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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

OIG Releases List of Top HHS Priorities for 2018

On November 17, 2017, the U.S. Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG") released a report: *Top Management and Performance Challenges Facing HHS.* In the report, OIG identifies the ten top management and performance challenges for HHS: ensuring program integrity in Medicare; ensuring program integrity in Medicaid; curbing the opioid epidemic; improving care for vulnerable populations; ensuring integrity in managed care and other programs delivered through private insurers; improving financial and administrative management and reducing improper payments; protecting the integrity of public health and human services grants; ensuring the safety of food, drugs, and medical devices; ensuring program integrity and quality in programs serving American Indian and Alaska Native populations; and protecting HHS data, systems, and beneficiaries from cybersecurity threats. The discussion of each of these challenges in the report includes key components of the challenge. For the challenge of ensuring program integrity in Medicare, the report lists the following key components: reducing improper payments; combating fraud; fostering prudent payment policies; and implementing health care reforms and the promise of health information technology.

In addition to these ten challenges facing HHS, OIG also included in its report four top priorities for OIG: fighting opioid and prescription drug abuse; protecting the health and safety of children served by HHS programs; preventing improper payments and fraud in home-based services; and partnering with States to enhance Medicaid program integrity.

OIG's report can be read in its entirety at: https://oig.hhs.gov/reports-and-publications/top-challenges/2017/2017-tmc.pdf.

OIG Announces Updates to Work Plan

In November, the U.S. Department of Health and Human Services Office of the Inspector General ("OIG") announced four updates to its Work Plan, which "sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections." The changes to the Work Plan indicate that OIG plans to compile and release reports on four topics: 1) Opioids in Medicaid: Concerns about Extreme Use and Questionable Prescribing in Selected States; 2) Medicaid Services Delivered Using Telecommunication Systems; 3) Medicare Claims on Which Hospitals Billed for Severe Malnutrition; and 4) Use of Funds by Medicaid Managed Care Organizations. OIG states that in looking into opioid use and prescribing in Medicaid it will seek to identify cases that appear to involve doctor shopping or pharmacy shopping.

Information about OIG's Work Plan and these updates is available at: https://oig.hhs.gov/reports-and-publications/workplan/index.asp.

CMS Issues Proposed Rule to Lower Medicare Prescription Drug Costs

On November 16, 2017, the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule ("Proposed Rule") proposing several changes to Medicare Advantage and the Prescription Drug Benefit Program that aim to increase flexibility for sponsors and beneficiaries. The proposed changes include: increasing transparency for Star Ratings for participating Part C and Part D plans; removing "meaningful difference" requirements for multiple Medicare Advantage or Plan D plans offered by an organization or sponsor in the same region; allowing electronic delivery of certain beneficiary documents; revising the regulations controlling maximum out-of-pocket and cost sharing limits; treating follow-on biological products as generics for low income subsidy and catastrophic cost sharing; allowing changes to prescription drug formularies during the benefit year to account for availability of new generic drugs; and implementing the Comprehensive Addiction and Recovery Act of 2016 by granting authority to Plan D plans to limit at-risk beneficiaries' access to opioids to selected prescribers and/or network pharmacies.

CMS estimates that the changes in the Proposed Rule would result in an estimated $195 million in savings per year from 2019 through 2023, "some of which would be passed onto beneficiaries in the form of lower premiums or additional benefits."

The Proposed Rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-25068.pdf.

CMS' Fact Sheet on the Proposed Rule is available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-16.html.

Hospitals Sue to Block Implementation of Cuts to 340B Payments

On November 1, 2017, the U.S. Department of Health & Human Services ("HHS") Centers for Medicare & Medicaid Services ("CMS") issued a final rule on changes and updates to the Hospital Outpatient Prospective Payment System ("OPPS"), including a controversial change to the 340B drug discount program under which CMS will pay for separately payable drugs and biologics purchased through the 340B Program at the amount equal to the average sales price ("ASP") minus 22.5 percent, rather than the ASP plus 6 percent that was paid in the past. CMS will continue to pay for non-340B Program drugs at ASP plus 6 percent. This change is expected to decrease drug payments by $1.6 billion.

Two weeks after the final rule was published, and after threatening litigation, the American Hospital Association, Association of American Medical Colleges, America's Essential Hospitals, Eastern Maine Healthcare Systems, Henry Ford Health System, and Park Ridge Health filed a lawsuit against HHS and Acting Secretary Eric Hargan in United States District Court for the District of Columbia. The plaintiffs bring one count for violation of the Social Security Act, alleging that HHS has exceeded its authority under the Act by arbitrarily and capriciously implementing a nearly 30% reduction in the reimbursement for 340B drugs. Plaintiffs also seek an injunction to stop HHS from implementing the reduction on the January 1, 2018 effective date of the final rule.

The November 1 Final Rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23932.pdf

The complaint filed against HHS is available at http://www.aha.org/content/17/171113-complaint-340b-final-opps-rule.pdf

OIG Releases Advisory Opinion Approving of Use of Preferred Hospital Network by Medigap Policy

On November 15, 2017, the U.S. Department of Health and Human Services Office of the Inspector General ("OIG") issued an advisory opinion – AO 17-06 – addressing the use of a preferred hospital network as part of Medicare Supplemental Health Insurance ("Medigap") policies. The Advisory Opinion was written in response to a request from a licensed offeror of Medigap policies ("Requestor"). The Requestor sought an opinion on its proposal to enter into an agreement with a preferred hospital organization under which its network hospitals would provide discounts of up to 100% on Medicare Part A inpatient deductibles incurred by the Requestor's Medigap plan policyholders that would otherwise be covered by the Requestor. The network hospitals would provide no other benefit to the Requestor or the policyholders, and the Requestor would pay the preferred hospital network an administrative fee each time the Requestor received the discount from a network hospital. If a policyholder were to be admitted to a hospital other than a network hospital, the Requestor would pay the full Part A hospital deductible. Requestor would return a portion of the savings resulting from the Proposed Arrangement directly to any Policyholder who had an inpatient stay at a Network Hospital in the form of a $100 credit toward his or her next renewal premium.

The OIG analyzed the proposed arrangement for compliance with the anti-kickback statute ("AKS") and the civil monetary penalties for beneficiary inducement ("Beneficiary Inducement CMP"). OIG concluded that the proposed arrangement did not satisfy any of the safe harbors for the AKS, but that it nonetheless did not violate the AKS because: neither the discounts nor the premium credit would increase or affect per-service Medicare payments; it would be unlikely to increase utilization; it would not unfairly affect competition among hospitals because the hospital network would have open membership; it would be unlikely to affect professional medical judgment because no physicians or surgeons would receive any remuneration; and policyholders would be fully informed of their freedom to choose any hospital without incurring additional liability or a penalty. OIG also concluded that it would likely not impose sanctions under the Beneficiary Inducement CMP because the proposed arrangement had a low risk of fraud and abuse and would potentially result in savings for beneficiaries.

The advisory opinion is available at: https://oig.hhs.gov/fraud/docs/advisoryopinions/2017/AdvOpn17-06.pdf

HHS Announces Risk Corridors Payment and Charge Amounts for 2016 Benefit Year

On November 15, 2017, the U.S. Department of Health and Human Services ("HHS") Centers for Medicare & Medicaid Services ("CMS") announced the risk corridors payment and charge amounts for the 2016 benefit year. Under the Affordable Care Act, HHS is directed to "establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of Exchange operations." Under the three-year payment framework established by HHS, if risk corridors collections for a particular benefit year are insufficient to make full risk corridors payments as calculated for that benefit year, risk corridors payments are reduced pro rata to the extent of any shortfall, and HHS then uses risk corridors collections for the subsequent benefit year toward risk corridors payment balances for the previous benefit years, until issuers have been reimbursed in full for the previous benefit year, before making payments for the current benefit year.

In its November 15 announcement, CMS states that since "2015 benefit year collections were insufficient to pay 2014 benefit year payment balances in full, HHS will use 2016 benefit year risk corridors collections to make additional payments toward 2014 benefit year payment balances." CMS states that it plans to charge amounts to insurers starting in November 2017 and beginning making payments to insurers in January 2018.

The CMS announcement is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf

CMS Announces Changes to the Child and Adult Core Health Care Quality Measurement Sets

On November 14, 2017, the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services ("CMS") issued an informational bulletin titled "2018 Updates to Child and Adult Core Health Care Quality Measurement Sets." Currently, state reporting on quality measures for care provided to Medicaid and CHIP enrollees is voluntary, however CMS provides the core sets as tools that states may use to monitor and improve the quality of health care based on a uniform set of measures. For CHIP enrollees, CMS is adding three new measures: Screening for Clinical Depression and Follow-Up; Contraceptive Care; and Asthma Medication Ratio. CMS states that these new measures are being added to allow states "to expand the measurement of quality of care in Medicaid in two areas – children with chronic health conditions and behavioral health, and addresses the important gap issue of access to contraception." CMS is also retiring four measures: Frequency of Ongoing Prenatal Care; Medication Management for People with Asthma; Behavioral Health Risk Assessment; and Child and Adolescent Major Depressive Disorder.

Senate Budget Committee Advances Tax Bill with Individual Mandate Repeal

On December 2, 2017, the Senate passed a tax reform measure that includes a repeal of the individual mandate under the Affordable Care Act ("ACA"). The Senate bill must now be reconciled with the House version of the bill which does not include the repeal of the ACA's individual mandate. Repealing the individual mandate is estimated by the Congressional Budget Office ("CBO") to reduce federal deficits by approximately $338 billion over the 2018-2027 period. However, the CBO also estimates that it will result in an increase of uninsured individuals by 13 million, and an increase in premiums by 10% in the non-group market over the next ten years. Although the Bipartisan Health Care Stabilization Act of 2017, introduced last month, appropriates funding the cost sharing reduction ("CSR") subsidies recently cancelled by the Trump Administration, the CBO has stated that CSR funding would not help to mitigate the effects of repealing the mandate.

More information about the Tax Bill can be found here: https://www.budget.senate.gov/

The Bipartisan Health Care Stabilization Act of 2017 can be reviewed here: https://www.help.senate.gov/imo/media/doc/THE%20BIPARTISAN%20HEALTH%20CARE%20STABILIZATION%20ACT%20OF%202017-%20TEXT.pdf

A copy of the Senate bill can be viewed at: https://assets.bwbx.io/documents/users/iqjWHBFdfxIU/rXqXuQfYbRas/v0

A copy of the House bill can be viewed at: https://www.congress.gov/115/bills/hr1/BILLS-115hr1eh.pdf

OIG Reports $4.13 Billion in Expected Recoveries in FY 2017

On November 30, 2017, the Department of Health and Human Services Office of Inspector General ("OIG") issued its semiannual report to Congress, covering its activities during the 6-month period from April 2017 through September 2017. The report states that the OIG's expected investigative recoveries during FY 2017 is $4.13 billion. OIG activities over the report period included the largest joint federal and state fraud takedown in history, netting more than 400 defendants in 41 federal districts who were charged with participating in fraud schemes involving approximately $1.3 billion in false billings to Medicare and Medicaid. The takedown also included opioid-related charges against 120 individuals. The report noted that addressing the opioid abuse epidemic is a top priority for the OIG as it investigates fraud and diversion cases.

The OIG semiannual report can be viewed at: https://oig.hhs.gov/reports-and-publications/archives/semiannual/2017/sar-fall-2017.pdf

OIG Rescinds Patient Assistance Program's Favorable Advisory Opinion

On November 28, 2017, the Department of Health and Human Services Office of Inspector General ("OIG") issued an advisory opinion rescinding its former approval (AO No. 06-04) of a charitable organizations' proposal to assist financially needy Medicare beneficiaries with premiums and cost-sharing amounts. The OIG stated that the charitable organization failed to comply with certain factual certifications that it made to OIG, and instead, "(i) provided patient-specific data to one or more donor(s) that would enable the donor(s) to correlate the amount and frequency of their donations with the number of subsidized prescriptions or orders for their products, and (ii) allowed donors to directly or indirectly influence the identification or delineation of Requestor's disease categories." The OIG stated that the charitable organization's failure to comply with the certifications "materially increased the risk that Requestor served as a conduit for financial assistance from a pharmaceutical manufacturer donor to a patient, and thus increased the risk that the patients who sought assistance from Requestor would be steered to federally reimbursable drugs that the manufacturer donor sold." The OIG explained that this type of steering can lead to patients seeking a more expensive drug if copayment assistance is available for that drug (but not for a generic version of the drug) and it can also lead to drug manufacturers having a greater ability to raise the prices of their drugs when patients are insulated from the immediate out-of-pocket effects of price increases, while Federal health care programs (which are funded by taxpayers), bear the cost.

The OIG advisory opinion rescinding its approval can be found at: https://oig.hhs.gov/fraud/docs/advisoryopinions/2017/AdvOpnRescission06-04.pdf

CMS Publishes ACA Enrollment Numbers During Shortened Open Enrollment Period

Since the start of the ACA enrollment period on November 1, 2017, the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services ("CMS") has been tracking and releasing figures about insurance enrollments through HealthCare.gov. CMS reports that more than 3.6 million people have signed up for health care as of December 2, with 823,180 enrollments occurring during the most recent reporting period from November 26 to December 2. In total, approximately 989,000 enrollments are new consumers, while over 2.6 million are returning consumers. The pace of enrollments through the fifth week of the enrollment period has averaged approximately 720,000 enrollments per week. If this rate continues, through the final week and a half of the enrollment period (December 3-15), ACA enrollments can be expected to total somewhere around 4.8 million. As of December 10 last year, just over 4 million people had selected marketplace coverage. By the end of the open enrollment period for plan year 2017, which ended

on January 31 instead of December 15, approximately 9.2 million people had enrolled in coverage through HealthCare.gov.

CMS' enrollment figures are available at:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-sheets.html

2018 Medicare Parts A & B Premiums and Deductibles Announced

On November 17, 2017, the Centers for Medicare and Medicaid Services ("CMS") announced the 2018 premiums, deductibles and coinsurance amounts for the Medicare Part A and Part B programs.

Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services. The Medicare Part A annual inpatient hospital deductible that beneficiaries pay when admitted to the hospital will be $1,340 per benefit period in 2018, an increase of $24 from $1,316 in 2017. CMS reports that approximately "99 percent of Medicare beneficiaries do not have a Part A premium since they have at least 40 quarters of Medicare-covered employment."

Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and other items. In its press release, CMS stated the standard monthly premium for Medicare Part B enrollees will be $134 for 2018, the same amount as in 2017. CMS explained that "[s]ome beneficiaries who were held harmless against Part B premium increases in prior years will have a Part B premium increase in 2018, but the premium increase will be offset by the increase in their Social Security benefits next year." CMS also announced that the annual deductible for all Medicare Part B beneficiaries will be $183 in 2018, with no change from 2017. Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans are already finalized and are unaffected by the announcement.

The CMS announcement can be viewed here:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-17.html

A fact sheet on the 2018 Medicare Parts A & B premiums and deductibles can be viewed at:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-17.html.

The Inclusion of Two Noncovered Part B Drugs When Setting Payment Resulted in Payment of Extra $366 Million over Two Years, OIG Finds

On November 27, 2017, the Department of Health and Human Services Office of Inspector General ("OIG") released an issue brief stating that Medicare and its beneficiaries paid an extra $366 million from 2014 to 2016 due to the inclusion of noncovered, self-administered drug products when setting payment amounts for two Part B drugs.

The OIG identified two drugs (Orencia and Cimzia) for which CMS includes noncovered self-administered versions when calculating Part B payment amounts, even though Part B generally does not cover drugs that are self-administered. Part B spending for the two drugs would have been reduced by $366 million (19 percent of expenditures) over two years if the payment amounts were set using only the physician-administered versions (i.e., had the noncovered self-administered versions not been used in

determining payment). Twenty percent of the total would have come directly through reduced coinsurance owed by Medicare beneficiaries.

In response to this issue, the OIG made a recommendation to the Centers for Medicare and Medicaid Services ("CMS") that it seek a legislative change that would provide the agency flexibility to determine when noncovered versions of a drug should be included in Part B payment amount calculations. CMS did not agree with the OIG recommendation, stating that although situations in which a health care professional uses a version of a drug that is typically self-administered may be rare, changing the law could limit the flexibility to do so. CMS stated that this could negatively affect beneficiary access to medically necessary drugs as well as increase the cost of these drugs. CMS also stated that further analysis on the cost, policy and operational implications would be necessary before determining the law should be changed.

The OIG Issue Brief can be viewed here: https://oig.hhs.gov/oei/reports/oei-12-17-00260.pdf

CMS Cancels Mandatory Bundled Payment Models

On November 30, 2017, the Centers for Medicare and Medicaid Services ("CMS") issued a final rule cancelling new mandatory bundled payment models for cardiac and orthopedic care that were scheduled to begin January 1, 2018. The cancelled episode payment models ("EPMs") and cardiac rehabilitation ("CR") incentive payment model were established under the Obama administration in an effort to shift Medicare from a volume-based to a value-based payment system that encourages care coordination and quality. The bundled payment models had been delayed twice by CMS.

This rule also makes participation voluntary for eligible hospitals in approximately half of the geographic areas selected for participation in the CMS' Comprehensive Care for Joint Replacement ("CJR") Model (that is, in 33 of the 67 Metropolitan Statistical Areas ("MSAs")) selected and for low volume and rural hospitals in all of the geographic areas selected for CJR participation. The CJR Model will remain mandatory for the remaining 34 of the 67 geographic areas.

CMS issued an interim final rule with comment period in conjunction with the final rule. The agency is seeking feedback on a final policy for determining episode costs for participating CJR providers located in areas impacted by extreme and uncontrollable circumstances such as the hurricanes of 2017.

The final rule and the interim final rule can be viewed here: https://www.federalregister.gov/public-inspection/current

A fact sheet on the final rule and the interim final can be viewed here: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-30.html

To review a list of all CJR participant hospitals, their MSAs, the status (mandatory or voluntary) of their MSAs and their status as rural or low volume, go to: https://innovation.cms.gov/initiatives/cjr

GAO Recommends that CMS Conduct Fraud Risk Assessments for Medicare and Medicaid

On December 6, 2017, the Government Accountability Office ("GAO") issued a report recommending that the Centers for Medicare and Medicaid Services ("CMS") conduct fraud risk assessments for Medicare and Medicaid to use in developing a risk-based antifraud strategy and evaluation approach. The GAO stated that although CMS has taken steps to identify fraud risks such as flagging certain high-risk providers,

a full-scale fraud risk assessment by CMS would allow federal managers to consider and triage fraud risks across program activities, including plans for monitoring and evaluation. It would also allow CMS to design and implement a strategy with specific control activities to mitigate assessed fraud risks. The GAO also recommended that the CMS Administrator provide and require fraud-awareness training to its employees on a regular basis.

A copy of the GAO report can be viewed at: https://www.gao.gov/assets/690/688748.pdf

MedPac Finds Physician Supervision Requirements Do Not Cause CAHs and Rural Hospitals to Limit Their Services

On December 1, 2017, the Medicare Payment Advisory Commission ("MedPAC") issued a report to Congress indicating that the Centers for Medicare and Medicaid Services ("CMS") enforcement of direct supervision requirements for critical access hospitals ("CAHs") and small rural hospitals did not cause them to significantly limit their services. The report was generated as part of a mandate under the 21st Century Cures Act of 2016, which instructed CMS not to enforce physician supervision requirements for outpatient therapeutic procedures in CAHs and small rural hospitals through 2016, and also mandated that the MedPAC issue a report to Congress about the effects of extending the enforcement instruction on Medicare beneficiaries' access to and quality of care as well as its economic impact on the affected hospitals, by December 13, 2017.

In 2009, prior to the passage of the Cures Act, CMS had clarified the agency's then-current policy that a physician must be immediately available to furnish assistance and direction throughout the performance of an outpatient therapeutic procedure (i.e., direct supervision). CAH and rural hospital representatives expressed concerns that because they have difficulty recruiting physicians to practice in rural areas, the direct supervision requirement may limit beneficiary access to care in their hospitals. In response, CMS instructed all Medicare administrative contractors not to evaluate or enforce the supervision requirements for therapeutic services in CAH and rural hospitals with 100 or fewer beds from 2010 to 2013, and then extended this instruction not to enforce supervision from 2013 to 2016. CMS is continuing nonenforcement in 2018 and 2019, however, there is currently a legal and regulatory gap in the enforcement instruction for 2017.

The report indicated that the CAH representatives that were interviewed stated that they put quality of care and patient safety first when deciding whether to offer therapeutic services to a patient, and that CMS officials have not received any quality of care concerns about hospitals, whether rural or urban, using inappropriate physician supervision for outpatient therapeutic services. MedPAC expects that quality of care should be equal for outpatient therapeutic services regardless of whether it is provided in an urban or rural location. The Commission also believes that determining the supervision needed for these services is a clinical decision about the appropriate level of care needed to safely deliver the service to the beneficiary, rather than one requiring direct supervision.

A copy of the MedPAC report can be viewed at: http://www.medpac.gov/docs/default-source/reports/dec17_physiciansupervision_sec.pdf?sfvrsn=0

STATE DEVELOPMENTS

Study Commission Recommends Continuation of Expanded Medicaid

A Commission of New Hampshire lawmakers and stakeholders charged with studying the effectiveness and the future of the expanded Medicaid program voted unanimously to recommend the continuation of the expanded Medicaid program. As part of its report, the Commission recommended moving the program to a managed care model in 2019 rather than maintaining the current Premium Assistance model. It cited several reasons for this recommendation including the ability to reduce premium instability and address premium increases in the individual market to provide consistent benefits for all Medicaid participants, to better serve the medically frail and to remove the impact of the medically frail on the individual market. The Commission also made recommendations to assure the continuity of coverage during the transition period and to increase the rates to providers of behavioral health services. The Commission's recommendation will serve as the basis for legislation to be considered in the upcoming legislative session. One difficulty will be identifying a mechanism to pay the State's share of the coverage. As previously reported, the use of payments from hospitals and insurers was found by the federal government to violate current law.

Minuteman Members Have More Time to Select a New Plan

On November 21, the New Hampshire Department of Insurance issued a notice to Minuteman Health members advising them that they have additional time to select a new health plan. The current open enrollment period ends on December 15, 2017, but Minuteman members now qualify for a special enrollment period that will allow them to select a new plan until March 1, 2018. Members who select a new plan before December 31 will be eligible for coverage on January 1. Those selecting a plan in January, February or on March 1 will be eligible for coverage on the first day of the month following the date they selected coverage. The Department of Insurance also advised members that they may have received a letter from Anthem indicating they would be automatically assigned to an Anthem plan, however, this is only true if they do not make a different selection and only if they send their premium payment to Anthem. The premium payment may be different than the amount set forth in the Anthem letter.

2018 LEGISLATIVE UPDATES

HB 1102-FN This bill authorizes the commissioner of the department of health and human services to contract with a physician certified by the Academy Society of Addiction Medicine to review medication assisted treatment in New Hampshire.

HB 1241: This bill establishes a commission to study the benefits and cost of a "health care for all" program for New Hampshire.

HB 1362: This bill authorizes individuals and certain businesses to purchase health insurance from out-of-state companies. The bill grants rulemaking authority to the insurance commissioner for the purposes of the bill.

HB 1367: This bill declares that children do not have to be immunized against tetanus.

HB 1418-FN This bill requires the commissioner of the department of health and human services, in consultation with the insurance commissioner, to develop a list of certain critical prescription drugs for

purposes of cost control and transparency. Under this bill, the commissioner shall make an annual report on prescription drugs and their role in overall health care spending in the New Hampshire.

HB 1462-FN: This bill requires employers who offer health or dental benefits, or both, to its employees to maintain that coverage for an employee who has filed a compensable claim under the workers' compensation law for 24 months or until the employee has returned to work, whichever is shorter.

HB 1465: This bill requires Medicare supplemental insurance policies to provide coverage for hearing aids.

HB 1468: This bill establishes a commission to study legislative oversight activities related to the department of health and human services.

HB 1471: This bill clarifies the law relating to telemedicine services.

HB 1506-FN This bill: I. Establishes the regulation and licensure of assistant physicians by the board of medicine. II. Regulates their practice through assistant physician collaborative practice arrangements. III. Establishes a grant program in the department of health and human services to provide matching funds for primary care clinics in medically underserved areas utilizing assistant physicians.
HB 1516: This bill establishes a commission to examine the feasibility of the New England states entering into a compact for a single payor health care program.

HB 1530: This bill adds a requirement for submission of criminal history records prior to licensure or certification by an allied health professional governing board.

HB 1560: This bill provides that sex reassignment drug or hormone therapy or surgery shall not be covered under the state Medicaid plan.

HB 1571: This bill authorizes the board of nursing to operate or contract for an alternative recovery monitoring program for nurses impaired by substance use disorders or mental or physical illness.

HB 1574: This bill requires a health care provider and a patient to sign a form upon dispensing controlled drugs explaining the addictive nature of such drugs.

HB 1577: This bill provides for the regulation of the use of general anesthesia, deep sedation, or moderate anesthesia by dentists and the reporting of adverse events.

HB 1606: This bill makes various changes to the regulation of doctors of naturopathic medicine including the scope of practice of naturopaths and the procedures of the naturopathic board of examiners.

HB1617: This bill inserts definitions in the RSA chapter relating to communicable disease for clarification purposes.

HB 1625: This bill requires facilities licensed under RSA 151 which perform digital foot scanning of patients and newborns to provide patients and the parents of the newborn an opportunity to "opt out" of such procedure.

HB 1643: This bill prohibits balance billing under the managed care law.

HB1654: This bill prohibits holding an injured driver or passenger responsible for medical costs determined to not be reasonable.

HB1664: This bill clarifies the eligibility to reappoint a member of a governing board of an allied health profession to an additional full term.

HB1665: This bill clarifies the authority of the governing boards of allied health professionals concerning individuals who are certified by such boards.

HB 1672-FN: This bill requires a search warrant issued by a judge based upon probable cause for any federal request for information relative to users of therapeutic cannabis created by the registry.

HB 1707-FN: This bill requires the physician who performs an abortion, or the referring physician, to provide the pregnant woman with certain information at least 24 hours prior to the abortion, and to obtain her consent that she has received such information.

HB 1732-FN: This bill establishes a nursing professionals' health program for aiding nurses impaired or potentially impaired by mental or physical illness including substance abuse or disruptive behavior.

HB 1740: This bill repeals the provision relating to the costs of blood testing orders when certain individuals have been exposed to another person's bodily fluids.

HB 1741: This bill allows an insured to pay the least amount for covered prescription medication under the managed care law.

HB 1746: This bill prohibits certain practices of pharmacy benefit managers.

HB 1747-FN: This bill requires manufacturers to pre-package class II controlled drugs which are going to be dispensed in New Hampshire in blister packs with serial numbers on each pill.

HB1751: This bill requires insurance coverage for treatment for pediatric autoimmune neuropsychiatric disorders.

HB 1755-FN: This bill establishes an office of the inspector general to independently advocate for the people and provide assistance in the exercise of their Article 14 rights.

HB 1769-FN: This bill prohibits discrimination against physicians based on maintenance of certification.

HB 1783-FN: This bill requires newborns to be screened for Krabbe Leukodystrophy.

HB 1787-FN: This bill prohibits discrimination against health care providers who conscientiously object to participating in certain medical procedures.

HB 1790-FN-A: This bill establishes a New Hampshire health access corporation and health access fund.

HB1791-FN: This bill declares that a contract between an insurance carrier or pharmacy benefit manager and a contracted pharmacy shall not contain a provision prohibiting the pharmacist from providing certain information to an insured.

HB 1793-FN-A This bill establishes a single payer health care system to provide health care for the citizens of New Hampshire

The bill text is not yet available for the following Legislative Service Requests:

2018-2004 HB Title: relative to the New Hampshire health protection program.

2018-2209 HB Title: relative to notification procedures and certain sunset provisions of the New Hampshire health protection program.

2018-2646 HB Title: relative to Medicaid managed care.

2018-2647 HB Title: relative to the law regarding Medicaid expansion.

2018-2723 SB Title: relative to medication synchronization.

2018-2727 SB Title: relative to members of the dental profession.

2018-2740 SB Title: relative to an exemption from the board of registration of medical technicians.

2018-2744 SB Title: relative to the office of professional licensure and certification.

2018-2824 SB Title: deleting immunization/vaccination requirements for Hepatitis B.

2018-2826 SB Title: relative to testing for Lyme disease.

2018-2834 SB Title: relative to the nursing facility bed moratorium.

2018-2860 SB Title: relative to balance billing under the managed care law.

2018-2879 SB Title: establishing a commission to assess benefits and costs of a "health care for all" program for New Hampshire.

2018-2887 SB Title: relative to the controlled drug prescription health and safety program.

2018-2890 SB Title: relative to licensure of facilities located within 15 miles of a critical access hospital.

2018-2920 SB Title: limiting the use of electroconvulsive therapy.

2018-2922 SB Title: establishing positions in the office of professional licensure and certification and making an appropriation therefore.

2018-2931 SB Title: establishing a committee to study the consolidation of the board of mental health practice and the board of licensing for alcohol and other drug use professionals.

2018-2948 SB Title: relative to the medical review subcommittee of the board of medicine and time limits for allegations of professional misconduct before the board.

2018-2956 SB: Title: reforming New Hampshire's Medicaid and Premium Assistance Program.

2018-2962 SB: Title: relative to unclassified positions within the department of health and human services.

2018-2969 SB: Title: relative to adoption of emergency medical and trauma services protocols.

2018-2973 SB: Title: deleting the suspension of home health services rate setting.

2018-2993 SB: Title: relative to insurance coverage for prescription contraceptives.

2018-2994 SB: Title: relative to pharmacy claim fees and copayments.

2018-3030 HB: Title: making hormonal contraceptives available directly from pharmacists by means of a standing order.

The following Legislative Service Request has been withdrawn:

2018-2207 HB Title: making hormonal contraceptives available directly from pharmacists by means of a collaborative pharmacy practice agreement. **(Withdrawn)**

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Cinde Warmington, Kara J. Dowal, Karolyn McCauley and Alexander W. Campbell contributed to this month's Legal Update.

BIOS

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