

Health Law UPDATE

March 2017

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FEDERAL UPDATE

House GOP Unveils ACA Repeal/Replace Bill

On March 6, 2017, House Republicans revealed the American Health Care Act (AHCA) to repeal and replace the Affordable Care Act (ACA). In response, many politicians and lobbyists have expressed their disappointment that the AHCA did not completely replace the ACA, referring to it as “Obamacare lite” or “Obamacare 2.0.” Additionally, the American Medical Association, American Hospital Association, American Academy of Pediatrics, American Psychiatric Association and the Federation of American Hospitals have criticized the AHCA and expressed concern that the new plan will negatively impact patients and the practice of medicine.

Although current House leadership hopes to get the repeal and replacement legislation through the House in the next few weeks, the process of amending and debating the bill undoubtedly will take time. We will continue to monitor the proposed amendments to the AHCA.

Below are some highlights of the proposed legislation:

Status Quo: The AHCA did not change the ACA’s provision that allows parents to keep their children on their insurance until they are 26. Further, consumers who maintain continuous coverage cannot be denied insurance because of pre-existing conditions. The AHCA also maintained the ACA’s cost-sharing reductions for co-payments and deductibles until 2020.

Gradual Freeze on Medicaid Expansion: One of the biggest concerns for hospitals and medical providers is the AHCA’s significant changes to the Medicaid program. Under the ACA, the Medicaid program was expanded to cover more low-income Americans. Under the AHCA, Medicaid expansion would continue through January 1, 2020. At that point, enrollment would freeze and legislators expect that enrollees will drop out of the program as their incomes and circumstances change.

Medicaid Funding: The AHCA would convert Medicaid to a “per capita cap” system, wherein states would get a lump sum from the federal government for each enrollee. Beyond providing a lump sum on a per-person basis, the AHCA limits federal responsibility, shifting that burden to the states. However, since states are not likely to have the funds to make up the difference, they will be forced to reduce eligibility, curtail benefits or cut provider payments.

Hospitals: Under the ACA, the federal government eliminated “disproportionate share payments” or funds provided to certain hospitals to offset some of the cost of caring for patients who cannot afford to pay. Under the AHCA, these disproportionate share payments will be reinstated. Nevertheless, with the AHCA’s proposal to cut Medicaid funding, hospitals will be forced to increase their charity care spending which will result in decreased revenues.

Coverage for Older Customers: The AHCA allows insurers to charge older customers no more than five times the amount they charge to their

younger customers. Under the ACA, insurers were limited to charging no more than three times what is charged to younger customers.

Individual Mandate: The AHCA does not mandate that all Americans be covered by health insurance or pay a penalty. However, in order to discourage gaps in coverage, the AHCA provides that anyone who does not have coverage for a period of 63 days or more in the previous year is subject to a 30 percent increase in premiums as a penalty.

Tax Credit: Under the AHCA plan, the ACA’s income-based premium assistance is replaced to provide individuals tax credits tied to age: individuals younger than 30 would receive a \$2,000 annual credit, younger than 40 would receive a \$3,000 annual credit, younger than 50 would receive a \$3,500 annual credit while those 60 or older would receive a \$4,000 annual credit. The subsidies would diminish for individuals earning more than \$75,000 and households earning more than \$150,000, declining by \$100.00 for every \$1,000 in income. The credits disappear for individuals who earn more than \$215,000 with a cap for \$290,000 for joint fillers.

Tax Breaks: The AHCA would repeal the 3.8 percent Medicare tax on investment income, a 0.9 percent surcharge on wages above \$250,000 and the 0.9% Medicare payroll tax hike. Additionally the AHCA proposed to strike down the 2.3 percent medical device excise tax and would repeal the limit that insurance companies can deduct only \$500,000 of their executives’ pay as a business expense starting in 2018.

Health Savings Accounts: The AHCA allows individuals to contribute more to Health Savings Accounts by nearly doubling the cap. The penalty for withdrawing from a Health Savings Accounts will be reduced from 20 percent to 10 percent. Additionally, individuals with health savings accounts, flexible spending accounts or health reimbursement accounts can use pre-tax funds to buy over-the-counter medicines.

Excise Tax on High-Cost Company Sponsored Programs: In December 2015 Congress enacted a two-year delay in the controversial excise tax on high-cost health plans under the ACA, postponing its effective date from 2018 to 2020 (Cadillac Tax). Under the AHCA, the Cadillac Tax would remain but not take effect until 2025.

Planned Parenthood: The AHCA states that Medicaid cannot directly or indirectly fund any health-care organization that “provides for abortions”. Further, under the AHCA, tax credits would not be allowed for health plans that cover abortion (except in cases of rape, incest, or to save the life of the mother).

For more information, contact:

John D. Fanburg | 973.403.3107 | jfanburg@bracheichler.com

Carol Grelecki | 973.403.3140 | cgrelecki@bracheichler.com

Reena Shah | 973.364.5205 | rshah@bracheichler.com

President Trump Continues to Advance Regulatory Reform Agenda

On February 24, 2017, President Trump issued Executive Order 13777 (Order) instructing the heads of each agency to designate certain agency personnel who will be responsible for enforcing and advancing the President's regulatory reform agenda. Pursuant to the Order, each agency head is instructed to designate a Regulatory Reform Officer (RRO) to oversee the implementation of regulatory reform initiatives and policies consistent with the President's recent orders on the matter and applicable law. The RRO will report directly to the agency head and regularly consult with agency leadership. Each agency must also create a Regulatory Reform Task Force (RRTF), consisting of various members of the agency and chaired by the RRO, to evaluate existing regulations and identify those that should be repealed, replaced or modified.

The agency task forces must consider several factors when deciding which regulations are in need of reform. Some of these factors include whether the regulation (i) eliminates jobs or inhibits job creation, (ii) is outdated, unnecessary, or ineffective, (iii) imposes costs that exceed benefits or (iv) is no longer required because they are derived from Executive Orders that have been rescinded. The Order also instructs each RRTF to seek input from entities significantly affected by the regulations including state and local governments, small businesses, consumers and trade associations. Each RRTF is expected to provide a report to their respective agency within ninety (90) days of the Order detailing the agency's progress in implementation regulatory reform initiatives and policies and identifying regulations for repeal, replacement or modification.

For more information, contact:

Mark Manigan | 973.403.3132 | mmanigan@bracheichler.com

Lani M. Dornfeld | 973.403.3136 | ldornfeld@bracheichler.com

Cheryll A. Calderon | 973.403-3159 | ccalderon@bracheichler.com

Aetna Awarded \$51.4 Million Against Hospital for Overcharges and Kickbacks

On February 15, 2017, a federal Judge in Texas confirmed an award of \$51.4 million to Aetna Life Insurance Co. against Humble Surgical Hospital. Aetna claimed that the hospital charged Aetna up to 10 times more than typical market rates for services rendered, including \$74,000 for bunion surgery and \$139,000 to repair a crooked toe. The hospital was out-of-network with Aetna, but encouraged patients to use its services by waiving copayments or charging them in-network fees. The hospital then billed Aetna out-of-network rates. The hospital also paid illegal kickbacks to doctors who referred patients to it through the use of shell corporations that paid the doctors a percentage of facility fees collected from Aetna.

The hospital has filed an appeal of the judgment to the federal appeals court.

For more information, contact:

Riza I. Dagli | 973.403.3103 | rdagli@bracheichler.com

Keith J. Roberts | 973.364.5201 | kroberts@bracheichler.com

Lauren D. Goldberg | 973.364.5228 | lgoldberg@bracheichler.com

HHS Finds That Fraud and Abuse Laws Impeded Gainsharing Arrangements, But Offers No Solution

The Department of Health & Human Services (HHS) released a report to Congress assessing the impact of fraud and abuse laws on gainsharing arrangements and other similar arrangements between physicians and hospitals.

In the report, HHS recognized that the federal Anti-Kickback Statute and Stark law banning physician self-referrals are "an impediment to robust, innovative programs that align providers by using financial incentives to achieve quality standards, generate cost savings, and reduce waste." HHS concluded that those laws make it significantly harder to structure an effective gainsharing or similar arrangement between physicians and hospitals.

Unfortunately, while HHS had hoped to present options for amending anti-kickback or anti-self-referral laws to make such arrangements easier to implement, the report failed to provide any legislative or regulatory options for consideration.

The report confirms HHS' position that a previously proposed exception to the fraud and abuse laws, broadly allowing for gainsharing arrangements, would be futile.

For more information, contact:

Joseph M. Gorrell | 973.403.3112 | jgorrell@bracheichler.com

Mark Manigan | 973.403.3132 | mmanigan@bracheichler.com

Nicole G. Medrozo | 973.403.3101 | nmedrozo@bracheichler.com

Court Adopts New Payment Eligibility Standard For CMS Home Health Services

On February 1, 2017, a federal court in Vermont ruled that the Centers for Medicare and Medicaid Services (CMS) has been using the wrong standard of eligibility to pay for home healthcare services. According to the ruling, CMS has wrongly required that to be eligible for payment, the purpose of the services must be to improve the beneficiary's health. In fact, CMS must pay for services so long as they aid in maintaining the beneficiary's health condition.

The court required CMS to:

- Create a page on its website addressing the new standard.
- Include a "frequently asked questions" section to the webpage.
- Publish a statement disavowing the former "improvement" standard and affirming the "maintenance" standard.
- Issue a Technical Direction Letter and Memorandum for Medicare Administrative Contractors with training instructions on the changes.
- Organize a national call to Medicare providers and adjudicators to correct incomplete and inaccurate answers given by a CMS representative during a prior national call about the "improvement" standard.

For more information, contact:

Lani M. Dornfeld | 973.403.3136 | ldornfeld@bracheichler.com

Debra C. Lienhardt | 973.364.5203 | dlienhardt@bracheichler.com

Robert A. Paster | 973.403.3144 | rpaster@bracheichler.com

STATE UPDATE

New Jersey Tackles Opioid Crisis

New Law Placing Prescription Limits and Mandating Insurance Coverage for Substance Use Disorders

On February 15, 2017, Governor Christie signed into law a bill that limits prescriptions by physicians for opioid painkillers and requires insurance carriers to cover treatment for addiction and substance use disorders. Under the new law, the strictest on opioid prescription in the country, a five-day limit is imposed on initial prescriptions for opioids. The law contains certain exceptions, such as for cancer or hospice patients. Previously, the limit in New Jersey was a thirty-day supply.

The law also requires insurers to cover up to 180 days of drug treatment for patients, including both outpatient and inpatient treatment. In addition, insurers may not impose utilization review or management requirements on treatment or prior approval requirements for covered medication-assisted treatments. Insurers also must not impose prepayment obligations and may only charge a plan's regular copayments, deductibles and co-insurance for substance use disorder treatment.

The law also requires the state to provide monitoring in order to prevent fraud or abuse and to ensure that providers are not improperly treating patients who do not actually require substance abuse treatment. The new drug treatment mandate does not apply to insurance programs that are not subject to state regulation, such as Medicare or large-employer plans.

For more information, contact:

Lani M. Dornfeld | 973.403.3136 | ldornfeld@bracheichler.com
Carol Grelecki | 973.403.3140 | cgrelecki@bracheichler.com
Jonathan J. Walzman | 973.403.3120 | jwalzman@bracheichler.com

Governor Christie Calls on Horizon to Establish a Fund in NJ to Help Combat the Opioid Epidemic

On February 28, 2017, in the last budget address of his tenure, Governor Christie called on Horizon Blue Cross Blue Shield (Horizon) to establish a permanent fund to assist the state's efforts to combat the opioid epidemic in New Jersey. Under Christie's plan, Horizon would be required to establish and pay into a fund to help provide access to inpatient and outpatient drug rehabilitation treatment for low income individuals.

According to the Governor, as the sole insurer in the state enjoying not-for-profit status and a surplus of nearly \$2.9 billion, Horizon not only shares in the financial obligation of caring for the state's most vulnerable citizens but also has the ability to set aside excess surplus monies and other revenue to help fight the disease of opioid addiction. Christie argued that Horizon's designation as a non-profit company, as well as his efforts to expand Medicaid, have contributed to the company's continued success and propelled it to become the state's largest insurer. In his address, Governor Christie emphasized that the immediate need for the fund was to assist in increasing patient access to rehabilitation services but also left open the possibility of using the fund for other purposes in the future.

In a swift response, Horizon argued that the Governor overstated the company's earnings and cash reserves, noting that industry regulations

require insurance providers to maintain significant reserves in order to cover unexpected claims for its 3.8 million members, 900,000 of which include Medicaid patients.

For more information, contact:

John D. Fanburg | 973.403.3107 | jfanburg@bracheichler.com
Mark Manigan | 973.403.3132 | mmanigan@bracheichler.com
Cheryll A. Calderon | 973.403-3159 | ccalderon@bracheichler.com

Legislature Takes Further Steps to Tackle NJ Opioid Crisis

On February 24, 2017, Assembly Bill No. 3104 (A3104) was introduced that would require court-ordered testing for infectious diseases of persons who have been administered an opioid antidote by a first responder.

On February 15, 2017, the Assembly passed a resolution (AR157) urging the State Board of Medical Examiners to adopt CDC guidelines for prescribing opioids for chronic pain.

On February 15, 2017, the Assembly passed a resolution (AR156) urging school districts and nonpublic schools to adopt policies to address abuse of prescription opioids by students.

For more information, contact:

Riza I. Dagli | 973.403.3103 | rdagli@bracheichler.com
Joseph M. Gorrell | 973.403.3112 | jgorrell@bracheichler.com
Cheryll A. Calderon | 973.403-3159 | ccalderon@bracheichler.com

Other Pending Bills

Prohibiting Gender Discrimination—On February 27, 2017, Senate Bill 3017 (S3017) was introduced that would prohibit health insurers and health maintenance organizations, including health benefit plans or contracts issued pursuant to the New Jersey Individual Health Coverage Program, New Jersey Small Employer Health Benefits Program, State Health Benefits Program, School Employees' Health Benefits Program and the Medicaid Program from discriminating in providing coverage and services based on gender identity.

Regulating Telemedicine—On February 27, 2017, an Assembly bill (A1464) that would establish a set of guidelines governing the practice of telemedicine was held in committee per the request of its sponsor, Pam Lampitt. The Senate version of the bill (S291) advanced from the Senate budget committee in late 2016 and is on second reading.

For more information, contact:

Debra C. Lienhardt | 973.364.5203 | dlienhardt@bracheichler.com
Keith J. Roberts | 973.364.5201 | kroberts@bracheichler.com
Cheryll A. Calderon | 973.403-3159 | ccalderon@bracheichler.com

Brach Eichler In The News

John D. Fanburg presented a legal report at the Annual Meeting of the New Jersey State Society of Anesthesiologists on March 11th. He also presented a legal report at the Semi-Annual Meeting of the Radiological Society of New Jersey on the same date.

Lani M. Dornfeld will present, "Curiosity Killed the Cat and Other Common HIPAA Pitfalls," at the Home Care & Hospice Association of New Jersey on

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March 21st. Details may be found at:

http://www.homecarenj.org/index.php?option=com_jevents&task=icalrepeat.detail&evid=52&Itemid=158&year=2017&month=03&day=21&title=curiosity-killed-the-cat-and-other-common-bipaa-pitfalls&uid=00870463443981c423c7fa7d2ba43dc7

Lani M. Dornfeld also will present “Advance Planning for Buying or Selling a Home Care or Hospice Business,” at the Home Care & Hospice Association of New Jersey on April 20th. Details may be found at:

http://www.homecarenj.org/index.php?option=com_jevents&task=icalrepeat.detail&evid=86&Itemid=158&year=2017&month=04&day=20&title=advance-planning-for-buying-or-selling-a-home-care-or-hospice-business&uid=8d7ae8320252cc4a289c3a807b84ba72

HIPAA CORNER

Florida Health System Pays \$5.5 Million for HIPAA Violations

Memorial Healthcare System (MHS), a Florida non-profit organization that operates numerous hospitals and healthcare facilities, has paid \$5.5 Million to the federal Department of Health & Human Services (HHS) to settle allegations of federal HIPAA law violations. MHS reported to HHS that protected health information of over 115,000 individuals had been

illicitly accessed by MHS employees and disclosed to affiliated physician office staffs. Specifically, the login credentials of a former employee of an affiliated physician’s office had been used to access electronic protected health information (ePHI) maintained by MHS from April 2011 to April 2012. The ePHI contained names, birth dates, social security numbers and other confidential information. MHS failed to implement procedures for reviewing, modifying and terminating users’ right of access, in violation of HIPAA. Further, MHS did not regularly review information system activity on applications that store ePHI.

The Acting Director of the HHS Office for Civil Rights stated in response to the violations, “Access to ePHI must be provided only to authorized users, including affiliated physician office staff... Organizations must implement audit controls and review audit logs regularly. As this case shows, a lack of access controls and regular review of audit logs helps hackers or malevolent insiders to cover their electronic tracks.”

For more information, contact:

Lani M. Dornfeld | 973.403.3136 | ldornfeld@bracheichler.com
Brett I. Fischer | 973.403.3135 | bfischer@bracheichler.com

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Health Care Practice Group | 101 Eisenhower Parkway, Roseland, NJ 07068 | 973.228.5700

Members

Riza I. Dagli | 973.403.3103 | rdagli@bracheichler.com
Lani M. Dornfeld | 973.403.3136 | ldornfeld@bracheichler.com
John D. Fanburg, Chair | 973.403.3107 | jfanburg@bracheichler.com
Joseph M. Gorrell | 973.403.3112 | jgorrell@bracheichler.com

Carol Grelecki | 973.403.3140 | cgrelecki@bracheichler.com
Debra C. Lienhardt | 973.364.5203 | dlienhardt@bracheichler.com
Mark Manigan | 973.403.3132 | mmanigan@bracheichler.com
Keith J. Roberts | 973.364.5201 | kroberts@bracheichler.com

Counsel

Debra W. Levine | 973.403.3142 | dlevine@bracheichler.com
Richard B. Robins | 973.403.3147 | rrobins@bracheichler.com

Edward J. Yun | 973.364.5229 | eyun@bracheichler.com

Associates

Colleen Buontempo | 973.364.5210 | cbuontempo@bracheichler.com
Cheryll A. Calderon | 973.403.3159 | ccalderon@bracheichler.com
Lindsay P. Cambron | 973.364.5232 | lcambron@bracheichler.com
Kathryn B. Carey | 973.364.5209 | kcarey@bracheichler.com
Shannon Carroll | 973.403.3126 | scarroll@bracheichler.com
Brett I. Fischer | 973.403.3135 | bfischer@bracheichler.com
Lauren D. Goldberg | 973.364.5228 | lgoldberg@bracheichler.com

Ed Hilzenrath | 973.403.3114 | ehilzenrath@bracheichler.com
Nicole G. Medrozo | 973.403.3101 | nmedrozo@bracheichler.com
Robert A. Paster | 973.403.3144 | rpaster@bracheichler.com
Reena Shah | 973.364.5205 | rshah@bracheichler.com
Jonathan J. Walzman | 973.403.3120 | jwalzman@bracheichler.com
Brian Wong | 973.403.3106 | bwong@bracheichler.com

Brach Eichler is on LinkedIn! Be sure to follow us for all of the latest Firm news!

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