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Health Care Regulatory and Legislative Update

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CBO Releases Score of House's American Health Care Act

On Wednesday, the Congressional Budget Office (*"CBO"*) released its Report estimating the direct spending and revenue effects of the American Health Care Act of 2017, H.R. 1628 (*"AHCA"*), as passed by the House of Representatives on May 4, 2017. Although the AHCA as written will not see a vote in the Senate, the CBO Report provides new fodder for debate as the Senate crafts its own health care reform legislation.

As widely reported, the CBO Report estimates that should the AHCA become law, over the next decade:

- the cumulative federal deficit would be reduced by $119 billion, and
- 23 million fewer Americans would have health coverage.

These two key financial analyses are not unexpected, as they are not far off from the CBO's analysis of the March version of the bill. More interesting is the Report's analysis of the effect of certain provisions added to the bill during last minute negotiations. Those provisions, which were added as "manager amendments" to the AHCA shortly before passage, allow states to waive certain Affordable Care Act (*"ACA"*) insurance requirements. One waiver would allow states to modify the ACA's essential health benefits (*"EHBs"*) requirements, which set forth the minimum categories of benefits an insurance plan must cover. A second type of waiver would allow states to opt-out of the "community rating" requirements of the ACA, which prohibit insurers from charging unhealthy people higher premiums than healthy people. The CBO estimates that about one-sixth of the population resides in states that would pursue the

waivers. As a consequence, the agency predicts that for those states, the bill would make insurance economically out of reach for some sick consumers and destabilize insurance markets. The Report explains:

> "people who are less healthy (including those with preexisting or newly acquired medical conditions) would ultimately be unable to purchase comprehensive nongroup health insurance at premiums comparable to those under current law, if they could purchase it at all—despite the additional funding that would be available under H.R. 1628 to help reduce premiums. As a result, the nongroup markets in those states would become unstable for people with higher-than-average expected health care costs. That instability would cause some people who would have been insured in the nongroup market under current law to be uninsured. Others would obtain coverage through a family member's employer or through their own employer." (See page 5 of the Report)

Because continued coverage for those with preexisting medical conditions has been a stated goal for policymakers on both sides of the aisle, this portion of the CBO Report will likely be a major talking point in the Senate's health care reform debate.

United States Files Second False Claims Act Complaint against UnitedHealth This Month

On May 16, 2017, the Department of Justice (*"DOJ"*) announced that it had filed its second False Claims Act (*"FCA"*) complaint against UnitedHealth Group Inc. (*"UHG"*) this month, alleging that UHG knowingly obtained inflated risk adjustment payments for its Medicare Advantage Plans beneficiaries and did not refund the overpayments as required by the FCA. According to the DOJ press release, UHG is the nation's largest Medicare Advantage Organization (*"MAO"*), with more than 50 Medicare Advantage and Drug Prescription plans providing healthcare services and prescription drug benefits to millions of Medicare beneficiaries throughout the United States. As an MAO, UHG receives a monthly "risk adjustment" payment from Medicare for each enrolled beneficiary. The risk adjustment payments are based, in significant part, on the health status of the beneficiary. The DOJ complaint alleges that UHG knowingly disregarded information about beneficiaries' medical conditions, which increased the risk adjustment payments UHG received from Medicare. In particular, the DOJ alleges that UHG conducted medical chart reviews to identify additional diagnoses not reported by treating physicians in order to increase risk adjustment payments, but ignored when those same chart reviews uncovered invalid diagnoses in order to avoid returning overpayments to the Medicare program.

UHG plans to defend both FCA suits and has separately filed its own lawsuit against the government challenging the federal regulation requiring Medicare Advantage program plans to report and return overpayments within 60 days or expose themselves to FCA liability.

Missouri Hospital and Clinic to Pay $34 Million to Settle Allegations That Compensation Paid to Oncologists Violated the Stark Law

On May 18, 2017, the Department of Justice (*"DOJ"*) announced that it had entered into a $34 million settlement agreement with Mercy Hospital Springfield (*"Hospital"*), and its affiliate Mercy Clinic (*"Clinic"*), both of Springfield, Missouri. The settlement resolves allegations that the Clinic violated the Stark Law by

compensating twelve Clinic oncologists in a manner that took into account the volume and value of the oncologist' referrals to the Hospital's infusion center. The DOJ contends that due to the Stark Law violations, the defendants also violated the False Claims Act (*"FCA"*) by submitting false claims to the Medicare program for infusion services rendered to patients who were referred by the Clinic physicians to the Hospital's infusion center. The FCA complaint was originally filed by an employed physician under the whistleblower provisions of the FCA. The physician will share in $5.4 million of the settlement.

According to the whistleblower's unsealed complaint the improper physician compensation arrangements arose after ownership of the infusion center was transferred from the Clinic to the Hospital in order to generate savings on the cost of chemotherapy drugs through the federal 340B drug pricing program. The complaint alleges that after the ownership transfer, in response to Clinic physicians' concerns that they would lose a substantial portion of the income they had received under the Clinic's collections-based compensation model, the Hospital paid the physicians for infusion services an amount in excess of the physician work or overhead so they would be "made whole" for any income they stood to lose as a result of the ownership transfer. The defendants have also entered into a corporate integrity agreement in connection with the settlement.