HEALTHCARE**LEGAL**NEWS

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IN THIS ISSUE

FURTHER EROSION IN HEALTHCARE REFORM

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In mid-October 2011, HHS pulled the rug out from under one of the major components of the Patient Protection and Affordable Care Act ("PPACA") - the Community Living Assistance Services and Supports Act, better known as the CLASS Act. The CLASS Act is a voluntary, national insurance program for Americans to pay for long-term services they may need in the future.

One of the provisions of the CLASS Act required the Secretary of HHS to certify that the program would be actuarially sound (*i.e.*, financially self-supporting) for 75 years. After 19 months of study, Kathleen Sebelius announced on October 14, 2011 that HHS is unable to make this certification. One of the issues was adverse selection - the fear that the program would not attract young, healthy individuals, but that people would wait to enroll until they were older and/or in poor health. As a result, HHS has placed implementation of the CLASS Act on hold. Some Republicans are now pushing for a bill to completely repeal the CLASS Act.

The indefinite delay in implementing the CLASS Act adds to doubts that national healthcare reform will ever function as originally intended by Congress. Further examples of erosion of the provisions included in the PPACA include:

- In April 2011, Congress repealed the requirement that companies report transactions over $600 paid to all businesses for goods and services on Form 1099.
- Studies have indicated that anywhere from 10% to 30% of employers will drop health insurance when state sponsored individual insurance exchanges go live in 2014, forcing many thousands of employees into the untested individual exchange market.
- Some believe that the individual penalties are not high enough to incentivize people to buy health insurance, particularly young, healthy adults called the "young invincibles".
- The IRS has delayed Form W-2 reporting of the value of employer-provided health insurance until 2012.

Finally, it remains to be seen if PPACA will survive the numerous constitutional challenges and/or full repeal if President Obama is not re-elected.

LABOR & EMPLOYMENT NEWS

SHOULD YOUR ORGANIZATION HAVE AN AFFIRMATIVE ACTION PLAN? RECENT DECISION REQUIRES HOSPITALS TO RE-EVALUATE WHETHER THEY ARE SUBJECT TO FEDERAL AFFIRMATIVE ACTION REQUIREMENTS

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As you may have heard by now, the Office of Federal Contract Compliance Programs ("OFCCP") has now asserted jurisdiction over many hospitals that have long believed themselves beyond the reach of the OFCCP and its affirmative action plan requirements. This vast expansion of OFCCP jurisdiction is due in large part to the October 2010 decision in *OFCCP v. Florida Hospital of Orlando*.

In that case, an Administrative Law Judge ("ALJ") for the United States Department of Labor determined that Florida Hospital of Orlando was a "government subcontractor" based solely on the hospital's TRICARE contracts. TRICARE is a federal healthcare program for active and retired members of the military and their families. TRICARE contracted with Humana Military Healthcare Services, Inc. ("HMHS") to provide networks of healthcare providers for TRICARE beneficiaries. In turn, Florida Hospital of Orlando contracted with HMHS to become a participating hospital and provide care to hospitalized TRICARE beneficiaries.

Florida Hospital of Orlando argued it was not a federal subcontractor and that its participation in TRICARE was akin to participation in Medicare, where participants are not subject to OFCCP jurisdiction. The ALJ rejected Florida Hospital's argument, reasoning that Medicare does not provide services, but merely pays for them. Because TRICARE's focus is on the delivery of services and not simply payment for services, TRICARE is not akin to Medicare which is a federal financial assistance program.

There are more than 500,000 TRICARE providers. OFCCP has expanded its jurisdiction to include hospitals that have never believed themselves to be government contractors.

Hospitals in this situation have two choices - either concede jurisdiction and meet the affirmative action and other requirements of OFCCP or challenge the OFCCP's asserted jurisdiction. Prior to making a decision, the hospital must first assess whether it would be deemed a government contractor or subcontractor even under the new standards. For instance, if a hospital simply treats patients covered by TRICARE, but does not have an agreement with TRICARE or one of the TRICARE network providers such as HMHS, a strong argument can be made that the institution is not a government contractor or subcontractor. Second, the Florida Hospital of Orlando decision was an ALJ decision and has been appealed to the Department of Labor's Administrative Review Board. Given the decision's widespread impact, it is unlikely the ALJ's decision will be the last word on this subject.

HEALTHCARE REFORM NEWS

CMS EASES STANDARDS FOR HEALTHCARE PROVIDERS TO BECOME ACOS

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On October 20th, 2011, CMS issued its Final Rule on Medicare accountable care organizations (ACOs). ACOs are a key component of the Affordable Care Act aimed at slowing rising Medicare costs while delivering high quality healthcare to Medicare beneficiaries. When CMS announced its proposed rule on ACOs in March, 2011, many in the healthcare industry argued that the rule was unnecessarily restrictive and that, as a consequence, they would not organize into ACOs.

In the Final Rule, CMS relaxed several requirements. Most notably, CMS reduced the number of quality measures required to qualify for performance bonuses from 65 to 33. CMS also eliminated a requirement that 50% of participating physicians achieve meaningful use of electronic medical records. In addition, under the Final Rule, healthcare providers can participate in an ACO and share in savings without risk of losing money.

Another change contained in the Final Rule relates to beneficiary assignment. Based on their history of utilization of primary care services, Medicare beneficiaries will be preliminarily assigned prospectively to an ACO instead of retrospectively as they would have been under the proposed rule. Also, the Final Rule allows community health centers and rural health clinics to organize their own ACOs or join already existing ACOs and it relaxes the timetable to launch an ACO with healthcare providers allowed to apply in 2012. Lastly, to entice healthcare providers to organize into ACOs, CMS will give physician-owned and rural providers early access to expected savings to use to start an ACO.

The Final Rule was accompanied by: 1) an interim final regulation from the Office of Inspector General relating to waivers of fraud and abuse provisions; 2) a final policy statement from the Federal Trade Commission and Department of Justice on antitrust enforcement relating to ACOs participating in the Medicare Share Savings Program (MSSP); and 3) a fact sheet from the IRS confirming that IRS Notice 2011-10 continues to state the position of the IRS as to ACOs and the MSSP.

LITIGATION NEWS

MEDICAL MALPRACTICE STATUTORY CAPS IN JEOPARDY

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Challenges to statutory limitations on jury verdicts in medical malpractice actions are on the rise. In two recent cases, juries in Florida and Michigan issued verdicts awarding millions of dollars to patients as a result of medical malpractice claims. These two verdicts illustrate different methods of attacking the legislative caps that states have imposed on noneconomic damages in malpractice actions.

In Florida, the jury awarded $2 million in damages for pain and suffering and loss of companionship suffered by the parents of a woman who died during childbirth, allegedly due to medical negligence. Florida law imposes a $1 million cap on noneconomic damages in such cases. Attorneys for the plaintiff claimed that the cap violates the U.S. Constitution on equal protection and protection from government takings grounds. The Florida federal district court denied the plaintiff's claims on U.S. Constitutional grounds, but referred the case to the Florida Supreme Court to determine whether the cap violates the Florida Constitution.

Michigan limits noneconomic damages in medical malpractice actions to $280,000 generally and $500,000 in certain special cases (adjusted annually for inflation), including spinal cord injury cases. A Michigan jury recently awarded the family of a quadriplegic $130 million in damages due to alleged malpractice. The verdict represents the plaintiff's estimate of the cost of caring for the child until 2077, which is presumably an element of noneconomic damages not capped by the statute. Regardless of whether or not the jury intended some of the $130 million award to compensate the plaintiff for noneconomic damages, the verdict is large enough that it renders the legislative cap on economic damages meaningless, at least in that particular case.

Healthcare providers should closely monitor developments in this area to determine whether to adjust their reserves, self-insured retention amounts or professional liability insurance limits in those states in which the liability caps are invalidated.

HEALTHCARE IT NEWS

MOBILE IS COMING TO HEALTHCARE

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Like it or not, mobile technology is coming to healthcare. In fact, it is already here. Doctors now use iPads to enter data into a patient's EMR during the patient's visit and patients' smartphones can help monitor their caloric intake or find doctors who accept their insurance policies. Healthcare organizations increasingly are on a daily basis integrating smartphones and tablets into their healthcare infrastructure. A 2010 Pew Research study found that out of the 85 percent of adults that use a cell phone, 17 percent have used it to look up health-related information and 9 percent have health-related software applications (*i.e.*, an "app") on their phones.

The Federal government has taken advantage of mobile technologies for some time. Since January 2010, HHS has invested $5 million dollars to develop and promote its eHealth/mHealth smoking cessation program aimed at teens, young adults and adults. In September 2011, the National Coordinator for Health Information Technology launched the *Million Hearts Challenge*, which is a call to innovators and developers to create an app to empower patients to take charge of their cardiovascular disease. The first prize is $50,000.

But many healthcare organizations are hesitant to take full advantage of mobile health due to privacy and security concerns. In October, the Office of the National Coordinator (ONC) announced a 24-month public education campaign that will focus on the need to exchange healthcare data. The ONC has solicited public comment on a proposal to expand the campaign's data collection efforts to include gauging consumer opinions on using mobile devices to communicate protected health information.

Healthcare organizations that seek to take advantage of mobile technologies should evaluate whether the technology handles PHI. If so, then HIPAA and HITECH must be addressed. Healthcare organizations that incorporate mobile devices into their business environment must also consider proper security measures such as the ability to wipe devices remotely.

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