OF NOTE

Placement of Migrant Children with Human Traffickers

In February, a *Washington Post* editorial argued that the Office of Refugee Resettlement, part of the U.S. Department of Health and Human Services, needs to clarify who is responsible for monitoring the welfare of unaccompanied migrant children while they await their immigration hearings. A Senate report confirmed that at least six children were placed by HHS in a trafficking ring at an egg farm in Trillium, Ohio. The same report documented 13 other cases of migrant children being placed in trafficking situations with 15 more cases showing some evidence of trafficking. HHS has strengthened its background-check process but states they are not accountable for the care of the children once they are placed in a home. The HHS believes the care and safety of the minors in placement is the responsibility of state and local child protection agencies. "Handing Minors Over to Human Traffickers", The Editorial Board, *Washington Post*, February 6, 2016 https://www.washingtonpost.com/opinions/handing-minors-over-to-human-traffickers/2016/02/06/c74812f4-c938-11e5-88ff-e2d1b4289c2f_story.html

Statistics on Human Trafficking

An article, published by the *Catholic News Agency,* reported the following statistics from the U.S. Department of Justice: 83 percent of victims in confirmed sex trafficking incidents are U.S. citizens; 67 percent of labor trafficking victims are undocumented immigrants; and 28 percent of labor trafficking victims are documented immigrants. Tina Frudnt, a survivor of human trafficking and founder of the survivor-run program, Courtney's House, warns that victims are usually 11 to 14 years old. Traffickers approach young children as friends and slowly manipulate them into dangerous situations. For victims of labor trafficking, it is easily hidden as the jobs appear very similar to a common workplace situations in the beginning. Slowly, working conditions worsen and mistreatment becomes the norm. Catholic Relief Services and the U.S. Conference of Catholic Bishops have both partnered with the U.S. State Department to protect victims and prevent trafficking. "What You Think You Know about Human Trafficking Is Probably Wrong", *Catholic News Agency*, February 11, 2016 http://www.catholicnewsagency.com/news/what-you-think-you-know-about-human-trafficking-is-probably-wrong-55418/

Lower Drug Prices Found Through Online Tools

Across zip codes and pharmacies, prices of generic drugs can vary vastly, but without access to published prices consumers do not know if they are receiving a fair price. Two websites, GoodRx and Blink Health, are making prescription drug prices available to the public. These sites are offering prices that are usually only available to insurers. GoodRx shows prices for generic drugs at various pharmacies and connects consumers to coupons. Blink Health not only shares prices but allows patients to buy online and pick up at local pharmacies. This is beneficial to the uninsured who are paying higher prices and those who have insurance plans that require a flat fee for prescription drugs, usually $10. Purchases made through these sites do not include name brand drugs and usually do not count toward insurance deductibles. Express Scripts, the nation's largest drug-benefits manager, recognizes that these sites could help some consumers save money but believes most consumers save more using insurance. "New Online Tools Offer Path to Lower Drug Prices", Katie Thomas, *The New York Times*, February 9, 2016 http://www.nytimes.com/2016/02/10/business/taming-drug-prices-by-pulling-back-the-curtain-online.html?_r=0

OF NOTE

HHS Considering Action on Drug Patents to Control High Prices

A recent article on *The Hill* (www.thehill.com) addresses prescription drug prices. In January, 50 House Democrats sent a letter to the HHS urging them to issue guidelines on administrative action surrounding a rule that could lower drug prices. As part of a 1980 law, when federally-funded research was involved in creating a new drug, the HHS can break the patent to lower the price if they rule the drug is not made "available to the public on reasonable terms." At this time there are not guidelines for when and how this power can be used. "HHS Considering Action on Drug Patents Over High Prices", Peter Sullivan, *The Hill*, February 10, 2016 http://thehill.com/policy/healthcare/269003-hhs-considering-action-on-drug-patents-over-high-prices

One Health System's Plan to Lower Health Care Costs

Intermountain Healthcare, a nonprofit health system in Salt Lake City, created a new health plan, SelectHealth Share, which guarantees to hold yearly rate increases to one-third to one-half less than other employers. Intermountain recognizes there are financial risks if patients require a lot of expensive care. Therefore, they are focusing on the most costly patients by creating a special clinic to serve the sickest patients. At this time, the clinic is open to serve 1,000 chronically ill patients but only has 140 enrolled. Intermountain believes the clinic is promising but will not have information to share publically until this summer. Intermountain has also agreed to care for a third of its patients for a fixed amount which requires careful monitoring of patients' health to keep expenses at a minimum. In order for this to work, Intermountain acknowledges that everyone has to play their role. Doctors have to agree to use electronic medical records and share outcomes. Employers must offer affordable plans and a health savings account. Employees are required to participate in health risk assessments and health screenings to ensure early detection. "A Novel Plan for Health Care: Cutting Costs, Not Raising Them." Reed Abelson, *New York Times*, February 17, 2016 http://www.nytimes.com/2016/02/18/business/a-novel-plan-for-health-care-cutting-costs-not-raising-them.html

Are Americans 'Gaming' Obamacare?

In a recent *LA Times* column, Michael Hiltzik reported on claims that Americans are "gaming" Obamacare by gaining access to insurance only when they get sick. The HHS recently asked insurers to provide data about high-cost individuals enrolling during special enrollment periods (SEPs). Most insurers provided comments but none of those reviewed by Hiltzik reported empirical data. SEPs can include life events such as marriage, divorce, or birth of a child. Other nontraditional SEPs include becoming a U.S. citizen, moving to a new state, or becoming eligible for subsidies. Hiltzik reports that studies by the Urban Institute and the University of Michigan found a large number SEPs eligible consumers (about 85 percent) do not enroll. Insurance providers want to make SEPs shorter and require more documentation but this may only increase the number of sicker patients using SEPs. If the process is too complicated, consumers who do not need immediate care, such as the young, will not follow through. Only the sickest will complete a difficult process because they have the highest need for health care. "More Signs That 'Gaming' By the Sick Is Not a Problem in Obamacare." Michael Hiltzik, *LA Times*, February 17, 2016 http://www.latimes.com/business/hiltzik/la-fi-mh-

gaming-by-sick-americans-is-not-a-problem-in-obamacare-20160217-column.html

The State of Rural Hospitals: Closing and At-Risk

Health care costs are driving some rural hospitals to close their doors. In a recent article on *Becker's Hospitals Review*, Ayla Ellison reports 15 things to know about rural hospital closures. Over 60 rural hospitals closed since 2010 and more than 673 rural hospitals are in danger of closing. Of those in danger, sixty-eight percent are critical access hospitals. It was found that rural hospitals in southern states and facilities in states that have not expanded Medicaid are more vulnerable to closing. States that have extended Medicaid experience a 50 percent drop in care administered to patients without health insurance, according a study from the University of Michigan in Ann Arbor. The closing of hospitals has many different effects on the community. If all 673 rural hospitals were to close, 99,000 healthcare jobs and an estimated $277 billion would be lost, according to iVantage. "The Rural Hospital Closure Crisis: 15 Key Findings and Trends." Ayla Ellison, *Becker's Hospital Review*, February 11, 2016 http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html

Palliative Care Benefits for All Patients

Palliative care became a medical specialty in 2007 and today more than 70 percent of hospitals offer palliative care services. Palliative care focuses on quality of life, emotional and spiritual needs of the patient and caregivers, treatments to ease symptoms and help in documenting a patient's preferences for medical care. Palliative care can be used at any point in the illness without stopping curative treatment. Sometimes palliative care is confused with hospice and thus avoided by patients who could benefit from its services. Dr. Eric Widera, from U.C.S.F Cancer Center, explains, "We hear this all the time: 'They're not ready for palliative care,' as if it's a stage people have to accept, as opposed to something that should be a routine part of care." Several studies have shown that people who use palliative care services score higher on quality of life measures, are less likely to suffer from depression, spend less time in intensive care units and report greater satisfaction with care. "In Palliative Care, Comfort Is the Top Priority," Paula Span, *New York Times*, February 12, 2016 http://www.nytimes.com/2016/02/16/health/in-palliative-care-comfort-is-the-top-priority.html

Canadian Palliative Care Center Rejects Doctor-Assisted Suicide

Bruyère Continuing Care, a publically funded Catholic health institution and Ottawa's biggest palliative care hospital, will not offer doctor-assisted suicide to eligible patients. The Catholic Health Sponsors of Ontario said doctor-assisted suicide will not be offered in their institutions, "nor will we directly or explicitly refer a patient to receive this same medical procedure." Death with Dignity Canada responded saying "we believe that all publically funded institutions, including Catholic hospitals, hospices and health authorities need to respect Canadians' charter rights for assisted death if the person meets the eligible criteria." Catholic Health Sponsors of Ontario's president and chief executive John Ruetz emphasizes that Ontario's Local Health System Integration Act which "makes it clear that no health care organization will be obligated to provide a health service that is contrary to its religious beliefs." Although the act states that physicians in Ontario are governed by the College of Physicians and Surgeons of Ontario which created a draft of guidelines on doctor-assisted suicide, the draft requires doctors refer patients without delay. As a federal law is expected in early June allowing doctor-

assisted suicide, publically funded Catholic facilities rules concerning doctor-assisted suicide will be challenged.
"Catholic Hospital, the Biggest Palliative Care Centre in Ottawa, Says It Won't Offer Doctor-Assisted Death." Elizabeth Payne, *National Post*, March 1, 2016
http://news.nationalpost.com/news/canada/catholic-hospital-the-biggest-palliative-care-centre-in-ottawa-says-it-wont-offer-doctor-assisted-death

Houston Prepares for Zika

As the Zika virus spreads throughout Latin America, some U.S. cities are preparing for its arrival. One such city is Houston, Texas. Pete Hotez, the dean for the National School of Tropical Medicine at Baylor College of Medicine, sees Houston as the perfect breeding ground for the virus. Houston has a steady flow of people arriving from other countries at their major international airport. Houston also has high numbers of mosquitos in the summer which can carry the Zika virus. Lastly, Zika is a disease of poverty. Less affluent neighborhoods have more trash on the streets which hold standing water and those spots become places for mosquito larvae to thrive. The city, county and state plan to prevent the spread of Zika through careful monitoring at the airport and more frequent trash pickup. The area officials are asking the citizens to help by removing trash that holds standing water and seeking immediate medical attention for any symptoms of the virus. "Houston Prepares Now for Zika's Potential Arrival This Summer," Joe Palca, *NPR*, March 21, 2016
http://www.npr.org/sections/health-shots/2016/03/21/470683503/houston-prepares-now-for-zikas-potential-arrival-this-summer

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, assistant director, supervised the contributions of health law students Ashtyn Kean (JD anticipated 2017) and Merlow Dunham (J.D./M.H.A. anticipated 2019).

When Fear Becomes an Unintended Public Health Problem

At a time when health crises are common occurrences in daily headlines, such as the Zika virus in 2016 and the Ebola outbreak in 2014, public health authorities are urged to alert the public, not alarm. This balance is especially needed due to the growing trend in people turning to social media, friends and politicians for health sources, as opposed to more accurately informed medical professionals and public officials. The days of organized press conferences by National Institute of Health and Centers for Disease Control officials seem to be long gone, drowned out by those seeking their five minutes of fame. The Ebola outbreak in 2014 revealed this concerning trend, as tweets, talk show hosts and online commentary dominated the news stream, as opposed to professors, public health officers, physicians and government officials like in earlier years. This trend resulted in widespread public ignorance regarding virus transmission, as medically inaccurate and unproven falsities spread by politicians and otherwise overshadowed scientists' retorts. These falsities led medical center communication teams to have to "play defense" against those articulating incorrect information in order to quell needless alarm instigated by the media and elsewhere. This article continues to vouch for "measured and precise" messages to the public, like that of World Health Organization Director-General Margaret Chan's announcement regarding the Zika virus as a "public health emergency," as well as President Obama's reassuring message on *CBS This Morning* thereafter.

Doug Levy, *National Public Radio*, Feb. 19, 2016 http://www.npr.org/sections/health-shots/2016/02/19/467123373/when-fear-becomes-an-unintended-public-health-problem

Many Dislike Health Care System but Are Pleased With Their Own Care

A poll conducted by NPR, the Harvard T.H. Chan School of Public Health, and the Robert Wood Johnson Foundation has indicated that only one third of the American public say their health care is "excellent," even though the United States has the most advanced health care in the world. Even fewer than that one-third is impressed with the American health care system as a whole. Interestingly, the poll indicated that 80 percent of Americans say they receive "good or excellent" care, but subsequently rate their respective state's health care system as "fair or poor." Dr. Georges Benjamin, executive director of the American Public Health Association, opines that this distinction between personal health care satisfaction and system-wide dissatisfaction is an "amazing kind of schizophrenia about our system;" essentially that while the U.S. delivers the best medicine and nursing in the world, our system is "wildly complex and hard to navigate," thus resulting in personal approval but system-wide disdain. Subsequently, Sarah Dash, vice president for health policy at the Alliance for Health Reform in Washington, D.C., states that health care is designed for the health care system and doctors, not for patient needs and efficiency, as evidenced by repeat tests, lack of results, and multiple doctor visits. These inefficiencies promote system-wide discontent. The poll further indicated that quality of care can be heavily dependant on a patient's income: "[a]dults with incomes below $25,000 a year are about three times as likely as higher income people — 34 percent versus 13 percent — to say the health care they personally receive is only fair or poor." Likewise, while the Affordable Care Act includes a number of pilot projects aimed at cheaper and improved patient care, little has changed since its implementation. The poll indicates "74 percent of people believe their health care has stayed about the same since the ACA was implemented. And for the minority who've seen a change, about 14 percent say their care is better while 9 percent say it's worse." Alsion Kodjak, *National Public Radio*, Feb. 29, 2016 http://www.npr.org/sections/health-shots/2016/02/29/468244777/many-dislike-health-care-system-but-are-pleased-with-their-own-care

Health Apps May Pose Major Privacy Concerns

New research has begun to suggest that mobile health apps aimed at tracking personal information regarding health, fitness, and specific medical conditions are posing serious privacy concerns. A study published in the *Journal of the American Medical Association* has found that many of these health apps are transmitting sensitive medical information to third parties, aggregators and advertising networks. Such sensitive medical information includes disease status and medication compliance. Researchers from the Illinois Institute of Technology Chicago-Kent College of Law compiled all available Android diabetes apps' privacy policies and permissions on which to base this study. By installing a random selection of the apps, the researchers determined whether data were transmitted to third parties (any website not directly under the developer's control). 211 of the apps remained available after six months, and 80 percent of these apps had no privacy policies. Further, not all of the provisions contained in those 41 apps containing privacy policies actually protected privacy. More than 80 percent of those 41 collected user data, almost 50 percent shared data, and only four policies said they would ask for permission from the user to share data. Another study by the same authors, containing an analysis of 65 diabetes apps, indicated that sensitive

information, such as insulin and blood glucose levels, was routinely collected and shared with third parties. As such, the authors of these studies note that these apps' collection and sharing of sensitive health information is not generally prohibited by law, and therefore urge caution for those using them. Ashley Welch, *CBS News,* March 8, 2016 http://www.cbsnews.com/news/health-apps-may-pose-major-privacy-concerns/

Hacking of Health Care Records Skyrockets

Health care record hacking is up 11,000 percent in the last year alone, and amounts to 100 million records stolen. While most are entirely unaware, roughly one out of every three Americans has had their health care records compromised. Many of these hacked and stolen records appear on the "dark web," where hackers advertise their records openly. Medical records are a gold mine and provide a lifetime of information, including the patients' name, address, social security number and medical conditions. Unlike credit cards, which sell for $1-$3 on the dark web, and social security numbers, which go for $15 each, health care records, sold at $60 a piece, cannot be quickly cancelled. Hackers and criminals can use these records to do just about anything, including ordering prescriptions, paying for treatments and surgeries, and filing false tax returns. For instance, John Kuhn, a recent hack victim, was billed $20,000 for a surgery he never had after a hospital visit for a simple x-ray. Kuhn's medical records were stolen, along with the hospital's hard drive. Kuhn was able to demonstrate to the hospital's billing department that he never received the surgery by showing his lack of a scar on his belly, though other victims are not so lucky. For this reason and more, security officials, and Kuhn himself, advise free credit monitoring, understanding security policies, following good password practice, using email variations and pin codes, and avoiding giving out your social security number to hospitals and doctor's offices. Tom Costello, *NBC News,* Feb. 13, 2016 http://www.nbcnews.com/news/us-news/hacking-health-care-records-skyrockets-n517686

The End of Prescriptions as We Know Them in New York

On March 27, New York became the first state to require all prescriptions be created electronically – a requirement that will be backed up with penalties for physicians who fail to comply, including fines and imprisonment. Minnesota has a similar law requiring electronic prescriptions, but does not mandate punishment for non-compliance. The law comes from a 2012 state law known as I-Stop, which was designed to decrease prescription opiod abuse, a problem that has become enormous in New York. According to the State Health Department, there were more controlled-substance prescriptions written from 2013-2014 than there were residents in the state – 27 million versus 20 million. Further, in 2004, there were 341 opiod-related deaths in New York, as compared to 1,227 in 2013. The first major component of I-Stop is an online registry that a physician must check before prescribing a controlled medication, which was implemented in 2013. The second major component is the transition to electronic prescriptions, and is intended to reduce fraud and mistakes caused by misinterpreted handwriting. New York's Attorney General Eric T. Schneiderman helped write the legislation, and states that "[p]aper prescriptions had become a form of criminal currency that could be traded even more easily than the drugs themselves… By moving to a system of e-prescribing, we can curb the incidence of these criminal acts and also reduce errors resulting from misinterpretation of handwriting on good-faith prescriptions." The shift has not appeared to cause too many difficulties for hospitals and nursing homes to adopt thus far, and even some health care providers

are relieved to be saying goodbye to the prescription pad. Sharon Otterman, *The New York Times*, March 14, 2016 http://www.nytimes.com/2016/03/15/nyregion/new-york-to-discard-prescription-pads-and-doctors-handwriting-in-digital-shift.html?ref=health

Major Companies Form "Health Transformation Alliance" to Reduce Health Care Costs

Twenty companies–including IBM, Coca-Cola, and Verizon–formed the "Health Transformation Alliance," which will share health spending and patient outcomes data in an effort to reduce health care costs. The Alliance covers about four million people and plans to use its data findings to change how the companies contract for employee health care, potentially by forming a purchasing cooperative to negotiate for lower prices with providers that have better outcomes in treating certain sicknesses. The new big-employer initiative was devised by the American Health Policy Institute, a think tank focused on developing employer strategies to provide affordable care to employees and headed by Tevi Troy, a top health official in the George W. Bush administration. While several big employers like Sears Holdings Corp. have experimented with creating their own private health exchanges, some members of the Alliance have been skeptical of such approaches, arguing that they have demonstrated modest savings at best. The formation of the Alliance demonstrates an innovative way that companies can use their collective data and market power in a bid to lessen the financial burden of increasing health care costs. Louise Radnofsky, *The Wall Street Journal*, Feb. 4, 2016 http://www.wsj.com/articles/companies-form-health-insurance-alliance-1454633281

CMS Publishes the Long-Awaited 60-Day Repayment Final Rule

Six years after the authorizing statute and four years after the Proposed Rule was issued, CMS has published the long-awaited Final Rule regarding reporting and returning Medicare Part A and B overpayments. Since the inception of section 6402(a) of the Affordable Care Act, there has been confusion among providers, regulators, and courts regarding the requirements and impact of Social Security Act section 1128J(d), which mandates that a person must report and refund a Medicare and Medicaid overpayment within 60 days the overpayment was "identified" or the cost report is due. Confusion centered on the duration of the look-back period and what it means to "identify" an overpayment, which the Final Rule clarifies. The Final Rule officially establishes a 6-year look-back period, as opposed to the 10-year look-back period offered in the Proposed Rule. The 6-year look-back period is not retroactive and is effective March 14, 2016. Also, the Final Rule states that providers have an obligation to exercise "reasonable diligence" through "timely, good faith investigation of credible information," including both proactive and reactive reviews of Medicare billing. This period of reasonable diligence may take "at most six months from receipt of credible information, absent extraordinary circumstances," such as complex investigations involving a Stark Law violation. An overpayment is not considered "identified" until the refund amount has been "quantified." After the timely investigation period, the 60-day clock starts running.

Failure to make reasonable diligence efforts, including not conducting diligence with deliberate speed after receipt of credible information, or failure to otherwise comply with this rule is treated as a violation of the federal False Claims Act. The Final Rule is effective March 14, 2016, is not retroactive, and applies to Medicare Part A and Part B providers and suppliers. No final rule has been published that addresses Medicaid requirements. Torrey Young, Jana Kolarik

Anderson, and Lawrence Vernaglia, *The National Law Review*, Feb. 17, 2016 http://www.natlawreview.com/article/who-what-and-when-cms-final-60-day-rule

Medicare Experiments with a New Reimbursement System for Drugs to Fight Problematic Incentives

In the current health care system, Medicare asks that physicians buy the drugs they prescribe to their patients, and Medicare reimburses the physicians the average sales price of the drugs plus a 6 percent bonus to cover their administrative costs. Analysts have determined that this policy creates a potentially problematic incentive for doctors. Medicare announced that it will use the Affordable Care Act to test a new reimbursement system, to see if reducing the financial incentives for prescribing expensive drugs results in different drug prescribing choices. In this sort of randomized experiment, physicians in certain places will receive 2.5 percent of the cost of the drug plus a flat fee to cover administrative costs. The aim of this reimbursement system is to narrow the payment gap between different drugs and determine if new payment incentives can lead to more rational, and perhaps less expensive, prescribing behavior. Over time, the spending and health outcomes for Medicare patients in the places testing the new policy and those who continue with the old policy can be compared for findings. While health care facilities that prescribe both cheap and expensive drugs will likely not experience a huge financial change, such as most community doctors and large hospitals, doctors who tend to pay above-average prices for drugs may see financial struggle, such as small, independent practices. The pharmaceutical industry is concerned that this new policy may direct physicians away from newer drugs, cutting into their sales. If pharmaceutical companies raise the price of drugs, the price increases could financially hurt physicians because of the time lapse between when prices in the market shift and when the government starts paying the new prices. Margot Sanger-Katz, *TheUpshot*, March 10, 2016 http://www.nytimes.com/2016/03/10/upshot/medicare-tries-an-experiment-to-fight-perverse-incentives.html?ref=policy

Medically Assisted Suicide Permitted in California Starting in June

The End of Life Option Act will go into effect June 9 in California, allowing physicians to prescribe lethal doses of medication to terminally ill patients who want to hasten their deaths. The California Medical Association has released guidelines for the process, including that two physicians must agree the patient has less than six months to live before prescribing the life-ending medication, and the patient must make two verbal requests at least fifteen days apart and one written request that is signed, dated, and witnessed by two adults within forty-eight hours of self-administering the medication. California is the fifth state to permit this end-of-life option for the terminally ill, joining Vermont, Oregon, Washington, and Montana. Kelly Gooch, *Beckers Hospital Review*, March 11, 2016 http://www.beckershospitalreview.com/legal-regulatory-issues/california-will-allow-medically-assisted-suicide-starting-in-june-6-things-to-know.html ; the law can be found at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15