Legal Lens

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, associate director, supervised the contributions of Brandon Hall (J.D. anticipated 2019) and Valerie De Wandel (J.D./Ph.D. expected 2020).

COVERAGE AT WORK: THE SHARE OF NONELDERLY AMERICANS WITH EMPLOYER-BASED INSURANCE ROSE MODESTLY IN RECENT YEARS, BUT HAS DECLINED MARKEDLY OVER THE LONG TERM

National Health Interview Survey data shows that the share of workplace plan coverage for nonelderly individuals rose from 56.3 percent in 2013 to 58.4 percent in 2017. Over the last two decades, the share has declined even more, with the greatest reductions occurring among those with incomes under 400 percent of poverty. Factors including the improvement of the economy since the 2008-09 recession, and the ACA's "individual mandate" requirement are two causes that may have encouraged more Americans to enroll in employer coverage, with the law's employer mandate possibly boosting the availability of coverage for lower-wage workers. On the other hand, the availability of subsidies in the ACA marketplaces may have encouraged small employers to stop offering coverage, as they may not be subject to the law's employer mandate. Nevertheless, rising premiums have helped allocate a decline in individual market enrollment. Although an improving economy and individual mandate may have increased enrollment of job-based health insurance, it is foreseeable that a decrease in such enrollment will continue in the long-run. Chris Lee, *Henry J. Kaiser Family Foundation,* February 1, 2019. https://www.kff.org/health-reform/press-release/coverage-at-work-the-share-of-nonelderly-americans-with-employer-based-insurance-rose-modestly-in-recent-years-but-has-declined-markedly-over-the-long-term/

WHAT CALIFORNIA'S 2015 MEASLES OUTBREAK CAN TEACH US ABOUT VACCINE POLICY

Over the last few years, measles occurrences have been rising, with 70 documented cases in the Pacific Northwest in late February 2019. In 2015, the county in California where the outbreak occurred, was a location noted for high rates of non-medical exemptions for vaccination. In the recent Washington state outbreak, Clark County had an overall measles mumps-rubella (MMR) vaccination rate of just 83 percent in 2017 according to the state health department. More than two-thirds of the schools that reported had a coverage rate that was less than the necessary herd immunity level. California's new immunization policy has raised public policy and public health concerns for all states. One concern is that parental substitution of medical and non-medical exemptions and distribution of medical waivers should be monitored more closely to ensure they are allocated to those with priority. Additionally, as unvaccinated children seem to

be located mostly in areas of high rates of exemption, the concentration of exemptions should be monitored as well. Such supervision of the exemption process is necessary to maintain coverage and protect public health. *Policies for Action*, February 28, 2019. https://www.policiesforaction.org/blog/what-california%E2%80%99s-2015-measles-outbreak-can-teach-us-about-vaccine-policy

IS YOUR SLEEP APNEA MACHINE SNITCHING TO YOUR INSURER?

A loophole in the health data privacy law may allow doctor-ordered data of patients to be shared with insurers and other health companies. Manufacturers of heart monitors, glucose meters, and continuous positive airway pressure sleep machines were reported to have shared data to external companies without the consent of the user. While this may seem controversial, this data sharing was completely legal because those companies are not covered by HIPAA. According to Jordan T. Cohen, an associate with Mintz, Levin, Cohn, Ferris, Glovsky and Popeo P.C., "When an organization that is not regulated by HIPAA obtains health information, they do not have to comply with HIPAA's privacy protections that prohibit use and disclosure of the data." Due to this, patients are being encouraged to investigate the privacy policies of their medical devices before providing information to an entity not liable under HIPAA privacy law. Ayanna Alexander, *Bloomberg News*, March 20, 2019. https://www.bna.com/sleep-apnea-machine-n57982097106/

FEDERAL JUDGE AGAIN BLOCKS MEDICAID WORK REQUIREMENTS

For a second time in under a year, a federal judge has struck down the Trump administration's requirement that some Medicaid recipients work to obtain or maintain benefits. In the ruling, Judge James Boasberg held that the Department of Health and Human Services (HHS) acted arbitrarily and capriciously in approving the work requirements because HHS did not demonstrate how the imposed work requirements furthered a "core objective" of Medicaid. That core objective, Judge Boasberg ruled, is to provide "medical coverage to the needy." In two separate opinions, Judge Boasberg struck down Kentucky's and Arkansas' work requirements. Kentucky's requirements were set to take place just before the decision was made, and Arkansas had already implemented its work requirements, resulting in the loss of access to healthcare coverage for 18,000 enrollees. Further, the decision could have a ripple effect nationally. Currently, eight other states have passed Medicaid work requirement laws, and another seven are waiting on approval from HHS. However, those states, and HHS seem to be undeterred by the ruling, vowing to move forward with approval and implementation. Both states have also pledged to appeal the ruling. Phil Galewitz, *Kaiser Health News*, March 27, 2019. https://khn.org/news/federal-judge-again-blocks-medicaid-work-requirements/

FRANCISCAN ALLIANCE MUST DEFEND $320M PENSION LAWSUIT

A federal district court judge in Indiana hit on two hot button issues with one opinion. The first issue is whether pension plan participants have standing to sue over plan mismanagement that does not result in reduction or denial of promised benefits. A circuit split currently exists, with the Third, Fourth, and Fifth circuits denying standing to pension participants who allege mismanagement without corresponding benefit cuts. The Second circuit, has ruled the opposite. Judge Robert J. Miller, of the U.S. District Court for the Northern District of Indiana ruled that the Franciscan workers have standing because of alleged underfunding of Franciscan Alliance health system (Franciscan), and Franciscan's failure to obtain insurance against insolvency from the Pension Benefit Guaranty Corporation. Addressing the second significant issue in the opinion, Judge Miller ruled against dismissing a claim that Franciscan was exempt from the Employee Retirement Income Security Act of 1974 (ERISA) under the church plan exemption. Franciscan is one of many religiously-affiliated hospitals that have been accused of misusing ERISA's church plan exemption in order to underfund pension plans, in some cases, by hundreds of millions of dollars. A 2017 U.S. Supreme Court case broadening the scope of ERISA's church plan exemption left several remaining questions to be decided. In the case of Franciscan, Judge Miller opted not to rule in the health system's favor, instead, moving forward with claims of breach of ERISA's fiduciary duty requirements, as well as state breach of contract claims. Jacklyn Wille, *BNA*, March 28, 2019. https://www.bloomberglaw.com/document/X9K1HEBC000000?bna_news_filter=employee-benefits&jcsearch=BNA%252000000169c47ed97aade9c7fe1f4b0000#jcite

ASSOCIATION HEALTH PLAN RULING COULD RESULT IN THOUSANDS LOSING COVERAGE

A recent U.S. district court decision has invalidated a 2018 Department of Labor (DOL) rule (the Rule) permitting association health plans (AHPs), effective immediately, holding that the Rule ran afoul of both the Affordable Care Act (ACA) and the Employee Retirement Income Security Act of 1974 (ERISA). Under the Rule, associations and employers were permitted to band together to create AHPs. While there is some debate about whether the rule violates the ACA, there seems to be little debate that the Rule runs afoul of ERISA. In his holding, the district court judge held the Rule ignores the language and the purpose of both the ACA and ERISA. Further, the judge found the Rule "does violence to ERISA," and runs counter to "Congress's clear intent that ERISA cover benefits arising out of employment relationships." The decision is likely to disrupt the healthcare coverage of thousands, due to the existence of some 30-plus AHPs which are already providing coverage. However, it is not yet clear whether the Trump administration will appeal the decision, or what the next step(s) will be for those who relied on the AHPs, given the immediate effect of the judge's decision. Shelby Livingston, *Modern Healthcare,* March 30, 2019. https://www.modernhealthcare.com/insurance/association-health-plan-ruling-could-result-thousands-losing-coverage

SDNY HANDS SELF-INSURED HEALTH PLANS A TOTAL WIN

Self-insured health plan sponsors scored another big win recently, when the Southern District of New York (SDNY) recently upheld a plan's prohibition on assignments of benefits under the Employee Retirement Income Security Act of 1974 (ERISA). Courts have overwhelmingly held in favor of upholding the prohibition of assignment of benefit clauses, as reinforcing of ERISA plan language as supreme. The suit was brought by a group of out-of-network providers as a claim for benefits under ERISA 502(a)(1)(B) under the theory that out-of-network providers had derivative standing by obtaining from the patient/participants an assignment of benefits, a designation as authorized representative under ERISA, and a general power of attorney. United's plan language, however specifically prohibited assignments of benefits. The plaintiffs alleged that despite the plan's anti-assignment clause, United had waived such prohibition by (1) remitting payments directly to the plaintiff / providers; (2) sending notices of claim denials to the plaintiff / providers, and noting that the providers could appeal such denial if their patients had properly authorized them to do so; and (3) offsetting payments to the plaintiff / providers by overpayments. The SDNY held that none of the actions evidenced a clear manifestation of an intent to waive the anti-assignment clauses, and thus, the plan language was controlling. Thus, because the anti-assignment language was included in the documents and properly drafted, United prevailed. Mark Stember, JD Supra, April 3, 2019.
https://www.jdsupra.com/legalnews/sdny-hands-self-insured-health-plans-a-89228/

ECONOMIC RIPPLES: HOSPITAL CLOSURE HURTS A TOWN'S ABILITY TO ATTRACT RETIREES

The United States is once again facing a surge of rural hospital closures like the crisis of the 1980s. Since 2010, 104 rural hospitals have closed, with some 400 more at risk of insolvency and closure. These closures have obvious adverse impacts on rural populations' abilities to access health care, but the disastrous economic consequences that follow rural hospital closures have some communities on edge. Rural hospitals are often one of, if not the, largest employer with their communities. Further, rural communities tend to be older. And for retirement communities, such as Celina, Tennessee, a retirement town of about 1,500, the loss of its 25-bed hospital has served as a deterrent for future retirees, who are reluctant to face a 20-mile drive to the next available health care provider. The closure of the hospital means 147 nurses, aides and clerical staff must find new jobs. As the 11th rural hospital to close in Tennessee in recent years, the economic and health care impacts are becoming all too familiar. Blake Farmer, *Kaiser Health News*, April 10, 2019.
https://khn.org/news/economic-ripples-hospital-closure-hurts-a-towns-ability-to-attract-retirees/

NEW BENEFICIARIES ARE LEADING TO FINANCIAL WOES FOR HOSPITAL ACOs

Hospital-led accountable care organizations (ACOs) are facing increased financing challenges, in addition to heightened scrutiny from the Centers of Medicare and Medicaid Services (CMS) similar savings as their physician-led counterparts. According to

researchers with the University of Wisconsin Health, as Medicare beneficiaries develop more complex diseases, they are more likely to switch from a physician to a hospital-led ACO. Similarly, the Medicare Payment Advisory Commission found that beneficiaries who switched ACOs have higher health care spending than the market average. Last year, an analysis from CMS found that physician-led ACOs get net savings of $182 million but hospital ACOs have net losses of $231 million. Adding further pressure, CMS will implement a redesigned Medicare Shared Savings Program starting July 1, where an ACO must take on more risk or be kicked out of the program. The new program accounts for risk adjustment concerns, allowing a one-time benchmark increase of up to 3 percent to account for unexpected higher use. However, the National Association of ACOs has indicated that the study is the latest evidence that the 3 percent risk adjustment change is not enough and that hospital-led ACOs are potentially facing an insurmountable bias. Robert King, *Modern Healthcare*, April 15, 2019. https://www.modernhealthcare.com/finance/new-beneficiaries-are-leading-financial-woes-hospital-acos

STRUCTURAL RACISM- A 60-YEAR-OLD BLACK WOMAN WITH BREAST CANCER

As a result of racial disparity in health care, Chicago established the Metropolitan Chicago Breast Cancer Task Force in 2008. Local researchers had discovered an increasing gap between black women and white women in cancer-related mortality. When new breast cancer treatments became available, the breast cancer mortality rate among white women in Chicago decreased but less so for black women. Consequently, the task force sought to identify variation and gaps in the quality and access of breast cancer treatment and screening, rather than biologic differences. The task force noted that black women in Chicago were almost 40 percent less likely than white women to receive care at a highly rated breast cancer imaging center, leaving them more likely to have their cancer missed on screening exams. Kristen Pallok, B.S., Fernando De Maio, Ph.D., and David A. Ansell, M.D., M.P.H, *The New England Journal of Medicine*, April 18, 2019. https://www.nejm.org/doi/full/10.1056/NEJMp1811499?query=TOC