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New Hampshire MGMA – February 8, 2012 - LEGAL UPDATE

FEDERAL DEVELOPMENTS

HEALTH CARE REFORM UPDATE

1. CMS Adopts Interim Final Rule for EFT Standards

Section 1104 of the Affordable Care Act requires CMS to adopt standards for electronic funds transfers (“EFTs”) applicable to claims payments by health plans to providers. (An EFT is a transfer of funds initiated electronically to instruct or authorize a bank to debit or credit an account.) Adoption of these uniform standards is part of an effort to encourage the transition from paper to electronic claims by making it more efficient and cost effective. CMS hopes the standards will help providers and others match claims to payments. The uniform standards are expected to save plans, providers and other entities up to \$4.5 billion over ten years.

CMS issued the first set of such standards in July of 2011, which adopted standards for use in determining (1) whether an individual is eligible for health plan coverage and (2) the status of a health claim submitted to a health plan.

The second set of standards were published on January 10, 2012. This regulation includes the following two standards regarding EFTs: (1) a standardized format for when a health plan authorizes or initiates an EFT with its bank; and (2) a standard specifying the information to be contained within the EFT.

Under existing practice, health claim EFTs include two components, the payment/processing information and adjustments to the claim that are described in a “remittance advice” notice. The remittance notice may not arrive at the same time as the payment information, which requires the provider to match the two items back together. This process can be costly and inefficient. In an attempt to solve this problem the regulations require the use of a trace number that automatically matches the payment information and remittance notice so that the provider is not required to do it manually.

Although the use of EFTs for health care claims is not currently extensive (such that the new standards may not initially have a substantial impact on health plans) it is anticipated that the percentage of claims paid through EFT will increase substantially in the future.

Compliance by health plans with the new standards is required beginning January 1, 2014. Comments on the regulations are being accepted until March 12, 2012.

2. Hospital Supervision Payments To Be Reduced According to MedPAC Recommendations

MedPAC is exploring ways to pay the same amount for the same service regardless of the provider type and eliminate “siloeed” payment systems. MedPAC has recommended setting the payment rate for supervision services provided in hospital outpatient departments to be the same as in physicians’ offices. According to MedPAC, evaluation and management, “E&M,” services should be reimbursed the same in a physician’s office as in a hospital outpatient department.

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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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MedPAC estimates that if the recommendation is phased in over three years and capped at no more than 2% for any particular hospital, it would reduce hospitals' overall Medicare revenues by .6% and outpatient Medicare revenues by 2.8%.

MedPAC cited an increased shift of hospital employment by physicians which has caused the billing of E&M services to move from free-standing practices to outpatient departments. MedPAC noted that the percentage of E&M services provided in outpatient departments increased at an annual rate of 3.5% per year from 2004 through 2008, 9.9% in 2009 and 12.9% in 2010. MedPAC notes that these shifts have been incentivized by payment rates where payments for identical services in an outpatient perspective payment system are much higher than a physician fee schedule.

It is important to note that Medicare initiated this payment differential in order to reimburse hospitals for additional costs related to the provision of services and administrative and facility overhead. While the recommendation was accepted at the MedPAC meeting on January 12 and 13, 2012, the change in reimbursement will have to be further approved. The American Hospital Association has stated that these cuts would jeopardize patient access to unique vital care as cutting hospital reimbursement for evaluation and management services in hospital outpatient departments threatens patient access to care that is not otherwise available in the community.

3. Controversy over Birth Control Mandate

In August 2011 the federal Department of Health and Human Services (DHHS) issued an interim final rule under the Affordable Care Act that would have required most health insurance plans to cover preventive services for women, including recommended contraceptive services, without a co-pay or deductible. The interim final rule allowed certain nonprofit religious employers the choice of whether or not to cover contraceptive services.

On January 20, 2012 DHHS announced that under the final rule, *all* insurance plans will have to cover such services. The final rule has sparked controversy because the rule forces Catholic hospitals and universities to provide contraception in their employee health plans. The Catholic Church considers it morally wrong to prevent conception by any artificial means.

In promulgating the rule, the Obama administration relied on the recommendations of the Institute of Medicine that birth control is not just a convenience but is medically necessary to ensure women's health and well-being. DHHS Secretary Kathleen Sibelius said in a statement released January 20th: "This decision was made after very careful consideration, including the important concerns some have raised about religious liberty. I believe this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services. The administration remains fully committed to its partnerships with faith-based organizations, which promote healthy communities and serve the common good."

Beginning August 1, 2012, most new and renewed health plans will be required to provide contraceptive services without cost sharing. Nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan will have an additional year to comply, until August 1, 2013.

Many Catholic organizations are resisting the rule, saying it would force them to violate their beliefs.

4. New Accounting Standard for Bad Debts

The Financial Accounting Standards Board (FASB) has issued an accounting standard update that will change the way many healthcare entities present information on bad debts in their financial statements. Specifically, the update will affect providers who recognize patient revenue at the time the services is rendered regardless of whether the provider expects to collect that amount.

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Accounting Standard Update 2011-07 – Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities (ASU 2011-07) requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally these entities must provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts.

According to FASB, this change will be an improvement from current GAAP because it will result in the presentation of an amount of net patient revenue (after any provision for bad debts) that is closer to the amount that the health care entity expects to collect. The result will be an improvement in the quality of financial statements.

The FASB update will apply to those health care entities that record revenue for services rendered prior to the time that collectability is ultimately determined, and thus will affect various types of providers, including clinics, hospitals, home health agencies, nursing homes, rehab facilities, and physician practices. For nonpublic entities, the amendments are effective for the first annual period ending after December 15, 2012.

QUALITY ASSURANCE

5. Is Your Smartphone Secure...from INFECTION?

Recent health care technology surveys indicate that the use of hand-held devices is increasing dramatically among physicians and other health care providers. According to a recent industry study (<http://blog.comptia.org/2011/11/21/7-key-opportunities-for-solution-providers-to-support-mobility-in-health-it/>), 38 percent of physicians use health-related mobile apps daily on smart phones or tablets, and they expect that number to increase above 50 percent within the next year. A study from Manhattan Research found that 71 percent of physicians they surveyed already consider a Smartphone essential to their practice. Most hospitals, even those mid-size and smaller, have begun implementing technology to facilitate conversion to electronic medical records (EMR), with providers increasingly imputing information on laptops and, more recently, hand-held devices. The federal government, as part of the HITECH Act, offers financial incentives approaching of \$44,000 for clinicians who adopt and can demonstrate “meaningful use” of an electronic medical records (EMR) system.

Some concern has been raised about the ability of physicians to rapidly adapt to new EMR technology and about the security of widespread use of hand-held devices to handle sensitive medical information in the age of HIPAA. However, there is another concern related to the proliferation of hand-held devices in hospitals and other clinical settings that has only recently been considered: Do devices like smart phones provide a new vector for bacterial and viral infection?

Two recent studies has raised concerns: In 2009, Turkish doctors published a study examining the contamination rate of healthcare workers’ mobile phones and hands in the operating room and ICU. Ulger, Fatma, et al. (2009). “Are we aware how contaminated our mobile phones are with nosocomial pathogens?”. *Annals of Clinical Microbiology and Antimicrobials* 8(7). The study found that 94.5% of phones demonstrated evidence of bacterial contamination with different types of bacteria, including a sizable percentage of resistant organisms. The study reasonably concluded that “mobile phones used by [healthcare workers] in daily practice may be a source of nosocomial infections in hospitals.

Another study examined the threat of infection from mobile phones of patients, companions and visitors. Sait Tekereoglu, Mehmet, et al. (2011). “Do mobile phones of patients, companions and visitors carry multidrug-resistant hospital pathogens?” *AJIC: American Journal of Infection Control* 39(5), 379-381. That study concluded that mobile phones of non-hospital staff represented an even higher risk for nosocomial pathogen colonization than those of health care workers.

With the proliferation of mobile devices in today’s society generally and within hospitals and medical offices in particular, those responsible for infection control should address the problem of potential contamination from mobile more effectively

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than the issue has been to date. As the 2011 study points out, “successful decontamination will not be easily accomplished with classic methods,” primarily because mobile devices are sensitive to liquid contact and high temperatures, making frequent disinfection impossible. Until other disinfection methods are available, or devices are made to withstand current techniques, the best solutions are likely the old stand-bys: staff education, frequent hand washing and the use of technology-appropriate disinfectant wipes. In higher-risk areas, mobile devices may need to be restricted, especially for the public. Further possible solutions include ultraviolet irradiation and the use of easily cleanable silicon device covers

EMPLOYER BRIEF

6. Religion and Employment: The Impact of *Hosanna-Tabor Evangelical Lutheran Church and School v. Equal Employment Opportunity Commission*.

In a decision issued January 11, 2012, the United States Supreme Court held that certain teachers in religious church schools are not protected by employment discrimination laws. The case was decided on constitutional grounds.

The Hosanna-Tabor Evangelical Lutheran Church School hired Cheryl Perich as a teacher. After completing certain theological and academic requirements she became a “called” teacher, and was designated a commissioned minister. Ms. Perich developed narcolepsy and ultimately was fired for reasons she believed were related to her disability. The Equal Employment Opportunity Commission brought suit on behalf of Ms. Perich claiming she was terminated and retaliated against in violation of the Americans with Disabilities Act (the “ADA”).

The ADA is one of many employment discrimination laws that protects employees from alleged discrimination in the workplace. Ms. Perich claimed she should have been protected by the ADA. The Establishment and Free Exercise Clauses of the First Amendment, on the other hand, bar suits brought on behalf of “ministers” against their churches claiming termination in violation of federal employment discrimination laws. The Church School claimed the constitution protected its ability to hire and fire its “ministers.” Because the Supreme Court determined Ms. Perich was not only a teacher, but a “minister” as well, the Court concluded she could not be protected by employment discrimination laws, and her case was dismissed.

The holding is seemingly narrow. “Churches” cannot be sued for employment discrimination as a result of employment decisions relating to church ministers. This “ministerial exception” now extends to church schools’ employment relationships with minister-teachers.

The post-decision commentary has been interesting. Commentators have noted both that churches should not be above the law, while noting the government should not have the authority to resolve essentially religious disputes. This case garnered attention because the church operated a school, and Ms. Perich taught mostly secular subjects. The Justices themselves, during oral argument, seemed to agree that the issue of where to draw the line between church and state, as well as religion and schools, is a complex one.

New Hampshire HB 1653: Conscientious Objection to Providing Health Care Services

Interestingly, a similarly complex issue seems ripe for discussion in the New Hampshire legislature as it relates to health care providers. Legislators are currently discussing whether an employer should be liable for taking any action against an employee who objects to participating in a health care service, and whether an employee should be immune from any action or liability for so doing.

Specifically, HB 1653, currently before the House Judiciary Committee, gives all health care providers the right to conscientiously object to participating in a health care service. A health care provider who conscientiously objects to participating in any way in a health care service, for any religious, philosophical or ethical reason, cannot be civilly or

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criminally liable for such objections. HB 1653 also provides it “shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or national certifying board which certifies competency in medical specialties to discriminate against any health care provider in any manner based on his or her conscientious objection to participating in a health care service, including, but not limited to, termination, transfer, refusal of staff privileges at a health care institution, refusal of board certification, administrative action, refusal to provide standard residency training opportunities, or any other disciplinary action.” There is no limit on what type of health care service a provider can “conscientiously object” to. The bill is currently under discussion.

7. **Disability Discrimination and Excessive Absenteeism**

The First Circuit (the appeals court for the United States District Court of New Hampshire), recently issued an opinion in favor of the employer in an Americans With Disabilities Act (ADA) reasonable accommodation claim involving an employee who was frequently absent. See Colon-Fontanez v. Municipality of San Juan, No. 10-1026 (1st Cir. October 12, 2011).

Employers often struggle with determining just how to accommodate the needs of an employee with a disability who is frequently absent from work. The answer is not easy and is always fact specific. However, in the case of Nitza Colon-Fontanez, the court was clear.

Colon-Fontanez was an auction officer for the city of San Juan, Puerto Rico. After developing fibromyalgia, she was frequently absent from work, so much so that by 2008 she was absent 56% of the time. When she asked for a city parking spot near her office, the city said “no.” She filed a suit claiming discrimination in violation of the ADA.

The First Circuit found her ADA claim had been properly dismissed. Because **attendance** was an **essential function of the job**, and she failed to attend work, she was not a qualified individual protected by the ADA. The court also found she was not retaliated against for seeking an accommodation.

This decision offers guidance in two areas:

- The ADA may not require an employer to accommodate excessive absenteeism if attendance is an essential function of the job. However, employers should note that in this case, the employee was absent over a period of years more than 50% of the time.
- Retaliating against an employee for seeking an accommodation may result in an ADA violation. Employers should be sure to refrain from any such retaliation and engage in a reasonable accommodation discussion with qualified employees under the ADA.

8. **Equal Employment Opportunity Commission Issues a Draft Strategic Plan for FY 2012-2016**

The EEOC has issued its strategic plan for upcoming years ahead. The EEOC enforces:

- Title VII of the Civil Rights Act of 1964 which prohibits employment discrimination on the basis of race, color, religion, sex or national origin;
- The Age Discrimination in Employment Act of 1967 (ADEA) which prohibits employment discrimination against individuals 40 years of age and older;
- The Equal pay Act of 1963 (EPA) which prohibits discrimination on the basis of sex in compensation for substantially equal work performed under similar conditions;
- Title I and Title V of the Americans with Disabilities Act of 1990 (ADA) which prohibits employment discrimination on the basis of disability in the private sector and in state and local government; and
- The Genetic Information Non-Discrimination Act of 2008 (GINA) which prohibits employment discrimination based on genetic information.

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New Hampshire MGMA – February 8, 2012 - LEGAL UPDATE

These laws apply to private employers with 15 or more employees (although the ADEA applies to employers with 20 or more employees and there is no minimum employee requirement under the EPA).

While the EEOC has bold plans, its top priority, is to: **combat employment discrimination through strategic law enforcement.** The EEOC has the power to investigate, conciliate and litigate claims. Its chief goal will be systematic discrimination and discriminatory practices and policies in federal agencies.

For the full Plan, please see: <http://www.eeoc.gov/eeoc/newsroom/1-18-11a.cfm>
http://www.eeoc.gov/eeoc/plan/strategic_plan_12to16_DRAFT.cfm

The best way to ensure your workplace is free from unlawful discrimination is to develop or review appropriate policies, implement effective workplace training and ensure employment practices are carefully undertaken and reviewed.

9. **Beware of Retaliation Claims under Wage and Hour Laws: Fact Sheet #77A**

The prohibition against retaliation by an employer for an employee or a former employee's raising a wage and hour issue is far reaching. Retaliation claims at the Equal Opportunity Employment Commission are on the rise and makeup over a third of all charges filed with the EEOC.

We have reported in the past on the Kasten v. St. Gobain holding from the United States Supreme Court where the Court expanded the Fair Labor Standard Act's retaliation provisions to cover internal and verbal complaints about wage and hour issues made by an employee.

The United States Department of Labor, Wage and Hour Division has now issued Fact #77A (December 2011), which incorporates this holding and explains in no uncertain terms when an employer can be liable for retaliating against an employee or a former employee for making a complaint. Technically it is a violation of Section 15-A:3 of the Fair Labor Standards Act for any person to "discharge or in any other manner discriminate against an employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act, or has testified or is about to testify in any such proceeding, or has served or is about to serve on an industry committee." In the Fact Sheet, the Wage and Hour Division confirms that a complaint can be made orally or in writing and both are protected. The Fact Sheet further explains that the FLSA protects "any person" from retaliating against "any employee," which protection applies to all employees of an employer even in those instances in which the employee's work and the employer are not covered by the FLSA. This might mean an individual is protected from making complaints even when there is no current employment relationship between the parties. An aggrieved employee may file a retaliation complaint with the Wage and Hour Division or may file a private cause of action seeking appropriate remedies. Remedies can include employment, reinstatement, lost wages and an additional equal amount as liquidated damages.

The Fact Sheet can be found at: <http://www.dol.gov/whd/regs/compliance/whdfs77a.pdf>

10. **Fact Sheet 77B: FMLA**

In December 2011, the Wage and Hour Division also issued Fact Sheet 77B protecting individuals under the Family Medical Leave Act. Again, clarifying actions that may involve retaliation, the Wage and Hour Division offered examples of prohibited conduct including:

- Refusing to authorize FMLA leave for an eligible employee;
- Discouraging an employee from using FMLA leave;
- Manipulating an employee's work hours to avoid responsibilities under the FMLA;
- Using an employee's request for or use of FMLA leave as a negative factor in employment actions such as hiring, promotions or disciplinary actions; or

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- Counting FMLA leave under “no fault” attendance policies.

The Fact Sheet can be found at: <http://www.dol.gov/whd/regs/compliance/whdfs77b.pdf>

NEW HAMPSHIRE UPDATE

11. Legislative Review

New Hampshire legislators convened for the second year Session of the 162nd General Court on January 4, 2012. After a long fall of considering retained bills, no time was wasted in giving consideration to a number of the 870 bills filed since the end of the 2011 Session. Although health care industry stakeholders and legislators alike face uncertainty as they await the implementation of a state Care Management system for Medicaid and many of the federal mandates of the Affordable Care Act, New Hampshire’s House and Senate are looking at several proposals that would reform health care in New Hampshire.

Medical Malpractice Reform

SB 17, relative to evidence of admissions in medical injury actions. Also known as the “I’m Sorry” legislation that was actively supported by the New Hampshire Medical Society, SB 17 was re-referred to Senate Judiciary during the 2011 Session for further study. If adopted, SB 17 would prohibit any statement expressing sympathy, condolence or fault made by a provider to a patient or patient’s representative as a result of an unanticipated outcome of medical care from becoming evidence of admission during medical injury actions. Although the Committee recommended that the legislation be Inexpedient to Legislate on a split vote, the recommendation was overturned on the Senate floor, allowing for the bill to be adopted. SB 17 now moves onto the House for consideration but has not been assigned to a Committee or scheduled for a public hearing at this time.

Planned Parenthood Defund Legislation

HB 228, prohibiting the use of public funds for abortion services. Introduced at the beginning of 2011 in an attempt to defund Planned Parenthood in New Hampshire, HB 228 was retained in the House Health, Human Services and Elderly Affairs Committee for additional work over the summer. After several work sessions, Committee members voted definitively to recommend that the legislation be Inexpedient to Legislate to the full House. House leadership, whose members supported the original legislation, delayed floor action on the bill in order to secure the necessary votes to overturn the Committee recommendation. On January 25th, the House voted to adopt HB 228 with a brand new amendment prohibiting the use of any federal funds, including those given to the state under Title X, for abortion services and prioritizing the providers who should receive any state or federal dollars for women’s health services. Language was also included that prohibited the Department of Health and Human Services from entering into contracts with or providing grants to any organization that performs non-federally qualified abortions.

Right of Conscience for Health Care Providers

HB 1653, relative to the rights of conscience for medical professionals. HB 1653 allows for a wide variety of health care providers, including but not limited to physicians, physicians’ assistants, pharmacists, nurses, nurses aides, nursing home employees and medical school students to conscientiously object to providing health care services based on their religious, moral or ethical beliefs. The bill also prohibits the penalization of providers and health care institutions in the event a conscientious objection takes place. Opponents of the legislation are concerned that the language affords little protection to patients in the event of an emergency and believe the definitions of providers and institutions in the bill are the repercussions the bill would have regarding access to care and the New Hampshire chapter of the ACLU testified they would oppose the bill if adequate notification was not given to patients regarding their provider’s objection to treatment. Proponents believe the legislation is necessary as New Hampshire is only one of three states not to have a general

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New Hampshire MGMA – February 8, 2012 - LEGAL UPDATE

conscientious objection statute on the books and want to show citizens and providers that the legislature supports their right to an individual conscience. The House Judiciary subcommittee that worked on the legislation will recommend that the bill be Ought to Pass to the full Committee but only by a slim margin.

Protected Health Information

HB 1613, relative to protected health information. Legislation has again been introduced in the House to address privacy breaches of protected health information under federal law. If adopted, HB 1613 would require covered entities and business associates as defined under HIPAA's privacy regulations to notify patients within 5 business days of a breach or potential breach that has involved 10 or more individuals. Sponsors of the legislation spoke about the effect a breach could have on the identity of those whose records are compromised. The New Hampshire Medical Society testified that they believe HIPAA already affords patients with the medical records protections that they need and believes there could be unintended consequences if a patient is notified of a potential breach. The New Hampshire Hospital Association testified that analyzing health information for a potential breach and sending out notice within 5 business days would have tremendous fiscal implications for any provider. The bill will head to subcommittee this week for additional study.

Health Care Exchanges

The New Hampshire House and Senate currently have differing views on what the state should do in the event the Affordable Care Act is not overturned by the US Supreme Court in part or in its entirety later this year. This is most clearly demonstrated by two pieces of pending legislation awaiting action, one in each body.

SB 163, relative to the New Hampshire health benefit exchange. SB 163 was introduced in the Senate at the beginning of 2011 to create a public corporation for the purposes of running a state exchange. As the Session came to a close, decisions made by the House and Executive Council to return monies to the Federal Government that would have been used both to plan and implement a state based exchange seemed to overshadow any action taken by the Senate. SB 163 was re-referred to Senate Commerce for additional work over the summer. Several stakeholder meetings were held and amendment language was voted out of Committee early this year enabling the state to create its own exchange as a result of the careful work of citizen health groups, insurance carriers and representatives of providers in collaboration with the Senate. The legislation has since been tabled, some saying that the proposal lacks the necessary numbers for adoption, others believing that the contingency clauses relative to the dismantling of the exchange in the event Affordable Care Act is found unconstitutional are not strong enough to garner House support. In addition to the stakeholder group, the Business and Industry Association, New Hampshire's statewide chamber of commerce, has recently come out in support of the establishment of a state exchange. They believe that it is important for the state to control and shape a program that is best suited to fit New Hampshire's unique health insurance needs that would also be able to maximize choice for businesses and employees alike.

HB 1297, relative to health care exchanges. While the Senate continues to deliberate on the establishment of a state exchange, the House Commerce Committee is considering legislation that would prohibit New Hampshire from entering into any health care exchange developed by the state or federal government. Members of the stakeholder group who worked in the Senate on language to support a state exchange all testified in opposition of the legislation in a hearing held several weeks ago. On February 2nd, the prime sponsor introduced an amendment to a subcommittee for consideration that was less severe than the original bill. The language eliminates the intent clause of the bill, which would have prevented the state from defaulting to a federal exchange but continues to prohibit any state agencies, departments or subdivisions from "planning, creating, participating or enabling" a state health exchange. Supporters of the amendment explained that it ties the hands of state officials and prohibits action before the US Supreme Court has a chance to opine on any aspect of the Affordable Care Act. Opponents are concerned that if adopted, the amendment would prohibit the state from using important, knowledgeable resources that could easily determine the best course of action for the state to take. The subcommittee made no recommendation on the amendment and will most likely continue the dialogue over the next few weeks before a decision is ultimately reached.

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New Hampshire MGMA – February 8, 2012 - LEGAL UPDATE

Cancer Treatment

HB 1642, relative to destination cancer hospitals. A bill being considered before the House Health, Human Services and Elderly Affairs Committee this week has the potential to open the doors for destination cancer hospitals to do business in New Hampshire. HB 1642 is a proposal that would allow facilities with 50 or fewer beds to provide comprehensive cancer treatment to a population made up of a majority of out-of-state residents. Many members of House leadership have signed on as co-sponsors to the legislation, which they believe will bring jobs and additional revenue to the state. Opponents, which include the New Hampshire Hospital Association and New Hampshire Medical Society, have concerns about provisions that allow the hospitals to bypass the Certificate of Need process as well as language that would exempt the facilities from paying the Medicaid Enhancement Tax. Cancer Treatment Centers of America, a for-profit private company that owns and runs inpatient and outpatient clinics in Illinois, Pennsylvania, Oklahoma, Arizona, Washington with one under construction in Georgia, has emerged as the main proponent of the legislation.

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