the U.S. Department of Health and Human Services Office of Inspector General (OIG) announced modifications to 2 previously issued advisory opinions, Advisory Opinions 06-10 and 07-18, concerning patient assistant programs which provide cost-sharing assistance for expensive medications

to patients who qualify for the financial assistance and have a disease relative to the specific charity that was funding the patient assistance. OIG found that what it had previously approved is now problematic, and that the charities involved would have to make changes to their patient assistance programs in order to maintain a favorable opinion from OIG. The changes requested by OIG, which were fulfilled by the charities, concern the specificity of drug cost and type. The charities certified that changes had been made to their patient assistance programs by ensuring that their program does not discriminate based on the progression or symptom types of the specified disease, that their programs do not favor any one drug or manufacturer or cater to specialty or high-cost drugs exclusively, and that their programs evaluate financial need in a consistent and comprehensive manner to ensure fairness.

***OIG Permits Hospitals to Discount or Waive Amounts Owed on Non-Covered, Self-Administered Drugs***

In a policy statement issued on October 30, the U.S. Department of Health and Human Services Office of Inspector General (OIG) said that hospitals would not face administrative sanctions if they choose to discount or waive amounts owed by Medicare beneficiaries for self-administered drugs (SADs) not covered by Medicare Part B (or noncovered SADs that may be covered by Medicare Part D) and administered in an outpatient setting. Hospitals that choose to do this must make sure that the discounts or waivers are uniformly applied without regard to a beneficiary's diagnosis or type of treatment, are not marketed or advertised, and are not claimed as bad debt or cost-shifted to any payer or individual.

***CMS Issues OPPS Final Rule***

On October 30, the Centers for Medicare and Medicaid Services (CMS) released the over 1200 page 2016 Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rule. The rule includes a decrease of $133 million in reimbursement for hospitals as compared to 2015, but ASCs will see an increase of 0.3% or $128 million in reimbursement if they meet the quality reporting requirements. The final rule also addresses the "two midnight" rule under Medicare Part A. The final rule underscores the policy, wherein Part A will only cover hospital stays that are longer than two midnights or were fully intended to be. However, the rule also provides more flexibility by allowing a determination of payment to be made on case-by-case basis if an admission that did not meet the two midnight criterion. This determination will be made based on the judgment of the admitting physician as supported by the medical record documentation subject to medical review.

Additionally, the final rule indicates changes to CMS's approach to education and enforcement regarding hospital admissions. CMS began using Beneficiary and Family Centered Care (BFCC) quality improvement organizations (QIOs) instead of Recovery Auditors to review short-stay inpatient claims under the "two midnight" policy. The goal of the BFCC QIO reviews is to educate physicians about the policy, and to refer providers to Recovery Auditors based on patterns of practice.

The rule also addresses a wide range of other topics such as the restructuring of APC payments, a change in device pass-through payment intended to enable initial access to certain new medical devices, ASC payment updates and changes to the hospital and ambulatory quality reporting programs.

***CMS Proposes Discharge Planning Rule***

On October 29, the Centers for Medicare and Medicaid Services (CMS) proposed a rule that underscores the importance of patient attitudes and preferences in the discharge planning process for hospital and other post-acute care providers. By implementing the Improving Medicare Post-Acute Care Transformation Act of 2014, the proposed rule would revise discharge planning requirements for hospitals,

including critical access hospitals (CAHs), long-term care hospitals, and rehabilitation facilities, as well as home health agencies. The rule requires providers to create a discharge plan within 24 hours of admitting or registering a patient, and to then have that plan finalized before discharge or transfer so that it could be utilized. The discharge plan must provide discharge instructions to patients, include a medication reconciliation process in order to help improve medication management and have a functional post-discharge follow-up process. When patients are being transferred, the plan must also include specific medical information for the new facility. Notably, this whole process would require significant involvement on the part of the patient in helping to develop and execute the discharge plan.

***OIG Issues Advisory Opinion***

On October 14, the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued Advisory Opinion 15-13, in response to an integrated health system's proposal to offer patients free shuttle van services concluding that, while the proposed arrangement could potentially generate prohibited remuneration under the anti-kickback statute, the OIG would not impose administrative sanctions on the health system.

The health system, which provides health care services in a rural state, is comprised of a medical center, a community hospital, and a multi-specialty clinic. Additionally, another community hospital and an ambulatory surgical center would be impacted by the proposed arrangement. The health system submitted documentation showing that a lack of public transportation in its service area created a barrier to health care access for residents. In response to this, the health system proposed to offer a free van shuttle service between medical facilities as well as a central drop-off and pick-up location in the center of town for patients and families. This service would be provided free of charge to patients and families without regard to their health insurance status or ability to pay for health care services. The health system would solely cover the cost of the shuttles in full. Furthermore, under the proposed arrangement, the shuttle vans would not be operated as ambulances or be operated by medical personnel, nor would they be used to advertise any services or be advertised to the public in any way. The availability of the shuttle vans would be communicated only to current patients of the health system.

In examining the proposed arrangement, OIG noted that the shuttle van service could be perceived as inducement to Federal health program beneficiaries to obtain items or services from the health system and also noted that the shuttle van service could exceed nominal value. However, OIG concluded that the proposed arrangement posed minimal risk for fraud and abuse because the availability of the service would not be determined in a manner related to the past or anticipated volume or value of services and would not be conditioned on the patient's use of specific items or services or on the patient's ability to pay. The OIG distinguished this from other suspect arrangements where transportation is provided based on the patient's diagnosis, treatment or type of insurance coverage. In addition, the transportation would not include air, luxury or ambulance-level transportation. The drivers would not be paid on a per-person-transported basis and the transportation would only be provided locally. The service would not be advertised and no items or services would be marketed during the transport. The hospital system would bear the cost of the shuttle service and would not provide services in a manner intended to benefit private practice physicians. Regulators also noted the hospital system's certification of the lack of availability of public transportation in the area. For all these reasons, the OIG determined the arrangement presented a low risk of fraud or abuse.

***FTC Issues Guidance to States Regarding Monitoring of State Regulatory Boards***

On October 13, the Federal Trade Commission (FTC) issued guidance for use by state officials

concerning antitrust compliance for state regulatory boards controlled by active market participants. The guidance was prompted by a U.S. Supreme Court case wherein a dental regulatory board was found to not be entitled to antitrust immunity under the doctrine of sovereign immunity protecting state action. The court explained that because the board was controlled by "active market participants" and its decision to restrict market participation in the provision of teeth-whitening services was not "actively supervised" by the state, the immunity doctrine did not apply. The non-binding FTC guidance is designed to help determine when a regulatory board needs to seek active supervision in order to invoke state action defense while clarifying active supervision and its criteria.

The FTC guidance may be found at: https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf

**OIG Releases 2016 Work Plan**

On November 2, the OIG released its 2016 Work Plan which describes new and ongoing reviews that will be the subject of the OIG's focus during the 2016 fiscal year. Some of the areas identified in the Work Plan include a review of whether hospitals subject to inpatient prospective payment are appropriately billing Medicare Part B services associated with inpatient stays, whether practitioners ordering items and services reimbursed by Medicare are eligible to order such services, whether the Office of Civil Rights is providing adequate oversight over the security of e-PHI and whether the Food and Drug Administration's oversight of hospital's networked medical devices is sufficient.

The full Work Plan may be found at http://www.oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf.

## State Developments

***NH Retirees Face Increased Prescription & Premium Costs***

On October 20, the NH State Legislature's Joint Legislative Fiscal Committee voted 7-3 to increase co-pays for all state retirees covered by the retiree health benefit program, resulting in a $5 increase in prescription costs to beneficiaries effective January 1, 2016. The increase would help to close a $10.6 million shortfall in the retiree health plan by saving the state approximately $2 million. Governor Hassan did not support the decision, having previously urged legislators to instead take advantage of the program's $5.3 million surplus supplemented with an additional $5.3 million in general funds to maintain the benefits at their current cost.

On November 3, the same committee voted 6-4 to increase premium contributions for state retiree health benefit program beneficiaries under age 65 from 12.5% to 17.5%. This change will take effect on January 1, 2016 and help close the $10.6 million shortfall in the retiree health plan by saving the state $2.8 million. With this increase in addition to the prescription cost hikes and the $5.3 million surplus, a $400 thousand shortfall is left for the state legislature to address.

***NH Board of Medicine Issues Emergency Rules for Prescribing Opioid Analgesics***

On November 4, the New Hampshire Board of Medicine (Board) announced in a press release that it has implemented emergency rules related to the prescription of opioid analgesics. Governor Hassan had submitted a draft proposal for new rules to the Board, however, the Board opted to adopt an alternate proposal after hearing feedback from the medical community. The Board's emergency rules require the following:

- Adherence to the guidelines in the Federation of State Medical Boards Model Policy on the Use of Opioid Analgesics in Treatment of Chronic Pain, July 2013.
- Utilization of informed consent for chronic pain patients.
- Utilization of a risk assessment tool for chronic pain patients.
- Provision of educational information to acute pain patients which includes instruction on proper disposal of unused opioids.
- Provision of a written pain agreement between the provider and the patient as well as a toxicology screening for all chronic pain patients receiving opioids.

The Board will initiate the process for establishing permanent rules regarding opioid prescription practices based using a multi-disciplinary work group. The emergency rules which took effect on November 6, will remain in place for 180 days as permanent rules are finalized.

The full text of the emergency rules can be found at: http://www.nh.gov/medicine/documents/emergencyrules_opioidprescribing_11-4-15.pdf.

***GHN & Tufts Joint Venture to Start Offering Small Business Plans***

In an October 28 report, Tufts Health Plan announced that its joint venture with the Granite Health Network—a hospital consortium comprised of Catholic Medical Center, Concord Hospital, Southern New Hampshire Medical Center, Wentworth-Douglass Hospital, and Lakes Region General Hospital—received state permission to offer health plans to small businesses starting January 1, 2016. The Tufts Health Freedom Plan will be offered through brokers, and is intended to offer an alternative to major insurance providers in the midst of large industry mergers.

***NHMS Selects New Executive Vice President***

On October 23, the New Hampshire Medical Society announced that it had a selected James G. Potter as its new Executive Vice President. Mr. Potter has executive experience at several national organizations, including the American College of Radiology, the American Academy of Physician Assistants, and the American Chiropractic Association. Additionally, he worked for the American Medical Association and has served on various nonprofit boards.

## Legislative Updates

**Governor Calls for Special Session to Address Heroin Crisis**

Governor Hassan has called a Special Session of the Legislature to address the heroin crisis which has claimed more than 500 lives in New Hampshire in the past two years. Lawmakers will return to the State House on November 18 to pass rules governing the special session. It is expected that much of the work to be done during the session will occur in December. Many lawmakers have already expressed a reluctance to rush into changing laws and it is expected that many proposed changes will be put off until the regular session which begins in January.

***2016 Legislative Service Requests***

Legislators have so far filed 780 legislative service requests (LSRs) to be considered in the upcoming session of the legislature. An LSR is a request to have a bill drafted. We will be tracking those related to health care through the months ahead. Those we have flagged for tracking thus far are as follows:

**LSR 2012** - extending the New Hampshire health protection program
**LSR 2035 -** relative to the wellness and primary prevention council
**LSR 2037 -** relative to medical benefits under motor vehicle insurance
**LSR 2051 -** relative to the use of the Family and Medical Leave Act time as it applies to workmen's compensation
**LSR 2086 -** relative to consultations under the telemedicine law
**LSR 2087 -** relative to prescriptions under the telemedicine act
**LSR 2105 -** relative to transportation companies under the Medicaid managed care program
**LSR 2106 -** relative to brokers arranging transportation for Medicaid patients
**LSR 2107 -** requiring vendors under the Medicaid managed care program to provide certain reports
**LSR 2120 -** requiring the department of health and human services to report on the effectiveness of mental health treatment programs
**LSR 2201 -** relative to the health care premium contribution for retired public employees who are not Medicare eligible
**LSR 2202 -** relative to the health care premium contribution for retired public employees who are Medicare eligible
**LSR 2235 -** relative to sales by pharmacists under the controlled drug act
**LSR 2258 -** extending the prospective repeal of the certificate of need program
**LSR 2259 -** extending the New Hampshire health care quality assurance commission
**LSR 2266 -** requiring a medical care provider to inform a woman who is discovered to have dense breast tissue
**LSR 2286 -** relative to health insurance fraud and abuse reporting
**LSR 2338 -** adding post-traumatic stress disorder to qualifying medical conditions under therapeutic use of cannabis
**LSR 2345 -** establishing a commission to study health care for all in New Hampshire
**LSR 2363 -** relative to child support paid through the department of health and human services
**LSR 2368 -** relative to hospital rates for self-pay patients
**LSR 2393 -** extending the suspension of prior authorization requirements for a community mental health program on drugs used to treat mental illness
**LSR 2395 -** relative to membership of the oversight committee on health and human services
**LSR 2430 -** relative to administration of pharmaceuticals by optometrists
**LSR 2431 -** relative to emergency medical services
**LSR 2439 -** repealing the law governing access to reproductive health care facilities
**LSR 2444 -** relative to certain director positions in the insurance department
**LSR 2468 -** relative to disclosure of costs for out-of-network health care services
**LSR 2469 -** relative to qualifying medical conditions for purposes of therapeutic cannabis
**LSR 2486 -** relative to life, accident, and health insurance
**LSR 2513 -** repealing medical injury damage caps
**LSR 2554 -** establishing an office of health services planning and review within the department of health and human services
**LSR 2593 -** adding 2 alternative treatment centers under the law governing use of cannabis for therapeutic purposes
**LSR 2594 -** establishing a study committee to study the New Hampshire health protection act
**LSR 2615 -** relative to insurance incentives to lower costs of health care
**LSR 2628 -** relative to qualifying medical conditions for the use of cannabis
**LSR 2675 -** relative to repayment of LCHIP funding
**LSR 2677 -** relative to the controlled drug prescription health and safety program

**LSR 2679 -** establishing a committee to study the membership of a subcommittee of the board of medicine
**LSR 2680 -** establishing a committee to clarify compact licensing guidelines for physicians
**LSR 2692** - relative to collaborative practice between pharmacists and health care providers
**LSR 2718** - relative to communication of mammographic breast density information to patients
**LSR 2729** - relative to the powers of hospital security staff
**LSR 2758** - relative to the penalty for possession and use of fentanyl-class drugs, insurance coverage for substance use disorders, the acceptance of general funds by the prescription drug monitoring program, and the membership of the board of medicine
**LSR 2773** - relative to student health insurance plans
**LSR 2779** - revising the nurse practice act
**LSR 2780** - relative to the certification of school nurses
**LSR 2834** - relative to a special health care service license
**LSR 2849** - relative to licensing of alcohol and drug abuse counselors
**LSR 2852** - establishing an end of life choices study commission
**LSR 2860** - relative to the appropriation for Medicaid managed care
**LSR 2885** - relative to criminal history record checks of nursing home administrators
**LSR 2930** - establishing a commission to study the shortage of nurses for pediatric home health services
**LSR 2932** - to implement a system of care for children's behavioral health
**LSR 2940** - relative to Medicaid home health care services
**LSR 2942** - establishing a study committee on a new managed care long term supports and services ombudsman's program

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

## BIOS

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