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Tenacity, Creativity and Results are the three words that best describe Shaheen & Gordon's approach to addressing complex legal issues. Our health care team closely monitors the rapidly changing legal environment so that our clients are prepared to meet the challenges of today as well as tomorrow. Relying on a wealth of experience, we offer practical advice and assist in implementing recommendations tailored specifically to meet the needs of both large and small health care clients.

FEDERAL DEVELOPMENTS

House Republicans Announce Bill to "Repeal and Replace" ACA

On March 6, 2017, House Republicans released the full text of their bill to "repeal and replace" the Affordable Care Act ("ACA"). The release comes after much speculation and anticipation since the new administration took over in January. Titled the "American Health Care Act" ("AHCA"), the bill is 123 pages long and contains provisions repealing, replacing, or preserving many key provisions of the ACA:

- The bill repeals both the individual and employer mandates, and replaces income-based subsidies with tax credits that will be based on income level and age.
- AHCA would end Federal funding for Medicaid expansion starting in 2020, but would allow those currently enrolled through the eligibility expansion to remain in Medicaid as long as they are continuously insured. In addition, Federal funding for the entire Medicaid system would be transitioned to per-capita grants to states.
- The bill would keep the ACA's protection for individuals with preexisting conditions, but adds a provision allowing insurers to charge a 30% premium increase for those who enroll after experiencing a gap in coverage.
- AHCA retains the ACA provision allowing young adults to stay on their parent's insurance plans until age 26.
- Insurance plans will still be required to include the 10 essential health benefits in their plans.
- Insurers would still be prohibited from setting annual or lifetime maximum limits on benefits.

The AHCA can be read in its entirety at: https://housegop.leadpages.co/healthcare/.

Proposed Rule: ACA Insurance Market Stabilization

On February 15, 2017, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule designed to stabilize the individual and small group insurance market under the Affordable Care Act ("ACA"). The proposed rule would amend standards relating to special enrollment periods, guaranteed availability, and the timing of the annual open enrollment period in the individual market for the 2018 plan year; standards related to network adequacy and essential community providers for qualified health plans; and the rules around actuarial value requirements. More specifically, the rule proposes to improve the risk pool and promote stability in the individual insurance

market by taking steps to increase the incentives for individuals to maintain enrollment in health coverage and decrease the incentives for individuals to enroll only after they discover they require services by:

- Changing the open enrollment period for the benefit year starting January 1, 2018 to November 1 through December 15 – instead of through January 31 – which would require individuals to enroll in coverage prior to the beginning of the plan year and is consistent with future open enrollment periods.
- Increasing pre-enrollment verification of eligibility for all categories of individual market special enrollment periods for consumers purchasing coverage on the Federally-facilitated exchanges. Currently, consumers may simply attest to their eligibility for special enrollment periods.
- Revising CMS's interpretation of the guaranteed availability requirement to allow issuers to apply a premium payment to an individual's past debt owed for coverage from the same issuer in which the individual was enrolled within the prior 12 months. CMS believes this would have a positive impact on the risk pool by removing economic incentives individuals may have had to pay premiums only when they were in need of health care services and would encourage individuals to maintain continuous coverage throughout the year.
- Increasing the de minimis variation in the actuarial values used to determine metal levels of coverage for the 2018 plan year. CMS intends this change to allow issuers greater flexibility in designing new plans and to provide additional options for issuers to keep cost sharing the same from year to year.

CMS also proposed other changes intended to affirm the traditional role of states in overseeing their health insurance markets, while also reducing the regulatory burden on issuers participating in exchanges.

According to CMS, "The proposed changes in this rule are intended to promote issuer participation in these markets and to address concerns raised by issuers, States, and consumers. We believe such changes would result in broader choices and more affordable coverage."

The proposed rule is published in the Federal Register at 82 Fed. Reg. 10980, and may be read at: https://www.gpo.gov/fdsys/pkg/FR-2017-02-17/pdf/2017-03027.pdf. Comments must be received by 5:00 p.m. on March 7, 2017.

Anthem-Cigna Merger Blocked by Federal Judge; Cigna Looks to Terminate Merger Agreement

On February 8, 2017, Judge Amy Berman of the U.S. District Court for the District of Columbia issued an order enjoining Anthem Inc.'s proposed acquisition of Cigna Corp., based on a finding the merger would violate Federal antitrust laws.

The United States Department of Justice ("DOJ") filed suit in July 2016 to stop the merger, arguing that it would substantially lessen competition in the health insurance industry in dozens of

markets across the country. Eleven states, including New Hampshire and the District of Columbia joined the Justice Department's suit to stop the merger.

The Court found that the merger would likely harm competition and be anticompetitive in the market for the sale of health insurance to "national accounts" – customers with more than 5000 employees, usually spread over at least two states – within the fourteen states where Anthem operates as the Blue Cross Blue Shield licensee. The Court also found evidence that the merger would have anticompetitive effects on the sale of insurance to large groups in at least one market: Richmond, VA.

The court was not convinced by Anthem's argument that any anticompetitive effects of the merger would be outweighed by the efficiencies it would generate, stating that the purported efficiencies of the merger "are not verifiable, and it is questionable whether they are efficiencies at all."

"Today's decision is a victory for American consumers," said Acting Assistant Attorney General Brent Snyder of the Justice Department's Antitrust Division. "This merger would have stifled competition, harming consumers by increasing health insurance prices and slowing innovation aimed at lowering the cost of healthcare." The American Hospital Association and the American Medical Association also commended the decision. Both stated that the absence of health insurer competition jeopardizes access to and quality of healthcare. New Hampshire participated in the proceeding in an effort to stop the merger and Attorney General Joseph Foster praised the decision noting the already existing lack of competition in the New Hampshire health insurance market.

On February 14, 2017, Cigna announced that it would move to terminate the merger agreement between it and Anthem following the District Court's decision blocking the merger. Cigna filed an action seeking a declaratory judgment that it can legally terminate the merger agreement. The following day, Anthem filed suit seeking a temporary restraining order to enjoin Cigna from terminating the merger and seeking to compel Cigna to comply with the merger agreement. If Cigna is successful in terminating the agreement, it stands to collect a break-up fee exceeding $1 billion. Anthem requested pursuing an expedited appeal of the District Court's decision.

The Court's decision can be read in full at: https://www.justice.gov/atr/case-document/file/940946/download.

Aetna and Humana Halt Merger Plans

On February 14, 2017, insurers Aetna and Humana announced they will not pursue their merger agreement. The announcement follows a U.S. District Court for the District of Columbia decision in January that blocked the merger after the court concluded that it would substantially lessen competition. Aetna Chairman and CEO Mark Bertolini expressed disappointment in the current environment: "Our mutual respect for our companies' capabilities has grown throughout this

process, and we remain committed to a shared goal of helping drive the shift to a consumer-centric health care system." Under the merger agreement Aetna will pay Humana a $1 billion breakup fee.

The decision blocking the Aetna-Humana merger can be read here: https://www.justice.gov/opa/press-release/file/930361/download.

DOJ Issues New Guidance on Corporate Compliance Programs

On February 8, 2017, the U.S. Department of Justice (DOJ) Fraud Section published new guidance on corporate compliance programs. The guidance, entitled "Evaluation of Corporate Compliance Programs", is a list of "important topics and sample questions" the DOJ uses when evaluating the effectiveness of corporate compliance programs. The guidance is intended to provide more transparency about federal prosecutors' review of compliance programs and the specific factors that prosecutors consider in conducting an investigation of a corporate entity, determining whether to bring charges, and negotiating plea or other agreements. These factors are commonly known as the "Filip Factors" and include "the existence and effectiveness of the corporation's pre-existing compliance program" and the corporation's remedial efforts "to implement an effective corporate compliance program or to improve an existing one."

While not specific to healthcare, the document addresses 11 issues that apply to practically all compliance programs:

1. Analysis and Remediation of Underlying Misconduct
2. Senior and Middle Management
3. Autonomy and Resources
4. Policies and Procedures
5. Risk Assessment
6. Training and Communications
7. Confidential Reporting and Investigation
8. Incentives and Disciplinary Measures
9. Continuous Improvement, Periodic Testing and Review
10. Third-Party Management
11. Mergers and Acquisitions

The guidance and suggested questions associated with each issue may be viewed at https://www.justice.gov/criminal-fraud/page/file/937501/download.

Rule Effective Dates Delayed for Substance Use Disorder Records and Medicare Payment Models

On February 16, 2017, the Substance Abuse and Mental Health Services Administration ("SAMHSA") announced it will delay the effective date of its final rule on the confidentiality of substance use disorder records. The delay follows instructions from the Trump administration requiring a 60-day review period for rules which have not taken effect. The new effective date will be March 21, 2017.

The final rule, 82 Fed. Reg. 10863, may be read at: https://www.gpo.gov/fdsys/pkg/FR-2017-02-16/pdf/2017-03185.pdf.

Following the same instruction from the Trump administration, the Centers for Medicare & Medicaid Services ("CMS") announced on February 17, 2017 that it would delay the effective date of its final rule mandating bundled payment models for cardiac and orthopedic care. The new effective date will be March 21, 2017.

The final rule, 82 Fed. Reg. 10961, may be read at: https://www.gpo.gov/fdsys/pkg/FR-2017-02-17/pdf/2017-03347.pdf.

HIPAA Noncompliance Costs Children's Medical Center $3.2 Million

On February 1, 2017, the Department of Health and Human Services Office for Civil Rights ("OCR") announced that it had imposed a civil monetary penalty ("CMP") of approximately $3.2 million on Children's Medical Center of Dallas in Texas for failing to comply with Health Insurance Portability and Accountability Act ("HIPAA") security requirements over a number of years.

OCR issued a Proposed Notice of Determination to Children's Medical on September 30, 2016, notifying it of its right to request a hearing. Children's Medical failed to request a hearing, and as a result has no right to appeal the imposition of the CMP. OCR issued its Notice of Final Determination on January 18, 2017.

OCR cited the following actions as the basis for imposing the CMP on Children's Medical:

- Children's Medical failed to implement proper access controls, or properly document a rationale for a decision to implement such controls, for over two years;
- Children's Medical failed to implement specific policies and procedures for the removal of hardware containing ePHI from its facility;
- Children's Medical suffered two breaches of ePHI in 2010 and 2013, affecting almost 2,500 individuals;
- Children's Medical's failure to implement access controls even after having knowledge of noncompliance; and
- Children's Medical's prior history of noncompliance with the Privacy and Security Rules.

The ruling calculated the penalties imposed by classifying the violations in the "reasonable cause" penalty tier, resulting in a $1,000 minimum per violation.

The final ruling may be found at: https://www.hhs.gov/sites/default/files/childrens-notice-of-final-determination.pdf

MHS Pays $5.5 Million Settlement for HIPAA Violations

On February 16, 2017, the Department of Health and Human Services Office for Civil Rights ("OCR") announced that Memorial Healthcare Systems (MHS) agreed to pay a $5.5 million settlement for potential violations of the Privacy and Security Rules under the Health Insurance

Portability and Accountability Act ("HIPAA"). MHS, a nonprofit corporation that operates a number of hospitals and ancillary facilities across Southern Florida, has also agreed to implement a robust corrective action plan.

The settlement follows a report from MHS that the protected health information ("PHI") of 115,143 individuals had been impermissibly accessed by its employees and impermissibly disclosed to affiliated physician office staff. Workforce access policies and procedures were in place, however MHS failed to implement procedures with respect to reviewing, modifying and/or terminating users' right of access, and failed to regularly review records of information system activity on applications that maintain electronic PHI ("ePHI") by workforce users and users at affiliated physician practices. "Access to ePHI must be provided only to authorized users, including affiliated physician office staff" said Robinsue Frohboese, Acting Director of OCR. "Further, organizations must implement audit controls and review audit logs regularly. As this case shows, a lack of access controls and regular review of audit logs helps hackers or malevolent insiders to cover their electronic tracks, making it difficult for covered entities and business associates to not only recover from breaches, but to prevent them before they happen."

OCR's announcement of the settlement can be read at: https://www.hhs.gov/about/news/2017/02/16/hipaa-settlement-shines-light-on-the-importance-of-audit-controls.html.

DOJ and House Continue Delay of Challenge to ACA's CSR Program

On February 21, 2017, the Department of Justice and the General Counsel for the House of Representatives filed a joint motion to continue to delay a lawsuit challenging insurer payments under the Affordable Care Act's (ACA) cost-sharing reduction (CSR) program.

The initial lawsuit was filed in November 2014. The House of Representatives challenged the Obama administration's interpretation of ACA Section 1402, alleging the Department of Health and Human Services and the Treasury exceeded their constitutional powers by expending funds without Congressional appropriations. Section 1402 requires insurance companies to reduce certain beneficiary costs and authorizes the government to off-set those costs by making direct payments to insurance companies. The U.S. District Court for the District of Columbia held in favor of the House in May 2016 and the administration appealed. In December 2016, the appeals court agreed to continue the proceedings until February 21 to allow President-Elect Trump and his administration time to review and consider the appeal.

Supreme Court Declines to Review Transitional Policy Challenge

On February 21, 2017, the U.S. Supreme Court declined to review a challenge to the Affordable Care Act's (ACA) transitional policy. The initial lawsuit was brought against the Obama administration by the American Freedom Law Center in 2014. The suit alleged that the administration's transitional policy (which allows insurance companies to temporarily continue offering coverage through non-ACA compliant plans) and hardship exemption (which permitted certain individuals whose policies were cancelled to avoid paying the individual mandate penalty)

violated the Administrative Procedure Act and equal protection under the Fifth Amendment. The District Court dismissed the action, finding plaintiffs lacked standing and failed to establish a causal connection between the challenged policies and the increase in their premiums. The District of Columbia Circuit affirmed the decision on the same basis. (*American Freedom Law Ctr. v. Obama*, No. 15-5164 (D.C. Cir. May 13, 2016)). *American Freedom Law Ctr. v. Obama*, No. 16-635, cert. denied (U.S. Feb. 21, 2017).

Transitional Policy Extension for ACA Compliance

On February 23, 2017, the Centers for Medicare & Medicaid Services (CMS) extended the transitional period for policies in small group and individual health insurance markets to become compliant with the Affordable Care Act (ACA). Under the extension, states can allow issuers that have renewed policies under the transitional policy continually since 2014 to renew such coverage for a policy year beginning on or before October 1, 2018, so long as all such policies do not extend past December 1, 2018. In the February 23 bulletin, CMS explained it believes this approach will facilitate smooth transitions from transitional coverage to ACA compliant coverage, which requires a calendar year policy year in the individual market.

New Market Saturation and Utilization Data Tool Issued by CMS

On February 23, 2017, the Center for Medicare & Medicaid Services (CMS) issued a fourth-release of a market saturation and utilization data tool that includes interactive maps and a dataset that shows national-, state-, and county-level provider services and utilization data for selected health service areas. As explained by CMS in a February 2 fact sheet, an interactive map allows comparisons of provider services and utilization data by geographic regions. According to CMS, one objective of making these data public is to assist health care providers in making informed decisions about their service locations and the beneficiary population they serve. The data can also be used by CMS to monitor and manage market saturation to prevent fraud, waste, and abuse and to show the degree to which use of a service is related to the number of providers servicing a geographic region.

The tool is available through the CMS website at https://data.cms.gov/market-saturation.

President Trump Issues Latest Executive Order on Federal Regulations

On February 24, 2017, President Trump signed an executive order on "Enforcing the Regulatory Reform Agenda." The executive order requires every Federal agency to designate a Regulatory Reform Officer ("RRO") who will oversee the implementation of regulatory reform initiatives and policies to ensure that agencies effectively carry out regulatory reforms. Each agency is also required to organize a Regulatory Reform Task Force – headed by its RRO – which will evaluate existing regulations and make recommendations to the agency head regarding their repeal, replacement, or modification, consistent with applicable law. Regulatory Reform Task Forces are directed to focus on reforming regulations that eliminate jobs, or inhibit job creation, are outdated, unnecessary, or ineffective, or that impose costs that exceed their benefits.

The executive order can be read in full at: https://www.whitehouse.gov/the-press-office/2017/02/24/presidential-executive-order-enforcing-regulatory-reform-agenda.

GAO Finds that HHS Is Not Meeting Its Own Goals for Utilization of EHRs in Post-Acute Settings

On February 27, 2017, the Government Accountability Office ("GAO") released a report, titled "Electronic Health Records: HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings," concerning the U.S. Department of Health and Human Services' ("HHS") efforts to increase the use of electronic health records ("EHRs") in post-acute care settings.

HHS has implemented four key efforts aimed at increasing the use of EHRs: the provision of financial awards through the Office of the National Coordinator for Health Information Technology ("ONC"); Medicaid matching funds; ONC Certification of EHRs for post-acute care; and the Centers for Medicare & Medicaid Services ("CMS") data mapping and data element library.

GAO found that these efforts are designed to increase the use of health IT in general and the use of EHRs and electronic exchange of health information specifically in post-acute care settings, HHS has not measured the effectiveness of each of its efforts to promote the use of EHRs, and it lacks a comprehensive plan to meet its goal of increasing the proportion of post-acute care providers electronically exchanging health information. The report includes a recommendation from GAO that HHS (1) evaluate the effectiveness of its key efforts to increase the use of EHRs and electronic information exchange, and (2) comprehensively plan for how to achieve the department's goal regarding the use of EHRs and electronic information exchange in post-acute care settings.

The GAO report may be read in its entirety at: http://www.gao.gov/assets/690/682337.pdf.

OCR Newsletter Highlights Importance of Monitoring and Reporting Cybersecurity Threats

In its February 2017 newsletter, the U.S. Department of Health & Human Services Office for Civil Rights ("OCR") took aim at online threats to the privacy and security of electronic protected health information. In the letter, OCR highlighted the work of the United States Computer Emergency Readiness Team ("US-CERT"), a branch of the National Cybersecurity and Communications Integration Center within the Department of Homeland Security, which develops timely and actionable information on threats to the federal and state governments, critical infrastructure owners, international organizations, and private industry, and also responds to cybersecurity incidents and analyzes data it collects itself and from partners about emerging cyber threats. OCR is urging covered entities both to report cybersecurity incidents to US-CERT and to monitor US-CERT's website or email bulletins for reports on cybersecurity vulnerabilities.

Information of reporting cybersecurity incidents and threats can be found at US-CERT's website: https://www.us-cert.gov/report.

Covered entities can subscribe to US-CERT's various email lists at: https://www.us-cert.gov/mailing-lists-and-feeds.

CMS Releases Data on 2016 Medicare Advantage and Part D Program Audit Scores and Enforcement Actions

On March 1, 2017, the Center for Medicare & Medicaid Services ("CMS") released a report on the results of program audits of Medicare Advantage ("MA") and Part D sponsors conducted between October 2016 and February 2017. During this five-month period, CMS imposed civil monetary penalties ("CMPs") on 17 sponsors in amounts ranging from $28,975 to $2,498,850. CMS reported that the CMPs were imposed in response to failures to comply with one or more of the following Medicare requirements: Part D formulary benefit administration, or Part C or Part D organization/coverage determinations, appeals, and grievances. CMS also noted two important considerations in its report: (1) a sponsor's audit score does not necessarily correlate with the amount of the CMP or the determination to impose a CMP; and (2) the amount of the CMP does not automatically reflect the overall performance of sponsors.

The CMS report and audit scores can be found at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/HPMS_Memo_CMPs_2016_Program_Audits.pdf.

Data on the specific CMPs imposed can be found at: https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html.

OIG Alerts Consumers That Its Hotline Telephone Number Is Being Used in Scam

The U.S. Department of Health and Human Services Office of Inspector General ("OIG") recently issued a fraud alert confirming that its hotline telephone number is being used as part of a telephone spoofing scam targeting individuals throughout the country. These scammers represent themselves as OIG employees and can alter the appearance of the caller ID to make it seem as if the call is coming from the OIG Hotline phone number: 1-800-HHS-TIPS (1-800-447-8477). OIG reports that the perpetrators use various tactics to obtain or verify the victim's personal information, which can then be used to steal money from an individual's bank account or for other fraudulent activity.

OIG confirmed that it will not use the hotline telephone number to make outgoing calls and individuals should not answer calls from 1-800-HHS-TIPS. The public is encouraged to remain vigilant, protect their personal information, and guard against providing personal information during calls that purport to be from the HHS OIG Hotline telephone number, and should continue to call into the OIG hotline to report fraud. OIG encourages those who believe they may have been a victim of the telephone spoofing scam to report that information through the OIG hotline by calling 1-800-HHS-TIPS (1-800-447-8477) or emailing spoof@oig.hhs.gov.

The fraud alert can be read in full at: https://oig.hhs.gov/fraud/consumer-alerts/alerts/phone-scam.asp.

STATE DEVELOPMENTS

REMINDER:

- **Annual Reports for New Hampshire business entities are due to the Secretary of State by April 1, 2017.**

The NH Department of State Corporation Division is in the process of updating their databases.

NH Business Name lookup **after September 30, 2016** (NH QuickStart link)
(https://quickstart.sos.nh.gov/online/BusinessInquire)

If you have made a Corporation Division filing since October 1, 2016, the status will be displayed but you may not yet be able to view the filing documents online.

NH Business Name lookup **prior to September 30, 2016** (Legacy link)
(https://www.sos.nh.gov/corporate/soskb/csearch.asp)

Rules Governing Uniform Prior Authorization Receive Conditional Approval from JLCAR

On February 17, 2017, the Joint Legislative Committee on Administrative Rules conditionally approved the proposed rules for the Uniform Prior Authorization Form and Electronic Standard for Prescription Drug Benefits (NH Admin. Rules INS 2705). Health insurers, PBs and utilization review entities must begin using the form by December 31, 2017 but may begin using it on or after July 1, 2017.

The text of the rules may be found at:
https://www.nh.gov/insurance/legal/documents/ins2705_cond_appr_req_amend.pdf

Other relevant information including background information, instruction and a copy of the uniform form may be found at: https://www.nh.gov/insurance/legal/index.htm

New Hampshire Hospital Association Prevails in Case Involving Calculation of DSH Payments

On March 2, 2017, New Hampshire District Court Judge Landya McCafferty ruled in favor of the NH Hospital Association ("NHHA") and some of its member hospitals in a case involving the manner in which disproportionate-share hospital ("DSH") payments are calculated. The case arises out of a CMS posting on its web-site answering frequently asked questions in which CMS maintained that in calculating the hospital-specific DSH limit, a state much subtract payments received from Medicare and private insurers. The NHHA and its member hospitals contested this action stating that the Secretary of Health and Human Services and CMS acted in excess of their statutory authority in promulgating and enforcing the FAQs because the FAQs conflict with the unambiguous language of the Medicaid Act. CMS defended its action stating that the FAQ do not

conflict with the Medicaid Act and were a reasonable interpretation of the statute. The Court found in favor of the NHHA and hospitals concluding that even if the Secretary had the authority to interpret the statute to require the subtraction of private insurer and Medicare payments, doing so through FAQs, rather than through regulation, was an action in excess of statutory authority. In a separate count, the NHHA and its member hospitals alleged that the FAQs violated the Administrative Procedures Act ("APA"). Specifically, they alleged the FAQs substantially altered the obligations imposed by the existing regulations and were not promulgated using notice-and-comment rulemaking as required under the APA. The Court agreed finding that the promulgation of FAQs without rulemaking was in violation of applicable law. The Court had previously granted a preliminary injunction barring CMS from enforcing the policy set forth in the FAQs pending resolution of this matter.

The full decision may be found at https://www.hhs.gov/sites/default/files/february-2017-ocr-cyber-awareness-newsletter.pdf

New Hampshire to Receive Less Funding Than Expected Under 21st Century Cures Act

Original projections were that New Hampshire could receive approximately $10 million in funding to treat substance abuse issues in the state under the 21st Century Cures Act. Those projections were based on an understanding that funding would be based on the per-capita levels of overdose deaths in each state. New Hampshire, with its very high per capita rate of drug deaths, would have received additional funds, however, the methodology used by the Substance Abuse and Mental Health Services Administration ("SAMHSA") in the final formula is based on the total population. SAMSHA responded to inquiries about the methodology by stating that the formula was designed to target states with the highest number of overdose deaths and the greatest unmet need for treatment.

2017 Legislative Updates as of March 4, 2017

We are currently tracking the following Bills:

HB 157: This bill adds chronic pain to the qualifying medical conditions under therapeutic use of cannabis. **Status: House HHS Committee voted Ought to Pass.**

HB 158: This bill adds opioid addiction to the qualifying medical conditions under therapeutic use of cannabis. **Status: House HHS Committee voted Inexpedient to Legislate.**

HB 159: This bill adds fibromyalgia to the qualifying medical conditions under therapeutic use of cannabis. **Status: House HHS Committee voted Inexpedient to Legislate.**

HB 160: This bill adds post-traumatic stress disorder to the qualifying medical conditions under therapeutic use of cannabis. **Status: House HHS Committee voted Ought to Pass.**

HB 162: This bill establishes a procedure for the annulment of a mental health record. **Status:**

Science, Technology and Energy Committee voted Inexpedient to Legislate

HB 184-FN: This bill repeals RSA 328-J, the regulation of medical imaging and radiation therapy under the board of medical imaging and radiation therapy. **Status: House Executive Departments and Administration Committee voted Ought to Pass with Amendment. Amendment changes the bill from a repeal of the license requirement to an extension of the enactment date of the license requirement from July 1, 2017 to July 31, 2018.**

HB 197: This bill adds myelitis disorder or disease to the qualifying medical conditions under therapeutic use of cannabis**. Status: House HHS Committee voted Inexpedient to Legislate.**

HB 200: This bill authorizes heath care facilities and physicians to dispense medication and use equipment and therapies which are not Food and Drug Administration approved. **Status: Voted Inexpedient to Legislate by the House.**

HB 208: This bill establishes a commission to study current mental health procedures for involuntary commitment. **Status: Voted Out to Pass with Amendment by the House. Amendment added additional members to the commission.**

HB 222: This bill makes certain changes to the law regarding use of cannabis for therapeutic purposes, including broadening the definition of "qualifying medical condition." **Status: House HHS Committee voted Inexpedient to Legislate.**

HB 250: This bill establishes a commission to study the benefits and costs of a "health care for all" program for New Hampshire. **Status: House Commerce and Consumer Affairs voted Ought to Pass with Amendment. Amendment reduces commission from 16 members to 5 and adds additional questions for study.**

HB 256: This bill authorizes a person to self-order laboratory testing without a health care provider's request under certain circumstances. **Status: Voted Inexpedient to Legislate by the House.**

HB 291: This bill removes the requirement that the board of veterinary medicine adopt rules regarding prescribing opioids and that veterinarians query the controlled drug prescription monitoring program when prescribing such drugs. **Status: Voted Ought to Pass with Amendment by the House. Amendment did not substantially change the bill.**

HB 295: This bill repeals the prohibition against assigning medical payments under motor vehicle liability policies to health care providers. **Status: House Commerce and Consumer Affairs voted Inexpedient to Legislate.**

HB 321: This bill establishes a commission to study a public option program for health insurance in New Hampshire. **Status: House Commerce and Consumer Affairs voted Inexpedient to**

Legislate.

HB 322: This bill declares that certain licensing boards for health care providers may adopt rules to require completion of a certain survey as part of the license renewal process. This bill is a result of the commission established in 2016, 252. **Status: House Executive Departments and Administration voted Ought to Pass.**

HB 329: This bill establishes a committee to study balance billing by health care providers. **Status: House Commerce and Consumer Affairs voted Ought to Pass.**

HB 334: This bill exempts from licensure by the board of medical imaging and radiation therapy persons who perform sonography in certain circumstances. **Status: House Executive Departments and Administration voted Ought to Pass with Amendment. Amendment changes the exemption to an exemption from licensure for any "person who is regulated in another profession [and] acting within the scope of that person's license, registration, or certification."**

HB 361: This bill deletes the authority of the commissioner of the department of health and human services to adopt rules regarding certain child immunizations/vaccines. **Status: House HHS Committee voted Inexpedient to Legislate.**

HB 362: This bill declares that immunization/vaccine requirements shall not be established for diseases that are noncommunicable in a child care or school setting, including hepatitis B. **Status: House HHS Committee voted Ought to Pass with Amendment. Amendment limits the exemption simply to diseases that are noncommunicable, without regard to setting.**

HB 442: This bill prohibits employers from asking a job applicant about his or her criminal history prior to an interview. **Status: House Labor Committee voted Inexpedient to Legislate.**

HB 443: This bill prohibits prescription drug manufacturers from offering to pay or reimburse an individual for his or her insurance copayment. **Status: House Commerce Committee voted Inexpedient to Legislate.**

HB 455-FN: This bill prohibits pharmacy benefit managers from requiring providers to attain accreditation, credentialing, or licensing other than by the pharmacy board or other state or federal entity. **Status: House Commerce Committee voted Ought to Pass.**

HB 468-FN: This bill allows persons licensed as mental health practitioners in other states to practice in this state 60 days after application to the board of mental health practice, pending final approval. **Status: House Executive Departments and Administration voted Ought to Pass.**

HB 469: This bill requires licensed pharmacies to establish continuous quality improvement programs to identify weaknesses in processes and systems and make appropriate corrections. This

bill is a request of the pharmacy board. **Status: House HHS Committee and Executive Departments and Administration Committee both voted Ought to Pass.**

HB 471-FN: This bill requires the department of health and human services to publish an annual report consisting of an aggregate statistical summary of all induced terminations of pregnancy performed in New Hampshire. This report shall be available to the public. Data submitted by providers shall be for statistical purposes only and not public records. **Status: Retained in House HHS Committee.**

HB 472: This bill permits qualifying patients and registered caregivers to cultivate cannabis for therapeutic use. **Status: House HHS Committee voted Inexpedient to Legislate.**

HB 510: This bill declares that with the insured's permission, medical payments under a motor vehicle liability policy may be assignable to a health care provider. **Status: House Commerce Committee voted Inexpedient to Legislate.**

HB 511: This bill establishes a commission to study creating a public health oversight program within the department of health and human services. **Status: House HHS Committee voted Ought to Pass with Amendment. Amendment adds members to the commission and increases the scope of its study.**

HB 572-FN: This bill extends the suspension of prior authorization requirement for a community mental health program on drugs used to treat mental illness. **Status: House HHS Committee voted Ought to Pass.**

HB 575-FN: This bill allows the board of acupuncture to certify individuals as acupuncture detoxification specialists. **Status: House Executive Departments and Administration voted Ought to Pass with Amendment. Amendment clarifies requirements for board certification.**

HB 578-FN: This bill prohibits an abortion of a viable unborn child, except in cases of medical emergency. **Status: House Judiciary Committee voted Ought to Pass with Amendment. Amendment simplifies the bill's provisions.**

HB 589-FN: This bill repeals the law relative to providing certain parameters for access to reproductive health care facilities. **Status: House Judiciary Committee voted Inexpedient to Legislate.**

HB 596-FN: This bill permits a person who has been involuntarily committed to a treatment facility under RSA 135-C to request a review hearing every 2 years. **Status: Retained in House Judiciary Committee.**

HB 602-FN-A: This bill prohibits the placement of certain persons with mental illness in the secure psychiatric unit. The bill establishes a commission to develop plans and oversee the establishment

of a secure psychiatric hospital to treat such persons who would present a serious likelihood of danger to themselves or others. This bill also makes an appropriation for the purposes of the bill. **Status: Introduced and referred to House Judiciary Committee.**
HB 606-FN-A: This bill establishes a scholarship fund for health care providers who stay in New Hampshire for 5 years and makes an appropriation therefor. **Status: Voted Inexpedient to Legislate by the House.**

HB 611: This bill clarifies premium rates for individuals and small employers under the law relating to portability, availability and renewability of health care coverage. **Status: House Commerce Committee voted Inexpedient to Legislate.**

HB628-FN: This bill establishes a system of paid family and medical leave insurance. **Status: Retained in House Labor Committee.**

HB 630-FN-A: This bill establishes the state health information and analysis program. Under this bill, the commissioner of the department of health and human services, the insurance commissioner, the commissioner of the department of corrections, and the attorney general shall enter into a memorandum of understanding to collaborate in the development of publicly available information on health care system patient safety, cost, quality, access to coverage and care, system performance, and efficiency and information pertaining to the delivery and financing of the health care system in New Hampshire, including information on new health system projects and associated costs. The bill establishes a health information and analysis planning council to provide consultation for the development of a public data resource for New Hampshire. The bill also establishes a fund for the implementation and administration of the requirements of the program. **Status: Retained in House HHS Committee.**

HB 633-FN: This bill allows health insurance policies without mandates to be sold to New Hampshire residents. Under this bill, if the policy or certificate does not include certain mandated coverages, it must be submitted to the insurance commissioner for approval. **Status: House Commerce Committee voted Inexpedient to Legislate.**

HB 638-FN-LOCAL: This bill repeals the New Hampshire health protection program. **Status: House HHS Committee voted Inexpedient to Legislate.**

HB 650-FN: This bill makes various changes to the regulation of psychology practitioners including the requirements of the board of psychologists relating to investigation and hearings concerning disciplinary proceedings, the form of complaints against licensees, and the disclosure of patient records. **Status: House Executive Departments and Administration voted Ought to Pass with Amendment.**

SB 15: This bill adds a new qualifying medical condition for the purposes of receiving cannabis for therapeutic use**,** severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects. **Status:**

Voted Ought to Pass by Senate.

SB 17: This bill clarifies hepatitis C as a qualifying medical condition for the use of cannabis for therapeutic purposes. . **Status: Voted Ought to Pass by Senate.**

SB 26: This bill clarifies the definition of "facility caregiver" for purposes of the use of cannabis for therapeutic purposes law to include community living facilities certified under RSA 126-A:19 and RSA 126-A:20. **Status: Voted Ought to Pass by Senate.**

SB 54: This bill increases the number of hours of alcohol and drug use education required for initial licensure as a master license alcohol and drug counselor or as a licensed alcohol and drug counselor. **Status: Laid on Table by Senate.**

SB 59: This bill creates a process for certain individuals to request a blood testing order when they have been exposed to a source individual's bodily fluids. **Status: Voted Ought to Pass with Amendment by Senate. Amendment makes various changes.**

SB 61: This bill clarifies the procedure for receipt of medical records of a deceased spouse or next of kin. **Status: Introduced and referred to Senate HHS Committee.**

SB 65: This bill adds certain vaccines to the law which allows licensed pharmacists to administer vaccines including hepatitis A, hepatitis B, Tdap, MMR, and meningococcal vaccines. **Status: Introduced and referred to Senate HHS Committee.**

SB 126: This bill requires the public utilities commission to award funds from the renewable energy fund to hospitals with renewable energy projects. **Status: Introduced and referred to Senate Energy.**

SB 139: This bill modifies the requirements for licensure of magnetic resonance technologists by the board of medical imaging and radiation therapy. **Status: Senate Executive Departments and Administration voted Inexpedient to Legislate.**

SB 144-FN: This bill clarifies the definition of "qualifying medical condition" to include certain conditions which trigger certain medical symptoms. This bill also deletes the requirement that a medical provider document how the injury affects activities of daily living. **Status: Voted Ought to Pass with Amendment by Senate. Amendment clarifies the statements signed by applicants for a registry identification card.**

SB 146-FN: This bill requires the commissioner of the department of health and human services to develop a centralized state system for transporting persons subject to involuntary emergency admission. This bill is a result of the committee established in 2016, 101. **Status: Senate HHS Committee voted Ought to Pass. Senate Finance Committee voted Inexpedient to Legislate.**

SB 149: This bill authorizes individuals and certain businesses to purchase health insurance from out-of-state companies. The bill grants rulemaking authority to the insurance commissioner for the purposes of the bill. **Status: Introduced and referred to Senate HHS Committee.**

SB 150: Under this bill, a pharmacy intern under the direct supervision of a pharmacist may administer immunizing vaccines. **Status: Introduced and referred to Senate HHS Committee.**

SB 151: This bill prohibits a nursing facility from requiring that a patient sign a mandatory arbitration agreement. **Status: Introduced and referred to Senate HHS Committee.**

SB 152: This bill allows for temporary employment in a residential care facility or as a licensed nursing assistant by persons awaiting the results of a criminal history background check. **Status: Introduced and referred to Senate HHS Committee.**

SB 154: This bill allows pharmacies to dispense oral contraceptives to persons 18 years of age or older without a prescription. **Status: Introduced and referred to Senate HHS Committee.**

SB 155: This bill declares that step 2 of the Medicaid managed care program shall not be implemented until July 1, 2019. **Status: Introduced and referred to Senate HHS Committee.**

SB 156: This bill clarifies the process of paying for filling prescriptions for covered persons. The bill also adds authority for the pharmacy board to adopt rules for enforcement of requirements for the price of filling prescriptions. **Status: Introduced and referred to Senate HHS Committee.**

SB 157: This bill adds rulemaking for persons with substance use disorder for the purposes of the managed care law. This bill also requires health carriers to notify covered persons of their rights as a managed care consumer. **Status: Introduced and referred to Senate HHS Committee.**

SB 158: This bill declares that if substance use disorder services are a covered benefit under a health benefit plan, no prior authorization shall be required for prescribed medications for a substance use disorder. **Status: Introduced and referred to Senate HHS Committee.**

SB 159: This bill adds Ehlers-Danlos syndrome to the definition of "qualifying medical conditions" for the purposes of therapeutic cannabis. **Status: Introduced and referred to Senate HHS Committee.**

SB 189-FN: This bill requires insurance policies to cover 3-D tomosynthesis mammography. **Status: Introduced and referred to Senate Commerce Committee.**

SB 212: This bill adopts the physical therapy licensure compact, implemented by the physical therapy governing board. **Status: Voted Ought to Pass by Senate.**

SB 220-FN: This bill changes the definition of mental illness for the purpose of involuntary commitment to include ingestion of opioid substances. **Status: Introduced and referred to Senate HHS Committee.**

SB 236: This bill makes the Medicaid expansion law permanent. The program would currently expire December 31, 2018. **Status: Introduced and referred to Senate HHS Committee.**

SB 237-FN: This bill allows medical providers who practice in metropolitan areas to be reimbursed by Medicaid for telehealth services. **Status: Senate HHS Committee voted Ought to Pass.**

SB 238-FN: This bill clarifies the term "usual and customary price" for the purposes of filling prescriptions to mean the price an individual would pay for a prescription at a retail pharmacy if that individual did not have a prescription drug benefit or insurance. **Status: Introduced and referred to Senate HHS Committee.**

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Cinde Warmington, Kara J. Dowal, S. Amy Spencer and Alexander W. Campbell contributed to this month's Legal Update.

BIOS

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Cinde, a partner at Shaheen & Gordon, leads the Health Care Practice Group and focuses her practice entirely on representing health care clients. Her prior clinical and administrative experience makes her uniquely qualified to assist providers in facing a rapidly changing regulatory environment.

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