

RATH YOUNG PIGNATELLI

New Hampshire MGMA – June 9, 2010 - LEGAL UPDATE

The attorneys of Rath, Young and Pignatelli, P.C. have truly enjoyed the opportunity to provide the New Hampshire MGMA with monthly legal updates, and appreciate the warm welcome we have consistently received from members.

1. HEALTH CARE REFORM BILL UPDATE

A. Changes to the Tax Code for Benefits Provided to Dependent Children

The Patient Protection and Affordable Care Act (the "Act") requires all health care plans offering dependent coverage to provide coverage to adult children until age 26.¹ Although health plans in New Hampshire were already required to offer such coverage under certain circumstances, the requirement under the Act expands the definition of dependent and also includes corresponding changes to the Internal Revenue Code (the "IRC") that could impact employers and employees in New Hampshire. These changes to the IRC exclude from the employee's gross income amounts paid or reimbursed to employees for medical expenses associated with those children now required to be covered.

Effective September 14, 2009, New Hampshire amended the Insurance Law by defining the term "dependent" for purposes of health insurance coverage as an unmarried individual who is:

- (1) Under age 19;
- (2) Under age 25 and a full-time student; or
- (3) Under age 26, a resident of New Hampshire and not provided coverage under any other group plan or Medicare.

New Hampshire Revised Statutes Annotated 415:5, I(3).

The Act impacts the New Hampshire law in two ways. First, New Hampshire insurers will now be required to provide dependent coverage up to age 26, regardless of New Hampshire residence or other criteria specific to the New Hampshire law. Second, as described below, some dependents covered under this provision of New Hampshire law would not have qualified as dependents or children under the IRC prior to the changes made by the Act.

¹ In the case of "grandfathered plans" (i.e., plans existing prior to enactment), coverage must only be offered to these dependents if they are not eligible for employer-sponsored coverage.

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The Healthcare Practice Group provides a wide range of regulatory, corporate and litigation support to healthcare providers and suppliers throughout New England and nationally.

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Before the enactment of the Act, an employee's child generally had to be under age 20 (or under age 24 if a full-time student) to qualify as a dependent under federal tax law for purposes of the income exclusion associated with reimbursement of medical expenses with respect to such child. The Act and Notice 2010-38 published by the IRS provide that, effective March 30, 2010, coverage provided under an employer health plan as well as amounts paid or reimbursed under such plan for medical expenses for an employee's child who has not reached age 27 as of the end of the employee's taxable year are excluded from the employee's income.²

Notice 2010-38 also confirms that these changes apply to Section 125 cafeteria plans. As such, coverage and reimbursement provided with respect to children under 27 are "qualified benefits" under the cafeteria plan and employers may permit employees to make pre-tax salary reductions to pay for the benefits. Mid-term elections by employees in cafeteria plans are only permitted due to specific change in status events, which do not contemplate the eligibility change here. To remedy this problem, the IRS indicated it will amend its regulations retroactive to March 30, 2010 to include situations where children become newly eligible under the Act. In addition, in recognition of the potential need of employers to amend cafeteria plans to accommodate these changes and the prohibition on retrospective amendments to such plans, the IRS will allow employers to permit employees to immediately make election changes if the plan is amended to cover the newly qualified children by December 31, 2010, and the amendment is made retroactive to the first date employees are permitted to make the new salary reductions (but not earlier than March 30, 2010).

The changes discussed above impact New Hampshire employers directly and indirectly:

- (1) Employees will now be able to continue coverage for their children until age 26 regardless of the child's residence or student status;
- (2) Employees whose dependents receive coverage under an employer plan will no longer be taxed on the benefit of that coverage or any medical expenses paid or reimbursed under that coverage for any child under age 27 during the taxable year. Because coverage and reimbursements for these children are not considered wages, they are also exempt from income tax withholding; and
- (3) If employers wish to permit employees to pay for medical coverage for the newly qualifying children on a pre-tax basis under a cafeteria plan, an amendment to the plan must be made by December 31, 2010 (and must be retroactive to the first day such pre-tax reductions were permitted).

B. HHS Web Portal Under Development

The Department of Health and Human Services has begun implementing the web portal for individuals and businesses to use when finding and comparing information about affordable options. An interim final rule requires insurers to submit information by May 21, 2010. The portal is scheduled to be fully developed and released on October 1, 2010. The rule allegedly contains comprehensive descriptions of benefits available under each policy, the basic premium before adjustments, and cross-sharing. The site will also contain a calculator. In addition to the insurance offered in the private market, the portal will make available information about coverage and costs of any state-sponsored high risk insurance pool, new high risk insurance pools under PPACA, Medicaid and the CHIP program in each state.

² There is a discrepancy in the Act between the age of dependency for coverage purposes (i.e., up to 26) and the age of children for income exclusion purposes (i.e., up to 27).

C. Early Retiree Reinsurance Program

DHHS is establishing an interim final rule for the early retiree re-insurance program which provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees (55 or older and not entitled to Medicare), their spouses and dependents. Beginning June 1, 2010, and continuing until January 1, 2014, the program is intended to help offset the cost under employer sponsored plans; however, participation in the ERRP program is not automatic and employers and their health care plan designs must be certified by the Department of Health and Human Services as eligible to participate. In addition, the reimbursement amount will be 80% of the cost of the early retiree's health insurance claims between \$15,000 and \$90,000 per year that are paid by the health plan. Costs for an insured health plan include actual claims paid but not premiums for coverage.

D. National Provider Identifiers

No later than January 1, 2011, all providers of medical or other items or services and suppliers under Medicare and Medicaid programs must qualify for a national provider identifier ("NPI") and include it on all applications and claims. A new interim final rule with comment period will implement these changes effective July 6, 2010. While Medicare has required the NPI reporting since May 23, 2008, it is now clear that claims from providers or suppliers who do not contain an NPI will be rejected. In addition, under the interim rules, for the Medicaid provider enrollment process, all Medicaid providers will be required to include their Medicaid NPI on all Medicaid enrollment forms filed with the state.

In addition, the interim rule requires that claims for durable medical equipment, prosthetics, orthotics and supplies may be made *only if the written order for the item has been communicated by the ordering physician and the claim identifies the ordering physician by his or her legal name and NPI*. In addition, the physician or eligible professional who orders or refers must be enrolled in PACOS even if the physician or provider is only enrolled for the purposes of referring.

E. Benefit Extensions & Federal Stimulus Money

Congress is considering several measures that will affect federal payments and benefits.

On May 28, the House of Representatives passed the American Jobs and Closing Tax Loopholes Act of 2010 (H.R. 4213). Because of opposition to deficit-spending measures, House leaders were forced to strike some \$80 billion in benefits from their bill. For example, the Bill:

- Removes the six-month FMAP extension that had been included in previous House and Senate bills. "FMAP" stands for Federal Medical Assistance Percentages; under FMAP, typically the federal government paid New Hampshire a 50% match for Medicaid expenditures. However, last year's federal stimulus legislation increased the match by 6.2%, through December 2010. Several states, including New Hampshire, have been counting on the FMAP extension to help balance their budgets. Governor Lynch's office estimates that the State would receive \$48 million in FY 2011 from the FMAP extension.
- Drops an extension of the COBRA subsidy for workers whose employment is involuntarily terminated, with the result that workers who lose their jobs or on after June 1 will no longer receive government assistance with their premium costs for COBRA coverage.

However, the Bill does offer some relief to physicians: it blocks the Medicare physician payment cut that went into effect June 1, and instead increases physician payment rates by 2.2% for the rest of 2010 and by 1% for 2011.

The Senate has yet to act on these measures, but it is widely hoped that it will do so quickly after Congress reconvenes on June 7.

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2. NEW HAMPSHIRE LEGISLATIVE UPDATE

HB 1371, allowing an injured employee to have a witness present at the examination by health care providers performing independent medical examinations and establishing a committee to study certain aspects of independent medical examinations.

HB 1371 was introduced to amend RSA 281-A:38 to allow injured employees the right to record any examination by health care providers performing independent medical examinations or to have a witness present during the exam. HB 1371 was later amended by the Senate to require the injured employee to sign a prepared statement that they acknowledge that their rights to privacy are waived based on the circumstances of voluntarily allowing a witness to participate in the examination where their medical history or condition will be discussed in detail. The witness must also not interfere with any portion of the exam, but is allowed to observe or take notes. The amendment also includes a provision establishing a legislative committee to study the feasibility of an injured employee recording their independent medical examination and whether practitioners performing more than 10 examinations in a year should file a yearly report with the Department of Insurance. The House agreed to the Senate version of the bill and HB 1371 is awaiting Governor Lynch's signature.

HB 1649, relative to health information and patient rights.

HB 1649 originally began as legislation that contained significant restrictions as to those persons or health care providers able to obtain health information or records for patients being treated. The legislation was eventually amended to exclude all consent provisions that would have limited the transfer of certain health information. HB 1649 now amends RSA 332-I:1 and 332-I:2 to allow individuals, guardians or legal representatives to obtain an audit trail of any provider named by the individual, including whether the provider had access to their electronic health care records for the previous 3 years and what the provider accessed. The bill has been signed into law by the Governor and is effective January 1, 2011.

SB 392, requiring public hearings concerning health insurance cost increases in health care services.

SB 392 was amended to require the Insurance Commissioner to hold an annual public hearing for the purposes of discussing health care costs and trends that have led to rate increases in the previous year, pursuant to RSA 420-G:14-a. Apart from the public hearing, the Commissioner must evaluate claims costs, administrative loads and health carrier profits and will consider any cost variation that has occurred due to the "sickness or complexity" of the served population. According to the bill, health insurance carriers, providers or third party administrators may be asked to testify at the public hearing in order for all appropriate information to be provided to allow the Commissioner to make his or her determination. The Commissioner will then compile and provide an annual report based on his or her findings. Also included in the bill is a new requirement that hospitals charge no greater than the amount generally billed to patients covered by insurance to those patients who are categorized as "self-paying," and notify the patients of this policy. The House and Senate were in agreement with the changes to SB 392 and the bill is awaiting the Governor's signature.

SB 505, establishing the commission on health care cost containment and appropriating a special fund.

SB 505 was originally introduced as a measure to establish a health care cost Commission comprised of 3 full time Commissioners tasked mostly with exploring the effect of rising health care costs on basic hospital services, particularly for uninsured patients. The Commission would have also determined rate setting for each individual hospital. The bill was later amended to establish the Commission on Health Care Cost Containment pursuant to RSA 21:S made up of Legislators, members of the Department of Insurance, Department of Health and Human Services, the Citizens Health Initiative and four members of the public with expertise in health care policy economics, issues relative to small businesses and consumers, to study hospital billing practices and the existing health care cost reimbursement system. A onetime assessment on insurance carriers with more than 1,000 covered lives in New Hampshire, hospitals and ambulatory surgical centers will fund the Commission in the aggregate amount of \$250,000. The first meeting must be

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held by September 1, 2010. The amendments to this legislation were agreed to by both the House and Senate and the bill awaits Governor Lynch's signature.

SB 510, establishing a committee to evaluate the parity between oral and intravenous chemotherapy.

SB 510 was originally introduced to establish a Commission of legislators and expert practitioners to discuss the parity between oral and intravenous chemotherapy use. The House amended the legislation to create a Committee consisting only of Legislators to collect data about the parity or disparity between oral and intravenous use, receive public comment or testimony on the issue, determine the cost to insurers to provide coverage and to look at how other states have dealt with the issue. This amendment to SB 510 was approved by the Senate and is awaiting the Governor's signature.

HB 1168, clarifying the definition of gross misconduct for purposes of unemployment compensation.

HB 1168 was introduced to amend the definition of "gross misconduct" under RSA 282-A:35 to include fraudulent activity within the workplace as an offense that would result in the guilty employee losing all wages earned prior to the date of discharge for the purposes of unemployment compensation. The House did not agree with the Senate amended version of the legislation and requested a Committee of Conference. The only change that was agreed to by both bodies was to include any theft committed by an employee relative to their profession greater than \$500 in the definition of "gross misconduct." The Conference Committee amendment has been adopted by both Houses and awaits the Enrolled Bill process.

HB 1403, relative to wrongful termination.

HB 1403 was introduced at the beginning of the 2010 Legislation Session as a bill amending the Wrongful Termination Statute to include a new section under RSA 275:70 to offer legal protection to individuals who had been "bullied" or subject to abusive conduct, including but not limited to psychological, verbal and physical abuse, at their place of employment. After hearing several hours of testimony on the issue, the House Labor, Industrial and Rehabilitative Services Committee unanimously recommended that the bill be Inexpedient to Legislate. Many Committee members believed that there was adequate protection under existing law to deal with many of the issues addressed in HB 1403.

SB 469, requiring the department of labor to warn employers of certain violations prior to imposing a fine.

SB 469 sought to amend the civil penalties section of the Labor Law under RSA 273:11 to allow for the Commissioner of the Department of Labor to issue a written warning under any circumstance in which the Commissioner believes that no threat or harm to public safety will occur. The employer then has 60 days to fix the violation before going to a hearing. The Senate Commerce, Labor and Consumer Protection Committee had several concerns with the impact the legislation would have on the Department's resources and believed the bill needed additional study. The Senate voted to send the bill to Interim Study for the fall. A recommendation will be made by the Senate early next year whether future legislation should or should not be introduced for the 2011 Legislative Session.

The Committee to Study the Certificate of Need Process

The Committee to Study the Certificate of Need Process was established during the 2009 Legislative Session under HB 234. The Committee has been meeting at least monthly for almost a year and has begun a comprehensive look of the entire Certificate of Need process. The Committee is currently awaiting an extension to continue their exploration of the issue. Currently, the Committee is focused on the following aspects of the CON process:

- Whether the CON Board should take the leasing of equipment into consideration, instead of just overall capital costs of projects.
- Whether an annual Public Hearing for the purposes of hearing testimony and discussing projects and standards that have been developed to identify the effectiveness of the standards and the whole overall process is necessary.
- Whether the Board should consist of a 3 person model that studies the current method used by the CON Board and to decide what wholesale changes could be made to benefit the progression of the entire process.

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- Whether the Board should also be responsible for developing a comprehensive State Health Plan.
- Whether threshold standards currently in statute should be amended and whether a “fast track” process for certain projects should be adopted.
- The funding formula that should be used for the purposes of funding the new CON Board.

The Committee will begin their work again in mid-June on these issues, with a goal of recommending, drafting and proposing legislation for the 2011 Session.

Budgetary Issues

After several weeks of debate between the House and Senate on how best to close the \$295 million deficit for the remainder of the Biennium, Conferees were unable to reach a final agreement, forcing Governor Lynch and the Executive Council to call a Special Session beginning on June 9, 2010 to deal with the issue.

3. FEDERAL LAW UPDATE

A. More on the Red Flag Rules

The Federal Trade Commission has again pushed back the deadline for compliance with the Red Flag Rules from June 1, 2010 to December 31, 2010, as Congress considers legislation that would affect the scope of the entities covered by it. Recently, the American Medical Association, American Osteopathic Association and The Medical Society of the District of Columbia filed suit against the Federal Trade Commission charging that the FTC’s rule exceeds the powers delegated to it by Congress and that its application to physicians is arbitrary, capricious and contrary to the law. The AMA’s arguments are similar to those successfully made by the American Bar Association in similar litigation.

B. Federal Trade Commission Enforcement

Commissioner Christine Varney, head of the Department of Justice, Antitrust Division, has recently offered comments on the FTC’s enforcement initiatives, specifically with regard to health care reform. Commissioner Varney suggested “that accountable care organizations may be a good example of how providers might work together to deliver more efficient, high-quality care without inhibiting competition, so long as their collaborations are properly constructed.” The Commissioner noted it will continue to scrutinize mergers that present a competitive concern. ACOs are intended to provide robust competition with expanded choice.

The U.S. Justice Department entered into a settlement agreement with a group of orthopedic surgeons from Boise, Idaho. The physicians are alleged to have met and agreed not to accept state workers’ compensation rates and also agreed to threaten to terminate contracts with Blue Cross of Idaho. The proposed settlement prevents the Idaho Orthopaedic Society and named orthopedics from agreeing with their competitors on fees and contract terms. It also prohibits them from collectively denying medical care to patients, refusing to deal with any payor or threatening to terminate contracts. <http://www.justice.gov/atr/cases/f259200/259200.htm>

C. Ambulatory Surgical Centers; Proposed Rule Change

CMS issued a proposed rule on April 23, 2010 amending one of the existing conditions of coverage that ambulatory surgical centers must meet in order to participate in the Medicare program. The condition of coverage has met with significant response from the surgical center community. Currently, pursuant to final rules issued effective November 18, 2008, ASCs must provide patient rights information to patients or the patient’s representative in advance of the date of the surgical procedure. The new rule proposes to allow the ASC to provide patients or the patient’s representative or surrogate with the required patient rights information on the day of the procedure when the procedure must, to safeguard

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the health of the patient, be performed on the same day as the physician referral. Any comments to the rule must be received no later than June 22, 2010.

D. Equal Employment Opportunity Commission Rules Soon to Come

The EEOC has said it expects to issue its final rule interpreting GINA (Genetic Information Non-Discrimination Act) by June 2010. The rules are intended to clarify the obligations on employers, employment agencies, unions and training programs that have access to workers' genetic information and also potentially include exceptions for employers who inadvertently obtain genetic information. The rules may also clarify interaction between GINA and the ADA and the FMLA. The EEOC is also working on proposed rules relating to the age discrimination and employment act, one better defining the disparate impact analysis and the other addressing the meaning of "reasonable factor other than age."

4. NEW HAMPSHIRE LAW UPDATE

A. JUA

On May 24, 2010, the New Hampshire Insurance Department announced that it was filing amendments to New Hampshire Administrative Rule Ins 1700 relative to the continued operation of the New Hampshire Medical Malpractice Joint Underwriting Plan. The Commissioner has published an explanation for the changed rules. The Commissioner explains that the public purpose of the plan is to insure the availability of adequate medical malpractice liability insurance to health care providers where such insurance is not readily available from private insurance companies. The Commissioner goes on to explain that in January, 1976, the IRS issued a written determination concluding that the plan is an integral part of state government and is exempt from taxation. The plan, therefore, never filed Federal tax returns and has not paid any Federal taxes. In response to the Tuttle case, the Commissioner has determined that an examination was required to review the plan's tax status, operations and finances because of the number of issues and questions raised. The purpose of the Commissioner's review was to insure that the JUA plan could guarantee the availability of medical malpractice insurance to providers. Because some of the arguments of the plaintiffs in the Tuttle case and statements made by the lower court have challenged the plan's status as a public entity, the plan's exemption from Federal taxation is in jeopardy. If the plan is a private entity, then the plan could be subjected to claims by the IRS that it is in fact not tax-exempt, and instead owes taxes, interest and penalties to the Federal government for the past 35 years, a liability that could exceed \$100 million dollars.

While the Supreme Court did not expressly determine whether or not the plan is a private entity or part of state government, examiners have recommended modifications to Ins 1700 to insure the plan operates consistently with the long-standing tax exempt status of the plan. The revised rules accomplish the following:

- Clarify the authority and duties of the Board of Directors and the servicing organization;
- Establish a clear process to determine the necessary capital and reserves required for the operation of the plan, as well as to determine whether the plan has assets in excess of necessary capital and reserves;
- Eliminate provisions related to the funding of the stabilization reserve fund by a surcharge as the provisions are obsolete;
- Provide for a change in accounting rules the plan must follow to GAAP and change the accounting year to a fiscal year;
- Insure that the plan is governed by 91-a;
- Eliminate the obligation of New Hampshire consumers to pay a surcharge if the plan faces a deficit;
- Policyholders will also no longer be obligated to pay a surcharge or assessment in the event of a shortfall;
- Policyholders who paid any surcharge between 1986 and 1993, however, will be repaid to the extent the funds are available;

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- The proposed amendments eliminate provisions in the current rule that create the possibility of distribution of plan assets to plan policyholders;
- The proposed amendments expressly state that no private party can profit from a distribution of any earnings or assets of the plan in order to maintain the tax exempt status of the plan so that there is no private inurement.

Information concerning the JUA and the proposed rules can be found on the website of the Department of Insurance at <http://www.nh.gov/insurance/legal/jua.htm>.

B. The Attorney General Report on Catholic Medical Center and Dartmouth-Hitchcock Clinic

On May 21, 2010, the Office of Attorney General, through the Director of Charitable Trusts, released its report on the proposed affiliation transaction between Dartmouth-Hitchcock Health and CMC Health Care System. The Attorney General described that “at its essence, the transaction reorganizes the corporate structures of CMCHS and its affiliates, Catholic Medical Center and Alliance Health Services, resulting in these organizations ceding control to DHH and becoming a part of a regional integrated healthcare delivery system overseen and controlled by DHH.”

The Attorney General determined that “the transaction is not permitted by applicable law, specifically RSA 7:19-B IV because it would result in DHH obtaining control over core functions of the CMC charities, which until this point have operated as an independent catholic hospital.” The Attorney General determined that the transaction would result in profound change of the governance, diminish the fiduciary duties of the Board of Directors, and inhibit the ability of CMC charities to carry out their charitable missions. In order to continue with the transaction as contemplated, the Attorney General determined that the Probate Court would have to approve the transfer of control pursuant to its jurisdictional authority under the theory of “deviation.”

The Attorney General also determined that there was information it lacked regarding the effect of the transaction on the cost of delivering health care, and objected that there were insufficient safeguards in place to insure the calculation of post-affiliation surplus was not subject to manipulation or abuse by the parties.

The Attorney General also questioned salaries of certain executives and indicated that “nonprofit leaders must be aware that they are stewards of the charitable assets they oversee, and those assets are held in trust for charitable purposes, not individual gain.” As a result, it is important for all executives of New Hampshire nonprofits, specifically hospitals, to be sure the board performs an analysis and independent review of the market value of executive compensation.

Dartmouth and CMC may proceed with certain aspects of the affiliation, but must seek Probate Court review in order to continue with the transaction as proposed. The affiliation is also subject to a number of other legal approvals, including the Federal Trade Commission.

C. The Legality of Search Warrants for Medical Records

Exeter Hospital has helped to create law on the issue of producing a patient’s medical records in response to a search warrant without the patient’s authorization or consent. A decision was issued on May 6, 2010 by the New Hampshire Supreme Court. While the New Hampshire Supreme Court affirmed a lower court’s decision requiring the hospital to turn over patient records pursuant to a search warrant without the patient’s authorization, the Supreme Court has established additional safeguards in order to protect the privacy of the medical records.

Specifically, the Supreme Court established the following procedures, which must be followed in order to require a provider to produce health records in response to a search warrant:

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1. Any search warrant for privileged medical records shall order the hospital or medical provider to comply within a reasonable time by producing records under seal for in camera review by the trial court.

2. The trial court shall then determine the manner by which the patient shall be provided notice that such records were produced and shall give the patient and hospital or medical provider an opportunity to object to their disclosure.

3. Upon objection, the state must demonstrate “essential need” for the information contained in the record, i.e., the state must prove both that the information is unavailable from another source and that there is compelling justification for its disclosure.

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