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).

GENERATION OF SICKER KIDS FEARED UNDER IMMIGRATION PROPOSAL

A long anticipated Trump administration immigration proposal may greatly disturb the country's pediatric care system and lead to the intensification of federal authorities determining whether immigrants and their children would receive public benefits like Medicaid and supplemental nutrition. Under the proposed plan, the Department of Homeland Security proposed rule (RIN 1615-AA22), the number of immigrants who would be denied public benefits could rise from 3 percent to 47 percent. According to a spokesperson from the American Academy of Pediatrics, the impending rule is already having an impact as some immigrant families have decided not to renew coverage. According to Sara Rosenbaum, former chair of a congressional Medicaid policy advisory group and a health policy professor at George Washington University, efforts to release the rule could be slowed by the logistics of determining the fiscal impact, as is required for rule-making. Victoria Pelham, *Health Care on Bloomberg Law*, Aug. 30, 2018 https://www.bna.com/generation-sicker-kids-n73014482133/

THE REMEDY OF SURPRISE MEDICAL BILLS MAY LIE IN STITCHING UP FEDERAL LAW

A gap in the protections afforded to out-of-network beneficiaries under the Employment Retirement Income Security Act of 1974 (ERISA) has led to a renewed focus on exorbitant balance-billing charges by out-of-network providers and has led to a demand for closing the so-called "balance-billing loophole". While in-network providers are contractually obligated to predetermined rates for services with insurance companies, out-of-network providers have no such contractual ceiling and thus, can charge whatever rate they deem "fair" for the services provided. ERISA regulates employer-sponsored insurance plans which are "self-funded," i.e., that the employer contributes payments to. Further, ERISA, has nearly widespread field preemption over insurance, limiting states' abilities to try to rectify this harm to patients. And while states continue to try to work around ERISA's preemptive scope, it appears there are at least three viable solutions moving forward: (1) amending the ERISA statute, (2) revise the federal regulations regarding out-of-network payments, and/or (3) allow the issue to continue in state courts—such as Georgia, Texas and Colorado—continue to weigh in the determination of "what is a fair price?"

Michelle Andrews and Julie Appleby, *NPR*, Sept. 10, 2018
https://www.npr.org/sections/health-shots/2018/09/10/645561263/the-remedy-for-surprise-medical-bills-may-lie-in-stitching-up-federal-law

LACK OF SURGICAL CARE IN U.S. PRISONS MAY COST LIVES

According to the report published in JAMA, autopsy reports examined on behalf of inmates that died while at Florida's Miami Dade County revealed that two-thirds of those deaths occurred because of surgical neglect. Dr. Tanya Zarikson, the study's principal author, indicated that according to her team's findings, out of 301 autopsy reports, 51 deaths were due to lack of surgery, and 18 were caused by trauma. Experts indicated that this calls for greater attention, as not all correctional facilities conduct autopsy and data collection, meaning that although the study was small, this neglect is likely occurring on a greater scale. According to Dr. Joe Hines, a professor and chief of surgery at David Geffen School of Medicine, the call for greater concern to this incident is prominent because the quality of care our incarcerated population is receiving reflects the care allotted to other undermined populations that do not have access to quality healthcare. Linda Carroll, *Reuters Health News*, Sept. 12, 2018
HTTPS://WWW.REUTERS.COM/ARTICLE/US-HEALTH-PRISON-SURGERY/LACK-OF-SURGICAL-CARE-IN-U-S-PRISONS-MAY-COST-LIVES-IDUSKCN1LS2KN

THE NEW APPLE WATCH SHOWS THE MONEY BIG TECH SEES IN HEALTH

The new Apple Watch is proof that Big Tech companies are trying to reconfigure health care to a new, unique image where technology could potentially become the forefront of medical care. The new watch, for example, can monitor heart beats for abnormal, dangerous conditions, using an electrocardiogram. This new technological advancement indicates that the business of keeping people healthy is a logical frontier. Although this new innovation seems enticing, there are logical reasons for skepticism. Concerns among analysists include false positives and panics when technology fails, even with other companies, such as Google and Amazon, use teams of health care practitioners to evaluate and accommodate the providing of information. These tech giant companies becoming involved in the health realm have encouraged others, such as Uber Technologies Inc. and Lyft Inc., to also mark their territory in this techno-health frontier. Zachary Tracer, Spencer Soper, Gerrit De Vynck, and Dina Bass, Bloomberg, Sept. 15, 2018
https://www.bloomberg.com/news/articles/2018-09-14/the-new-apple-watch-shows-the-money-big-tech-sees-in-health

RULING ON HEALTH CARE SUBSIDIES COULD PROVE COSTLY FOR GOVERNMENT

A ruling by a U.S. Court of Federal Claims judge in favor of a Montana insurer that had

sued the Trump administration for abruptly ending cost-sharing reduction payments guaranteed by the Affordable Care Act (ACA) is likely to have a considerable ripple effect. The judge held that [u]nder the ACA, it is "clear and unambiguous" that the government had an obligation to provide insurers those cost-sharing subsidies, which are discounts that enhance the value of health insurance policies. And the government can expect these costs to snowball, as other similar cases are pending for recovery of the promised subsidies, including one suit that has been certified as a class action suit. In defense of the Trump administration, the federal government has argued that President Trump's decision to end the payments is permissible because Congress did not intend to fund them, as evidenced by the lack of express authorization of funds for such. But the ACA states that the Secretary of Health and Human Services (HHS) "shall make periodic and timely" payments to insurers that are "of equal value" to the cost-sharing reductions that are passed along to customers. And while we await the outcome of the similar and outstanding cases against the administration, there are hopes that insurers finally have sufficiently accounted for all of the market disruptions imposed by the administration, and can better predict future costs under the administration's policies. Robert Pear, *The New York Times*, Sept. 22, 2018 HTTPS://WWW.NYTIMES.COM/2018/09/22/US/POLITICS/TRUMP-INSURANCE-SUBSIDY-PAYMENTS-OBAMACARE.HTML

BUYER BEWARE: NEW CHEAPER INSURANCE POLICIES MAY HAVE BIG COVERAGE GAPS

Citing the Affordable Care Act's (ACA) insurance being too expensive, the Trump administration has greatly expanded the permissible duration of short-term plans from three months (under the Obama administration) to three years (plan duration one year, that duration being renewable twice). Short-term, limited duration insurance plans have created cheaper alternatives to traditional marketplace plans under the ACA, but their expansion has exposed a number of negative effects experts expect these plans to cause. First, because the plans are state-regulated, the plans do not have to comply with neither the ACA's coverage requirements nor its essential health benefit mandates. Second, are hidden costs. Patients with short-term plans rarely get prescription coverage, are subject to high deductibles, and only cover a percentage of hospital or other costs. Third is the lack of reinvestment in coverage and care by the insurance provider, based on a report by the National Association of Insurance Commissioners demonstrated that term plans paid out only 55 percent of their premiums in actual healthcare, whereas under the ACA, companies are "required to spend 80-85 percent" of premiums for health care or else issue a refund to customers. Finally, are the likely disruptions to the future of the ACA marketplace. The Departments of Health and Human Services (HHS) and the Congressional Budget Office (CBO) estimate that over the next five years, an estimated 1.6-2 million people may leave the marketplace in favor of the short term, limited duration plans, many of whom will be younger and healthier individuals,

which will drive up the marketplace plan costs. Alison Kodjak, *NPR*, Oct. 1, 2018 https://www.npr.org/sections/health-shots/2018/10/01/652141154/buyer-beware-new-cheaper-insurance-policies-may-have-big-coverage-gaps

SURROGACY EXPENSES NOT COVERED BY HEALTH PLAN: JUDGE

A federal district court judge in Maine became the most recent to hold that the terms of the plan are controlling in employer-sponsored ERISA plans, finding that the plan reasonably denied coverage to a woman for expenses related to a surrogate pregnancy, because the terms of the plan specifically contained an exclusion for costs related to such surrogate pregnancy. The woman claimed that because it was not her own egg being fertilized, she was a "gestational carrier" as opposed to a "surrogate." The judge found that argument unpersuasive, holding that based on the terms of the plan specifically excluding "surrogate exclusion," it was "hard to believe" that the plan intended to cover either a gestational carrier or a surrogate carrier, holding: "just as it would not be inconsistent for a plan to cover surgical expenses, but exclude expenses for [elective] cosmetic surgery, it is not inconsistent for the plan to cover pregnancy costs, while excluding costs for a certain type of pregnancy." In other words, the terms of the plan agreement, unless overtly ambiguous, control the coverage limitations of the plan. While here, the judge noted some ambiguity in the terms of plan, the judge—based on interpreting the terms of the plan agreement and based on Florida District Court precedent—ultimately held the plan's interpretation was reasonable, and thus, ruled against the woman. Jacklyn Wille, *BNA*, Oct. 1, 2018 https://bnanews.bna.com/employee-benefits/surrogacy-expenses-not-covered-by-health-plan-judge