Corporate Counsel Committee

SUPREME COURT DECISION ON THE AFFORDABLE CARE ACT

By: Paula Stanndard, Brian Stimson, Bob Driscoll, Carolyn Smith, Sean Hyatt, Joyce Gresko, Elinor Hiller, and Keavney Klein of Alston & Bird LLP

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On June 28, the much-anticipated decision in National Federation of Independent Business v. Sebelius was released by the Supreme Court.¹ The headline news (at least after some initial erroneous reports by major news outlets were corrected) was that the Court upheld the Affordable Care Act’s (ACA’s) “individual mandate,” which requires almost all Americans to obtain health insurance or face a penalty.¹

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Affordable Care Act’s (ACA’s) “individual mandate,” which requires almost all Americans to obtain health insurance or face a penalty. While that view is generally accurate, the decision itself is more complex and was surprising to many observers. In particular, although the individual mandate was upheld, a majority of the Court did hold that the mandate was constitutionally impermissible as an exercise of Congressional authority under the Commerce Clause of the U.S. Constitution, which is the area where most of the pre-opinion discussion focused. Indeed, Chief Justice John Roberts even favorably referenced the frequently discussed analogy used by mandate opponents that a federal mandate to buy health insurance was no different (and no more permissible constitutionally) than a federal mandate compelling citizens to buy vegetables. But even though mandate opponents prevailed regarding the mandate’s


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We have a fantastic meeting planned that includes several valuable CLE programs to help you in your practice, various opportunities to network and socialize with your TIPS friends, colleagues and clients at events including our Welcome and Diversity Reception at the Sheraton and the James K. Carroll Leadership and Awards Dinner at the beautiful and historic Chicago Symphony Orchestra, along with the chance to give back through our public service projects.
ANOTHER SOCIAL MEDIA REPORT BY THE NLRB OFFERS NEEDED GUIDANCE FOR EMPLOYER POLICIES

By: Joel O’Malley, Esq. of Dorsey & Whitney

The National Labor Relations Board released its second Social Media Report in January of this year, providing the General Counsel’s analysis of 14 challenged employer social media policies (see our February 27 eUpdate). The Board released another Report reviewing seven additional employer policies. The Board alleged that six of these policies interfered with employees’ rights under the National Labor Relations Act, and found one policy to be lawful. While much of the new Report reiterates prior analysis, the Board significantly expands upon its views of employees’ rights to discuss confidential company and coworker information online. Most importantly, the Board expressly approves and fully quotes one particular social media policy, which may serve as a useful guide for employers to review or create their own policies.

An employer should not broadly prohibit employees from disclosing confidential, sensitive, or non-public information concerning the employer or fellow employees, or from revealing personal information about other employees or the employer’s clients or customers. Employees have a right to discuss their wages and other working conditions with coworkers or third parties; thus, broadly prohibiting posts about employees’ personal, or the company’s non-public, information is seen by the General Counsel as potentially chilling that type of discussion with fellow employees or third parties (e.g., potential union representatives).

In the new Social Media Report, the General Counsel expands his views on the extent to which employers may permissibly prohibit the posting of private or confidential company or coworker information. The General Counsel found unlawful several employer social media policies that broadly barred employees from posting non-public company information on a public website, even when that information was explained by the employer to be the company’s private financial performance data, customer wins or losses, customer plans, maintenance, cost increases, customer news, business related travel plans or schedules, or personal information about coworkers. In the General Counsel’s view, information about company performance, cost increases, and customer wins or losses has potential relevance in collective-bargaining negotiations regarding employees’ wages and other benefits. Because this information specifically encompasses the protected activities of discussing terms and conditions of employment, employees could reasonably construe such a policy as precluding them from having protected discussions among themselves or with non-employees.

In addition to discussing the posting of confidential and non-public information, the General Counsel also provides again, as in the second Social Media Report, lengthy lists of prohibited employer policies. These lists of prohibited policies only get employers so far in ensuring their own policies are lawful. This recent Report may be more useful to employers, however, in that the General Counsel finally sets forth a complete social media policy that, in the General Counsel’s view, is lawful under the National Labor Relations Act. This pre-vetted policy may provide a useful starting point for employers to develop their own policies that can meet their specific needs in different industries and with unique workplace cultures. The policy is quoted in full below:

**Social Media Policy**

At [Employer], we understand that social media can be a fun and rewarding way to share your life and opinions with family, friends and co-workers around the world. However, use of social media also presents certain risks and carries with it certain responsibilities. To assist you in making responsible decisions about your use of social media, we have established these guidelines for appropriate use of social media.

This policy applies to all associates who work for [Employer], or one of its subsidiary companies in the United States ([Employer]).

Managers and supervisors should use the supplemental Social Media Management Guidelines for additional guidance in administering the policy.

**GUIDELINES**

In the rapidly expanding world of electronic communication, social media can mean many things. Social media includes all means of communicating or posting information or content of any sort on the

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VOLUNTEERS NEEDED!

Join TIPS Members and the Midwest Brain Injury Clubhouse and clean up Chicago’s Union Park!

August 3, 2012
10 AM - 1:30 PM

With the assistance of the Chicago Park District, join the Tort Trial & Insurance Practice Section’s Law in Public Service Committee and the Midwest Brain Injury Clubhouse in beautifying Chicago’s Union Park. Activities will include: organizing the basement, cleaning gym cages, picking up branches, raking leaves and other outdoor activities.

The Midwest Brain Injury Clubhouse is a community based day program that provides life-long rehabilitative services and support to persons affected by brain injury and stroke.

Family and friends are welcomed to join!

Interested participants should meet in the Sheraton Hotel Chicago lobby on August 3, 2012 at 9:45 for transportation to the park. Please feel free to dress appropriately for clean-up activities. With the exception of gloves, all supplies will be provided by the Park District. Participants will also be provided Disaster Kits by the ABA TIPS Task Force on Disaster Response and Preparedness.
In 2009, the penalties for HIPAA violations were increased 500 times the prior amount. Recent changes to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules dramatically increase attorneys’ and their clients’ potential liability for HIPAA violations.

**HIPAA now applies directly to some attorneys**

The HIPAA privacy and security rules apply to “covered entities,” which includes most health care providers, health care clearinghouses, health insurers, and employee group plans that have 50 or more participants or that are administered by a third party. Effective February 2010, HIPAA also applies directly to “business associates” of covered entities, which includes attorneys who (1) represent a covered entity or a covered entity’s business associate, and (2) receive protected health information from the client or the client’s business associate in the course of representing the client. “Protected health information” is individually identifiable information about a person’s health, health care, or payment for his or her health care. The net result is that attorneys who are business associates of covered entities and larger law firms’ group health plans, must comply with most HIPAA requirements or face increased HIPAA penalties.

**Must self-report HIPAA breaches**

Effective February 2010, covered entities and business associates must self-report HIPAA violations that pose a significant risk of financial, reputational or other harm to the individual whose information was breached. If the business associate learns of such a breach, it must report the breach to the covered entity without unreasonable delay. The covered entity must report a breach to the affected individual or his or her personal representatives and the federal Department of Health and Human Services (HHS). If the breach involves more than 500 persons, the covered entity must also report information about the breach through local media. Needless to say, the self-reporting requirement increases the potential for HIPAA penalties. HIPAA civil penalties are now mandatory.

In 2009, the penalties for HIPAA violations were increased 500 times the prior amount. To make matters worse, effective February 2011, the Office of Civil Rights (“OCR”) is required to impose HIPAA penalties if the covered entity or business associate acted with willful neglect, i.e., “the conscious, intentional failure or reckless indifference to the obligation to comply” with HIPAA requirements. The new penalty structure is as follows:

<table>
<thead>
<tr>
<th>Conduct of Covered Entity or Business Associate</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not know and, by exercising reasonable diligence, would not have known of the violation.</td>
<td>$100 to $50,000 per violation; Up to $1,500,000 per identical violation per year.</td>
</tr>
<tr>
<td>Violation due to reasonable cause and not willful neglect.</td>
<td>$1,000 to $50,000 per violation; Up to $1,500,000 per identical violation per year.</td>
</tr>
<tr>
<td>Violation due to willful neglect but the violation is corrected within 30 days after the covered entity knew or should have known of the violation.</td>
<td>Mandatory fine of $10,000 to $50,000 per violation; Up to $1,500,000 per identical violation per year.</td>
</tr>
<tr>
<td>Violation due to willful neglect and the violation was not corrected within 30 days after the covered entity knew or should have known of the violation.</td>
<td>Mandatory fine of not less than $50,000 per violation; Up to $1,500,000 per identical violation per year.</td>
</tr>
</tbody>
</table>

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4th Annual ABA TIPS School Kits for Kidz

For the fourth year in a row, TIPS is sponsoring the TIPS School Kits for Kidz program. This year we are going to once again provide students in Chicago, the home of the ABA, with desperately-needed school supplies to give them the tools necessary to achieve their goals in life.

There are 404,151 children in the Chicago Public Schools.

Over 350,000 of these students are low income.

15,580 are homeless.

Please join TIPS in trying to make a difference for students at Webster Elementary School in Chicago where 97% of the students are low income. A full year of school supplies can be purchased for $17 per student.

Orders can be placed online at
http://shop.kitsforkidz.org/catalog/American-Bar-Association,813.htm
SUBROGATION RIGHTS OF HEALTH PLANS ESTABLISHED UNDER
ERISA

By:  Evan P. Banker, Esq. of Chalat Hatten & Koupal PC

This article explains the process of determining the reimbursement rights of ERISA-based health plans, current legal trends, equitable defenses, and negotiation strategies.

The Employee Retirement Income Security Act of 1974 (ERISA) governs nearly all employer-maintained benefit plans.1 Sixty percent of American workers who have employer-sponsored health insurance are enrolled in self-funded ERISA plans,2 which are exempt from state laws regarding insurance and subrogation.3 This represents an 81.7% increase in self-funded plan enrollees over the last ten years.4 Of relevance to the practitioner representing personal injury plaintiffs is the self-funded plan’s right to bring a federal civil action “to enforce any provisions . . . of the terms of the plan.”5

When a tort settlement or verdict is reached, payors of health benefits frequently assert a subrogation interest in the recovery. Plans established under ERISA routinely claim exemption from Colorado’s made whole and common fund statute, CRS § 10-1-135, although only those that are self-funded and with appropriately drafted plan language are entitled to the exemption.6 This article explains the process for determining a health plan’s status and subrogation rights.

Plan Funding and Federal Preemption

When an ERISA plan is self-funded by the employer, it is exempt from state laws governing insurance.7 The plan document will be construed under federal law and, if appropriately drafted, its terms will be given full effect.8 Plan drafters typically include onerous subrogation rights, providing for reimbursement of every dollar paid without regard for procurement costs or attorney fees.

On the other hand, where a plan established under ERISA holds one or more policies of insurance that pay for the injured employees’ health benefits, state laws regulating insurance apply to the plan equally as they would to the insurer.9 ERISA preserves the states’ traditional role of regulating insurance policies issued within their borders.10 Therefore, when the employer does not bear the risk of loss—but rather puts that burden on an insurer—it is not entitled to federal preemption.11

The plan’s funding determines the applicable law. Thus, the first step for the practitioner dealing with an asserted subrogation interest from an ERISA plan is to ascertain whether the plan is funded by the assets of the employer or by policies of insurance.

The key to understanding the plan’s funding can be found in its required federal filings. Employers maintaining ERISA plans must file an IRS form 5500 annually with the U.S. Department of Labor (DOL). These are publicly available documents, and can be found at www.freeerisa.com (registration required), or requested from the plan administrator. The form 5500, with its Schedule As and Cs, will give the practitioner the best understanding of the plan’s funding.

Form 5500, page one, elements 9a and 9b—“plan funding arrangement” and “plan benefit arrangement”—each lists the following options: (1) insurance; (2) section 412(e)(3) insurance contracts; (3) trust; and (4) general assets of the sponsor. If only boxes (3) and/or (4) are selected in both elements, the inquiry ends there. Trust and general assets of the sponsor specifically exclude all policies of insurance.12 The plan is fully self-funded and federal law controls subrogation issues.

If any other funding arrangement is selected, the practitioner must consult the attached Schedules to find

4. Id
8. FMC Corp. supra note 3.
10. Id.
11. Id.
the relationship between the payor of benefits and the plan. Large companies may maintain many plans of insurance for various employee benefits, such as health, vision, dental, life, and disability coverage. Therefore, multiple funding arrangements may be selected, describing the multiple plans. To add to the confusion, the party seeking reimbursement usually is not the employer directly, but rather is a company whose primary business is insurance. This is true even in cases where the plan is fully funded by the assets of the employer. In those situations, the insurance company is acting as a claims administrator.

**Hypothetical**

A personal injury plaintiff had been receiving health benefits through a United Healthcare (United) plan, provided by her employer. The attorney receives a letter from United stating that the plan is established under ERISA and will be seeking full reimbursement. The diligent attorney must retrieve the employer’s form 5500 and attached schedules. United may be acting as an insurer, or merely as a claims administrator. The attorney should first search the Schedule A for the one relating to the United Healthcare Health and Welfare Benefits Plan.

If the attorney finds a Schedule A related to United, box 8 of Schedule A should describe the benefit type paid on behalf of the beneficiary, usually “health.” Any matching selection but “stop loss (large deductible)” ends the inquiry. The plan is insured and subject to state laws regarding insurance and subrogation. (See the accompanying sidebar entitled “Schedule A.”)

If the benefits provider is not listed on a Schedule A, the practitioner likely will find it in Schedule C. The “service codes” in Part I, element (2)(b) of the schedule may include: (1) claims processing; (2) contract administrator; and/or (3) plan administrator (codes 12, 13, and 14, respectively). These codes indicate that the health benefits are being paid by the employer directly, with the insurance company acting only as an administrator. State laws are preempted by federal law, and the plan document will control subrogation issues. A company providing insurance would not be listed on schedule C. (See the accompanying sidebar entitled “Schedule C.”)

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**SCHEDULE A**

(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

For calendar year or fiscal year ending:

<table>
<thead>
<tr>
<th>A. Name of plan</th>
<th>B. Three-digit plan number (PN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPPER MOUNTAIN WELFARE PLAN</td>
<td>501</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Plan sponsor’s name as shown on line 2a of Form 5500</th>
<th>D. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POWDER-COPPER LLC</td>
<td>27-1231235</td>
</tr>
</tbody>
</table>

**Part I**

Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

<table>
<thead>
<tr>
<th>(a) Name of insurance carrier</th>
<th>(b) EIN</th>
<th>(c) NAIC code</th>
<th>(d) Contract or identification number</th>
<th>(e) Approximate number of persons covered at end of policy or contract year</th>
<th>(f) Policy or contract year</th>
</tr>
</thead>
<tbody>
<tr>
<td>REGENCY BLUE CROSS BLUE SHIELD OF UTAH</td>
<td>47-02000139</td>
<td>54550</td>
<td>10005237</td>
<td>795</td>
<td>01/01/2010-07/01/2010</td>
</tr>
</tbody>
</table>

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**Part II**

Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same group organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<table>
<thead>
<tr>
<th>Benefit and contract type (check all applicable boxes)</th>
<th>Carrier</th>
<th>Other (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Health (other than dental or vision)</td>
<td>b</td>
</tr>
<tr>
<td>c</td>
<td>Vision</td>
<td>d</td>
</tr>
<tr>
<td>e</td>
<td>Temporary disability (accident and sickness)</td>
<td>f</td>
</tr>
<tr>
<td>g</td>
<td>Supplimental unemployment</td>
<td>h</td>
</tr>
<tr>
<td>i</td>
<td>Stop-loss (large deductible)</td>
<td>j</td>
</tr>
<tr>
<td>k</td>
<td>PPO contract</td>
<td>l</td>
</tr>
</tbody>
</table>
Stop-Loss Insurance

If a plan is fully self-funded, subrogation issues are governed by federal law.\(^{15}\) If it is fully insured, it is governed by state law.\(^{16}\) Stop-loss insurance is an arrangement whereby the employer is responsible for paying benefits up to a predetermined maximum loss, either in aggregate or per employee.\(^{17}\) After that limit is reached, the plan is insured against further losses. Policies of stop-loss insurance reported on Schedule A are those funded with employee contributions, and therefore are considered assets of the plan.\(^{18}\)

Although this seemingly creates a gray area between insured and self-funded plans, circuit courts have decided the issue (the Second, Third, Fourth, Fifth, Sixth, Eighth, and Ninth) have held that the plan maintains its self-funded status.\(^{19}\) The Tenth Circuit has not considered the issue, and there is a split of authority from the district court judges within the Circuit. Judge Kane of the District of Colorado has held that the shifting of risk renders the plan insured, and thus subject to state laws on subrogation.\(^{20}\) However, the District of Kansas has sided with the majority trend in a more recent decision.\(^{21}\)

Plan Language and Federal Common Law

If a plan is insured and subject to state law, issues of subrogation are governed by CRS § 10-1-135. A thorough analysis of that statute was published in The Colorado Lawyer in February 2011.\(^{22}\) If the practitioner determines that a plan is self-funded and therefore governed by the plan document and federal common law, it is imperative that the attorney read the plan document.
A fully self-funded plan may bring a federal action seeking “appropriate equitable relief” to enforce the terms of the plan document, including subrogation rights. To pass muster, the subrogation language must meet the requirements that it is seeking equitable (rather than legal) relief, and that it seeks reimbursement from a specifically identified fund. A well-drafted plan document immediately creates an equitable trust on any personal injury recovery. If the plan document is so drafted, the practitioner has little law-based leverage for negotiating the plan’s interest.

On the other hand, if the plan fails to identify a specific fund to which it is entitled, fails to limit its recovery to that fund, or attempts to impose liability on the beneficiary instead of creating an equitable lien on the fund, the subrogation provision may be held unenforceable. A study in comparing and contrasting two plan provisions was undertaken by the Eleventh Circuit in Popowski v. Parrott:

[The] United Distributors Plan creates a lien “on any amount recovered by the Covered Person whether or not designated as payment for medical expenses.” It further clarifies that “[t]he Covered Person . . . must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.”

[T]he Mohawk Plan, unlike that of the United Distributors Plan, claims a right to reimbursement “in full, and in first priority, for any medical expenses paid by the Plan relating to the injury or illness,” but does not specify that that reimbursement be made out of any particular fund, as distinct from the beneficiary’s general assets.

The first subrogation provision was enforced and the second was not. The United Distributors Plan survived scrutiny because it created a lien on the specific fund—the amount recovered—and claimed a right to repayment only from that fund. The Mohawk plan failed because it simply claimed a right to recovery directly from the beneficiary.

Equitable Defenses

When dealing with a fully self-funded plan with a subrogation interest properly asserted in equity, defenses to repayment are limited. There exists a relatively even split among the circuits as to whether equitable defenses, such as made whole, may be raised in defense of a constructive trust on the settlement fund. The First, Fourth, and Eighth Circuits have rejected the made whole defense to self-funded ERISA subrogation interests, and the Sixth, Seventh, Ninth, and Eleventh Circuits endorse it, provided the plan language has not specifically disclaimed its availability.

The Tenth Circuit has been silent on the issue. This allows the practitioner some negotiating leverage where a plan has not specifically disclaimed made whole. However, practitioners should be cautioned that, although the U.S. Supreme Court has not explicitly resolved the Circuit split, the decision in Sereboff v. Mid-Atlantic Med. Servs., Inc. did seem to foreclose the use of equitable defenses. In that case, the Court characterized Mid-Atlantic’s reimbursement claim as one to enforce an equitable lien by agreement, rather than a claim of equitable subrogation, which would have opened the door to equitable defenses like made whole, common fund, laches, and unjust enrichment.

The Third Circuit is the first to uphold equitable defenses since Sereboff. In a case where an ERISA subrogated benefits provider sought reimbursement of the full amount paid—despite the fact that after attorney fees, the beneficiary would have had to reach into his own pocket to repay the plan—the court decided, “[e]quity abhors a windfall.” The court applied the doctrine of unjust enrichment and remanded the case. In distinguishing Sereboff, the Third Circuit relied on the provision of 29 U.S.C. § 1332(a)(2) allowing a plan to seek “appropriate equitable relief,” and the Sereboff

26. Id.
27. Id.
29. Barnes v. Ind. Auto Dealers Benefit Plan, 64 F.3d 1389, 1395 (9th Cir. 1995); Catelynland Oaks v. Haugt, 209 F.3d 811, 813 (6th Cir. 2000); Cutting v. Jerome Foods, Inc., 993 F.2d 1293, 1297-98 (7th Cir. 1993); Casel v. Bruner, 112 F.3d 1510, 1521 (11th Cir. 1997).
30. Sereboff, supra note 6 at 368.
32. Id.
Court’s decision not to decide what is “appropriate.” This may be a case destined for certiorari.

Negotiation Strategies

Even in cases where the fully self-funded subrogated benefits provider has a legally enforceable entitlement to full reimbursement, viable negotiating strategies exist. With a catastrophically injured client, public perception may help. For example, in a case where a Wal-Mart employee was rendered severely brain-damaged and reimbursement would have entirely wiped out the employee’s tort recovery, widespread negative publicity forced Wal-Mart’s hand, and it forgave the lien.

In smaller cases, negotiation is centered on the practicalities of litigation. If a personal injury client would not be willing to initiate a case without an agreement in place regarding subrogation reimbursement, a lien holder may agree in advance to a reduction so that the claimant has an incentive to litigate. If, during mediation, settlement offers being made by the tortfeasor are financially untenable without some yield in the subrogation interest, the lien holder may accept a reduction to mitigate its risk. In any case, it is paramount that the perfected ERISA subrogation interest be negotiated before the settlement is finalized.

Conclusion

With the proliferation of self-funded ERISA plans, the ability to determine an ERISA plan’s funding status and the enforceability of plan language, coupled with practical negotiating skills, are essential elements of representing the personal injury client. Familiarity with the form 5500 and federal case law will provide a solid basis for well-reasoned advice to clients and good-faith negotiation of ERISA-based subrogation claims.

33. Id.
TIPS Dog Vaccination Clinic

Sponsored by the ABA Tort Trial & Insurance Practice Section's Animal Law Committee
Co-Sponsored by the TIPS Law in Public Service Committee, Best Friends Animal Society and Safe Humane Chicago

ABA Annual Meeting
TIPS Public Service Project
Saturday, August 4, 2012
10:00 AM—2:00 PM
Rainbow Beach & Park Field House
3111 E. 77th Street
(access park facilities from 79th Street)
Chicago, Illinois

Please join us and volunteer to participate at the TIPS Dog Vaccination Clinic Public Service Project during the 2012 ABA Annual Meeting in Chicago!

This clinic will offer free microchips, low cost vaccinations, free spay/neuter vouchers, and the opportunity for attendees to speak with trainers who will be on-site.

The TIPS Task Force on Disaster Preparedness & Response will also be on-site to distribute disaster kits comprised of a flash drive and a list of recommended items for families and pet owners to download on the flash drive, which should be kept in a safe place for use in a disaster situation.
permissibility under the Commerce Clause, their victory was short-lived, because a 5-4 majority of the Court also found that the mandate could be characterized as a “tax” on not buying health insurance and it is permissible as an exercise of Congressional taxing power. Thus, the individual mandate survived, sparing the Court the burden of determining which parts, if any, of the ACA could operate if the mandate were struck down and how such a decision would impact activities already carried out under the ACA.

The Court also addressed the ACA’s provisions related to Medicaid expansion, which threatened states with loss of all federal Medicaid funding unless state Medicaid programs were expanded to cover all people (not just the elderly, blind, pregnant women and children) below a certain income level. Seven justices found that the threatened loss of all federal Medicaid dollars to induce expansion was so coercive as to violate the Spending Clause of the U.S. Constitution and exceeded federal authority to encourage states to regulate. This holding is significant because, although the Court has long suggested that there are limits to the federal government’s ability to condition grants to the states on the state’s compliance with federal requirements, this case marks the first time that a statute was held to be unconstitutional under the Spending Clause. As with the mandate, however, the Court’s holding that Congress had exceeded its powers did not prove fatal: the Court also held that the remedy for the violation was that the federal government could permissibly withhold new federal funding—i.e., funding tied to the expansion—from states unwilling to expand Medicaid as contemplated by the ACA. States, however, cannot be threatened with loss of existing Medicaid funding if they do not expand Medicaid.

Parsing the opinions issued (just short of 200 pages) also is somewhat of a challenge. Although four opinions were issued, only selected portions of the Chief Justice’s opinion were written “for the Court” (meaning that four other justices expressly joined his opinion in those sections). For the majority of issues decided, determining a “holding” requires reading all of the decisions and, for each proposition, determining which propositions are agreed to by shifting alliances of five or more justices. For example, although the opinion of Justices Antonin Scalia, Anthony Kennedy, Clarence Thomas and Samuel Alito is described as a “dissent,” it is this opinion, paired with the Chief Justice’s opinion (writing only for himself), that provides the “holding” of the Court on the Commerce Clause issue. Similarly, there is no one opinion joined by five justices addressing the Medicaid issue. Rather, the holding is determined by grouping the Chief Justice’s opinion that the Medicaid expansion provision is unconstitutional as written (which was joined by Justices Stephen Breyer and Elena Kagan, thus garnering three votes) with the joint dissent’s opinion (which garnered four votes) reaching the same conclusion. Because the joint dissent would have struck the entirety of the Medicaid expansion as a result of the unconstitutionality of the undue coercion of the states, one must look to a different grouping of five justices to support the Court’s holding that the provision can survive if only “new” Medicaid funding is threatened by a state’s failure to expand the program. For this proposition, the Chief Justice’s opinion (and its three votes on this point) is grouped with the opinion of Justice Ruth Bader Ginsburg, who was joined by Justice Sonia Sotomayor. Thus, although Justices Ginsburg and Sotomayor disagreed with the other seven justices that Medicaid expansion violated the Constitution, they agreed with the Chief Justice on the proper remedy if there were a Constitutional violation, thereby providing the fourth and fifth votes on that point.

In this advisory, we provide highlights of the Supreme Court’s decision and an initial analysis of the major holdings. We then analyze the opinion’s likely impact on state Medicaid programs and state health insurance exchanges, as well as other key stakeholders. We also review the likely political impact of the Court’s decision. This is a preliminary examination of the Court’s decision, and we will continue to study and analyze the opinion in the coming weeks. We also will continue to monitor the Congressional and political responses to the Court’s decision.

What Did the Court Decide?

The Supreme Court found that Congress exceeded its Commerce Clause powers, yet upheld the individual mandate under Congress’s taxing power.

A five-justice majority of the Court, consisting of Chief Justice Roberts writing on his own behalf, and Justices Scalia, Kennedy, Thomas and Alito, who issued a joint dissent, held that Congress exceeded its regulatory powers under the Commerce Clause when...
it adopted the individual mandate. They reasoned that the mandate expanded Congress’s powers under the Commerce Clause to include the authority to compel the purchasing of health insurance. As Chief Justice Roberts explained, this expansion surpassed the Court’s precedent limiting the Commerce Clause powers to the regulation of economic activity:

... [O]ur cases have “always recognized that the power to regulate commerce, though broad indeed, has limits.” The Government’s theory would erode those limits... Congress already enjoys vast power to regulate much of what we do. Accepting the Government’s theory would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal Government.

He stressed that a country in which Congress can “use its commerce power to compel citizens to act ... is not the country the Framers of our Constitution envisioned.”

The majority soundly rejected the federal government’s argument that the mandate regulates commerce since all citizens use health care services at some point in their lives. The joint dissent wryly observed that “[i]f every person comes within the Commerce Clause power of Congress to regulate by the simple reason that he will one day engage in commerce, the idea of a limited Government power is at an end.” The joint dissent and the Chief Justice likewise dismissed as wordplay the argument that the mandate regulates “the self-insurance market.” The Chief Justice further commented that “[i]ndividuals are no more ‘activ[e] in the self-insurance market’ when they fail to purchase insurance ... than they are active in the ‘rest’ market when doing nothing.”

A majority of the Court also declined the government’s invitation to uphold the mandate under the Necessary and Proper Clause, rejecting the argument that the mandate was an integral part of a comprehensive scheme of economic regulation. The joint dissent found that the mandate exceeded the scope of the Necessary and Proper Clause, as it violated the Constitution’s “principle of enumerated (and hence limited) federal power” by “convert[ing] the Commerce Clause into a general authority to direct the economy.” The Chief Justice agreed that the government’s use of the Necessary and Proper Clause would distort the Constitution’s framework by expanding the Commerce Clause into the new field of inactivity:

... [S]uch a conception of the Necessary and Proper Clause would work a substantial expansion of federal authority. ... Congress could reach beyond the natural limit of its authority and draw within its regulatory scope those who otherwise would be outside of it. Even if the individual mandate is “necessary” to the Act’s insurance reforms, such an expansion of federal power is not a “proper” means for making these reforms effective.

In reaching this holding, both the Chief Justice and the joint dissent distinguished Gonzales v. Raich on the ground that Raich did not expand Congress’s Commerce Clause power to include the authority to compel economic activity.

After concluding that Congress exceeded its Commerce Clause power by adopting the individual mandate, the Chief Justice, writing for the Court in a portion of his opinion joined by Justices Breyer, Kagan,}

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2 Although the Chief Justice was writing only for himself in Part IIIA of his opinion, the proposition that the mandate exceeded Congressional authority under the Commerce Clause is properly described as a holding of the Court because the joint dissent of Justices Scalia, Kennedy, Thomas and Alito, who did not join the Chief Justice’s opinion, also applied similar reasoning and found that the mandate exceeded Congressional authority. Compare Opinion of Roberts, C.J., at 30 (“The commerce power thus does not authorize the mandate.”) with joint dissent at 4-13 (discussing Commerce Clause authority and concluding that the individual mandate “exceeds federal power.” Id. at 13.). Under these circumstances, “[w]hen a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, ‘the holding of the Court may be viewed as the position taken by those Members who concurred in the judgments on the narrowest grounds.’” Marks v. United States, 430 U.S. 188, 193, 97 S.Ct. 990 (1977) (citing Gregg v. Georgia, 428 U.S. 153, 169 n.15, 96 S.Ct. 2909, 2923 (1976)).

3 Roberts Opinion at 23-24 (emphasis added).

4 Id. at 23.

5 Dissent at 12.

6 Roberts Opinion at 24, n.6.

7 The Necessary and Proper Clause states “The Congress shall have power to make all laws which shall be necessary and proper for carrying into execution the foregoing powers, and all other powers vested by this Constitution in the Government of the United States, or in any department or officer thereof.”

8 Dissent at 9.

9 Roberts Opinion at 30.

10 Dissent at 9. In Raich, the Court held that Congress had the power under the Necessary and Proper Clause to prohibit intrastate cultivation and possession of marijuana because the intrastate prohibition enabled Congress’s interstate regulation of marijuana. Gonzales v. Raich, 545 U.S. 1 (2005).
Ginsburg and Sotomayor, found that the “requirement that certain individuals pay a financial penalty ... may reasonably be characterized as a tax.”11 While “the Act describe[d] the payment as a ‘penalty,’ not a ‘tax,’” the Court took a “functional approach” to the payment by “disregarding the designation ... and viewing its substance and application.”12

Under the functional approach, three considerations warranted treating the payment as a tax and not a penalty:

First, for most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more. It may often be a reasonable financial decision to make the payment rather than purchase insurance.... Second, the individual mandate contains no scienter requirement. Third, the payment is collected solely by the IRS through the normal means of taxation—except that the Service is not allowed to use those means most suggestive of a punitive sanction, such as a criminal prosecution.13

In the Court’s view, the fact that the payment could impact individual conduct does not affect the payment’s function as a tax. The Court explained that “taxes that seek to influence conduct are nothing new” and pointed to taxes on cigarettes, marijuana and sawed-off shotguns as examples of lawful taxes that influence individual conduct without being transformed into penalties.14

The Court also rejected the argument the payment runs afoul of the Direct Tax Clause, which prohibits the levying of capitation taxes without apportionment.15 Capitation taxes are paid “without regard to property, profession, or any other circumstances.”16 Because the payments required under the individual mandate are triggered by earning a certain level of income and then failing to buy health insurance, the Court found that such payments are not, by definition, capitation taxes.

In light of the Chief Justice’s opinion and the joint dissent’s prior holding on the Commerce Clause power, the Court considered whether “it should be similarly troubling to permit Congress to impose a tax for not doing something.” The Court explained that “[t]hree considerations allay this concern. First, and most importantly, it is abundantly clear the Constitution does not guarantee that individuals may avoid taxation through inactivity.”17 Second, the Court polices the taxing power’s outer limits, and will invalidate a “so-called tax when it loses its character as such and becomes a mere penalty with the characteristics of regulation and punishment.”18 Third, “the taxing power does not give Congress the same degree of control over individual behavior.”19 That is, Congress’s taxing power only authorizes Congress to require individuals to pay money. It does not permit Congress to fine or imprison persons who fail to obey its commands, leaving them with “a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice.”20

Because the Court construed payments under the individual mandate as taxes authorized by the Constitution, the Court had no reason to analyze whether the individual mandate was severable from the ACA’s other provisions.

The Supreme Court held that the ACA’s Medicaid expansion provision is unconstitutionally coercive.

Under the Spending Clause, Congress has the authority to grant federal funds to states contingent on the states’ acceptance of certain conditions, as long as the states’ acceptance of the conditions is voluntary and knowing. If the states have no choice—if the pressure exerted by the financial inducement is so coercive as to be compulsive—Congress has exceeded its Spending Clause authority and violated the Constitution.

Seven Justices agreed that the provision of the ACA that threatened the states with the withdrawal of all their federal Medicaid funding unless they complied with the ACA’s Medicaid expansion provisions violated the Constitution’s Spending Clause. The Court held, by a

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11 Roberts Opinion at 44.
12 Roberts Opinion at 33-34. While the Court used a functional approach for its constitutional analysis, it construed the payment as a penalty and not a tax when analyzing the application of the Anti-Injunction Act (AIA). Id. at 12-13. The AIA bars actions to enjoin or otherwise obstruct the collection of taxes, and thus requires taxpayers to challenge taxes by paying them and then suing for a refund. The Court held that the AIA did not apply because “[t]he Anti-Injunction Act and the Affordable Care Act ... are creatures of Congress’s own creation. How they relate to each other is up to Congress, and the best evidence of Congress’s intent is the statutory text.” Id.
13 Roberts Opinion at 35-36.
14 Id. at 36-37.
15 Id. at 41.
16 Id. (emphasis in original).
17 Id.
18 Id. at 42, quoting Department of Revenue of Mont. v. Kurth Ranch, 511 U.S. 767, 779 (1994).
19 Id. at 43.
20 Id. at 44.
5-4 majority, that the remedy for this violation was to invalidate this condition as it applies to funding for the current Medicaid program, thus permitting the federal government to withdraw only the funding related to the ACA Medicaid expansion where a state refuses to comply with the Medicaid expansion. By the same 5-4 majority, the Court held that the unconstitutional condition was severable from the rest of the ACA.

In his opinion, joined by Justices Breyer and Kagan, the Chief Justice noted that Congress’s Spending Clause authority permits it to establish cooperative federal-state programs and to condition the receipt of funds under such programs. However, the legitimacy of such an exercise of the Spending Clause power “rests on whether the state voluntarily and knowingly accepts the terms of the ‘contract.’” The Chief Justice noted that “Congress may use its spending power to create incentives for states to act in accordance with federal policies. But when ‘pressure turns into compulsion,’ the legislation runs contrary to our system of federalism.”

The Chief Justice concluded that “the financial inducement”—in this case, the threat to all of a state’s federal Medicaid funding if the state failed to comply with the Medicaid expansion—“is much more than the ‘relatively mild encouragement’” that the Court had found permissible in South Dakota v. Dole: “it is a gun to the head.” The threatened loss of such a large percentage of a state’s overall budget is “an economic dragooning that leaves the states with no real option but to acquiesce in the Medicaid expansion.”

Importantly, in reaching this conclusion, Chief Justice Roberts found “[t]he Medicaid expansion . . . accomplishes a shift in kind, not merely degree” in the Medicaid program. Instead of covering medical services to four categories of needy persons, “Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level,” a population of childless adults not previously covered by Medicaid, as “an element of a comprehensive national plan to provide universal health insurance coverage.” He rejected the government’s contention that the Medicaid expansion is merely a modification of the existing program that the states accepted when they accepted the Medicaid statute’s reservation of “the right to alter, amend, or repeal any provision.” “[I]f Congress intends to impose a condition on the grant of federal monies, it must do so unambiguously,” and it cannot “surpris[e] participating states with post-acceptance or ‘retroactive’ conditions.” Here, “[a] state could hardly anticipate that Congress’s reservation of the right to ‘alter’ or ‘amend’ the Medicaid program included the power to transform it so dramatically.

Rounding out the majority, Justices Scalia, Kennedy, Thomas and Alito, in their joint dissent, agreed with the Chief Justice that the Medicaid expansion was unconstitutionally coercive:

The ACA does not legally compel the States to participate in the expanded Medicaid program, but the Act authorizes a severe sanction for any State that refuses to go along: termination of all the State’s Medicaid funding. For the average State, the annual federal Medicaid subsidy is equal to more than one-fifth of the State’s expenditures. A State forced out of the program would not only lose this huge sum but would almost certainly find it necessary to increase its own health-care expenditures substantially, requiring either a drastic reduction in funding for other programs or a large increase in state taxes. And these new taxes would come on top of the federal taxes already paid by the State’s citizens to fund the Medicaid program in other States.

The joint dissent noted that, “[i]n structuring the ACA, Congress unambiguously signaled its belief that every state would have no real choice but to go along

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21 Id. at 46-47.
22 Id. at 47.
23 Id.
25 Roberts Opinion at 51.
26 Id. at 52.
27 Id. at 53.
28 The four categories of needy people covered by pre-ACA Medicaid are the disabled, the blind, the elderly and families with dependent children.
29 Roberts Opinion at 53-54.
30 Id. at 55, quoting 42 U.S.C. § 1304.
31 Id. at 54.
32 Id.
33 Dissent at 28.
with the Medicaid expansion. If the anti-coercion rule does not apply in this case, then there is no such rule."34

In considering the proper remedy for the Medicaid expansion’s violation of the Spending Clause, Chief Justice Roberts noted that 42 U.S.C. § 1396c permits the Secretary of Health and Human Services (HHS) “to withhold all ‘further [Medicaid] payments . . . to the State’ if she determines that the State is out of compliance with any Medicaid requirement, including those contained in the expansion.”35 But Congress is not free “to penalize States that choose not to participate in that new [Medicaid expansion] program by taking away their existing funding.”36 Thus, the Secretary “cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.”37 Chief Justice Roberts’ opinion states “[t]hat fully remedies the constitutional violation we have identified.”38 Section 1396c “is unconstitutional when applied to withdraw existing Medicaid funds from states that decline to comply with the expansion.”39 He concludes that the unconstitutional application of section 1396c is severable from the rest of the ACA because “[w]e are confident that Congress would have wanted to preserve the rest of the Act.”40

While Justice Ginsburg, in an opinion joined by Justice Sotomayor, would have upheld the Medicaid expansion under the Spending Clause, given the holding, she “entirely agree[s] with the Chief Justice as to the appropriate remedy. It is to bar the withholding found impermissible—not, as the joint dissenters would have it, to scrap the expansion altogether.”41

Impact on the States and on the Medicaid Program

The Court’s decision on the Medicaid expansion will require further in-depth analysis to determine the full legal effect of the ruling and its likely impact not only on the ACA’s implementation and the implementation of other ACA Medicaid provisions, but also on the enactment of future changes to the Medicaid program. The Court’s decision also could have far-reaching impacts on overall coverage levels resulting from the ACA, on state and federal budgets, and on Medicare and Medicaid reimbursement.

Section 2001(a) of the ACA requires states to cover under-65, non-pregnant, non-Medicare or Medicaid-entitled individuals at or below 133 percent of the federal poverty level (FPL).42 For 2014, 2015 and 2016, the federal share of the cost to cover this “expansion population” is 100 percent; the federal share of covering this group declines gradually to 90 percent in 2020 and subsequent years, with each state paying 10 percent of the cost of coverage.43 The Congressional Budget Office estimated that, by 2019, the ACA’s Medicaid expansion would cover an additional 16 million uninsured, low-income Americans who otherwise would remain uninsured.44

Our initial reading is that the Court essentially has made the Medicaid expansion voluntary for states by ruling that states cannot be penalized through the loss of their present-day federal funding or “match.” Under the ACA, states that choose not to cover the “expansion population” would not only lose the enhanced federal match for that population (100 percent in 2014-2016 and phasing down to 90 percent in 2020 and thereafter), but also could forfeit the federal match they historically had received for the populations they already covered. A number of governors have expressed opposition to covering the “expansion population” and, therefore, may take advantage of the remedy included in the Court’s decision to decline covering the additional population without the risk of losing all federal Medicaid funding.

34 Dissent at 38, 46 (“it is perfectly clear from the goal and structure of the ACA that the offer of Medicaid expansion was one that Congress understood that no state could refuse”). Justices Ginsburg and Sotomayor would have found the Medicaid expansion within Congress’s Spending Clause power.
35 Roberts Opinion at 56 (emphasis in original), quoting 42 U.S.C. § 1396c.
36 Id. at 55.
37 Id. at 56.
38 Id.
39 Id. He notes, however, that the “holding does not affect the continued application of § 1396c to the existing Medicaid program. Nor does it affect the Secretary’s ability to withdraw funds provided under the [ACA] if a state that has chosen to participate in the expansion fails to comply with the requirements of that Act.” Id.
40 Id. at 57.
41 Ginsburg Opinion at 40; see also Ginsburg Opinion at 60-61. Justices Scalia, Kennedy, Thomas and Alito dissented with respect to the remedy. They believe that “[t]he most natural remedy would be to invalidate the Medicaid expansion” because the majority’s approach forces states to “choose between expanding Medicaid or paying huge tax sums to the federal fisc for the sole benefit of expanding Medicaid in other States.” Dissent at 47. Furthermore, the Court should not attempt to solve a constitutional problem by rewriting the Medicaid expansion. Id. at 48. They would also strike down the ACA in its entirety as inseverable. Dissent at 48-65.
42 In practice, the threshold is 138 percent of the FPL, due to a five percent income disregard in the eligibility calculation.
It is unclear the extent to which states will or will not participate in this now-voluntary expansion. States that choose to opt out of the Medicaid expansion could leave a significant number of individuals without affordable coverage options. Under the ACA, the federal government is authorized to provide health insurance premium subsidies for individuals between 100 and 400 percent of FPL, which will be used to purchase coverage from a qualified health plan through a health insurance exchange. If a state chooses not to cover the “expansion population” and does not otherwise provide coverage to individuals up to 100 percent of FPL, the people “in between” will have neither Medicaid coverage nor federal subsidies to purchase plans on the state’s exchange, and they could remain uninsured. Presumably, at least some portion of this “in-between” population would fall within the individual mandate’s exemption of individuals for whom coverage is unaffordable and therefore would not have to pay the penalty (or “tax,” as the Court has determined it is).

The Court’s ruling also has ramifications for Medicare and Medicaid reimbursement because the level of uninsured individuals will affect disproportionate share hospital (DSH) payments under the Medicare and Medicaid programs. Starting in 2014, the ACA requires reductions to DSH payments under both programs and adjustments based on the percentage of uninsured individuals. DSHs accepted a reduction in Medicare and Medicaid DSH payments in return for an increase in the number of patients with private or Medicaid coverage, but the Court’s ruling could limit the anticipated expansion of the Medicaid program significantly. The effect of the Court’s ruling may be more limited for states like Tennessee and Hawaii, which operate their Medicaid programs through waivers and receive allotments through a separate process.

The Court held that its ruling does not affect the validity of the non-Medicaid expansion provisions in the ACA, including the other Medicaid provisions. As a result, these other provisions can continue to be implemented, including other Medicaid provisions addressing issues such as program integrity, CHIP, demonstration projects and grants.

There are a number of questions that government regulators will need to consider in the coming weeks and months in order to provide guidance and clarity to federal agencies, states and other Medicaid stakeholders going forward. Resolution of these issues may require involvement of the courts.

- **What ACA provisions constitute the “Medicaid expansion” for purposes of the Court’s ruling?**

The implications of which ACA provisions constitute the Medicaid expansion may be significant because of the HHS Secretary’s authority under section 1904 of the Social Security Act (SSA)\(^45\) to withdraw federal Medicaid funds for a state’s failure to comply with Medicaid requirements. While the Court ruled that the Secretary cannot apply section 1904 of the SSA and withdraw existing federal Medicaid funds for a state’s failure to comply with the requirements of the Medicaid expansion, she can continue to apply section 1904 with respect to ACA Medicaid funds if a state fails to comply with other ACA requirements.

Chief Justice Roberts in his opinion does not expressly identify what provisions constitute the Medicaid expansion. Although he discusses the requirement to cover the newly eligible population, federal financing levels for this population and providing this population with an essential health benefits package, there is a lack of clarity about which other ACA provisions are part of the Medicaid expansion. The states argued that other ACA provisions are part of the Medicaid expansion, including (1) maintenance of effort requirements, under which a state is prohibited from changing eligibility standards for adults until the state’s health insurance exchange is operational, and for children until October 1, 2019; (2) requiring states to use a new income test based on modified adjusted gross income; and (3) requiring states to assume responsibility for providing care and services in addition to paying for care and services.

- **In the future, what changes can be made to the Medicaid program that are not unduly coercive on the states?**

In the past, Congress has made changes to the Medicaid program under section 1904 of the SSA, in which it reserves the right “to alter, amend, or repeal any provision” of the SSA. However, the Court found that conditioning the

\(^45\) 42 U.S.C. § 1304.
receipt of current Medicaid funding on coverage of the “expansion population” was impermissibly coercive, noting that the Medicaid expansion transformed the program dramatically. It is unclear what changes Congress could make to the Medicaid program in the future under this standard.

• **Now that covering the newly eligible population is voluntary, how will this provision be implemented?**

Now that the Medicaid expansion is no longer a requirement, a number of questions need to be answered on how it will be implemented. Is the Medicaid expansion going to be treated as a new state option? Is the January 1, 2014, start date an “all-or-nothing” proposition, or can a state that chooses not to cover the “expansion population” beginning on January 1, 2014, choose, at a later date, to cover that group under the state’s Medicaid program? It also is not clear what the result would be if a state chose to cover the “expansion population” beginning on January 1, 2014, but ceased to cover that group at a later date.

**Impact on Other Key Stakeholders**

The ACA and all implementing regulations—with one exception relating to Medicaid expansion—now are affirmed as the law of the land and will remain so, barring any successful litigation or successful legislative activity to repeal them. This provides all stakeholders with greater certainty about the future and increased stability. There is, nevertheless, a tremendous amount of work that will need to be accomplished between now and 2014 in order to achieve successful and timely implementation of the programs and reforms mandated by the ACA. Implementation of major programs is never easy. Given the magnitude of the changes made by these new programs, the shortness of the time in which to accomplish them and the delays in the development of some of the implementing regulations, it would be wise to expect some significant implementation and operational issues that will have to be addressed.

The Supreme Court’s decision does not mark the end of litigation over the ACA, although the action now moves to litigation over more discrete provisions of the ACA or the implementing regulations. Such litigation may challenge the constitutionality of some provisions or the statutory authority under the ACA to impose certain regulatory requirements. There are a number of current lawsuits that illustrate this. There is ongoing litigation that challenges the constitutionality of the Independent Payment Advisory Board, as well as litigation that challenges Congress’s constitutional authority to impose limitations on physician-owned hospitals. Also, religious organizations and employers have filed a number of lawsuits challenging, on constitutional and statutory grounds, the regulations requiring the provision of contraceptives as preventive services and the failure to provide a meaningful exemption for religious organizations.

Below we discuss some of the implications for certain stakeholders: the federal government, states, hospitals and other providers, drug and device manufacturers, employers and group health plan sponsors, and health insurance issuers.

• **Federal Government:** In the run-up to the issuance of the Supreme Court’s decision, HHS, the Centers for Medicare & Medicaid Services (CMS), the Center for Consumer Information and Insurance Oversight (CCIIO), the Department of Treasury, and the Department of Labor continued their ACA implementation efforts. Now that the constitutionality of the ACA as a whole has been resolved, these agencies need to strengthen their efforts to achieve implementation of the ACA reforms in the time frame established by the statute. In particular, CCIIO will need to work closely with states that intend to have a state-run exchange or a State Partnership with a “Federally Facilitated Exchange” in operation by January 1, 2014.

Given the Supreme Court’s decision on Medicaid expansion, CMS and its Center for Medicaid and CHIP Services will need to take prompt action to develop guidance on a number of issues, including the issues outlined above, arising out of the new “voluntariness” of Medicaid expansion on the part of the states. We also expect that the Congressional Budget Office will evaluate the federal budgetary impact of the Medicaid decision insofar as it may reduce federal spending for Medicaid coverage in states that may elect not to cover the expansion population, while potentially increasing the cost of federal subsidies for additional low-income individuals purchasing coverage through an exchange.

The Supreme Court’s decisions also may mark important milestones in the Court’s jurisprudence of

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46 See supra at 6-7.
the Constitution’s Commerce and Spending Clauses. For example, this is the first time the Court has held that Congress exceeded its Spending Clause authority to impose requirements on the states as a condition of the receipt of federal funds. Agencies across the federal government may need to assess their current programs in light of the decisions.

**The States:** The willingness of states to take action to implement ACA requirements, most notably health insurance exchanges and Medicaid expansion, has varied widely. With 26 states joining the constitutional challenge to the law, it is not surprising that many took a “wait-and-see” approach to ACA requirements. Despite the Court’s validation of most of the ACA, some states may continue to wait on the outcome of the 2012 elections and any subsequent Congressional efforts to repeal and/or replace the ACA. Given the short timeframe before many major requirements go into effect in 2014, we expect many states to focus on implementation activities in earnest. Some states still may decline to establish health insurance exchanges, with the result that a federally facilitated exchange will need to be operated for the state, at least for some period of time.

Given the short timeframe before the health insurance exchange requirements go into effect in 2014, we expect more states to focus on implementation activities in order to meet federal deadlines. At present, 14 states and the District of Columbia have established a state exchange through either legislative or executive action, and Arkansas is planning for a State Partnership exchange. Louisiana, Maine and New Hampshire have affirmatively decided not to create an exchange. The remaining states have either taken no significant action or are evaluating their options. If a state intends to operate a state exchange or a State Partnership exchange, it will have until November 16, 2012, to submit an exchange blueprint to HHS. Some states may wait until after the November elections to make a decision about whether or not to submit one. Now that it is clear that ACA implementation will proceed, many states may conclude that there is not sufficient time to set up a state-run exchange and will notify HHS; others may not take any action to notify HHS. Still other states may attempt to have an operable exchange for the 2014 coverage year (as determined by January 1, 2013), but will not be ready. In any of these situations, HHS will operate a Federally Facilitated Exchange for the state, either under a State Partnership—where the state may administer plan management functions and/or in-person consumer assistance functions—or without the state as a partner.

With respect to Medicaid expansion, seven states and the District of Columbia have already elected to cover all or part of the “expansion population,” pursuant to a state option in the ACA or a waiver. On the other hand, some believe that the “wait and see” approach of states that challenged the Medicaid expansion has been vindicated, at least in part, by the Supreme Court’s holding that the Medicaid expansion provisions violated the Spending Clause. States have a number of important—and difficult—decisions to make. The remedy granted by the Court was not the remedy sought by the states that challenged the Medicaid expansion, but they now must decide whether to accept the federal Medicaid expansion funds and the concomitant obligations and requirements or to forego such funds and avoid the potentially costly accompanying requirements. Regardless of the decision any particular state may make, there will be fiscal and political implications.

**Hospitals and Other Providers:** Implementation of the ACA’s health care delivery system and fraud and abuse reforms will continue without interruption. Come 2014, the affirmance of the individual mandate means that providers may begin to see the benefits of a greater number of privately insured patients. Depending on the decisions made by the states, the Supreme Court’s decision on Medicaid expansion may mean that providers will experience a more limited reduction in the number of uninsured patients they treat—and a more limited reduction in the amount of reduced fee or uncompensated care they provide. This may have a particular impact on DSHs that had accepted a reduction in Medicare and Medicaid DSH payments in return for an increase in the number of patients with private or Medicaid coverage. Medicare cuts on many providers that are to be used to finance other provisions of the legislation will remain in place.

**Drug and Device Manufacturers:** The Court’s decision allows implementation of key provisions impacting drug and device manufacturers to go forward. This includes ACA changes to the Medicare Part D Program (including closing the “donut hole”), the Medicaid Drug Rebate Program (including the definition of average manufacturer price (AMP)) and expansion of the 340B Drug Discount Program. The
As is the case with the president-supreme-court-ruling-affordable-care-act, Remarks by President on Supreme Court Ruling on the Affordable Care Act, June 28, 2012, • Employers/Group Health Plan Sponsors: Employers need to continue to plan for the temporary reinsurance program soon will be effective. Employers need to continue to plan for the reforms that will be effective starting in 2014 and to determine how the employer responsibility requirements and the availability of health insurance exchanges and subsidies will impact the decision to offer group health coverage. In this regard, there is not yet final guidance on a number of key issues, including how part-time employees will be defined and how “minimum value” will be determined for purposes of the employer penalties.

• Health Insurance Issuers: As is the case with employers/group health plans, the Court’s decision means that health insurance issuers will continue to implement the ACA requirements. For example, any rebates determined under the medical loss ratio (MLR) provisions will need to be paid by August 1, 2012, in accordance with final regulations. Preparation for the 2014 reforms, including the possibility of both state-run and federally facilitated exchanges, will continue. The taxes and fees imposed on health insurance issuers also will go into effect, including the contribution relating to the temporary reinsurance program, the industry fee, and the denial of deduction of compensation in excess of $500,000.

Likely Political Impact

The Court’s decision allows the Obama Administration to continue with implementation of the ACA. While this is a major legal win for the Administration, even in his statement following the decision’s announcement, President Obama acknowledged the “very real concerns that millions of Americans have shared” and said, “it should be pretty clear by now that I didn’t do this because it was good politics.”47 Health care and the fate of the ACA will continue to be an issue for both sides leading up to the 2012 elections, with Democrats seeking to re-educate Americans on the law’s provisions and value, and Republicans citing its cost impact on individuals, businesses and the economy. In a statement less than two hours after the decision was released, Governor Mitt Romney, the likely Republican nominee to challenge President Obama in November, vowed to take action to repeal “Obamacare” on his first day in office. The Romney campaign reportedly raised more than $4 million in the first 24 hours after the decision was announced, indicating that the ruling could energize those who favor repeal of the ACA.

Republicans in the House have scheduled a vote on repeal of the law for July 11, 2012, that is expected to

succeed, although no action is expected in the Senate, given the Democratic majority. House Speaker John Boehner (R-OH) said the “ruling underscores the urgency of repealing this harmful law in its entirety.” Senate Republicans also expressed disappointment with the Court’s decision, as well as support for repeal. Senate Republican Leader Mitch McConnell (R-KY) said the “decision makes one thing clear: Congress must act to repeal this misguided law. . . . It is my hope that with new leadership in the White House and Senate, we can enact these step-by-step solutions and prevent further damage from this terrible law.” Democrats in the House and Senate celebrated the decision as a victory and restated the law’s strengths: improving insurance transparency, affordability and preventive health care services.

Legislative changes to the ACA this year are highly unlikely prior to the elections this fall. With Republicans in control of the House and Democrats in control of the Senate, wholesale change also is unlikely in a lame duck session. It is possible that proposals targeting particular provisions, such as repealing the medical device tax and the Independent Payment Advisory Board (both of which already have gained bipartisan support), could gain some ground, if packaged with other legislative proposals that could move forward in a lame duck session. Broader changes to the structure of the ACA, including delay of effective dates or scaling back the availability of subsidies, also could come under consideration after elections, particularly if the modifications result in budgetary savings. It is not clear, however, what legislative action will be possible in a lame duck session, and proposals that increase the deficit may face significant hurdles.

**Conclusion**

Although the wait for the Supreme Court’s ruling on provisions of the Affordable Care Act has come to a close, the Court’s decision does not mark the end of questions about how the law will be implemented by the federal government and states, which states will expand Medicaid coverage and how, and what effect the ruling will have on other federal laws and programs. Nor does the Court’s decision remove the issue of “health care” from the political conversation, and there undoubtedly will be continuing legal and legislative challenges to the Affordable Care Act. We will continue to monitor events and keep you informed of the legal, legislative and political developments related to this case as they unfold.  

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ANOTHER SOCIAL MEDIA…

Internet, including to your own or someone else’s web log or blog, journal or diary, personal web site, social networking or affinity web site, web bulletin board or a chat room, whether or not associated or affiliated with [Employer], as well as any other form of electronic communication.

The same principles and guidelines found in [Employer] policies and three basic beliefs apply to your activities online. Ultimately, you are solely responsible for what you post online. Before creating online content, consider some of the risks and rewards that are involved. Keep in mind that any of your conduct that adversely affects your job performance, the performance of fellow associates or otherwise adversely affects members, customers, suppliers, people who work on behalf of [Employer] or [Employer’s] legitimate business interests may result in disciplinary action up to and including termination.

Know and follow the rules

Carefully read these guidelines, the [Employer] Statement of Ethics Policy, the [Employer] Information Policy and the Discrimination & Harassment Prevention Policy, and ensure your postings are consistent with these policies. Inappropriate postings that may include discriminatory remarks, harassment, and threats of violence or similar inappropriate or unlawful conduct will not be tolerated and may subject you to disciplinary action up to and including termination.

Be honest and accurate

Make sure you are always honest and accurate when posting information or news, and if you make a mistake, correct it quickly. Be open about any previous posts you have altered. Remember that the Internet archives almost everything; therefore, even deleted postings can be searched. Never post any information or rumors that you know to be false about [Employer], fellow associates, members, customers, suppliers, people working on behalf of [Employer] or competitors.

Post only appropriate and respectful contents

Maintain the confidentiality of [Employer] trade secrets and private or confidential information. Trade secrets may include information regarding the development of systems, processes, products, know-how and technology. Do not post internal reports, policies, procedures or other internal business-related confidential communications.

Respect financial disclosure laws. It is illegal to communicate or give a “tip” on inside information to others so that they may buy or sell stocks or securities. Such online conduct may also violate the Insider Trading Policy.

Do not create a link from your blog, website or other social networking site to a [Employer] website without identifying yourself as a [Employer] associate.

Express only your personal opinions. Never represent yourself as a spokesperson for [Employer]. If [Employer] is a subject of the content you are creating, be clear and open about the fact that you are an associate and make it clear that your views do not represent those of [Employer], fellow associates, members, customers, suppliers or people working on behalf of [Employer]. If you do publish a blog or post online related to the work you do or subjects associated with [Employer], make it clear that you are not speaking on behalf of [Employer]. It is best to include a disclaimer such as “The postings on this site are my own and do not necessarily reflect the views of [Employer].”

Using social media at work

Refrain from using social media while on work time or on equipment we provide, unless it is work-related as authorized by your manager or consistent with the Company Equipment Policy. Do not use [Employer] email addresses to register on social networks, blogs or other online tools utilized for personal use.
Retaliation is prohibited

[Employer] prohibits taking negative action against any associate for reporting a possible deviation from this policy or for cooperating in an investigation. Any associate who retaliates against another associate for reporting a possible deviation from this policy or for cooperating in an investigation will be subject to disciplinary action, up to and including termination.

Media contacts

Associates should not speak to the media on [Employer’s] behalf without contacting the Corporate Affairs Department. All media inquiries should be directed to them.

For more information

If you have questions or need further guidance, please contact your HR representative.

“The General Counsel found that this policy was not unlawful because “it provides sufficient examples of prohibited conduct so that, in context, employees would not reasonably read the rules to prohibit Section 7 activity.”

If you wish to discuss this recent guidance, feel free to contact an attorney in Dorsey & Whitney’s Labor & Employment group, Douglas R. Christensen at 612-340-8875, or Joel O’Malley at 612-492-6727 or omalley.joel@dorsey.com.
The government is serious about the new penalties: the OCR has imposed millions of dollars in penalties or settlements since the mandatory penalties took effect. Recent HIPAA amendments also authorize state attorneys general to sue individuals for HIPAA violations and recover penalties in the amount of $25,000 per violation plus fees. The amendments also permit affected individuals to recover a portion of any settlement or penalties related to a HIPAA violation, thereby increasing their incentive to report HIPAA violations. Regulations implementing the amendments are pending.

The good news is that if the covered entity or business associate does not act with willful neglect, the OCR may waive or reduce the penalties, depending on the circumstances of the violation. More importantly, if the covered entity or business associate does not act with willful neglect and corrects the violation within 30 days, the OCR may not impose any penalty; timely correction constitutes an affirmative defense.

HIPAA violations may be a crime

Even if not a business associate, attorneys and any other individuals may be liable under HIPAA’s criminal statute for improperly obtaining or disclosing protected health information from a covered entity without authorization:

<table>
<thead>
<tr>
<th>Prohibited Conduct</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowingly obtaining or disclosing protected health information without authorization.</td>
<td>Up to $50,000 fine and one year in prison.</td>
</tr>
<tr>
<td>If done under false pretenses.</td>
<td>Up to $100,000 fine and five years in prison.</td>
</tr>
<tr>
<td>If done with intent to sell, transfer, or use the information for commercial advantage, personal gain or malicious harm.</td>
<td>Up to $250,000 fine and ten years in prison.</td>
</tr>
</tbody>
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What your clients (and you) need to do to avoid penalties.

Given this increased exposure, covered entities and their attorneys need to do the following to avoid HIPAA penalties:

1. **Read the rules.** There is no substitute for actually knowing the rules, which are found at 45 C.F.R. part 164. The OCR maintains a very helpful website to facilitate HIPAA compliance: www.hhs.gov/ocr/privacy. Among other things, the website contains copies and summaries of the rules, guides, forms, and frequently asked questions.

2. **Assign HIPAA responsibility.** Covered entities must designate persons to serve as HIPAA privacy and security officers and document the designation in writing. The privacy and security officers are responsible for ensuring HIPAA compliance.

3. **Comply with use and disclosure rules.** The basic privacy rules are simple. In general, covered entities and business associates may not use, access or disclose protected health information without the patient’s valid, HIPAA-compliant authorization unless the use or disclosure fits within an exception. Covered entities and business associates may use or disclose protected health information for purposes of treatment, payment or certain health care operations without the patient’s consent. However, they may not use or disclose more than is minimally necessary for the permitted purpose.

4. **Comply with patient rights.** HIPAA grants patients certain rights concerning their health information. Among others, patients generally have a right to obtain copies of their protected health information, request amendment to their information, and obtain an accounting of impermissible disclosures. Covered entities and business associates must allow patients to exercise their rights. Cignet Health was fined $4.3 million for, among other things, failing to timely respond to patient requests to access their health information.

5. **Maintain written policies.** HIPAA requires covered entities and business associates to develop and maintain written policies that implement the privacy and security rule requirements. Having the required
policies is a key to avoiding penalties: it may be difficult to avoid a finding of willful neglect if you failed to implement the policies required by HIPAA. HHS has indicated that maintaining the required written policies is a significant factor in avoiding penalties imposed for “willful neglect.” In contrast, Rite Aid paid $1 million to settle HIPAA violations based on its failure to maintain required HIPAA policies.

6. Develop compliant forms. HIPAA requires that certain documents used by covered entities and business associates satisfy regulatory requirements. For example, HIPAA authorizations must contain certain elements to be valid. Covered entities must provide patients with a notice of privacy practices that contains certain statements. Other forms may be developed to ensure compliance with patient rights. Ensure your HIPAA forms satisfy the regulatory requirements.

7. Execute business associate agreements. Although HIPAA now applies directly to business associates, HIPAA still requires covered entities to execute “business associate agreements” with their business associates before disclosing protected health information to the business associate. Under proposed rules, attorneys and other business associates must execute similar agreements with subcontractors to whom the business associate discloses protected health information. The business associate agreements must contain certain elements. Breach of the business associate agreement exposes the business associate to contract claims by the covered entity in addition to the civil or criminal penalties that may follow HIPAA violations.

8. Train employees and agents. Having the policies and forms is only the first step. Covered entities and business associates must train their agents to comply with the policies and agreements. HIPAA requires that new employees be trained within a reasonable period of time upon hire, and as needed thereafter. Documented training is a second most important step to avoid HIPAA compliance. In commentary to HIPAA’s new penalties, HHS indicated that covered entities may avoid HIPAA penalties based on the misconduct of a rogue employee so long as the covered entity implemented appropriate policies and adequately trained the employee.

9. Use appropriate safeguards. The government recognizes that patient information cannot be absolutely protected; accordingly, HIPAA does not impose liability for “incidental disclosures” so long as the covered entity or business associate implemented reasonable administrative, technical, and physical safeguards designed to protect against improper disclosures. The security rule contains detailed regulations concerning safeguards that must be implemented to protect electronic health information. The privacy rule is less specific. Reasonable safeguards may include, e.g., not leaving protected health information where it may be lost or improperly accessed; checking e-mail addresses and fax numbers before sending using fax cover sheets; etc.

10. Respond immediately to any breach. This is critical for several reasons. First, HIPAA requires covered entities and business associates to investigate any privacy complaints, mitigate any breach, and impose appropriate sanctions against any agent who violates HIPAA. It may also require covered entities to terminate an agreement with a business associate due to the business associate’s noncompliance. Second, an entity may be able to ameliorate or negate any risk of harm to the affected individual by taking swift action, thereby avoiding the obligation to self-report HIPAA violations to the individual and the government. Third, a covered entity or business associate can avoid HIPAA penalties altogether if it corrects the violation within 30 days.

11. Timely report breaches. If a breach of unsecured protected health information poses a risk of significant financial, reputational or other harm to the individual, business associates must promptly report the breach to covered entities, and covered entities must notify the individual within 60 days. If the breach involves less than 500 persons, the covered entity must notify HHS by filing an electronic report no later than 60 days after the end of the calendar year. If the breach involves 500 or more persons, the covered entity must file the electronic report at the same time it gives notice to the individual. The written notice to the individual must satisfy certain regulatory requirements.

12. Document your actions. Documentation of proper action is essential to defend yourself against HIPAA claims. In addition, covered entities and business associates are generally required to maintain documentation required by HIPAA for six years.

13. Watch for new rules. As I write this article, the Office of Management and Budget is considering new HIPAA regulations, including those affecting business associate responsibilities. Attorneys and their health care clients should watch for the new regulations and implement any additional changes as necessary.
About the Author

Kim C. Stanger is a partner at Holland & Hart, LLP in Boise. Mr. Stanger handles simple and complex healthcare transactions, including practitioner and payor contracts; joint ventures; practice formations, acquisitions, and mergers; conversions; and physician integration. He helps clients comply with numerous laws and regulations governing healthcare, including Stark, the Anti-Kickback Statute, HIPAA, EMTALA, HITECH, Medicare and Medicaid requirements, and licensing rules.

Sources:
1 “HIPAA” is the Health Insurance Portability and Accountability Act. The HIPAA privacy and security rules are found at 45 C.F.R. part 164; 2 45 C.F.R. § 160.103 (definition of covered entity).
3 Id (definition of business associate).
4 Id (definition of protected health information).
5 45 C.F.R. § 164.400 et seq.
6 45 C.F.R. § 164.410.
7 45 C.F.R. §§ 164.402 and 408.
10 45 C.F.R. §§ 160.401 and 404; see 75 F.R. 40876.
11 See, e.g., reported enforcement actions listed at http://www.hhs.gov/ocr/privacy (last visited April 26, 2012).
13 45 C.F.R. § 160.408.
14 45 C.F.R. § 160.410.
16 45 C.F.R. § 164.530(a).
17 45 C.F.R. § 164.502(a).
18 45 C.F.R. § 164.502(b).
19 45 C.F.R. § 164.524.
20 45 C.F.R. § 164.526.
21 45 C.F.R. § 164.528.
23 45 C.F.R. § 164.316(e) and 530(f).
24 See 75 F.R. 48078-79.
26 45 C.F.R. § 164.506.
27 45 C.F.R. § 164.520.
28 45 C.F.R. § 164.308(b) and 502(e).
29 75 F.R. 40873.
30 45 C.F.R. § 164.314(a) and 504(e).
31 45 C.F.R. § 164.530(b).
32 75 F.R. 40879.
34 45 C.F.R. § 164.308-.316, and Appendix A to 45 C.F.R. subpart C of part 164.
35 45 C.F.R. § 164.530(c).
36 45 C.F.R. § 164.530(d)(4).
37 See 45 C.F.R. § 164.314(a)(2)(i)(D) and 504(c)(2)(iii).
38 See 45 C.F.R. § 164.508.
40 45 C.F.R. §§ 164.404-.410.
41 45 C.F.R. § 164.408(c).
42 45 C.F.R. § 164.408(b).
43 45 C.F.R. § 164.404.
44 45 C.F.R. § 164.530(j).
# 2012 TIPS CALENDAR

## August 2012
- **2-7** ABA Annual Meeting  
  Sheraton Chicago Hotel & Towers  
  Contact: Felisha A. Stewart – 312/988-5672  
  Speaker Contact: Donald Quarles – 312/988-5708

## October 2012
- **11-15** TIPS Fall Leadership Meeting  
  La Quinta Resort and Club  
  Contact: Felisha A. Stewart – 312/988-5672

- **18-19** Aviation Litigation National Program  
  The Ritz-Carlton  
  Contact: Donald Quarles – 312/988-5708

## November 2012
- **7-9** Fidelity & Surety Committee Fall Meeting  
  Marriott Hartford Downtown  
  Contact: Donald Quarles – 312/988-5708

## January 2013
- **23-25** Fidelity & Surety Committee Midwinter Meeting  
  Waldorf-Astoria Hotel  
  Contact: Donald Quarles – 312/988-5708

## February 2013
- **6-12** ABA Midyear Meeting  
  Hilton Anatole Dallas, TX  
  Contact: Felisha A. Stewart – 312/988-5672  
  Speaker Contact: Donald Quarles – 312/988-5708

## April 2013
- **23-28** TIPS Section Spring Leadership Meeting  
  JW Marriott  
  Washington, DC  
  Contact: Ninah Moore – 312/988-5498

## August 2013
- **8-13** ABA Annual Meeting  
  San Francisco Marriott  
  San Francisco, CA  
  Contact: Felisha A. Stewart – 312/988-5672