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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

Number of Health Insurers in New Hampshire Marketplace Will Increase to Five

On June 2, the New Hampshire Insurance Department announced that it had licensed Assurant Health and Maine Community Health Options to enter the New Hampshire health insurance marketplace in 2015. These insurers join Harvard Pilgrim Health Care and Minuteman Health, which had announced earlier this year that they would offer plans in 2015, as well as Anthem Blue Cross Blue Shield, which is already offering plans in the marketplace. Initially, Maine Community Health Options, which garnered 80% of enrollment in the Maine marketplace in the initial open enrollment period there, will offer plans only in Rockingham, Strafford, Carroll, and Coos counties. Minuteman and Maine Community Health Options will be the first member-run cooperative health plans operating in New Hampshire.

Forty Thousand New Hampshire Residents Enroll in Marketplace Plans, and 87 Percent Are New Customers

During the initial open and special enrollment periods for the health insurance marketplace, 40,262 New Hampshire residents selected private health insurance plans. The Obama Administration had predicted that only 19,000 New Hampshire residents would select plans, and New Hampshire's rate of enrollment as compared with the prediction (212%) was close to twice the national rate (113%), the third highest of any state in the country, and the highest of any state using a federal marketplace.

On May 9, Anthem announced that more than 35,000 of the 40,262 enrollees, or close to 87 percent of total enrollees, did not previously have an Anthem plan. Given that Anthem plans represented 90 percent of the individual market prior to the advent of the marketplace, these numbers suggest that a significant number of marketplace enrollees were previously uninsured. Anthem also reported that as of May 9, nearly 90 percent have paid their premiums. This compares favorably with a report of the national Blue Cross Blue Shield Association that 80 to 85 percent of marketplace enrollees nationwide had paid their first month's premiums.

Anthem Will Permit Extensions for One Additional Year

On May 11, Anthem announced that it would permit some 10,000 New Hampshire residents who have individual health insurance policies that don't comply with the Affordable Care Act to renew their policies for one additional year. The extension will be available to anyone whose policies are due to expire between October 1 and December 1.

New Hampshire Insurance Commissioner Requests Delay of Participation in "Employee Choice" Provision of SHOP Exchange for an Additional Year

The Affordable Care Act contained a provision for health insurance marketplaces that could be used by small businesses and their employees, known as Small Business Health Options (SHOP) exchanges. The SHOP exchange will allow small businesses to purchase coverage through an exchange, and includes a provision for "employee choice" by which employees may choose among available health plans and insurance carriers.

As discussed in past Legal Updates, the federal government postponed the launch of the SHOP exchanges until later this year. On May 16, the U.S. Department of Health and Human Services released a final rule that permits States to recommend that the implementation of the employee choice provisions be delayed until 2016. To obtain such a delay, the state Insurance Commissioner needs to certify that the delay is in the best interest of small employers and their employees and dependents because of the likelihood that implementing employee choice would cause issuers to price their products and plans higher than they would otherwise price them. (The insurers' concern is that employee choice could result in significant adverse selection in a State's small group market, and the administration's concern is that insurers' concern for the potential of such selection could cause insurers to price their products and plans higher than they might otherwise price them if the SHOP did not offer employee choice.)

On June 2, the New Hampshire Insurance Commissioner requested such a one-year delay, stating that in his opinion, based on the expert judgment of Insurance Department staff analysts and after consultation with affected stakeholders, a delay is in the best interests of New Hampshire small employers and their employees and dependents. According to the letter, both Anthem and Harvard Pilgrim, which dominate New Hampshire's small group market, as well as other stakeholders, expressed significant concerns about adverse selection as well as timing given that policy forms, benefit designs, and rate demonstrations were already due to the Department. It is expected that the federal government will grant New Hampshire's request for a delay until 2016.

IRS Announces Rule Designed to Deter Employers from "Dumping" Employees onto the Individual Health Insurance Marketplace

On May 13, the IRS clarified that an employee cannot receive tax-free contributions from an employer to purchase an individual health insurance policy.

Following the enactment of the Affordable Care Act, some employers determined that they could save money by declining to provide their own health insurance plan and instead reimburse employees with pre-tax dollars for premiums the employees paid for health insurance purchased through the individual health insurance marketplace or otherwise. On May 13, the IRS clarified that such an arrangement, known as an "employer payment plan," is considered to be a group health plan subject to the requirements of the Affordable Care Act. The clarification provides that such arrangements cannot be integrated with individual policies purchased by the employee to satisfy ACA requirements. As a result, they are potentially subject to a $100 per day ($36,500 per year), per employee, excise tax.

Employers can provide employees funds with which to purchase health insurance without running afoul of this rule, but such funds must take the form of taxable wages. Employers can also have an arrangement, without running afoul of the rule, under which an employee chooses whether to have an after-tax amount applied towards health coverage or to take that amount in cash compensation.

HHS Publishes Rule Prohibiting States From Imposing Certain Restrictions on Navigators, Certified Application Counselors, and Others Carrying Out Consumer Assistance Functions

On May 27, the U.S. Department of Health and Human Services published a rule governing the standards that states may impose upon Navigators, certified application counselors, and others who provide assistance to consumers in applying for health insurance in the marketplace.

Under the new rule, states or state exchanges are permitted to impose licensing, certification, or other standards only if those standards do not impair the ability of these individuals to help consumers or perform other tasks required by federal law. Among other requirements, Navigators, certified application counselors, and others carrying out consumer assistance functions cannot be required to refer consumers to other entities that are not required to provide fair, accurate, and impartial information; they cannot be prevented from providing services to all persons to whom they are required to provide assistance; they cannot be prevented from providing advice regarding substantive benefits or comparative benefits of different health plans; they cannot be subject to standards that would prevent the application of federal requirements; and in the case of Navigators, cannot be required to hold agent or broker licenses.

Special Enrollment Period for COBRA Participants Continues Through July 1

Outside of an open enrollment period, individuals may only enroll in marketplace coverage when they qualify to participate in a "special enrollment period," typically as the result of a qualifying event. One such event is the loss of COBRA continuation coverage. Individuals who voluntarily terminate COBRA coverage, as opposed to having it run out, are not ordinarily eligible to enroll in a marketplace plan on that basis until the next open enrollment period. However, through July 1, the health insurance marketplace is providing a one-time Special Enrollment Period that allows individuals with COBRA coverage to terminate that coverage and enroll in a marketplace plan instead. To take advantage of this option, eligible individuals must call the Marketplace Call Center at (800) 318-2596 to be approved for the Special Enrollment Period, after which they can apply online or by phone for a marketplace plan.

Federal Regulatory Update

CMS Issues Final Exchange and Insurance Market Standards for 2015 and Beyond

On May 16, CMS released a final rule on health insurance market standards, covering a wide-range of provisions affecting insurance coverage under the Affordable Care Act, including small business plans, standards for people who help consumers find coverage under the ACA, drug coverage determinations, insurer quality rating information, and efforts to stabilize premiums. The rule standardizes notices health insurers are required to provide to consumers when they make coverage changes, and when policies are renewed or discontinued. The rule also provides an expedited process to allow enrollees in health plans to obtain access to drugs that are not included in the plan's coverage. Under this rule, an enrollee or his or her physician can request an exception where the enrollee suffers from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function, or when the enrollee is undergoing a current course of treatment using a drug not covered by the plan. As part of the expedited process, the health plan must make a coverage determination within 24 hours after receiving the request and must continue to provide the drug throughout the duration of the enrollee's medical issue. The final rule also requires insurers to submit data to calculate quality ratings, which marketplaces must display starting in 2016.

The final rule also specifies the grounds for imposing civil monetary penalties (CMPs) on persons who provide fraudulent information to the health insurance exchanges. According to the rule, CMPs can be

imposed in several situations, including the negligent failure to submit correct information to a health insurance exchange; knowingly providing fraudulent information to ans exchange; and knowingly disclosing a patient's health insurance exchange information. While the final rule authorizes CMS to be in charge of imposing CMPs, it does not preclude giving the OIG the power to impose CMPs in the future.

CMS Issues Final Rule on Medicare Advantage and Prescription Drug Benefit Programs for Contract Year 2015

On May 19, CMS issued a final rule completing changes to the Medicare Advantage (MA) and Part D prescription drug benefit programs. The final rule follows a Notice of Proposed Rulemaking, issued January 10, in which CMS proposed dozens of new or amended regulations. The proposed rule contained a variety of controversial changes to the MA and Part D programs, including changes to criteria for protected drug classes, preferred pharmacies, and the medication therapy management programs. In the final rule, however, CMS stated that these proposals, and many others, will either "be addressed later" or are "effectively being withdrawn."

As identified by CMS, some key provisions of the final rule include:

- Improving payment accuracy: The final rule implements the Affordable Care Act requirement that MA plans and Part D sponsors report and return identified Medicare overpayments. The rule requires plan sponsors to report and return overpayments within 60 days of identification, and requires them to "report and return any overpayment identified within the 6 most recent completed payment years." While the proposed rule stated that any overpayments related to fraud would not be subject to the six-year limitation, the final rule removed that exemption, meaning that regardless of intent, only overpayments "identified within the 6 most recent completed payment years" need be returned.

- Requiring prescribers of Part D drugs to enroll in Medicare: The Affordable Care Act requires that physicians and eligible professionals who order durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), or certify home health care for Medicare beneficiaries, be enrolled in Medicare. The statute also permits the Secretary of Health and Human Services to extend these Medicare enrollment requirements to physicians and eligible professionals who order or certify all other categories of Medicare items or services, including covered Part D drugs. Accordingly, the final rule requires that as of June 1, 2015, physicians and eligible professionals who prescribe covered Part D drugs be enrolled in Medicare, or have a valid record of opting out of Medicare, in order for their prescriptions to be covered under Part D.

- Permitting revocation of Medicare enrollment for abusive prescribing practices and patterns: CMS will have the authority to revoke a physician or eligible professional's Medicare enrollment if CMS determines that he or she has a pattern or practice of prescribing that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements. CMS will also be able to revoke a physician or eligible professional's Medicare enrollment if his or her Drug Enforcement Administration Certificate of Registration is suspended or revoked, or if the applicable licensing or administrative body for any state in which he or she practices suspends or revokes his or her ability to prescribe drugs. CMS declines to define "abusive" but will instead evaluate the prescribing practices based on a set of criteria to determine whether they warrant a revocation.

OMB Proposes Updates to Exclusion and Civil Monetary Penalties Authorities

The OIG recently issued a pair of proposed regulations to update its exclusion and civil monetary penalty (CMP) authorities. Comments on the proposed rules are due to the OIG no later than July 8 and July 11, respectively. Below is a summary of the major provisions of each proposed regulation.

Exclusion

The first rule, published on May 9, would broaden OIG's authority to exclude individuals and entities from participating in Federal health care programs. The enhanced exclusion authority comes from the Affordable Care Act and would allow OIG to impose exclusions on individuals for conviction of an offense in connection with obstruction of an audit; failure to supply payment information to either Medicare or a state healthcare program; and making, or causing to be made, any false statement, omission, or misrepresentation of a material fact on an application to participation in a Federal health care program.

The ACA also expanded the OIG's authority to issue testimonial subpoenas in connection with the investigation of potential exclusions. Previously, the OIG's power to issue testimonial subpoenas extended only to CMP claims, and did not reach exclusion cases.

The OIG also indicated it is considering an "early reinstatement" process for those individuals excluded as a result of the loss, suspension or revocation of their state license. In doing so, the OIG highlighted specific instances in which it believes early reinstatement may be warranted, including: (1) where a medical board in one state permanently revokes a physician's license, yet another medical board in another state subsequently grants the physician a license; and (2) where an individual who has since changed professions, with no intent to regain his or her original license, still wishes to practice in a new health care related profession. The OIG specifically requested comments as to potential approaches to the "early reinstatement" process, and any factors that it should consider in an individual's request for reinstatement.

CMP

On May 12, OIG published a proposed rule which would implement several provisions of the ACA. This includes allowing for assessment of CMPs for: (1) failure to grant OIG timely access to records, upon reasonable request; (2) ordering or prescribing medication or services while excluded from participation in Federal health care programs when the excluded person knows or should know that the item or service may be paid for by a Federal health care program; (3) making false statements, omissions or misrepresentations in an enrollment application to participate in Federal health care programs; (4) failure to report and return a known overpayment; and (5) making or using a false record or statement that is material to a false or fraudulent claim.

The proposed rule also provides for CMP liability, consistent with the ACA, for Medicare Advantage or Part D contracting organizations that: (1) enroll an individual without his or her prior consent; (2) transfer an enrollee from one plan to another without his or her prior consent; (3) transfer an enrollee solely for the purpose of earning a commission; (4) fail to comply with statutory or regulatory marketing restrictions; or (5) employ or contract with any person who engages in conduct that violates certain provisions of the Social Security Act.

Further, OIG proposes a reorganization of the CMP regulations, which have become "cumbersome" over time. To add clarity to OIG's decision-making process, it has identified a list of factors that are applicable across all grounds for imposing CMPs. The list includes the nature and circumstances of the

violation, the degree of culpability of the person, the history of prior offenses, other wrongful conduct, and other matters as justice may require. As the fifth factor demonstrates, these are illustrative factors rather than a comprehensive list. The OIG also proposes to adjust the dollar amounts used to trigger aggravating and mitigating factors.

CMS Releases Final Rule Establishing Federally Qualified Health Center Prospective Payment System

On April 29, CMS released a final rule establishing a Medicare prospective payment system (PPS) for federally qualified health center (FQHC) services. As required by the ACA, beginning October 1, 2014, Medicare will pay FQHCs an all-inclusive, encounter-based rate for professional services furnished per beneficiary per day. The encounter-based per-diem base rate is $158.85. The proposed rate is estimated to increase total Medicare payments to FQHCs by as much as 32 percent. The rate will be adjusted for geographic differences in a similar manner to adjustments performed under the Medicare Physician Fee Schedule. It will also be adjusted when a FQHC furnishes care to a patient for the first time or to a patient receiving an initial preventive physical examination. For such visits, FQHCs will receive payment that is 34 percent higher than the encounter-based rate.

CMS and Office of the National Coordinator for Health Information Technology (ONC) issue Proposed Rule Allowing Flexibility for Certified EHR Technology and Extending Stage 2 of Meaningful Use

CMS recently issued a proposed rule that would allow eligible professionals and hospitals flexibility in how they use certified electronic health record (EHR) technology (CEHRT) to meet meaningful use requirements in 2014. The proposed rule would allow providers and hospitals to use the 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT to qualify for meaningful use program incentive payments in 2014. Eligible providers who use only the 2011 Edition CEHRT in 2014 must meet the same meaningful use objectives and measures for Stage 1 as were applicable in 2013. Those that use a combination of the 2011 and 2014 Edition CEHRT may choose to satisfy the 2013 Stage 1 objectives and measures or the 2014 Stage 1 objectives and measures, or if they are scheduled to begin Stage 2 in 2014, they may choose to attain the Stage 2 objectives and associated measures. These options are strictly for hospitals and providers that were unable to fully implement a 2014 Edition criteria compliant system because of delays in the availability of the technology. Beginning in 2015, all eligible hospitals and professionals would still be required to report using 2014 Edition CEHRT.

The proposed rule also formalizes CMS and ONC's previously stated intention to extend Stage 2 through 2016 and begin Stage 3 in 2017. Comments on the proposed rule must be submitted to CMS by July 21.

CMS Seeks Comments on "Sunshine Act" Dispute Resolution and Correction Process; Comment Period Closed

On May 5, CMS announced that as of June 1, physicians and teaching hospitals would be able to register with CMS to receive notices from and access to CMS's Open Payments database. The CMS Enterprise Portal is accessible at https://portal.cms.gov. The database will contain information about payments and other transfers of value that pharmaceutical and medical device manufacturers and group purchasing organizations (GPOs) make to physicians and teaching hospitals as required by the Sunshine Act. Although registration is a voluntary process, it is required if the physician or teaching hospital wants to be able to review and dispute any of the data reported about them. Beginning sometime in July, physicians and hospitals will be able to access and review their own data. They will then have 45- to 60-days to resolve

any disputes with the manufacturers and GPOs. The information is scheduled to be made public on September 30.

On May 5, CMS announced that it was soliciting comments on the dispute resolution and correction procedures outlined above. Comments closed on June 2. It is expected that covered recipients and manufacturers and GPOs will seek to delay the September 30 publication date in order to allow enough time to resolve any disputes that may arise.

OMB Starts Review of Safe Harbors Rule from OIG

On May 15, the White House Office of Management and Budget (OMB) began review of a proposed rule on "safe harbors" from healthcare fraud prosecution. According to the OMB's regulatory agenda, the proposed rule would amend the safe harbors to the anti-kickback statute and the civil monetary penalty rules under the authority of the OIG. It would add new safe harbors, some of which codify statutory changes set forth in the Medicare Prescription Drug Improvement and Modernization Act of 2003 and the Affordable Care Act. All of these safe harbors "would protect certain payment practices and business arrangements from criminal prosecution and civil sanctions under the anti-kickback provisions of the statute." The OIG will also propose to codify the ACA's revised definition of "remuneration" and add a "gainsharing" exception to the civil monetary penalty rules in 42 C.F.R. Part 1003. An example of gainsharing is an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts.

The rule is scheduled for publication in July.

Other Federal Updates

OIG Releases Report on Improper Payments for Evaluation and Management Services

On May 29, OIG released a reported titled, "Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010," which set forth the results of the OIG's review of Part B claims for Evaluation and Management (E/M) services and evaluated physician compliance with E/M documentation requirements. According to the report, Medicare inappropriately paid $6.7 billion for claims for E/M services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. The OIG also found that 42 percent of claims for E/M services in 2010 were incorrectly coded and 19 percent were lacking documentation. It also found that claims from high-coding physicians were more likely to be incorrectly coded or insufficiently documented than claims from other physicians.

The OIG recommended that CMS educate physicians on coding and documentation requirements for E/M services as well as encourage contractors to review E/M services billed by high-coding physicians. The OIG also recommended that CMS follow up on claims for E/M services that were paid for in error. While CMS agreed with educating physicians on coding and documentation requirements for E/M services, it declined to review E/M services billed by high-coding physicians because a prior review resulted in a negative return on investment.

OIG Releases Spring 2014 Semiannual Report to Congress

On May 27, OIG issued its Spring 2014 semiannual report to Congress, summarizing its activities from October 1, 2013 through March 31, 2014. Some of the report's highlights include:

- In the first half of fiscal year 2014, OIG reported expected recoveries of more than $3.1 billion, consisting of nearly $295 million in audit receivables and approximately $2.83 billion in investigative receivables.

- OIG reported exclusions of 1,720 individuals and entities from participation in Federal health care programs; 465 criminal actions against individuals or entities engaged in crimes against Federal health care programs; and 266 civil actions, including False Claims Act cases and civil monetary penalty settlements.

- During the first half of FY 2014, Medicare Fraud Strike Force, a multi-agency group of investigators designed to fight Medicare fraud, filed charges against 94 individuals or entities, worked on 107 criminal actions and recovered $294 million. Strike force teams are currently operating in nine cities.

- With regard to Medicare Administrator Contractor (MAC) activities, the report states that MACs did not meet one-quarter of the quality assurance standards reviewed and that MACs had not resolved 27 percent of these unmet standards as of June 2012. OIG recommends that CMS require action plans for unmet quality standards, among other suggestions.

OIG Issues Special Advisory Bulletin Clarifying Position on Independent Charity Patient Assistance Programs

On May 21, the OIG issued a Supplemental Special Advisory Bulletin addressing independent charity patient assistance programs (PAPs) for federal health care program beneficiaries. PAPs provide cost-sharing assistance for patients who cannot afford their prescription medications. Pharmaceutical manufacturers may sponsor PAPs. The bulletin builds on the OIG's prior guidance on this topic and reaffirms the OIG's position that properly structured PAPs help beneficiaries and cautions that PAPs with certain problematic characteristics may experience increased regulatory scrutiny. Incorporating information learned from Advisory Opinion requests submitted to the OIG by PAPs and pharmaceutical manufacturers that provide financial support to PAPs, the supplemental bulletin focuses on three specific areas: (1) disease funds; (2) eligible recipients; and (3) the conduct of donors.

American Hospital Association Sues HHS Over Appeal Backlog

On May 22, the American Hospital Association (AHA), along with Baxter Regional Medical Center in Arkansas, Rutland Regional Medical Center in Vermont, and Covenant Health, which operates nine hospitals in Tennessee, filed a lawsuit against the Department of Health and Human Services over the two-year suspension of appeals at the Office of Medicare Hearings and Appeals, where Administrative Law Judges hear appeals. The AHA's complaint requested an order from the U.S. District Court for the District of Columbia to force the agency to meets its statutory obligations to decide Medicare payment appeals within 90 days instead of the current average of 16 months. The AHA said in its complaint that the backlog of unresolved appeals affects "human health and welfare by compromising the economic wellbeing of hospitals across the country." Combined, the two hospitals and the hospital system have $8.9 million in RAC appeals pending at OMHA.

HHS Levies Large Fines for HIPAA Violations

The Department of Health and Human Services recently announced that New York-Presbyterian Hospital (NYP) and Columbia University have agreed to settle charges that they potentially violated the HIPAA Privacy and Security Rules by failing to secure the electronic protected health information (ePHI) of thousands of patients stored on their shared network. The ePHI of approximately 6,800 individuals was

disclosed, including patient status, vital signs, medications and laboratory results. The monetary payments total $4.8 million, which is the largest HIPAA settlement to date.

The Office of Civil Rights (OCR) investigation revealed that the breach was caused when a physician employed by Columbia University who developed applications for both organizations attempted to deactivate a personally-owned computer server on the network containing NYP patient ePHI. Because of the lack of technical safeguards, deactivation of the server resulted in ePHI becoming accessible on internet search engines. The entities learned of the breach after receiving a complaint by an individual who found the ePHI of the individual's deceased partner, a former patient of NYP, on the internet. OCR also determined that neither organization had made efforts before the breach to ensure the security of the server. Additionally, both facilities failed to develop adequate risk management plans.

This settlement comes a month after OCR levied nearly $2 million in fines against two health care organizations to settle potential HIPAA violations arising out of the theft of unencrypted laptops. In one case, an unencrypted laptop was stolen from Concentra Health Services. Although Concentra had conducted multiple risk analyses citing the lack of encryption on its computers and other devices, it had not completed the task of installing encryption. In the other case, an unencrypted laptop was stolen from the car of a QCA Health Plan, Inc. employee. In a press release announcing the settlements, OCR's deputy director of health information privacy said that encryption is the best defense against such incidents.

OIG Issues Favorable Opinion Regarding the Use of "Preferred Hospital" Networks as part of Medigap Policies

On April 9, 2014, OIG issued Advisory Opinion No. 14-04, concerning the use of a "preferred hospital" network as part of Medicare Supplemental Health Insurance (Medigap) policies offered by a health insurer. Under the proposed arrangement, the health insurer would indirectly contract with hospitals for discounts on the otherwise-applicable Medicare inpatient deductibles for its policyholders and, in turn, the insurer would provide a $100 premium credit to policyholders who use a network hospital for an inpatient stay. This advisory opinion is virtually identical to Advisory Opinion No. 14-02, issued by the OIG in February, which came to the same conclusion about a similar proposed arrangement from an anonymous requesting party.

As in the prior opinion, OIG concluded that, in combination with the Medigap coverage, the discounts offered on inpatient deductibles by the network hospitals and the premium credits offered by the insurer would present a sufficiently low risk of fraud or abuse under the anti-kickback statute because: (1) neither the discounts nor the premium credits would increase or affect per-service Medicare payments; (2) the arrangement would be unlikely to increase utilization; (3) the arrangement would not unfairly affect competition among hospitals, because membership in a contracting hospital network would be open to any accredited, Medicare-certified hospital; (4) it would be unlikely to affect professional medical judgment because the policyholders' physicians would receive no remuneration; and (5) the insurer would make clear to its policyholders that they have the freedom to choose any hospital without incurring additional liability or penalty.

Medicare Lifts Ban on Coverage for Sex Reassignment Surgery

On May 30, the U.S. Department of Health on Human Services lifted a thirty-three year ban on Medicare coverage for sex reassignment surgery. The ruling came in a decision by the Departmental Appeals Board in response to a challenge filed last year by the American Civil Liberties Union and Gay and Lesbian Advocates and Defenders on behalf of a transgendered army veteran. Medicare will now cover

such surgeries on a case-by-case basis. The ruling does not apply to private health insurers or Medicaid, although it is expected to be influential in insurers' decisions on whether or not to provide coverage.

STATE DEVELOPMENTS

State Government Reaches Deal on Restructuring the Medicaid Enhancement Tax

In the waning days of the 2014 legislative session, a deal was reached to restructure the Medicaid Enhancement Tax. In the agreement, the terms of which were negotiated between Governor Maggie Hassan and the state's hospitals, 25 of the state's 26 hospitals agreed to drop the lawsuit that they had brought over the tax. Under the agreement, critical access hospitals will get back 75 percent of uncompensated care costs, and noncritical access hospitals will get back 50 percent of uncompensated care costs in 2016 and 2017, and 55 percent of such costs starting in 2018. The agreement assumes that uncompensated care will decrease over time as more people buy health insurance, but contains protections for the state such that if revenue from the tax drops below a certain threshold, the state will lower its payments back to the hospitals.

The Agreement will very gradually drop the rate of the tax over time, from the present rate of 5.5 percent to 5.45 percent in 2016 and 5.4 percent in 2015, and it will continue to drop in the following years to 5.25 percent, but only if total uncompensated care costs drop below $375 million. Rehabilitation hospitals will no longer be subject to the tax. The State also agreed that all the revenue from the tax will be set aside in a special fund, to be known as the Uncompensated Care and Medicaid Fund, and to be used for health care services only (including Medicaid). Hospitals will be required to make a nonbinding estimate of their projected tax payment on or before January 15, and file a tax return and pay the tax in full on or before April 15. Payments more than 60 days past due may be collected by offsetting the payments against state payments due to the hospital under Medicaid or any other state program.

Joint Fiscal Committee Approves New Hampshire's Application for Expanding Medicaid

On May 22, the state's joint fiscal committee approved New Hampshire's Medicaid expansion plan. The proposal now goes to CMS, which must approve the necessary waiver for the state's plan to go into effect.

The plan will make Medicaid available to all adults between the ages of 19 and 65, who are not currently eligible for Medicaid and whose incomes are up to 138% of the Federal Poverty Level (FPL), which is currently $15,400 per year for a single person, or $32,000 for a family of four.

Currently, low-income adults are eligible for Medicaid in New Hampshire only if they qualify as parents (up to 53% of FPL), adults with disabilities (up to 76% of FPL), pregnant women (up to 185% of FPL), or the working disabled (up to 450% of FPL). Non-pregnant adults without children or a disability are currently ineligible regardless of income, except for limited family planning benefits available under the previously-implemented Medicaid Family Planning Expansion.

The expansion includes several approaches. The "Health Insurance Premium Payment Program" (HIPP Program) provides premium assistance for low-income adults with employer-sponsored health insurance, and is already in operation. The "Bridge to Premium Assistance" program will make Medicaid managed care available for eligible low-income adults without access to employer sponsored health insurance starting July 1, 2014. If a federal waiver is approved by March 31, 2015, the "Premium Assistance" program will start on January 1, 2016, replacing the "Bridge to Premium Assistance" program,

and will provide eligible low-income adults without access to employer-sponsored health insurance with premium assistance to purchase health insurance on the marketplace.

The program will expire on December 31, 2016 in the absence of new legislation. Approximately 58,000 individuals are expected to enroll under the expansion.

Meridian Health Announces It Will Leave New Hampshire Medicaid Program

On June 3, the State announced that Meridian Health Plan, one of the three managed care organizations (MCOs) hired by the state to administer its Medicaid program, is withdrawing from the program. Meridian told news outlets that it is withdrawing to focus on its core markets in the Midwest. (It currently operates in Michigan, Illinois, and Iowa.) Meridian Health Plan will provide services through July 31, by which time the 31,000 Meridian Health Plan members must switch to a managed care plan provided by New Hampshire Healthy Families or Well Sense Health Plan, the other two participating MCOs.

Legislative Update

The following legislation has passed both the House and Senate and has been signed into law by the Governor:

- **HB 597, *relative to a drug-free workplace for licensed health care facilities and providers***. This bill will require health facilities to develop policies for a drug-free workplace that includes procedures for drug testing when reasonable suspicion exists.

- **SB 226, *relative to reporting of health care associated infections.*** DHHS requested this bill to clarify the limitations to collecting data for reporting of health care associated infections. DHHS has a statewide database of all reported infection information in order to monitor quality improvement and infection control activities in hospitals and ambulatory surgical facilities. Under current law, the hospitals and ambulatory surgical facilities are not allowed to provide DHHS with data that identifies an individual patient. Under the new law, those providers may provide to DHHS data or patient identifiers as set forth in the protocols established by the National Healthcare Safety Network. However, a patient's name, address, phone number and social security number may not be included.

The following legislation has passed both the House and Senate and is awaiting enrollment and/or action by the Governor:

- **SB 340, *requiring the insurance department to hold public hearings before approval of products to be sold on the health exchange***. This bill will require the state Insurance Department to hold at least two public information sessions concerning the proposed provider networks of insurance products proposed to be sold on the Health Benefits Marketplace, including information on the proposed network of hospitals and essential community providers to be made available to the public at or before the information sessions.

- **SB 369, *relative to payment of the Medicaid enhancement tax***. This bill was rewritten to provide for the deal reached between the State and the hospitals on the Medicaid Enhancement Tax, covered in detail above.

• **HB 658, *relative to registration for medical technicians*.** This bill establishes the Board of Registration of Medical Technicians and requires individuals employed as medical technicians to register with the Board.

• **HB 1434, *allowing a mentally competent adult to make medical decisions for an adult who lacks health care decision making capacity*.** This bill will allow a person's next of kin to make health care decisions without involving court action when there is no advance directive.

• **SB 213, *establishing a registry for physician orders for life-sustaining treatment*.** This bill establishes the New Hampshire POLST (provider order for life-sustaining treatment) Registry, effective July 1, 2015. Under this bill, a patient may execute a form to be signed by the patient and his or her physician relative to life-sustaining treatment to ensure that the patient's preferences are known in the event of an emergency. This bill establishes a statewide registry for the collection and dissemination of physician orders for life-sustaining treatment to help ensure that medical treatment preferences for an individual nearing the end of his or her life are honored.

• **HB 584, *relative to covered prescription drugs*.** This bill requires insurers to allow covered persons to purchase their 90-day supply of covered prescriptions drugs at the pharmacy of their choice within the insurer's network.

The following legislation was passed in different versions by the House and Senate, was sent to a Committee of Conference to reconcile, and the House and Senate Members were unable to come to an agreement, so the legislation will not be enacted into law.

• **HB 582, *relative to early offers for medical injury claims.*** Both bills would have modified the "early offer" procedure for resolution of claims of medical injury that went into effect on January 1, 2013.

The following legislation was passed in different versions by the House and Senate and no Committee of Conference has been empaneled.

• **SB 308, *relative to innovation in the delivery of health care*.** Under the Senate version of the bill, the attorney general may issue certificates for cooperative agreements among health care providers and entities governing the sharing of personnel, facilities, and other assets. Under the proposed law, health care providers are not required to enter into cooperative agreements or to request approval of a cooperative agreement from the attorney general. However, parties to a cooperative agreement approved by the attorney general will be entitled to state action immunity under federal antitrust laws. The House version of the bill would instead establish a committee to study the issue.

• **HB 255, *establishing a commission to study medical costs and payments under workers' compensation law*.** The bill establishes a commission to study medical costs and payments under workers' compensation law.

The following legislation was referred to an Interim Study Committee for further review:

• **SB 406, *relative to certain health care data*.** This bill would require the state Department of Health and Human Services to make limited use research data sets related to health care costs

available to the public upon request.

• **HB 1219, *relative to the work schedule of pharmacists*.** This bill establishes requirements for the staffing and work schedule for a pharmacy by a pharmacist. Violations are subject to disciplinary action by the board of pharmacy.

• **SB 250, *relative to ambulatory surgical facilities*.** This bill authorizes ambulatory facilities to allow patients to stay in the facility for 48 hours from the time of admission. The law currently requires that after 24 hours the patient shall be either discharged or transferred to another health care facility.

• **SB 256, *requiring health care facilities to implement a process to inform patients about palliative care options*.** This bill requires health care facilities to implement a process to inform patients about palliative care options as part of the licensure and re-licensure requirements.

• **HB 1328, *relative to licensure of insurance exchange navigators*.** This bill requires that insurance exchange navigators be licensed by the insurance department. Under this bill, insurance exchange navigators shall submit to a background check as a condition of licensure. As discussed above, the U.S. Department of Health and Human Services recently published a rule governing the standards that states may impose upon Navigators, certified application counselors, and others who provide assistance to consumers in applying for health insurance in the marketplace.

• **SB 297, *relative to apportionment of damages*.** This bill provides that damages in a civil action shall be based on the proportionate fault of the parties who are not immune from liability.

The following legislation was deemed Inexpedient to Legislate by the House or Senate:

• **HB 1539, *relative to the repeal date of the certificate of need law*.** This bill changes the repeal date of the certificate of need law from June 30, 2016 to June 30, 2015.

• **SB 360, *relative to the issuance of itemized medical bills for medical services*.** This bill requires health care providers to issue an itemized bill to every patient. Current law allows providers to offer an itemized bill free of charge if the patient requests it. This language was amended out of the bill before it was passed by the Senate; the House deemed the bill Inexpedient to Legislate.

• **HB 1294, *requiring that all providers be allowed to participate in the health exchange*.** This bill requires an insurer participating in New Hampshire's health insurance exchange to provide any willing provider the opportunity to negotiate to participate in its provider network.

• **HB 1325, *relative to death with dignity for certain persons suffering from a terminal condition*.** This bill allows a mentally competent person who is 18 years of age or older and who has been diagnosed as having a terminal condition by the patient's attending physician and a "consulting physician" to request a prescription for medication which will enable the patient to control the time, place, and manner of such patient's death. The bill provides for immunities from civil and criminal liability and professional disciplinary action for participating in good faith compliance with the scheme, including being present when the patient takes the medication to end his or her life. No health care provider would be under any obligation to participate.

• **HB 1509, *relative to including nonprofit charitable enterprises in the business enterprise tax***

and lowering the rate of the tax. This bill includes in taxation under the business enterprise tax the enterprise value of nonprofit charitable organizations organized under Internal Revenue Code section 501(c)(3) that exceed $1.5 million in gross annual operating expenditures or $75,000 in enterprise value tax base. The bill also lowers the rate of the business enterprise tax.

EMPLOYMENT LAW UPDATE

NLRB Continues Strike Down Employee Conduct Policies that May Chill Protected Activity (Hills and Dales General Hospital, 360 NLRB No. 70; 07-CA-053556)

In the case of *Hills and Dales General Hospital and Danielle Corlis*, the NLRB again struck down portions of an employee conduct policy as violating the NLRA, which applies to both union and nonunion employers. Under the NLRA, employees have the right to engage in concerted activities for their mutual aid or protection, and it is unlawful for employers to interfere with, restrain, or coerce employees in the exercise of these rights.

At issue were three paragraphs in the hospital's "Values and Standards of Behavior Policy." The first challenged paragraph prevented employees from "making negative comments about [their] fellow team members," including management and coworkers. The second required employees to "represent [the hospital] in the community in a positive and professional manner in every opportunity." The last of the challenged language provided that employees "[would] not engage in or listen to negativity or gossip." The Board found that all three sections were unlawful under the NLRA because employees would reasonably construe them to prohibit protected Section 7 activity.

Notably, in finding the second challenged paragraph unlawful (requiring employees to represent the hospital in a positive and professional manner at every opportunity), the Board reversed the ALJ's finding that previously upheld this section. Departing from the ALJ, the Board concluded that the "requirement that employees 'represent [the Respondent] in the community in a positive and professional manner' [was] just as overbroad and ambiguous as negative comments and 'negativity'" in the other paragraphs, and therefore unlawful.

This case is yet another reminder that employment policies should be carefully tailored to avoid these pitfalls. Healthcare employers should remember that the above-referenced protected activities apply to both union and nonunion employees alike.

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BIOS

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