HEALTHCARE LAW UPDATE

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STATE UPDATE

Governor Sherrill Signs Law Extending Telemedicine Pay Parity

On June 30, 2026, Governor Mikie Sherril signed P.L.2026, c.29 into law, extending from July 1, 2026 until December 31, 2027 the requirement that health benefits plans in New Jersey cover and pay for health care services delivered to an individual through telemedicine or telehealth at a provider reimbursement rate that equals the reimbursement rate for the same services when delivered in person in New Jersey, provided the services are covered by the individual's health benefits plan when delivered in person in the New Jersey. The pay parity requirement applies to behavioral health services provided through real-time, two-way audio without a video component. However, the pay parity requirements do not apply to physical health care services provided through real-time, two-way audio without a video component. Health benefits plans subject to the law include plans issued in New Jersey by a carrier or a contract purchased by the State Health Benefits Commission or the School Employees' Health Benefits Commission, and include Medicaid and NJ FamilyCare.

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New Jersey Bill Targets Hospital Closures and Financial Distress

Legislation introduced on May 14, 2026, by State Sen. Raj Mukherji would expand the tools available to New Jersey regulators and local governments to address financially distressed hospitals and prevent abrupt closures. Under current New Jersey law, general acute-care hospitals must obtain a certificate of need and undergo a Department of Health review process, including a public hearing, prior to ceasing operations. However, recent hospital closures have highlighted gaps in enforcement, as operators facing financial distress may scale back services or cease operations in ways that undermine the intent of these requirements.

The proposed bill would require the Department of Health to notify the Attorney General and local municipal leadership when a hospital is failing financially or not complying with closure requirements. In such cases, the State, the Attorney General, or the municipality could petition the Superior Court to appoint a receiver to oversee operations of the distressed hospital, who would be authorized to stabilize the hospital or manage an orderly wind-down, with the goal of preserving access to care and avoiding sudden disruptions to the communities the hospital serves.

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New Jersey Attorney General Issues Guidance on Immigration Authority Access to Healthcare Facilities

On June 17, 2026, the New Jersey Attorney General issued guidance and model policies for health care facilities and other sensitive locations regarding access by federal immigration authorities to sensitive locations and to documents. Issued pursuant to the Safe Communities Act, the guidance applies broadly to facilities licensed by the New Jersey Department of Health and delineates the "minimum" protocols and protections that facilities must adopt to govern practices when immigration authorities seek to enter a facility or seek patient information from the facility. In accordance with the Act, the New Jersey Department of Health must adopt the model policy or a policy providing greater protections and publish the policy on its website.

The guidance sets forth the legal right of facilities to decline access by immigration officers to areas not generally open to the public or to provide patient information, unless the officers present a warrant or court order signed by a judge or demonstrate exigent circumstances. The guidance and model policies address the specific steps that facilities must take to operationalize the right to deny access to immigration authorities, including: (i) distinguishing between judicial and administrative warrants; (ii) the need for a process to evaluate the warrants quickly and seek legal counsel when immigration officers arrive at the premises; (iii) demarcation of public and private spaces; (iv) identification of staff responsible for interacting with immigration officers; (v) the collection of appropriate information from immigration officers; and (vi) training for all staff about the protocols and policies adopted. As explained in the guidance, in the absence of exigent circumstances, facilitators do not have a legal obligation to provide access to federal immigration officers if they have only an administrative warrant. The guidance provides that it is not intended to supplant more protective policies for facilities that have already adopted a policy.

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Renewal Deadline for Health Care Service Firms Extended

The New Jersey Division of Consumer Affairs (DCA) issued a notice in the June 1, 2026 New Jersey Register advising Health Care Service Firms that the DCA is extending the 2026 deadline for renewal of health care service firm registrations from July 1, 2026 to October 1, 2026. The extension is being granted due to the burdens associated with the fairly new regulatory requirement to submit specific financial documentation, including, among other documentation, financial statements, audits or reports, in order to renew registrations. Any health care service firm that fails to renew its registration by the October 1, 2026, deadline will lose its registration.

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FEDERAL UPDATE

HHS Streamlines No Surprises Act Dispute Resolution Process

On June 4, 2026, the U.S. Department of Health and Human Services, together with the Departments of Labor and Treasury, published a final rule designed to streamline the Independent Dispute Resolution (IDR) process under the No Surprises Act. The rule addresses several persistent operational challenges for providers and payers, including identifying claims that are eligible for IDR, determining the applicable legal framework, and navigating batching requirements. To improve transparency and facilitate access to the IDR process, health plans must now include enhanced information regarding remittances for out-of-network claims, including standardized claim adjustment reason

codes and remittance advice remark codes, the plan's legal business name and sponsor information, and a unique IDR registration number.

The rule also significantly reduces the administrative fee for participating in the IDR process from $115 to $15 per party, which is expected to make the IDR process more accessible, particularly for smaller providers and lower-dollar claims. In addition, CMS has expanded flexibility for batching claims by permitting certain items and services to be grouped when furnished to the same patient within a defined timeframe, billed under the same or comparable service codes, or, for specialties such as anesthesiology, radiology, pathology, and laboratory services, within the same Category I CPT code section. The rule is effective August 3, 2026, except that the reduced fee became effective as of June 11, 2026, and the revised batching standards become effective November 1, 2026.

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DOJ's Lawsuit Against Erlanger Health System Underscores Stark Law Risks in Physician Compensation Arrangements

In July 2024, the United States Department of Justice (DOJ) intervened in a whistleblower lawsuit against Erlanger Health System. In the lawsuit, the DOJ alleges that Erlanger violated the Federal Physician Self Referral Law (Stark Law) and thus submitted false claims to Medicare by compensating physicians at rates well above fair market value (FMV) in order to capture their downstream referrals.

Although the case focuses on compensation arrangements between a hospital and employed or affiliated physicians, it has broader implications for physician compensation arrangements generally. The DOJ's complaint alleges a number of factors that raise significant compliance risks under the Stark Law:

- Erlanger paid physicians not only salaries but also sign-on bonuses, retention bonuses, program bonuses, excess call payments, and productivity bonuses that were a significant component of a physician's total compensation and were paid despite concerns raised in internal and independent FMV analyses.
- Erlanger paid physicians significantly more than it was collecting for their professional services to capture their downstream referrals and benefit from the resulting downstream revenue.
- Erlanger utilized uncapped productivity bonuses that used higher per-wRVU rates for physician productivity bonuses as compared to the per-wRVU rates for physician base compensation.
- Erlanger relied on FMV analyses that were based on potential compensation under physician contracts rather than actual compensation paid, which was much higher, and relied on FMV analyses that omitted certain compensation components.

In March 2026, the United States District Court for the Eastern District of Tennessee denied Erlanger's motion to dismiss, allowing the DOJ's claims to proceed. Although the litigation remains ongoing, the case serves as a reminder that physician compensation arrangements should be periodically reviewed to ensure they remain commercially reasonable, consistent with FMV, and compliant with the Stark Law.

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New OIG Guidance Addresses Common Stark Law Misconceptions

In April 2026, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) updated its fraud and abuse FAQs to address certain common misconceptions regarding the relationship between the federal physician self-referral law (Stark Law) and the federal Anti-Kickback Statute (AKS). In its revised guidance, the OIG emphasized that compliance with a Stark Law exception does not insulate an arrangement from AKS liability. According to the guidance, because the AKS is

intent-based and the Stark Law is a strict liability statute, a financial arrangement may satisfy all of the elements of a Stark exception yet still violate the AKS, depending on the parties' intent and the surrounding facts.

The OIG also clarified that fair market value alone is not determinative of AKS compliance. While fair market value and commercial reasonableness are relevant considerations, they represent only part of the analysis, and do not substitute for meeting all elements of an applicable safe harbor or otherwise ensuring that remuneration is not intended to induce referrals, including requirements related to compensation structure, documentation, and the volume or value of referrals. These updates serve as a reminder that providers should not rely solely on Stark Law compliance or fair market value in assessing fraud and abuse risk, and must instead ensure that arrangements satisfy both an applicable Stark Law exception and an Anti-Kickback Statute safe harbor.

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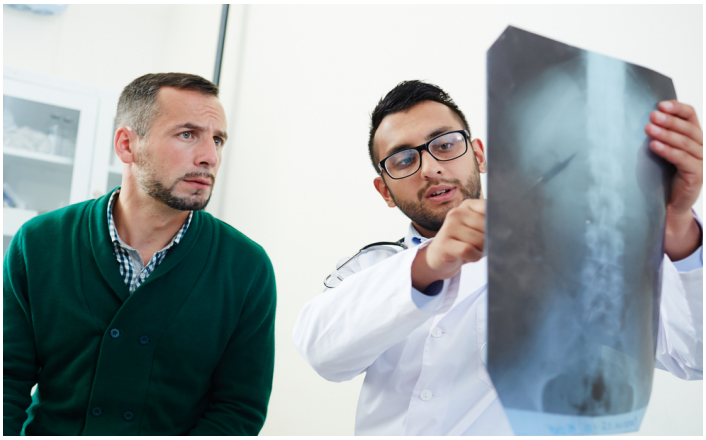
OIG Greenlights Concierge Program Refund Arrangement

On May 22, 2026, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) issued a favorable advisory opinion regarding an orthopedic surgeon's proposed warranty program.

The surgeon proposes to offer a concierge program in which patients could elect to pay for certain non-covered services and products that would improve surgical recovery and outcomes. Under the proposed arrangement, the surgeon would warrant that, if a patient substantially complies with the concierge program, the patient would not require revision surgery within two years of the initial surgery. If revision surgery is nevertheless required, the surgeon would refund the concierge program fees paid in connection with the initial surgery.

The proposed arrangement implicates the federal Anti-Kickback Statute (AKS) because the surgeon would be offering patients the possibility of a refund of concierge fees, which could induce patients to choose the surgeon for surgical services reimbursable by federal health care programs. However, the OIG concluded that the refund would satisfy the warranty safe harbor under the AKS, including the requirements that the surgeon and patients



report and disclose the refund and that the surgeon does not condition the refund on the patients' exclusive use of, or minimum purchase of, any of the surgeon's items or services.

Accordingly, the OIG concluded that the proposed arrangement would not violate the AKS. Moreover, because the arrangement satisfied all of the elements of the AKS warranty safe harbor, the OIG concluded that the proposed arrangement would not constitute a prohibited beneficiary inducement under the Federal Civil Monetary Penalties Law.

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OIG Issues Unfavorable Advisory Opinion on Royalty-Based Consulting Arrangement with Medical Device Manufacturer

On May 13, 2026, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) issued an unfavorable advisory opinion regarding a proposed royalty arrangement between an orthopedic device manufacturer and its physician consultants.

Under the proposed arrangement, the manufacturer would enter into agreements with consultants who would teach, train, and proctor other physicians about the manufacturer's products within a product line and participate in the manufacturer's development and strategy initiatives. If a consultant satisfied certain minimum hours and participation/interaction quality requirements, the consultant would be paid a "royalty" equal to a percentage of the net invoice price for all products sold within the consultant's assigned product line. If not, the consultant would be paid a pre-determined hourly rate for the consultant's consulting services actually provided.

The OIG found that the proposed arrangement would not satisfy an applicable safe harbor under the Federal Anti-Kickback Statute (AKS) and otherwise would pose unacceptable fraud and abuse risk. Specifically, the OIG determined that royalty payments could motivate consultants to recommend the manufacturer's products over a competitor's products even though the latter's products may be more clinically appropriate, and royalty payments may actually be a payment-for-referrals scheme. Indeed, the manufacturer could not certify that the consultants' services would not contribute to the generation of revenue from the products.

The OIG concluded that, generally, consulting arrangements may serve legitimate beneficial interests when structured in a way that does not encourage referrals. However, the proposed arrangement lacked appropriate safeguards against fraud and abuse risk and would be prohibited under the AKS if the requisite intent to induce referrals is present.

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Supreme Court Declines to Review Medicare Drug Price Negotiation Program Challenges

On May 18, 2026, the U.S. Supreme Court declined to hear appeals from several pharmaceutical manufacturers challenging the Medicare Drug Price Negotiation Program established under the Inflation Reduction Act. The program, which authorizes the Centers for Medicare & Medicaid Services (CMS) to negotiate maximum "fair" prices for certain high-cost drugs covered under Medicare Part D, had been the subject of multiple constitutional challenges. Pharmaceutical companies argued that the program compels speech in violation of the First Amendment and effectively forces participation in government programs in violation of the Fifth Amendment. Lower courts rejected these arguments, concluding that participation in Medicare is voluntary and that manufacturers may opt out of federal programs. By declining review, the Supreme Court leaves those decisions in place.

The Medicare Drug Price Negotiation Program is already underway. The first round of negotiations, covering 10 widely used drugs, resulted in price reductions ranging from approximately 38% to 79% off list prices, with negotiated rates taking effect January 1, 2026. CMS has since expanded the program to additional drugs, including certain GLP-1 therapies, with further selections expected in future years. While the Medicare Drug Price Negotiation Program is projected to generate significant federal savings and reduce beneficiary costs, the extent of out-of-pocket savings will vary depending on individual plan design and cost-sharing structures.

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LEGISLATIVE AND REGULATORY UPDATE

New Bill to Protect Reproductive Health Care Services

On May 28, 2026, the New Jersey Senate approved Bill S2260, which would strengthen protections for those seeking reproductive health care services and the providers offering such services. The Bill provides that reproductive health care activities include services related to pregnancy, assisted reproductive technology, contraception, miscarriage management, abortion, and certain gender or affirming care. The Bill would make it illegal for anyone (i) to interfere with reproductive or gender or affirming services; (ii) to knowingly restrict access to care or intimidate patients or providers; and (iii) to physically obstruct, injure, or cause property damage. In addition, the Bill would shield providers from professional discipline, insurance retaliation, and out-of-state legal actions that seek to punish lawful conduct related to reproductive health care activity in New Jersey. Currently, the Bill is awaiting a full New Jersey Assembly vote.

New Bill Targets Pharmacy Benefit Managers

On May 18, 2026, the New Jersey General Assembly passed Bill A1502, the Patient and Provider Protection Act, which would impose new obligations on pharmacy benefit managers (PBMs)—the intermediaries that administer prescription drug benefits for carriers and public programs. The Bill would establish a fiduciary duty requiring PBMs to act in the best interests of the carriers and State programs they contract with, prohibit self-dealing such as steering covered persons toward PBM-affiliated mail-order or specialty pharmacies, bar differential reimbursement that favors affiliated pharmacies, and tie pharmacy reimbursement to the National Average Drug Acquisition Cost (NADAC) benchmark. The Bill is intended to increase transparency in PBM practices and lower prescription drug costs for New Jersey patients.

New Bill Aims to Ensure Insurance Coverage for Sepsis Care

On May 21, 2026, the New Jersey State Senate introduced Bill S4329, which would require health insurance carriers to cover medically necessary sepsis-related services and treatments as determined by the treating physician. The Bill would also require that sepsis-related care be covered on the same terms as any other medical condition, prohibiting insurers from imposing special restrictions or reduced benefits for sepsis treatment. The Bill is intended to ensure that covered New Jersey residents have access to insurance benefits for sepsis diagnosis and treatment.

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HIPAA CORNER

OCR Continues Ransomware and Risk Analysis Enforcement Initiatives

The U.S. Department of Health and Human Services, Office for Civil Rights (OCR) announced the settlement of its HIPAA investigation of the employer-sponsored group health plan (Plan) of Spencer Gifts LLC. By way of background, the Plan filed a breach report with OCR in January 2022 after discovering that an unauthorized actor accessed the company's network and deployed ransomware, encrypting data on the company's systems, including servers storing the Plan's protected health information (PHI), and demanding a ransom. OCR found that the Plan had potentially violated HIPAA, including by failing to conduct an accurate and thorough risk analysis to determine potential risks and vulnerabilities to PHI and failing to implement appropriate HIPAA policies and procedures prior to the breach incident. Under the terms of the settlement, the Plan will pay a $450,000 fine and implement a two-year corrective action plan.

The settlement marks OCR's 20th ransomware enforcement action and 14th enforcement action in its Risk Analysis Initiative. OCR continues to emphasize that HIPAA covered entities and their business associates should take steps to mitigate or prevent cyberthreats, including:

- Identify where ePHI exists in the organization, including how ePHI enters, flows through, and leaves the organization's information systems.
- Periodically conduct, and update as needed, a risk analysis and develop and implement a risk management plan to address identified risks to the confidentiality, integrity, and availability of ePHI.
- Ensure audit controls are in place to record and examine information system activity.
- Implement regular review of information system activity.
- Utilize mechanisms to authenticate information to ensure that only authorized users are accessing ePHI.
- Encrypt ePHI in transit and at rest to guard against unauthorized access to ePHI when appropriate.
- Incorporate lessons learned from incidents into the organization's overall security management process.
- Provide workforce members with regular HIPAA training that is specific to the organization and the workforce members' respective job duties.

If you need assistance with your organization's privacy and security program, contact:

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ATTORNEY **SPOTLIGHT**

Get to know the faces and stories of the people behind the articles in each issue. This month, we invite you to meet Member and Healthcare Law Update Editor **Edward Hilzenrath**, and Associate **Vanessa Coleman**.

EDWARD HILZENRATH

Ed Hilzenrath has been with Brach Eichler since 2013. His practice focuses on representing a broad array of health care providers across a spectrum of healthcare-related legal matters, including corporate, transactional, and regulatory issues. In his free time, Ed can be found on the tennis court, where he captains the team at his local tennis club. Please reach out if you are looking for a friendly game!

VANESSA COLEMAN

Vanessa Coleman enjoys helping clients navigate the rapidly evolving healthcare landscape. Her practice focuses on general corporate, transactional, regulatory, and litigation matters for healthcare industry clients. Before becoming a lawyer, Vanessa taught seventh and eighth grade in the Mississippi Delta through Teach For America, where she worked closely with students with diverse learning needs. Advocating for her students taught her patience, persistence, and practical problem-solving—qualities that continue to shape the way she works with clients today.

On May 22, Managing Member and Healthcare Law Chair, John D. Fanburg, Member, Edward Hilzenrath, and Associate, Vanessa Coleman, issued a client alert entitled "Deadline Fast Approaching for Medical Practices to Have Accessible Diagnostic Equipment—Is Your Practice Ready?".

On May 28, Law.com published an article entitled "The Governance Gap: Effectively Managing Employee Use of AI in the Workplace", authored by Healthcare Law Member, Lani M. Dornfeld and Labor and Employment Member, Jay Sabin.

On June 2, Brach Eichler announced an important transaction representing our client Neurology Group of Bergen County—"Brach Eichler Represents Neurology Group of Bergen County in Landmark Privia Health Partnership". The team was led by Member and Healthcare Law Vice Chair, Caroline J. Patterson and included Member, Joseph M. Gorrell, and Counsel, Erika R. Marshall.

On June 4, for the 17th consecutive year, Brach Eichler's Healthcare Law practice was recognized in *Chambers USA: America's Leading Lawyers for Business*, earning a prestigious Band 1 ranking in New Jersey. In addition, the following received individual rankings: Managing Member and Healthcare Law Chair John D. Fanburg (Band 1 – Healthcare), Member, Joseph M. Gorrell (Senior Statespeople – Healthcare), and Member, Carol Grelecki (Band 2 – Healthcare).

On June 9, Managing Member and Healthcare Law Chair, John D. Fanburg, was quoted in a Bloomberg article entitled "NJ Allergan Ruling Adds Confusion to Doctor Testimony Rule".

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