HEALTHCARE**LEGAL**NEWS

January 12, 2012 • Volume 2, Number 1

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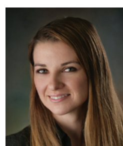
DW HEALTHCARE TEAM - NEWS & SUCCESS STORIES

Just Released - Brian Balow authored the *Allocation and Mitigation of Risk* chapter in the BNA E-Health Treatise, E-HEALTH, PRIVACY, AND SECURITY LAW, 2nd Ed. (Dec. 2011)

In December, 2011, Tatiana Melnik spoke on **HIPAA and Cloud Computing** at the opening of Online Tech's new data center in Ann Arbor, Michigan, from which Online Tech provides a cloud solution for healthcare companies.

Brian and Tatiana will be speaking on social media and healthcare at the National HIMSS Conference in Las Vegas in February 2012.

CMS ISSUED NEW HIPAA ELECTRONIC FUNDS TRANSFERS STANDARDS



By Tatiana Melnik, who is an associate in Dickinson Wright's Ann Arbor office, and can be reached at 734.623.1713 or tmelnik@dickinsonwright.com

On January 5, 2012, CMS issued an Interim Final Rule that specifies new standards under HIPAA for electronic funds transfers (EFT) and remittance advice transactions. Comments are due within 60 days after publication of this regulation, which is the second in a series of regulations to be issued over the next five years as required by Section 1104 of the Affordable Care Act's administrative simplification provisions to standardize electronic healthcare transactions. Once finalized, all covered entities must comply by **January 1, 2014.**

The common interchange structure standards adopted under HIPAA will minimize the industry's reliance on multiple formats for electronic data interchange (EDI). By creating greater uniformity in data exchange and reduction in the amount of paper forms needed for transmitting data, the administrative burden on covered entities will dramatically decrease. CMS estimates that as a result of this Interim Final Rule, covered entities could reduce administrative costs by up to $4.5 billion dollars over the next 10 years.

Despite the gains made since the passage of the initial EDI and EFT standards, healthcare policy makers determined that new EFT standards were required, in part, because the administrative burden in processing healthcare related transactions remains high. CMS, for example, cites a May 2010 study in the journal *Health Affairs* which found that physicians spend nearly 12 percent of every dollar they receive from

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patients to cover the costs of filling out forms and performing other excessively complex administrative tasks.

With the Interim Final Rule, HHS has adopted two standards for the healthcare EFT:

1. the CCD+Addenda implementation specifications in the 2011 National Automated Clearing House Association Operating Rules & Guidelines, and

2. the TRN Segment implementation specifications in the X12 835 TR3 for the data content of the Addenda Record of the CCD+Addenda.

CMS anticipates that healthcare EFT standards will have the most substantial cost and benefit impacts on commercial and government health plans, physician practices and hospitals. Specifically, health plans will have direct costs associated with implementing and using the standards due to required software upgrades and associated training. CMS anticipates that because physician practices and hospitals receive payments electronically and do not remit payments in this manner, these providers will incur little to no cost to implement the standards. Even so, physician practices and hospitals must upgrade billing software to address the new changes and staff members must be trained on the new standards.

Despite these initial and recurring costs, CMS estimates that over ten years, the savings for commercial health plans could be as much as $40 million and $31 million for Medicaid, the Children's Health Insurance Program and the Indian Health Service. Similarly, physician practices and hospitals should see savings of $3 billion to $4.5 billion over the next ten years as health plans implement the healthcare EFT standards.

Future administrative simplification rules will address adoption of a standard unique identifier for health plans, a standard for claims attachments, and requirements that health plans certify compliance with all HIPAA standards and operating rules.

HEALTHCARE REFORM NEWS

FINAL MEDICAL-LOSS RATIO RULE ISSUED BY CMS LEAVES CONCERNS OF INSURANCE BROKERS OUT IN THE COLD

By Rodney D. Butler, who is an associate in Dickinson Wright's Nashville office, and can be reached at 615.620.1758 or rbutler@dickinsonwright.com

As required by The Patient Protection and Affordable Care Act (PPACA), CMS issued on December 7, 2011, its Final Rule for medical-loss ratio requirements. Under PPACA, health insurance companies must spend a minimum percentage of premiums on healthcare; this requirement is better known as the medical-loss ratio. Specifically, PPACA requires that insurers in the individual and small group market spend at least 80% of premiums on medical care, and in large group markets, the requirement goes up to 85 percent.

CMS' "Interim Final Rule" from December, 2010, which was based upon recommendations from the National Association of Insurance Commissioners, did not permit the fees and commissions paid by health insurers to insurance brokers to be included in the percentage spent on medical care. However, insurance brokers had hoped that in its Final Rule, CMS would address the issue, especially in light of UnitedHealthcare's announcement that it would no longer pay commissions to brokers for policies sold to large employers in Texas and Florida.

Much to the dismay of insurance brokers, their concerns were not addressed in the Final Rule. In fact, the Final Rule does not address the subject at all.

In response to the Final Rule, the National Association of Health Underwriters and the National Association of Insurance and Financial Advisors have called upon Congress to pass corrective legislation in the form introduced in March 2011 in the United States House by Representatives Mike Rogers (R-Mich) and John Barrow (D-Ga) with 149 co-sponsors. The Access to Professional Health Insurance Advisors Act would exclude agent and brokerage fees from the medical-loss ratio calculation. Nevertheless, no action has been taken on this proposal after its referral to the House Subcommittee on Health shortly after its introduction.

Now that the Final Rule has failed to address the concerns of insurance brokers, it will be interesting to see if Congress moves forward with the proposed legislation or if other insurance companies follow the lead of UnitedHealthcare and stop payment of commissions to brokers. To further complicate matters, since 2012 is an election year and the US Supreme Court is scheduled to hear three days of oral argument regarding the constitutionality of PPACA in March, Congress may be reluctant to act in the near future. As a result, insurance brokers may continue to be left out in the cold until after the Supreme Court issues its decision in the judicial attack on PPACA or a new Congress and/or a new President address this issue in 2013.

REIMBURSEMENT NEWS

LATE CONGRESSIONAL ACTION STAVES OFF 27.4 PERCENT REDUCTION IN MEDICARE PHYSICIAN FEE SCHEDULE FOR TWO MONTHS

By Rodney D. Butler • rbutler@dickinsonwright.com

On December 23, 2011, by voice votes with no debate in either body, the United States House of Representatives and Senate passed a measure which delays for two months a 27.4% reduction in the Medicare Physician Fee Schedule that was set to take effect on January 1, 2012. This bill became law the very next day with the signature of President Obama.

Although the scheduled reduction in Medicare physician fees, which was announced by CMS in its Final Rule on November 1, 2011, is required under the Sustainable Growth Rate (SGR) formula, once again Congress has acted to delay the significant reduction in reimbursement rates.

However, the moratorium merely reset the effective date of the cuts from January 1, 2012 to March 1, 2012. As a result, future Congressional action will be necessary to prevent the considerable reduction in the Medicare physician fee schedule from taking effect. Although the current "fix" was piggybacked into the payroll tax cut extension legislation, it will be intriguing to observe whether Congress will be able to extend the physician fee schedule resolution through the end of 2012 or longer given the political climate and upcoming Presidential election. Unfortunately, physicians with a high Medicare patient population will continue to be caught in the middle until a long term solution is reached at both ends of Pennsylvania Avenue.

LITIGATION NEWS

FTC OPINION SUMMARY: IN THE MATTER OF THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS

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As a new year begins, it seems singularly appropriate that we write about the ever expanding intersection of antitrust and healthcare law.

The Federal Trade Commission (FTC) recently affirmed a ruling which found that a state dental board's practice of writing cease and desist letters to non-dentists who provided teeth whitening services violated Section 5 of the FTC Act. In *In re: North Carolina State Board of Dental Examiners*, the FTC held that the practice by the North Carolina State Board of Dental Examiners (Board) of writing cease and desist letters to non-dentists who offered teeth whitening services illegally thwarted competition and ordered the Board to stop engaging in this anticompetitive conduct.

In 2004, dentists in North Carolina first began to complain about the less expensive nature of teeth whitening services provided by non-dentists but rarely raised public health or safety concerns. In response, the Board sent cease and desist letters to non-dentist providers of teeth whitening services and landlords who leased them space in malls, kiosks and the like. The letters had the desired effect — non-dentist practitioners stopped offering the services, certain mall operators stopped leasing space for these services and several companies that had previously marketed teeth whitening products in North Carolina stopped marketing.

In its finding that there was no procompetitive justification for the Board's actions which resulted in higher prices and reduced choices for consumers, the FTC held:

- The Board's intent in sending the letters was to exclude non-dentist providers from the market for teeth whitening services;
- The Board's "health" or "safety" defenses were not cognizable defenses under the Sherman Act and even if they were, the Board provided no evidence to support such an assertion; and
- Under the rule of reason analysis, the Board's concerted conduct violated section 5 of the FTC Act.

The FTC also rejected the Board's defense of state action immunity by which it claimed that the "actions were both taken pursuant to a clearly articulated and affirmatively expressed state policy and actively supervised by the state itself". The Board did not provide any evidence of "active supervision" of its actions by the state and the "clear articulation" requirement was not met.

In its ruling, the FTC sent a strong message: absent clear articulation and ongoing state supervision, a state medical agency is not entitled to state action immunity from federal antitrust liability.

With this opinion, the FTC rings in 2012 by reinforcing the standard on state action immunity for state medical boards. It is likely that the FTC's increasing antitrust regulation and enforcement will continue in the healthcare arena throughout 2012.

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