OF NOTE

Q&A on the 'Unplanned Pregnancies' of the Catholic Church

This month the Vatican released its latest reflection on what some people call the "new movements" in the Catholic Church. The document, titled *Iuvenescit Ecclesia* (The Church Rejuvenates), was prepared by the Congregation for the Doctrine of the Faith. It attempts to discuss the relationship between the hierarchy and newly formed lay movements. The CDF acknowledges the movements as a "great source of renewal" and recognizes their ability to "fill the heart of the Church with joy and gratitude."

However, the document is truly designed to warn these movements to not become a "parallel church" outside the authority of the hierarchy. "To be Catholic, it argues, means in part accepting the authority of the bishops and the pope, and seeking their official recognition." In the end, the document actually asks both the hierarchy and the new movements to give a little in order to work together peacefully. The document says that the hierarchy must avoid "juridical straitjackets that deaden the novelty which is born from the specific experience." Meanwhile the new movements have to avoid "running parallel to ecclesial life or not [seeing themselves as] ordered in relation to the hierarchical gifts." John L. Allen Jr., *Cruxnow.com,* June 14, 2016

Love, Not Some Idea of Perfection, Leads to Happiness, Pope Says

"The world does not become better because only apparently 'perfect' -- not to mention fake -- people live there, but when human solidarity, mutual acceptance and respect increase," the pope said June 12 celebrating Mass for the Year of Mercy Jubilee. The Mass included individuals with Down Syndrome as well as altar attendants and lectors with disabilities.

During the Gospel story about the sinful woman who washed Jesus' feet, actors portrayed the scene while sign language interpreters were stationed throughout the square. "Each of us, sooner or later, is called to face -- at times painfully -- frailty and illness, both our own and those of others," Pope Francis said in his homily. "In an age when care for one's body has become an obsession and a big business, anything imperfect has to be hidden away, since it threatens the happiness and serenity of the privileged few and endangers the dominant model," the pope said. "In some cases, we are even told that it is better to eliminate them as soon as possible, because they become an unacceptable economic burden in time of crisis."

Prior to the Mass, the pope held a special audience for participants in a conference on catechesis for

disabled persons. One person asked the Pope Francis how parishes can fight discrimination and welcome individuals with disabilities. The pope replied acknowledging the fear that can arise by encountering someone who is different, however, “Differences are a richness because I have something and you have something else and by putting the two together we have something more beautiful, something greater." Cindy Wooden, *Catholic News Service*, June 12, 2016

Details on Death Certificates Offer Layers of Clues to Opioid Epidemic

Dr. James Gill works for a morgue in Farmington, Connecticut. Recently his office has had to increase storage space due to a 50 percent increase in autopsies. On one day, the morgue had nine bodies, “four were the remains of the people who likely died from an accidental drug overdose. A fifth was a probable suicide involving drugs.”

Dr. Gill is striving to gain more data on “exactly which drugs killed exactly which people.” He recounts the story of a mother who called to learn more information about her daughter’s overdose death.

"Can you tell me, did she suffer?" the woman wanted to know. "Was she in pain?" "And I explained to her," Gill said, "that, with an opioid death, the person just gradually goes to sleep and it's very painless. "And she started crying," Gill said. "And it gave her some comfort."

Gill believes the first step is a change in the way we fill out death certificates. “A death certificate needs to say more than something vague like ‘opioid intoxication’ to help both law enforcement and public health officials curb the distribution and hopefully abuse of opioids.” Doctors need to write more than “acute of multi-drug intoxication.” They need to write which drugs actually caused the death.

So far states decide exactly how to approach this topic. Some are better than others at recording drug information for data collection. Meanwhile, families may not want “heroin overdose” or “vicadin abuse” on their family member’s death certificate. What is known is that the rise in drug induced deaths requires a multi-prong approach and the first step is to recognize and name the actual culprits. Jeff Cohen, *Los Angeles Times*, June 1, 2016

Doctor-Assisted Suicide Legal in California Started June 9

The California End of Life Option Act took effect on June 9th. The law permits a terminally ill adult in California with a life expectancy under six months to get a prescription for a lethal dose of certain drugs. The bill was signed by Governor Jerry Brown

back in October. It makes California the 5th state to legalize doctor-assisted dying.

"The Life Option Act requires that a patient seeking lethal drugs make three formal requests to their attending physician: one written and two of them orally delivered and spaced at least 15 days apart. The law also requires informed consent and excludes children. The lethal drugs must also be self-administered." What lingers is the question of who and how many people will utilize this law. Jacob Gershman, *Wall Street Journal*, June 8, 2016

Government Seeks Limits on Short-Term Health Policies

The Obama administration is seeking to limit short-term health policies that include features currently banned under the Affordable Care Act. These plans usually do not cover pre-existing conditions. The proposal will create rules for such policies including limiting them to three months or less, and prohibiting individuals from renewing coverage at the end of the period. The proposal closes a gap which allowed healthier consumers to purchase these cheaper plans and remain on them for up to a year. The Administration hopes that by limiting these plans, healthier individuals will enter the ACA marketplace and slow down the need to raise premiums. Anna Wilde Mathews, Louise Radnofsky, and Stephanie Armour, *Wall Street Journal*, June 8, 2016

Congress Leaves for Recess Without Zika Funding

The 52-44 vote on the motion to limit debate on the $1.1 billion anti-Zika funding bill amounted to a last-minute attempt by Senate Majority Leader Mitch McConnell to move the legislation to the president's desk with the chamber ready to leave for a seven-week summer recess. Sixty "aye" votes were required to advance the measure. http://www.rollcall.com/news/policy/final-zika-vote-expected-senate-no-signs-deal#sthash.pF7YczrI.dpuf

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 Erin Grant (J.D./M.H.A. anticipated 2018) and Ryan Williams (J.D./M.H.A. anticipated 2017).

HHS Cracks Down on Short-Term Health Plans, Tweaks Risk Adjustments

The Department of Health and Human Services has issued new proposed regulations, limiting the availability of less-expensive short-term health plan options on insurance exchanges. The plans

addressed in these new regulations do not meet the requirements for qualified health plans under the Affordable Care Act (ACA); for example, plan premiums may be based on pre-existing conditions of the insured. Following enactment of the ACA, insurers continued offering these short term plans—designed to cover only short-term gaps in insureds' coverage—with the option to continually renew the "short term" coverage. The new proposed regulations address this pattern, limiting the duration of such policies to a maximum of three months without the option to renew the coverage. In addition, insurers must notify the insured under these policies that they owe a tax penalty as the policy does not comply with the mandate established under federal law. The limitation addresses the loophole offered by short-term coverage, incenting consumers toward the purchase of plans that meet the federal standard. Health policy interest groups interviewed suggest that the new regulations might particularly affect healthier, young adult insureds who have not utilized health plans offered on insurance exchanges at the predicted rates. Virgil Dickson, *Modern Healthcare,* June 8, 2016 http://www.modernhealthcare.com/article/20160608/NEWS/160609920/hhs-cracks-down-on-short-term-health-plans-tweaks-risk-adjustment

Missouri Throws First Big Wrench into Aetna-Humana Deal

Missouri is the first state to take issue with the potential Aetna-Humana currently pending approval from the Department of Justice. John Huff, the director of the Department of Insurance for the State of Missouri issued a preliminary order against the Aetna-Humana deal on May 25, 2016. Per the order, the proposed merger would result in anticompetitive effects. Should the merger be approved, Aetna and Humana would not be permitted to sell particular Medicare Advantage products in the state, and individual Medicare Advantage plans would be barred from being sold in rural counties. Aetna released a statement following the order, noting hope for further dialogue with state officials and emphasizing that the merger was still being investigated by the U.S. Department of Justice. The DOJ did not comment. Aetna and Humana now have thirty days to submit a proposal to mitigate anticompetitive effects which might result from the deal. Such a solution would likely involve divestiture of Medicare Advantage assets in certain locales with heightened anticompetitive activity. Even with such a proposal, commentators expressed skepticism that divesting of assets would remedy the antitrust concerns at issue. Bob Herman, *Modern Healthcare,* May 25, 2016 http://www.modernhealthcare.com/article/20160525/NEWS/160529950

OF NOTE

N.J. Hospitals Lose Court Challenge of Tiered Horizon Health Plan

A New Jersey appeals court reached a decision in a litigation action brought by ten hospitals. The state's Department of Banking and Insurance allowed the state's dominant insurance provider (Horizon Blue Cross and Blue Shield) to divide healthcare providers into two tiers with disparate out-of-pocket costs. The hospitals bringing the action had been placed into the lower tier, which consequently would result in higher out-of-pocket costs for patients. Plaintiffs argued that the state government's allowance of the tiered system was arbitrary, capricious, and unreasonable. Additionally, the hospitals expressed concern for the financial health of their institutions—and others similarly situated in the lower tier—who could lose patients to their higher-tiered competitive. The appellate court ruled against the hospitals, holding that use of the tiered system was not arbitrary, capricious, or unreasonable. Lisa Schencker, *Modern Healthcare,* June. 7, 2016 http://www.modernhealthcare.com/article/20160607/NEWS/160609923/n-j-hospitals-lose-court-challenge-of-tiered-horizon-health-plan

Pfizer Blocks the Use of Its Drugs in Executions

Pharmaceutical firm Pfizer announced its intent to place distribution limits on some of its products, preventing them from being used in lethal injections for capital punishment. The drugs in question will continue to be produced, as they are also distributed for medical use. However, Pfizer will restrict the sale of seven drugs to selected wholesalers. Distributors must certify that they will not resell the product to corrections departments and will be monitored for compliance. Many other European and American pharmaceutical firms have taken similar actions in recent years due to pressure from human rights groups. This wave of limitations from pharmaceutical firms has made it difficult for death-penalty states to obtain these drugs. This has led some states to postpone executions or covertly import drugs from sources abroad. Additionally, some states are experimenting with new combinations of drugs for lethal injections or looking to other means of capital punishment. In instances where lethal injections drugs are able to be obtained, death penalty states are not disclosing the source of the drug, either an effort not to inform manufacturers of the product's misuse or to shield suppliers from backlash from opponents of the death penalty. Erik Eckholm, *The New York Times*, May 13, 2016 http://www.nytimes.com/2016/05/14/us/pfizer-execution-drugs-lethal-injection.html?_r=0

Justices, Seeking Compromise, Return Contraception Case to Lower Courts

In a per curiam decision, the eight Justices of the U.S. Supreme Court have remanded one of the higher-profile cases of this term to the lower courts—making clear that the decision expresses no views on the merits of the legal issues. The case, *Zubik v. Burwell,* involved the Affordable Care Act's contraceptive mandate, which had previously been at the center of *Burwell v. Hobby Lobby* from the 2014 term. In the case, the petitioner religious employers argued that the accommodation allowing them to opt of providing contraceptive coverage to their female employees was not truly an accommodation as offering contraceptives in any way through their health plan infrastructure made them complicit in the behavior they consider to be morally objectionable. The court's decision does not result in a holding for either party and comes amid political deadlock to fill the seat on the Court left vacant by the death of Justice Antonin Scalia. This ultimate result was foreshadowed by an unusual order from the court following the oral argument for the case in March, in which the court called for additional briefing from both sides to "address whether and how contraceptive coverage may be obtained by petitioners' employees through petitioners' insurance companies, but in a way that does not require any involvement of petitioners beyond their own decision to provide health insurance without contraceptive coverage to their employees." In this per curiam decision the Court noted that as a result of this supplementary briefing, both the petitioners and the government have confirmed that such a scenario is a feasible reality. This result allows lower courts to direct parties to seek this compromise without establishing binding precedent—freeing the Supreme Court to potentially rule on the issue at a later time. Adam Liptak, *The New York Times*, May. 16, 2016 http://www.nytimes.com/2016/05/17/us/supreme-court-contraception-religious-groups.html

U.S. Supreme Court Endorses Theory That Could Expand False Claims Act Liability

In a unanimous opinion on June 16, written by Justice Clarence Thomas, the Supreme Court allowed for the potential to bring False Claims Act (FCA) cases against healthcare providers under a theory of "implied certification". In *Universal Health Services v. Escobar*, the Court ruled that FCA liability may be imposed via a theory of implied certification where payment is requested for specific representations about goods or services provided and where an organization's failure to disclose non-compliance with "material requirements would equate to misleading half-truths". The decision is viewed by some as an attempt by the court to fight healthcare fraud while also limiting providers' FCA liability exposure. The case has been remanded to the appellate court, but endorsed the idea that

healthcare providers might be subject to FCA liability where they providers violate some Medicare and Medicaid rules that are not related to conditions of payment. The qualitative standard discussed in the opinion establishes categories of conduct where FCA liability can be imposed; however the court also noted that the FCA "cannot be used as a vehicle for punishing garden-variety breaches of contract or regulatory violations." Aurora Aguilar and Bob Herman, *Modern Healthcare*, June 16, 2016 http://www.modernhealthcare.com/article/20160616/NEWS/160619930/u-s-supreme-court-endorses-theory-that-could-expand-false-claims-act

Transition from Volume-Based to Value-Based Care Slower than Predicted

The transition of Medicare reimbursement payments from a volume-based system to a value-based system has been "sluggish." Health and Human Services (HHS) recently reported that fewer than twenty-five percent of hospitals are on schedule to provide half of their patient care through a value-based system by 2018. The original targets set by CMS anticipated that, by 2016, thirty percent of traditional payments would be tied to quality or value of the patient care provided, and eighty-five percent of Medicare payments; in fact, only three percent of providers are on schedule for the targets set by CMS, and only twenty-three percent are expected to meet targets by 2019. A health system survey of 190 hospitals revealed that sixty-two percent of hospitals have less than ten percent of their care tied to value-based payments. Smaller hospitals were even less likely to have switched, because of insufficient capital to take on the risk required in value-based care. This exemplifies one of the biggest barriers for hospitals; a switch to value-based care requires a vast amount of patient data to identify, manage, and predict the cost of high-risk patient populations, as well as significant financial reserves for the hospital to effectively target and treat these costly populations. Still, HHS remains optimistic. The agency reported that as of this year, thirty percent of Medicare payments are currently tied to quality or value of care provision, as value-based reimbursements currently equal one-third of all Medicare reimbursement spending. This is ahead of the target set by CMS, originally to be reached at the end of 2016. Rajiv Leventhal, *HealthCare Informatics*, June 9, 2016 http://www.healthcare-informatics.com/news-item/payment/health-catalyst-hospitals-progressing-sluggishly-toward-hhs-value-based-0

2017 Insurance Premiums Predicted to Rise

A new study by the Kaiser Family Foundation (KFF) predicts that health insurance premiums will rise in 2017 faster than in previous years to date,

with the cost of the second-lowest silver plans expected to increase by an average of ten percent, compared to five percent in 2016. The lowest-cost silver plans are expected to increase by an average of eleven percent, with the highest increases occurring in Oregon at twenty-six percent, and the lowest in Rhode Island at a decrease of fourteen percent. However, many of the plans which offered the lowest-priced plans in their category in 2016 will not offer the lowest-priced plans in the same category this year, which means that enrollees may have to switch providers to maintain similar premium payments. For example, though Blue Cross Blue Shield offered the lowest premium in the second-lowest silver plan category last year in Providence, Rhode Island, it no longer does; the lowest premium in that category is now provided by Neighborhood Health Plan, while BCBS's lowest-priced plan in the category will see premiums increase by about twenty percent. Additionally, fewer insurers will be participating in the marketplace, in notable part due to UnitedHealth's withdrawal from public exchanges. This will likely impact premium prices in the individual market, though it remains to be seen how much prices will change. Cynthia Cox, et. al., *Kaiser Family Foundation*, June 15, 2016 http://kff.org/health-reform/issue-brief/analysis-of-2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/?utm_campaign=KFF-2016-June-ACA-Marketplace-Premiums&utm_source=hs_email&utm_medium=email&utm_content=30598647&_hsenc=p2ANqtz-9i5jC4iCpE4-9-YusMvaZBu75DYceUGpr5oPhIBPoRKPmYUwnxVQkbBguF6zXPoPqv0IOYTNghwR-RHg5ddr_vxLL4CA&_hsmi=30598647

Continuing Healthcare Reform: The Latest Proposal by Speaker Ryan Challenges Our Current System

Over past Presidential administrations, much healthcare reform debate has centered over who should control individuals' cost-related decision-making: Consumers, or the federal government. The Bush administration emphasized consumer-driven healthcare, which envisioned patients making crucial decisions related to their healthcare costs and service options. The Obama administration countered that these decisions were too complex for patients to make on their own, creating regulators to control consumer options. The latest healthcare reform plan, presented by House Speaker Paul Ryan, shifts the focus back to consumers. Though it retains the Affordable Care Act's foundational premise of universal access to care, the Ryan Plan calls for expansion of health savings accounts, increased insurance portability, and more service choices that depend on what

consumers are willing to spend. The proposed plan would allow a refundable tax credit for consumers who do not have access to coverage through their employer or federal programs like Medicare. This credit, which would rise with healthcare costs, would adjust for age to allow older Americans to receive appropriate care. The Ryan plan, however, loosens regulations on what plans may offer. Instead of requiring credits to be used in healthcare exchanges, consumers may use these credits on any qualified health plan, increasing insurer competition and lowering costs. If consumers do not spend their full credit on a plan, the excess is deposited into a spending account used for out-of-pocket expenses. Ultimately, the Ryan Plan seeks to provide greater consumer autonomy and increased competition in healthcare, while still retaining universal access to care. Thus, the healthcare debate is shifted from universal access to who should decide how individuals spend their healthcare dollars.
Scott Gottlieb, *Forbes*, June 22, 2016
http://www.forbes.com/sites/scottgottlieb/2016/06/22/paul-ryans-healthcare-plan-re-challenges-a-central-tenet-of-obamacare/#77a0b3f07c45

Medicare and Social Security Remain Top Priorities for Upcoming Presidential Administration

Earlier this June, the Obama administration announced that the financial outlook for Medicare had deteriorated over the past year, and that Social Security continues to face a dim financial prognosis. Financial leaders hope this announcement will influence the current Presidential candidates to take a stronger position on financial reform of these programs. Hillary Clinton has proposed increasing Social Security benefits and increasing participation in Medicare by allowing younger populations to "buy in" to the program, while Donald Trump has said he will not cut either program. Under current law, Medicare will exhaust its funds in 2028, and Social Security could be depleted by 2034. The worsened outlook for Medicare has resulted due to changes including a higher service usage rate than anticipated, lower worker productivity and decreased tax revenue. Costs of Medicare and Social Security are projected to grow faster than the economy, resulting partially from the increasing healthcare needs of aging Baby Boomers and increasing costs of expensive prescription drugs. President Obama has approached this issue by calling out to the nation's highest earners to contribute more to the program through taxes. Last year Congress also passed a law to provide a short-term fix to Social Security's disability trust fund, extending the depletion of the trust fund by seven years to 2023. Still, the "future financing gap" in Social Security remains an issue that will need to be discussed as dependency on the program grows.
Robert Pear, *New York Times*, June 22, 2016

http://www.nytimes.com/2016/06/23/us/politics/medicare-social-security-trustees-report.html?rref=collection%2Ftimestopic%2FHealth%20Care%20Reform&_r=0

MACRA Likely to Accelerate Trend in Healthcare Consolidation

April 2015 brought about one of the largest historical changes in physician reimbursement as the traditional fee-for-service method was replaced by the Medicare Access and CHIP Reauthorization Act, or MACRA. This new method is more consistent with the Center for Medicare and Medicaid's (CMS) push for care that is reimbursed based on quality of patient outcomes rather than volume. Under MACRA, this is accomplished through physician participation in alternative payment models (APM) of care, which hold physicians accountable for the quality and value of care provided. Now, healthcare leaders are beginning to see the implications of this legislation. First, it will create more predictability in how physicians are paid for their services. Also, and perhaps an unintended consequence of MACRA, implementation may lead to consolidation. Small and midsize practices do not currently have the administrative capabilities to comply with the vast reporting requirements, or the financial reserves to support the risk-based requirements, under MACRA, and so it is likely that these providers will seek to join larger provider groups or health systems to survive. This will likely accelerate the trend in healthcare consolidation. At the same time, rapid consolidation has already stirred tensions with existing antitrust legislation. Earlier this year, a judge ruled against the Federal Trade Commission's effort to block a merger between Penn State Hershey Medical Center and PinnacleHealth System in Pennsylvania, noting the "irony" that the same federal government that created the FTC to prevent economic monopolies also created a climate "that virtually compels institutions to seek alliances." Still, the biggest question remains how the impending aggregation of health systems will impact the cost of healthcare for consumers. Joseph Fifer, *Modern Healthcare*, June 25, 2016 http://www.modernhealthcare.com/article/20160625/MAGAZINE/306259979/commentary-macra-likely-to-accelerate-consolidation-will-the