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Late breaking news on medical-legal developments affecting physicians and health care professionals

UnitedHealth to Drop Out of Most Affordable Care Act Exchanges: In mid-April, UnitedHealth CEO Stephen Hemsley announced the company would pull out of most of its ACA marketplaces. However, the company will not withdraw from all the exchanges, and will continue to sell individual plans in what Mr. Hemsley said would be a "handful" of states. Thus far, UnitedHealth has withdrawn, fully or partially, from Arkansas, Georgia, Louisiana, Michigan and Oklahoma. Previously, the company had sold plans in thirty-four (34) states, and has not yet announced which states it plans to stay in. However, a recent analysis from the Kaiser Family Foundation concluded that UnitedHealth's withdrawal will not have a major impact on competition and prices on a national basis, as it has a relatively small ACA footprint and has consistently charged higher premiums for its products. Despite heavy losses in its ACA plans (expected to be some $1 billion on its exchange plans for 2015 and 2016), UnitedHealth nevertheless obtained substantial profits (said to total approximately $5.8 billion in 2015) from its other lines of business.

Medicare Draft Regulations Would Radically Change How Physicians are Paid: In a new 962-page proposed rule, CMS advances radical alterations to the way physicians will be paid for treating Medicare patients. The regulations were proposed pursuant to the 2015 Medicare Access and CHIP Reauthorization Act, which replaced the controversial "sustainable growth rate" formula. In order to move more physician payments through so-called "value-based arrangements," the regulations set forth a "Quality Payment Program." Physicians will have to choose one of two paths: the "Merit-based Incentive Program" ("MIPS," into which the majority of practitioners are expected to fall) or a qualifying "Alternate Payment Model" ("APM"). Although, based upon data from 2014, Medicare spending on inpatient services was nearly double that spent on physicians, CMS has targeted physicians to be responsible for keeping hospital expenditures down. Basically, MIPS combines parts of the Physician Quality Reporting System ("PQRS"), the Value Modifier ("VM" or "Value-based Payment Modifier") and the Medicare Electronic Health Record ("EHR") incentive program into one single program, theoretically based upon quality of care, resource use, clinical practice improvement and meaningful use of certified EHR technology. Based upon a composite performance score in each of these four categories, physicians will receive either a positive, or a negative, adjustment in compensation. Negative adjustments are capped at 4% in 2019, 5% in 2020, 7% in 2021 and 9% in 2022 and beyond, while positive adjustments must be paid out in an amount equal to the total negative payment adjustments among all providers, and can reach up to three times the amount of negative adjustments. To participate in an APM requires a physician to be in a qualifying program (one of which is the Accountable Care Organization ("ACO")), which may have the effect of steering doctors into large group practices or into employment by hospitals.

New Jersey Courts Block Procedural Maneuver Seeking to Revive Malpractice Case: In a published decision, A.T. ex rel. T.T. v. Cohen, -- N.J. Super. --, 2016 WL 1652090 (App. Div. 2016), the Superior Court of New Jersey, Appellate Division, affirmed a trial Court decision blocking plaintiffs' procedural maneuver attempting to circumvent New Jersey's Affidavit of Merit statute, N.J.S.A. 2A:53A-27, by seeking a voluntary dismissal of the action, without prejudice. Under New Jersey law, a plaintiff who brings a professional liability action, including a claim for medical malpractice against a physician, must file an Affidavit of Merit ("AOM"), signed by a practitioner in the same professional field as the defendant, stating the defendant's actions appear to have fallen outside the boundaries of acceptable professional standards. The AOM must be filed within sixty (60) days of the filing of the defendant's answer, and the Court is permitted to extend this deadline for an additional sixty (60) days upon a finding of "good cause." In this case, the plaintiff alleged, on her own behalf and on behalf of her infant daughter, the infant suffered a brachial plexus injury leading to Erb's palsy as a result of medical negligence at the time of birth. After the expiration of the 120-day period under the AOM statute, the defendants moved for summary judgment on the basis of the plaintiffs' failure to have timely filed an AOM. In opposition to the motion, the plaintiffs' counsel filed an untimely AOM, stating the failure to have timely filed was due to an "oversight," on the grounds that plaintiffs' counsel's law firm did not employ a "seasoned New Jersey medical malpractice attorney." The trial Judge adjourned the summary judgment motion, and the plaintiffs moved for a voluntary dismissal of the action, without prejudice, arguing the statute of limitations was tolled for the minor plaintiff, and that a new complaint could be filed within the statute of limitations, and a timely AOM provided at that time. The trial Judge refused to grant the motion for voluntary dismissal, reasoning this would have the effect of improperly circumventing the AOM statute, notwithstanding the tolling of the statute of limitations for the minor plaintiff, and instead granted the defendants' motion for summary judgment, dismissing the case, with prejudice. The Appellate Division affirmed the trial Judge's decision, holding that the trial Judge had not abused her discretion in granting the motion for summary judgment, and agreed that the procedural maneuver attempted by the plaintiffs' counsel would improperly circumvent the AOM statute. One of the Judges on the three-Judge panel filed a dissenting opinion, meaning the case is subject to review by the New Jersey Supreme Court as a matter of right.

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