I. COVID-19 LEGAL UPDATES

Brach Eichler has strived to keep abreast of the numerous legal developments occurring during the nationwide novel coronavirus (COVID-19) public health emergency. Brach Eichler has created a COVID-19 Resource Center that consolidates its various important client alerts and webinar series information in one place. Please visit the Resource Center for updates at https://www.bracheichler.com/covid-19-resource-center/.

II. NEW JERSEY DEVELOPMENTS

A. New Law Requires Health Care Facilities to Report COVID-19 Data

On February 4, 2021, Governor Phil Murphy signed into law Bill S2384/A4129 to require health care facilities to report certain coronavirus disease 2019 (COVID-19) data related to health care workers and certain first responders. Specifically, general acute care hospitals, special hospitals, ambulatory care facilities, ambulatory surgical centers, assisted living facilities, home health agencies, nursing homes, and hospice programs are required to report to the Department of Health (DOH) either directly or through a non-profit trade association, on a bi-monthly basis, de-identified data on the number of health care professionals, ancillary health care workers, and emergency medical services personnel employed by the facility who tested positive for COVID-19 and who died from COVID-19. The DOH will be required to issue a report concerning the occupational data received pursuant to the new law no later than 12 months after the end of both the state of emergency and public health emergency declared in response to the COVID-19 pandemic.

B. Executive Order Creates Interagency Health Care Affordability Working Group

On January 28, 2021, Governor Phil Murphy signed Executive Order 217 to create the Interagency Health Care Affordability Working Group. The Working Group will serve in an advisory capacity and report directly to the Office of the Governor. It will be chaired by the...
The other members of the Working Group will be the Commissioner or other agency head of the following departments and agencies: (i) the Department of Banking and Insurance; (ii) the Department of Human Services; (iii) the Department of Health; (iv) the Division of Consumer Affairs; and (v) the Department of the Treasury. Key objectives of the Working Group include the following:

- Developing and recommending policies to improve health care affordability, accessibility, and transparency for all New Jersey residents;

- Recommending the development and coordination of programs and policies of the participating departments as needed to support health equity for all New Jersey residents;

- Leveraging the State’s existing data resources and identifying strategies for enhancing and integrating State data resources to develop cost-growth benchmarks to foster accountability and contain health care costs and to utilize the data to identify cost drivers to inform strategic and collaborative action by members of the Working Group and other relevant stakeholders throughout the State;

Within nine months following the organization of the Working Group, the Department of Banking and Insurance will deliver to the Working Group a final report containing proposals for the development and implementation of cost growth benchmarks and health insurance affordability standards that will be applicable to both insurers and providers operating in the State’s health care market. The report will be made available to the public at the same time. It will include a plan under which the State can implement cost growth benchmarks and health insurance affordability standards by January 1, 2022, and will identify all policy and legislative changes needed to effectuate cost growth benchmarks and health insurance affordability standards.

C. **DOBI Data on Out-of-network Arbitrations is Positive For Providers**

On January 31, 2021, the New Jersey Department of Banking and Insurance (DOBI) released data detailing the status of arbitrations commenced under the New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act for calendar year 2020, and the results are encouraging for providers. The Act prohibits providers from balance billing a covered person for inadvertent out-of-network services and out-of-network services provided on an emergency or urgent basis above the amount of the covered person’s liability for in-network cost-sharing. The Act established an arbitration process to resolve out-of-network billing disputes between providers and insurance carriers (and self-funded plans that opt into the arbitration provisions of the Act) for inadvertent and emergency/urgent out-of-network services.

As of December 31, 2020, MAXIMUS Federal, the DOBI contractor handling arbitrations under the Act, had received 5715 arbitration requests, of which 4173 were resolved by decision, 813 were dismissed as ineligible and 729 were withdrawn. Of the 4173 arbitration awards issued, providers prevailed in 2,683 cases (64% of the total), while insurance carriers prevailed in 1489 cases (36% of the total). Providers were awarded $31.4 million, while carriers were awarded $5.2 million. Of the cases that were dismissed as ineligible, the primary reasons for dismissal were that
the health benefits plan was issued in a state other than New Jersey or the plan was a self-funded plan that did not opt into arbitration.

Also noteworthy is that between January 1, 2020 and December 31, 2020, DOBI received just 76 consumer complaints relating to out-of-network health care charges.

The takeaway from this data is that providers should not be discouraged from pursuing arbitration if they dispute a carrier’s or plan’s fee for out-of-network inadvertent or emergency/urgent services.

D. **Insurance Carrier Found Not Responsible for COVID-19 Coverage Claim**

On February 8, 2021, a New Jersey federal judge dismissed a medical practice’s claims against its insurance company for losses related to the COVID-19 pandemic. In the spring of 2020, the Eye Care Center of New Jersey (Eye Care) stopped performing non-urgent procedures in accordance with government orders prohibiting such procedures due to the COVID-19 pandemic. Eye Care sought coverage from Twin City Fire Insurance Co. (Twin City) under a commercial insurance policy it had with Twin City for losses sustained as a result of COVID-19 restrictions. However, the insurance policy stated that Twin City “will not pay for loss or damage caused directly or indirectly by the presence, growth, proliferation, spread or any activity of…virus”. Based on this exclusion, Twin City denied Eye Care’s claim. Eye Care sued Twin City for breach of contract.

The judge dismissed Eye Care’s coverage claims, stating that the exclusion barred coverage. The judge noted that the exclusion barred coverage for losses caused directly or indirectly by a virus and Eye Care’s losses were caused directly or indirectly by the COVID-19 virus. The judge pointed out “[B]ut for the ‘spread’ of COVID-19, governments would not have issued closure orders, and Eye Care would not have stopped performing non-emergency procedures.” The judge noted that other courts in New Jersey have come to the same conclusion when presented with similar facts. Eye Care argued that the government orders, not the virus, should be considered the proximate cause of its losses. The judge was not persuaded by Eye Care’s argument, as the exclusion stated specifically that coverage does not apply if losses are caused directly or indirectly by a virus, and the exclusion applies regardless of any other cause or event that contributes concurrently or in any sequence of the loss.

E. **New Law Protects Non-Profit Hospitals from Property Taxes but Requires Community Service Payments**

On February 22, 2021, Bill A1135/S357 was signed into law by Governor Phil Murphy to reinstate the property tax exempt status of non-profit hospitals, including satellite emergency care facilities, with for-profit medical providers on site. However, these hospitals will instead be required to pay annual community service contributions to their host municipalities to offset the costs of municipal services which directly benefit these hospitals and their employees. The new Law also establishes a commission to study this new system.

The new Law is a response to a 2015 tax court ruling that found AHS Morristown Medical Center operated largely as a for-profit hospital, making it subject to property taxes. The two sides
settled on an agreement that requires the hospital to pay the town $15.5 million over a 10 year period. The ruling spurred a flood of lawsuits from other communities attempting to subject their local hospitals to property tax assessments.

Under the new Law, for tax year 2021, the annual community service contribution for a hospital will be equal to $3 per day for each licensed bed at the hospital in the prior tax year, and the contribution for a satellite emergency care facility will be equal to $300 for each day in the prior tax year. For tax year 2022 and each tax year thereafter, the per day amount used to calculate the community service contribution for a hospital and a satellite emergency care facility will increase by two percent over the prior tax year. For the purpose of calculating the annual service contribution required to be paid by each hospital under the Law, the Law sets a minimum number of licensed hospital beds in each hospital. This minimum number may not be less than the number of beds in each hospital on January 1, 2020. Municipalities will be required to provide five percent of an annual community service contribution, or a voluntary payment that counts against such contribution, to the county in which the municipality is located to offset the cost of county services which benefit the hospital.

F. Cigna Moves to Dismiss Virus Coverage Suit

A New Jersey medical provider filed a lawsuit on August 12, 2020 in the U.S. District Court for the District of New Jersey against Cigna Health Life Insurance Co. (Cigna), alleging Cigna failed to pay benefits for diagnostic testing and services related to COVID-19. (Open MRI and Imaging of RP Vestibular Diagnostics, P.A. v. Cigna Health and Life Insurance Company, Case 2:20-cv-10345-KM-ESK). The plaintiff provider alleges that it properly billed Cigna for rendering diagnostic testing and services to patients related to COVID-19, and Cigna has denied these claims submitted by the provider from February through July 2020. The plaintiff provided as Exhibits to its complaint copies of Cigna’s denials of such claims. According to the complaint, Cigna’s denials include such reasons as “services were rendered as billed or matched the services billed, or billing was duplicative.” The provider alleges the denial of coverage provided “unelaborate” details for such denials.

The provider alleges that Cigna’s denial of coverage for COVID-19 diagnostic testing and services is in violation of the Families First Coronavirus Response Act (Section 6001(a)) (FFCRA), as amended by Sections 3201 and 3202(a) of the Cares Act. The FFCRA generally requires group health plans and health insurance issuers to provide benefits for certain items and services related to testing for the detection of COVID-19 or the diagnosis of COVID-19. Under FFCRA, group health plans and health insurance issuers may not impose any cost sharing requirements, prior authorization, or other medical management requirements when providing coverage for certain items and services related to testing for the detection of COVID-19 or the diagnosis of COVID-19. The Cares Act generally requires group health plans and health insurance issuers providing coverage to reimburse any provider who performs diagnostic tests for COVID-19 in amounts that equal the negotiated rate, or, if the group health plan or health insurance issuer does not have a negotiated rate with the provider, the case price for such service that is listed by the provider on its public website.

The provider also alleges that Cigna has been unjustly enriched by wrongfully denying these claims; that is, that Cigna has been able to keep insurance premiums instead of paying out such claims to the provider for services actually rendered. The provider seeks compensation under
an argument of *quantum meruit* (essentially, reasonable value of services). It also seeks damages totaling $398,665.00, in addition to attorneys’ fees, costs, and interest.

Cigna denied the allegations through an answer filed in November 2020. In December 2020, the provider amended the complaint to make technical changes to the CARES allegations to seek relief under the Employee Retirement Income Security Act of 1974 (ERISA). On February 24, 2021, Cigna filed a motion to dismiss the amended complaint based upon its argument that the provider failed to provide the core information needed to support an ERISA claim, such as the specificity of the plans at issue, the plan provisions that were breached, the identity of the patients behind the denied claims and whether the provider had been assigned their rights under the plans.

### III. FEDERAL DEVELOPMENTS

#### A. New Guidance Removes Barriers to COVID-19 Testing and Vaccinations

On February 26, 2021, the Centers for Medicare & Medicaid Services, the Department of Labor and the Department of the Treasury collectively issued new guidance to remove barriers to COVID-19 diagnostic testing and vaccinations and strengthen requirements that plans and issuers cover diagnostic testing without cost sharing. The guidance was issued in accordance with an Executive Order that President Joe Biden signed on January 21, 2021. The guidance clarifies that private group health plans and issuers generally cannot use medical screening criteria to deny coverage for COVID-19 diagnostic tests for individuals with health coverage who are asymptomatic and have no known or suspected exposure to COVID-19. Such testing must be covered without cost sharing, prior authorization, or other medical management requirements imposed by a plan or issuer. For example, covered individuals wanting to ensure they are COVID-19 negative prior to visiting a family member would be able to have a COVID-19 test without paying cost sharing.

The guidance also reinforces existing policy regarding coverage for the administration of the COVID-19 vaccine and highlights how providers can seek federal reimbursement for costs incurred when administering COVID-19 diagnostic tests or vaccines to uninsured individuals. One method is through the Provider Relief Fund program, which has a separate program for providers to submit claims and seek reimbursement on a rolling basis for COVID-19 testing, COVID-19 treatment, and administering COVID-19 vaccines to uninsured individuals. This program has already reimbursed providers more than $3 billion for the testing and treatment of uninsured individuals, and expects to see vaccine administration claims as states scale up vaccination efforts.

#### B. Open Notes Rule to be Effective April 2021

The implementation of the Federal “Open Notes” rule is scheduled to be effective April 5, 2021. The rule implements a portion of the 2st Century Cures Act related to information blocking, specifying that clinical notes are among electronic information that must not be blocked and must be available free of charge to patients. The Open Notes rule applies to all healthcare providers, including but not limited to, hospitals, physicians, medical practices, ambulatory surgical centers, skilled nursing facilities, long-term care facilities and healthcare clinics. Generally speaking, such access is through a patient portal or health applications on smart devices.
With limited exceptions, the rule effectively grants patients immediate access to health information in their electronic medical record without charge by the provider, including the notes their clinicians write. More specifically, the rule covers the following eight types of patient data that must be made available to patients electronically:

- Consultation Notes;
- Discharge Summary Notes;
- History and Physical;
- Imaging Narratives;
- Laboratory Report Narratives;
- Pathology Report Narratives;
- Procedure Notes; and
- Progress Notes.

Psychotherapy notes and notes that a provider has a reasonable assumption could be used in a civil or criminal court case or administrative proceeding are exempt from the rule.

C. OCR Settles “Right of Access” Cases

The Department of Health & Human Services, Office for Civil Rights (OCR) has settled two more cases in the OCR’s “right of access” initiative. There are now 16 published settlements in the initiative, and there are almost certainly more on the horizon.

The 15th settlement was by a private, not-for-profit health system in Nevada, which agreed to pay $75,000 to settle potential violations of HIPAA, and to enter into a settlement agreement with the OCR, including two years of monitoring by the OCR. The conduct at issue was the failure by the provider to timely send a patient’s records in a “designated record set” to a third party, the patient’s attorney, as requested by the patient. In this instance, the request was not fulfilled until approximately 11 months after the request was made. Under HIPAA, the “designated record set” includes both the medical and billing records related to a patient’s care. In the 16th settlement, a not-for-profit regional healthcare group paid $70,000, and entered into a settlement agreement, which included two years of monitoring, for the alleged failure to provide electronic access to patient records, including after the OCR provided technical assistance after the patient first complained of the issue.

These settlements are yet another reminder of the OCR’s dedication to ensuring patients are given timely access to their health records, including access to view and access to obtain copies in the form and format requested by the patient.