HEALTH LAW

Kirsten A. Lerch & Adam R. Crowley†

CONTENTS

INTRODUCTION

At the federal level, religious-based challenges to the Affordable Care Act ("ACA") continued, resulting in some of the highest-profile litigation of the past year. At the state level, the Court of Appeals decided *Doe v. Guthrie Clinic, Ltd.* and *Caronia v. Philip Morris USA*, which explored a hospital's responsibility for the actions of its employee and the viability of an independent equitable cause of action for medical monitoring in this state, respectively. The Appellate Division addressed intriguing topics, including the appropriate application of the statute of limitations for medical malpractice actions and whether the New York

† Ms. Lerch is an Associate with Gale Gale & Hunt, LLC; J.D., State University of New York at Buffalo; B.A., State University of New York College at Geneseo. Mr. Crowley is a Staff Attorney with Legal Services of Central New York; J.D., Syracuse University College of Law; B.A., University of Connecticut. This Article addresses developments in New York State and federal health law from July 1, 2013 to June 30, 2014.

Prompt Pay Act includes an implied private right of action. Further, proposed legislation on medical marijuana, Program Bill #57, and medical misconduct in relation to utilizing treatment methods that are not universally accepted, Bill A07558B/S.7854, have the potential to change the way physicians practice medicine. In addition, the legislation will undoubtedly impact patients, who may benefit from the passing of the legislation. Finally, state regulations took effect imposing new reporting and monitoring duties on practitioners who prescribe controlled substances.

I. NEW YORK STATE CASE LAW

A. New York State Court of Appeals

1. Doe v. Guthrie Clinic, Ltd.

In *Doe v. Guthrie Clinic, Ltd.*, the Court of Appeals declined to expand a hospital's responsibility for the actions of its employee.[1]

Following certification of a question by the United States Court of Appeals for the Second Circuit and acceptance of the question by the Court of Appeals pursuant to 22 N.Y.C.R.R. section 500.27, the Court determined that the plaintiff-appellant could not maintain a common law cause of action for breach of confidentiality against the defendant-respondent medical clinic where respondeat superior liability was absent.[2] Specifically, the following certified question was answered in the negative:

> Whether, under New York law, the common law right of action for breach of the fiduciary duty of confidentiality for the unauthorized disclosure of medical information may run directly against medical corporations, even when the employee responsible for the breach is not a physician and acts outside the scope of her employment.[3]

The plaintiff-appellant, "John Doe," commenced the initial lawsuit in federal court against the defendant healthcare entities for breach of confidentiality (pursuant to common law, New York Civil Practice Law and Rules ("N.Y. C.P.L.R.") 4505 and Public Health Law sections 4410 and 2803-c), breach of contract, negligent infliction of emotional distress, intentional infliction of emotional distress, and negligent hiring and/or supervision of its employees.[4]

1. 22 N.Y.3d 480, 482, 5 N.E.3d 578, 579, 982 N.Y.S.2d 431, 432 (2014).
2. *Id.* at 482, 489, 5 N.E.3d at 579, 583, 982 N.Y.S.2d at 432, 436.
3. *Id.* at 482, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.
4. *Id.* at 483, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.

On July 1, 2010, Doe received treatment from the Guthrie Clinic for a sexually transmitted disease ("STD").[5] While at Guthrie, a nurse recognized Doe as her sister-in-law's boyfriend.[6] The nurse accessed Doe's medical records, discovered that he was being treated at Guthrie for an STD, and sent text messages to her sister-in-law informing her of his STD.[7] The sister-in-law then forwarded the text messages to Doe and, according to him, the messages suggested that Guthrie staff members were making fun of his medical condition.[8] As a result, Doe complained to the clinic and the nurse was fired.[9] The clinic thereafter sent Doe a letter confirming that there had been unauthorized disclosure of his confidential health information and described the measures it had taken in response to the disclosure.[10]

The United States District Court for the Western District of New York granted defendants' motion to dismiss the action.[11] Doe subsequently appealed the dismissal of five of the eight causes of action.[12] The Second Circuit affirmed the dismissal of four of the five causes of action and reserved decision on the breach of fiduciary duty of confidentiality claim.[13]

In finding in favor of the defendant-respondents, the Court referred to a prior Court of Appeals decision, *N.X. v. Cabrini Medical Center*, in which a physician employed by the defendant hospital sexually assaulted a sedated patient.[14] The Court explained:

> A hospital has a duty to safeguard the welfare of its patients, even from harm inflicted by third persons, measured by the capacity of the patient to provide for his or her own safety . . . . This sliding scale of duty is limited, however; it does not render a hospital an insurer of patient safety or require it to keep each patient under constant surveillance . . . . As with any liability in tort, the scope of a hospital's duty is circumscribed by those risks which are reasonably foreseeable.[15]

5. *Id.* at 482, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.
6. *Guthrie Clinic, Ltd.*, 22 N.Y.3d at 482, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.
7. *Id.* at 482-83, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.
8. *Id.* at 483, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.
9. *Id.*
10. *Id.*
11. *Guthrie Clinic, Ltd.*, 22 N.Y.3d at 483, 5 N.E.3d at 579, 982 N.Y.S.2d at 432.
12. *Id.*
13. *Id.*
14. 97 N.Y.2d 247, 250, 765 N.E.2d 844, 846, 739 N.Y.S.2d 348, 349 (2002).
15. *Guthrie Clinic, Ltd.*, 22 N.Y.3d at 484, 5 N.E.3d at 580, 982 N.Y.S.2d at 433 (citing *N.X.*, 97 N.Y.2d at 252-53, 765 N.E.2d at 848, 739 N.Y.S.2d at 352).

The *Doe* Court, taking a firmer stance that in *N.X.*,[16] reasoned that to find in favor of the plaintiff-appellant under these circumstances would be akin to imposing absolute or strict liability upon the hospital. It noted that the nurse's actions were not in furtherance of hospital business as it was personal in nature, and thus was outside the scope of her employment. The Court reasoned that "a medical corporation's duty of safekeeping a patient's confidential medical information is limited to those risks that are reasonably foreseeable and to actions within the scope of employment."[17]

In response to the dissenting opinion by Judge Rivera that the majority's ruling would narrowly limit the plaintiff's remedies for breach of confidentiality. In response, the majority noted that the plaintiff-appellant's remedy would lie in a direct action against the medical entity. Such an action might contain claims for for negligent hiring, supervision or other negligence, or for failing to establish adequate policies and procedures to ensure that confidential patient information was safely maintained and that proper training on the policies and procedures of medical employees was undertaken.[18] The Court, however, noted that these causes of action were already resolved by the federal courts and therefore were not within its purview.[19]

This decision is certainly helpful to medical facilities insofar as it limits their liability for the actions of their employees to those breaches which are reasonably foreseeable by the facility. Certainly, the privacy and security of personal medical information is of paramount importance to many, as raised by the dissenting judge. While the plaintiff-appellant in this case did not succeed, the Court provided somewhat of a roadmap for future litigants in this situation with respect to how to frame their cases, and in particular, which causes of actions to plead.

2. Caronia v. Philip Morris USA

In *Caronia v. Philip Morris USA*, the Court of Appeals declined to recognize an independent equitable cause of action for medical monitoring.[20]

16. *Id.* at 484-85, 5 N.E.3d at 580, 982 N.Y.S.2d at 433. The *N.X.* Court determined whether the nurses could have prevented the wrongful conduct, and thus, imposing liability on the hospital was a question of fact for the jury as compared to the instant case, where the Court held as a matter of law that plaintiff's claim was not viable.

17. *Id.* at 485, 5 N.E.3d at 580, 982 N.Y.S.2d at 433.

18. *Id.* at 485, 5 N.E.3d at 580-81, 982 N.Y.S.2d at 433-34.

19. *Id.* at 485, 5 N.E.3d at 581, 982 N.Y.S.2d at 434.

20. 22 N.Y.3d 439, 452, 5 N.E.3d 11, 18, 982 N.Y.S.2d 40, 47 (2013).

Following certification of a question by the United States Court of Appeals for the Second Circuit and acceptance of the question by the Court of Appeals pursuant to 22 N.Y.C.R.R. section 500.27, the Court determined that the plaintiff-appellant smoker could not maintain an independent equitable cause of action for medical monitoring.[21] Specifically, the following certified question was answered in the negative: "Under New York Law, may a current or former longtime heavy smoker who has not been diagnosed with a smoking-related disease, and who is not under investigation by a physician for such a suspected disease, pursue an independent equitable cause of action for medical monitoring for such a disease?"[22] Since the Court answered the first question in the negative, it declined to answer the second certified question regarding the elements, statute of limitations, and accrual date for a medical monitoring cause of action as "academic."[23]

The plaintiff-appellants in this class action lawsuit were comprised of current and/or former smokers of Marlboro cigarettes over the age of fifty with histories of smoking one pack of cigarettes a day for twenty years or greater.[24] However, none of the plaintiffs had been diagnosed with lung cancer or were under suspicion of having lung cancer.[25] Plaintiffs commenced a punitive class action suit in federal court alleging negligence, strict liability, and breach of implied warranty of merchantability.[26] They requested equitable relief in the form of the creation of a medical monitoring program which would allow them to receive Low Dose CT chest scans for early detection of lung cancer at Philip Morris' expense.[27] In addition, plaintiffs amended their complaint and asserted a separate cause of action for medical monitoring.[28] The district court ultimately dismissed plaintiffs' claims.[29] The United States Court of Appeals for the Second Circuit affirmed the dismissal of the negligence, strict liability and breach of implied warranty of merchantability causes of action but acknowledged that the New York Court of Appeals had not considered whether an independent cause of

21. *Id.* at 444-46, 460, 5 N.E.3d at 13-14, 24, 982 N.Y.S.2d at 42-43, 53.

22. *Id.* at 446, 5 N.E.3d at 14, 982 N.Y.S.2d at 43.

23. *Id.* at 446, 452, 5 N.E.3d at 14, 19, 982 N.Y.S.2d at 43, 48.

24. *Id.* at 445, 5 N.E.3d at 13, 982 N.Y.S.2d at 42.

25. *Caronia*, 22 N.Y.3dat 445, 5 N.E.3d at 13, 982 N.Y.S.2d at 42. Of significance, plaintiffs did not allege that they suffered physical injury or damage to property. Rather, they asserted only that they were at an increased risk for developing lung cancer. *Id.* at 446, 5 N.E.3d at 14, 982 N.Y.S.2d at 43.

26. *Caronia*, 22 N.Y.3dat 445, 5 N.E.3d at 13, 982 N.Y.S.2d at 42.

27. *Id.*

28. *Id.* at 445, 5 N.E.3d at 13-14, 982 N.Y.S.2d at 42-43.

29. *Id.* at 445, 5 N.E.3d at 14, 982 N.Y.S.2d at 43.

action for medical monitoring existed in New York and therefore certified the instant questions for the Court.[30]

The Court observed that while it has the authority to recognize a new cause of action in tort, "that authority must be exercised responsibly, keeping in mind that a new cause of action will have both 'foreseeable and unforeseeable consequences, most especially the potential for vast, uncircumscribed liability.'"[31] It noted the long-held requirement in the New York tort system that a plaintiff actually sustain physical harm in order to recover.[32] Further, the Court pointed out that in prior New York cases which discuss medical monitoring, the plaintiffs alleged either personal injury, property damages, or both.[33] Further, it noted that two of these cases, *Askey v. Occidental Chemical Corp.*[34] and *Abusio v. Consolidated Edison Co. of N.Y.*,[35] one of which was relied upon by plaintiff-appellants (*Askey*), required that the plaintiffs sustain physical injury before he or she could recover consequential damages for medical monitoring.[36]

Although acknowledging the "important public health interest in fostering access to medical testing" (as raised in the dissenting opinion by Chief Judge Lippman), the Court reasoned that dispensing with the physical injury requirement would permit millions of potential plaintiffs to recover medical monitoring costs for something that is speculative in nature, since there is no guarantee that an asymptomatic plaintiff will ever be diagnosed with lung cancer.[37] Further, it explained that this would in turn deplete the tortfeasor's resources available to actually injured plaintiffs.[38] The Court concluded that the legislature is in a better position to study the impact of creating a medical monitoring cause of action, including logistical issues regarding implementation and administration of the program.[39] Therefore, the Court held that:

> [t]he policy reasons . . . militate against a judicially-created independent cause of action for medical monitoring. Allowance of such a claim, absent any evidence of present physical injury or damage to property, would constitute a significant deviation from our tort jurisprudence.

30. *Id.* at 445-46, 5 N.E.3d at 14, 982 N.Y.S.2d at 43.
31. *Caronia*, 22 N.Y.3d at 450, 5 N.E.3d at 17, 982 N.Y.S.2d at 46 (citing Madden v. Creative Servs., 84 N.Y.2d 738, 746, 646 N.E.2d 780, 784, 622 N.Y.S.2d 478, 482 (1995)).
32. *Id.* at 446, 5 N.E.3d at 14, 982 N.Y.S.2d at 43.
33. *Id.* at 445, 5 N.E.3d at 14, 982 N.Y.S.2d at 43.
34. 102 A.D.2d 130, 477 N.Y.S.2d 242 (4th Dep't 1984).
35. 238 A.D.2d 454, 656 N.Y.S.2d 371 (2d Dep't 1997).
36. *Caronia*,22 N.Y.3d at 448, 5 N.E.3d at 15-16, 982 N.Y.S.2d at 44-45.
37. *Id.* at 451, 5 N.E.3d at 17-18, 982 N.Y.S.2d at 46-47.
38. *Id.* at 451, 5 N.E.3d at 18, 982 N.Y.S.2d at 47.
39. *Id.* at 452, 5 N.E.3d at 18, 982 N.Y.S.2d at 47.

> That does not prevent plaintiffs who have in fact sustained physical injury from obtaining the remedy of medical monitoring. Such a remedy has been permitted in this State's courts as consequential damages, so long as the remedy is premised on the plaintiff establishing entitlement to damages on an already existing tort cause of action.[40]

The *Caronia* Court was clearly quite concerned about the large class of potential plaintiffs that would result if a medical monitoring cause of action was created without the requirement of physical injury. Expounding on the concerns raised in this case, should this cause of action be recognized, courts would be faced with the logistical issue of who would qualify as a plaintiff. Questions could be raised as to whether victims of second-hand smoke would be able to recover in addition to actual smokers.[41] The class of plaintiffs able to recover could become quite unwieldy, with increased pressure on the court system to adjudicate the claims as well as the detrimental effects noted above to plaintiffs actually suffering from lung cancer.

B. Appellate Division Cases

1. Perez v. Fitzgerald

In *Perez v. Fitzgerald*, the Appellate Division, First Department had occasion to clarify the N.Y. C.P.L.R. section 214-a's statute of limitations for medical, dental, and podiatric malpractice actions.[42] The appellate division overturned a trial court determination and held that the two-and-a-half year statute of limitations applicable to medical malpractice claims does not apply to claims involving chiropractic malpractice.[43]

The plaintiff commenced a malpractice claim against the defendant chiropractor, alleging that the defendant failed to diagnose the presence of a tumor on the plaintiff's spine when she presented with pain in her neck radiating to her arms in May 2005.[44] The plaintiff continued to treat the defendant over the following year and testified in a deposition and at trial that she considered the defendant, her chiropractor, solely for treatment of her neck and arm pain.[45] An orthopedist eventually diagnosed the presence of a tumor on the plaintiff's spine, and the

40. *Id.* at 452, 5 N.E.3d at 18-19, 982 N.Y.S.2d at 47-48.

41. *See* David D. Siegel, *Medical Monitoring: Divided Court of Appeals Holds New York Does Not Recognize Independent Claim for Monitoring by Smokers Not Yet Showing Symptoms*, N.Y. ST. L. DIGEST, No. 650, Feb. 2014, *available at* http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=46854.

42. 115 A.D.3d 177, 178, 981 N.Y.S.2d 5, 5 (1st Dep't 2014).

43. *Id.*

44. *Id.* at 178, 981 N.Y.S.2d at 5-6.

45. *Id.* at 178, 981 N.Y.S.2d at 6.

plaintiff commenced a malpractice claim against the defendant chiropractor in June 2009.[46] The complaint was filed after the expiration of the 214-a statute of limitation for medical malpractice claims but within the statute of limitations for general, non-medical, dental, or podiatric, malpractice.[47]

The case eventually resulted in trial.[48] At both the conclusion of the plaintiff's case and at the end of trial, the defendant moved to dismiss the complaint as time barred.[49] The defendant chiropractor argued that the shorter statute of limitations in N.Y. C.P.L.R. 214-a applied to chiropractors and pointed to other cases in which actions against nurses and physical therapists were found to fall within that limitations period.[50] The trial court reserved the issue for post-trial briefing.[51] The jury returned a verdict in favor of the plaintiff, but the trial court eventually ruled in favor of the defendant and dismissed the action as time-barred.[52]

In deciding which statute of limitations was applicable in this situation, the appellate division relied heavily on the Court of Appeals' decision in *Bleiler v. Bodnar*.[53] That case addressed when hospitals and nurses may be subject to "medical malpractice" for purposes of the shorter statute of limitations.[54] In *Bleiler*, the Court held that the shorter statute of limitations for medical malpractice is applicable to non-physicians only where a defendant rendered treatment "that constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician."[55] The contours of the *Bleiler* rule were clarified in the 1998 Court of Appeals decision *Karasek v. LaJoie*, where the court rejected using the broad definition of "practice of medicine" found in New York Education Law.[56] In *Karasek*, the Court

46. *Id.* at 179, 981 N.Y.S.2d at 6.

47. *Perez*, 115 A.D.3d at 179, 981 N.Y.S.2d at 6; N.Y. C.P.L.R. 214(6) (McKinney 2014) (providing a three-year statute of limitations for "an action to recover damages for malpractice, other than medical, dental or podiatric malpractice, regardless of whether the underlying theory is based in contract or tort.").

48. *Perez*,115 A.D.3d at 179, 981 N.Y.S.2d at 6.

49. *Id.*

50. *Id.* at 179-80, 981 N.Y.S.2d at 6.

51. *Id.* at 179, 981 N.Y.S.2d at 6.

52. *Id.* at 179-80, 981 N.Y.S.2d at 6.

53. *Perez*,115 A.D.3d at 180, 981 N.Y.S.2d at 7; 65 N.Y.2d 65, 479 N.E.2d 230, 489 N.Y.S.2d 885 (1985).

54. *Bleiler*, 65 N.Y.2d at 66, 479 N.E.2d at 230-31, 489 N.Y.S.2d at 886.

55. *Id.* at 72, 479 N.E.2d at 234, 489 N.Y.S.2d at 889.

56. 92 N.Y.2d 171, 175, 699 N.E.2d 889, 891, 677 N.Y.S.2d 265, 267 (1998); N.Y. EDUC. LAW § 6521 (McKinney 2014) (defining the "practice of medicine" in extremely broad and inclusive terms, namely the "diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.").

favored a more restrictive formulation of "medical malpractice," noting that the legislature provided a shorter statute of limitations for medical malpractice claims in order to grant "the named professionals with an added litigation advantage in order to combat unreasonable increases in malpractice insurance rates."[57] Despite adopting a narrower formulation of medical malpractice, the *Karasek* Court noted that non-physicians, including nurses and hospitals, could enjoy the shorter statute of limitations provided that their care fell within the *Bleiler* requirement that the actions at issue have a substantial relationship to the rendition of medical treatment by a licensed physician.[58]

In deciding the plaintiff's appeal, the appellate division noted that there was only one post-*Bleiler* decision addressing whether chiropractic care constituted medical care for purposes of the statute of limitations.[59] In that case, the third department held that the issue was a question of fact for the jury to decide and relied on language in *Bleiler* holding that a non-physician could be liable for medical malpractice under certain circumstances.[60] The *Perez* court further investigated past cases involving whether non-physicians could enjoy the shorter statute of limitations.[61] Those cases tended to afford the more favorable limitations period only where a non-physician acted at the direction of a licensed physician, were employed by a facility that provided care that was clearly medical in nature, or acted according to hospital protocol.[62] The court found that a chiropractic practice did not constitute medical treatment and that the plaintiff was not referred to the defendant chiropractor by a licensed physician.[63] Absent any connection between the chiropractic care plaintiff received and care from a licensed physician, the defendant could not enjoy the shorter statute of limitations reserved for medical malpractice.[64]

The importance of this case is twofold. First, it clarifies that chiropractors, absent a referral or consultation from a physician, do not render medical care that falls within the Court of Appeals' formulation in *Bleiler*. Second, the appellate division's decision should be of concern to attorneys who represent practitioners who practice in fields that may also

57. *Karasek*, 92 N.Y.2d at 177, 699 N.E.2d at 892, 677 N.Y.S.2d at 268.

58. *Id.* at 174-75, 177, 699 N.E.2d at 891-92, 677 N.Y.S.2d at 267-68

59. Perez v. Fitzgerald, 115 A.D.3d 177, 181-82, 981 N.Y.S.2d 5, 8 (1st Dep't 2014) (citingFoote v. Picinich, 118 A.D.2d 156, 157, 503 N.Y.S.2d 926, 927 (3d Dep't 1986)).

60. *Foote*, 118 A.D.2d at 157, 503 N.Y.S.2d at 927.

61. *Perez*, 115 A.D.3d at 182-83, 981 N.Y.S.2d at 8-9.

62. *Id.* (citations omitted).

63. *Id.* at 183, 981 N.Y.S.2d at 9.

64. *Id.*

not fall within the requirements of *Bleiler*. Those attorneys should be aware that their clients may not enjoy the shorter statute of limitations, thus limiting statutory defenses to be raised during litigation.

2. Maimonides Medical Center v. First United Life Insurance Co.

In *Maimonides Medical Center v. First United Life Insurance Co.*, the Appellate Division for the Second Department held that New York's Prompt Pay Law provides an implied private cause of action for medical providers seeking payment from insurance companies.[65] The Prompt Pay Law requires insurance companies to take certain steps in the event of a disputed claim for medical services.[66] Specifically, an insurer that disputes a medical charge must pay any undisputed portions of the charge within thirty or forty-five days of the charge's submission, depending on the method of submission.[67] The insurer must also inform the policyholder or medical provider of the reasons why it is disputing the charge.[68] Alternatively, an insurer may request additional information from the medical provider within thirty days of the charge to determine its ultimate obligations.[69] Failure to comply with the Prompt Pay Law carries potentially expensive consequences for an insurance company. An insurer who does not meet its obligations under the statute must pay the entire amount of the claim plus twelve percent annual interest.[70]

In *Maimonides*, the plaintiff hospital brought suit seeking payment for medical care rendered to six patients.[71] The complaint alleged a number of theories of liability, including breach of contract, unjust enrichment, and six violations of the Prompt Pay Law.[72] First United did not dispute that it failed to comply with the statute's requirements.[73]Rather, it moved to dismiss the Prompt Pay Law causes of action, arguing that the statute did not provide medical providers a private right of action to enforce the law's provisions.[74] Rather, First United claimed, power to enforce the Prompt Pay Law rested solely with the New York State Superintendent of Insurance.[75] More specifically,

65. 116 A.D.3d 207, 221, 981 N.Y.S.2d 739, 750 (2d Dep't 2014).
66. N.Y. INS. LAW § 3224-a (McKinney 2014).
67. *Id.* § 3224-a(a).
68. *Id.* § 3224-a(b)(1).
69. *Id.* § 3224-a(b)(2).
70. *Id.* § 3224-a(c)(1).
71. Maimonides Med. Ctr. v. First United Am. Life Ins. Co., 116 A.D.3d 207, 209, 981 N.Y.S.2d 739, 741 (2d Dep't 2014).
72. *Id.*
73. *Id.* at 210, 981 N.Y.S.2d at 742.
74. *Id.*
75. *Id.*

First United argued that the statute was simply part of a much larger state scheme designed to regulate the insurance industry.[76] As power to regulate the insurance industry is vested in the New York State Department of Insurance, the Prompt Pay Law cannot provide a private right of action.[77] The trial court was unimpressed with these arguments and ruled against First Union, holding that the plaintiff hospital could maintain its six causes of action pursuant to the Prompt Pay Law.[78]

In deciding First United's appeal, the appellate division looked to settled standards for deciding the presence or absence of a private cause of action. Namely, a private party may enjoy a cause of action "only if a legislative intent to create such a right of action is 'fairly implied' in the statutory provisions and their legislative history."[79] To determine whether such an intent is implied, the court may use a three-part inquiry. The elements of that inquiry are: (1) whether the plaintiff is part of the class that was intended to benefit from the statute; (2) whether a private right of action promotes the legislature's purpose in enacting the statute at issue; and (3) whether a private right of action is consistent with the statute's overall legislative scheme.[80] The appellate division noted that the only factor at issue was the third, which it termed "most critical."[81]

Perhaps the most significant factor weighing in favor of a private right of action was the language of the statute itself. The Prompt Pay Law states that an insurer "that fails to adhere to the standards contained in this section *shall be obligated* to pay to the health care provider . . . in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest . . . ."[82] The appellate division read this language as creating a specific right for health care providers, meaning that the "Prompt Pay Law is not simply remedial in nature, but affords health care providers and patients certain rights, and imposes an affirmative duty upon [insurance providers] to timely pay or dispute claims."[83] That conclusion weighed strongly in favor of finding a private cause of action, as the benefits created by the statute flow directly to

76. *Maimonides Med. Ctr.*, 116 A.D.3d at 210, 981 N.Y.S.2d at 742.

77. *Id.*

78. Maimonides Med. Ctr. v. First United Am. Life Ins. Co., 35 Misc. 3d 570, 581, 941 N.Y.S.2d 447, 456 (Sup. Ct. Kings Cnty. 2012).

79. *Maimonides Med. Ctr.*, 116 A.D.3d at 211, 981 N.Y.S.2d at 743 (quoting Brian Hoxie's Painting Co. v. Cato-Meridian Cent. Sch. Dist., 76 N.Y.2d 207, 211, 556 N.E.2d 1087, 1089, 557 N.Y.S.2d 280, 282 (1990)).

80. *Id.* (quoting Carrier v. Salvation Army, 88 N.Y.2d 298, 302, 667 N.E.2d 328, 329, 644 N.Y.S.2d 678, 679 (1996)).

81. *Id.* (quoting *Carrier*, 88 N.Y.2d at 302, 667 N.E.2d at 329, 644 N.Y.S.2d at 679).

82. N.Y. INS. LAW § 3224-a(c)(1) (McKinney 2014)(emphasis added).

83. *Maimonides Med. Ctr.*, 116 A.D.3d at 215, 981 N.Y.S.2d at 746.

health care providers.[84] The legislative history buttressed this position as the appellate division pointed to legislative memoranda stating that the Prompt Pay Law was meant to ease business difficulties faced by health care providers when insurers fail to timely pay medical claims.[85] Further, the state insurance lobby's role in opposing the Prompt Pay Act during its passage did nothing to assist First United's cause. Namely, the Life Insurance Council of New York opposed the legislation in 1997 partially on the grounds that the proposed language would "inevitably promote excessive legislation."[86] In other words, the state's insurance companies envisioned the exact private right of action that First United later argued did not exist.

It will be interesting to see what impact this decision will have in the relationship between New York's health providers and the insurance industry. It seems likely that we will see an increase in lawsuits utilizing the Prompt Pay Law as an avenue for forcing payment for medical services. Insurance companies should be aware of the statute's fairly straightforward requirements and the potentially costly consequences of failing to follow them.

II. PROPOSED AND NEWLY ENACTED NEW YORK STATE LEGISLATION

A. Medical Marijuana Legislation

Program Bill #57 was approved by the Legislature and was awaiting Governor Andrew Cuomo's signature as of June 30, 2014.[87] The bill would regulate the manufacture, sale, and use of medical marijuana. It would allow health care practitioners to approve (or "certify") their patients to use marijuana in non-smokeable forms[88] (*e.g.*, pills, oils, and

84. *Id.*

85. *Id.*

86. *Id.* at 217, 981 N.Y.S.2d at 747 (citation omitted).

87. By way of an update, Governor Cuomo signed the medical marijuana bill (the "Compassionate Care Act") into law on July 5, 2014. Jon Campbell, *Cuomo signs New York's medical marijuana bill*, USA TODAY, July 7, 2014, *available at* http://www.usatoday.com/story/news/nation/2014/07/07/cuomo-signs-medical-marijuana-1211111111111111bill/12323967/ (noting that New York is the twenty-third state to legalize medical marijuana); John Leland &Mosi Secret, *For Pot Inc., the Rush to Cash In Is Underway: A Competition to Get a Medical Marijuana License in New York*, N.Y. TIMES, Oct. 31, 2014, *available at* http://www.nytimes.com/2014/11/02/nyregion/a-competition-to-get-a-medical-marijuana-license-in-new-york.html?_r=0.

88. The proposed legislation specifically prohibits the *smoking* of medical marijuana due to the negative health effects of smoking. Memorandum: Governor's Program Bill, Program Bill #57 (2014), *available at* https://www.governor.ny.gov/sites/governor.ny.gov/files/archive/governor_files/documents/GPB-57-MEDICAL-MARIHUANA_MEMO.pdf.

vapors) for serious medical conditions, such as cancer, multiple sclerosis, and Parkinson's disease.[89] The legislation would create a new Title V-A in Article 33 of the Public Health Law and amend N.Y. tax law, finance law, general business law, penal law, and criminal procedure law.[90]

If approved, the infrastructure for the legislation would be in place no later than eighteen months from the date of signing, or until the commissioner and the superintendent of state police determines that it can be implemented in accordance with public health and safety interests, whichever event comes later.[91] The bill also gives the Governor final discretion to discontinue the medical marijuana program based on the recommendation of the commissioner and/or superintendent of state police that "there is a risk to the public health or safety."[92]

To receive medical marijuana, a patient would have to be certified by a New York physician. The term "certification" rather than "prescription" is used to avoid conflict with federal law.[93] A patient certification may only be issued by a physician if

> (a) a practitioner has been registered with the department to issue a certification as determined by the commissioner;
>
> (b) the patient has a serious condition, which shall be specified in the patient's health care record;

89. Other qualifying "serious conditions" include human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), amyotrophic lateral sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathies, or Huntington's disease. In addition, it would be used for clinically associated symptoms or a complication of the above diseases or their treatments, including: Cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, and severe or persistent muscle spasms. N.Y. PUB. HEALTH LAW § 3360(7)(a) (McKinney 2014); *see also* Erin McGrath, *Medical Marijuana Legislation in New York State*, 19 N.Y. ST. B.A. HEALTH L. J. 42, 43 (2014).

90. *See also* Memorandum: Governor's Program Bill, Program Bill #57 (2014), *available at* https://www.governor.ny.gov/sites/governor.ny.gov/files/archive/governor_files/documents/GPB-57-MEDICAL-MARIHUANA_MEMO.pdf.

91. N.Y. PUB. HEALTH LAW § 3369-b.

92. *Id.* § 3369-c.

93. Under federal law, marijuana is a Schedule 1 controlled substance and may not be prescribed by medical providers.Erin McGrath, *Medical Marijuana Legislation in New York State*, 19 N.Y. ST. B.A. HEALTH L. J., at 42. Further, while it is still illegal to sell or possess marijuana under federal law, in 2013 the Justice Department advised its prosecutors that "if state laws to legalize the substance properly limited its spread, and if companies complied with state laws, they should not be prosecuted." John Leland &Mosi Secret, *For Pot Inc., the Rush to Cash In Is Underway: A Competition to Get a Medical Marijuana License in New York*, N.Y. TIMES, Oct. 31, 2014, *available at* http://www.nytimes.com/2014/11/02/nyregion/a-competition-to-get-a-medical-marijuana-license-in-new-york.html?_r=0.

> (c) the practitioner by training or experience is qualified to treat the serious condition;
>
> (d) the patient is under the practitioner's continuing care for the serious condition; and
>
> (e) in the practitioner's professional opinion and review of past treatments, the patient is likely to receive therapeutic or palliative benefit from the primary or adjunctive treatment with medical use of marihuana for the serious condition.[94]

The act, as approved by the legislature, allows for contracts to be awarded to five marijuana growers ("registered organizations"), and each grower will be permitted to open up to four dispensaries to distribute medical marijuana to patients.[95] The commissioner will then ensure that the marijuana dispensaries are geographically distributed across the state.[96] The registered organizations would be "seed to sale" entities, and thus responsible for *all* activities involved in medical marijuana cultivation and sale.[97]

Once a patient receives certification from a physician, and after registering with the Department of Health ("DOH"), the DOH would issue a registry identification card to the patient. The patient must then present this card to a medical marijuana "registered organization" in order for the marijuana to be dispensed.[98] In addition to reviewing the patient's registry card, the registered organization would also be required to consult the patient's information on I-STOP (the prescription monitoring database) to ensure that the patient only received a thirty-day supply, the maximum dosage permitted by the law.[99] Further, the registered organization would provide the patient with a receipt as well as file all receipts and certification information with the DOH.[100] Of note, health insurers would not be required to provide coverage for medical marijuana dispensed to patients.[101]

Under the proposed legislation, individuals would be required to carry their registration card whenever they were in possession of medical

94. N.Y. PUB. HEALTH LAW § 3361.

95. *Id.* §3365(9).

96. *Id.*

97. *See Public Health Medical Use of Marihuana Referred to the Committee on Public Health*, Program Bill No. 57, 12117-01-4 (2014) (in assembly), *available at* http://www.governor.ny.gov/sites/governor.ny.gov/files/archive/governor_files/documents/GPB-57-MEDICAL-MARIHUANA_BILL.pdf; Erin McGrath, *Medical Marijuana Legislation in New York State*, 19 N.Y. ST. B.A. HEALTH L. J., at 42.

98. *See*N.Y. PUB. HEALTH LAW § 3363.

99. *Id.* § 3364(5)(b).

100. *Id.* § 3364(4).

101. *Id.* § 3368(2).

marijuana.[102] A patient would be required to keep the marijuana in its original packaging.[103] Further it would be illegal for the medical marijuana to be used or grown in a public place.[104]

Medical marijuana sold in New York would be subject to a 7% excise tax and the proceeds would be deposited into the Medical Marihuana Trust Fund. The revenue would then be allocated as follows: 22.5% would go to the county where the marijuana was grown, 22.5% would go to the county where the marijuana was sold, 5% would go to the office of alcoholism and substance abuse services, and 5% would go to the division of criminal justice services.[105]

The bill would amend the Penal Law to create a new felony and misdemeanor for those who abused the system: criminal diversion of medical marijuana in the first and second degrees, respectively. Specifically, it would be a class E felony for a physician to issue a certification when he or she has reasonable grounds to know that the patient has no medical need for the marijuana or is seeking it for purposes other than treatment of a serious medical condition. [106] Further, it would be a class B misdemeanor for an individual to sell, trade, deliver, or otherwise provide medical marijuana to another when the individual has reasonable grounds to know that the person is not registered to receive medical marijuana.[107]

If passed, the bill would be one of the most restrictive of its kind in the nation. Nonetheless, it has the potential to provide some relief to patients suffering from debilitating illnesses. In addition, as mentioned above, it would also be financially beneficial to the state due to the new tax revenue generated. On the other hand, it will be interesting to see the ripple effects of the implementation of the law including whether any abuses result.

B. Medical Professional Misconduct and the Utilization of Treatment Modalities that Are Not Universally Accepted by the Medical Profession

Proposed legislation which would undoubtedly provide greater reassurance to medical practitioners in New York State is Bill A07558B/S.7854.[108] It seeks to amend Section 230 of the Public Health

102. *Id.* § 3362(2)(b).

103. N.Y. PUB. HEALTH LAW § 3362(1)(d).

104. *Id.* § 3362(2)(a).

105. N.Y. ST. FINANCE LAW § 89-h; *see also* Erin McGrath, *Medical Marijuana Legislation in New York State*, 19 N.Y. ST. B.A HEALTH L. J. 42, 43 (2014).

106. N.Y. PENAL LAW § 179.10 (McKinney 2014).

107. *Id.* § 179.11.

108. N.Y.A. 7558B, 237th Sess. (2014); N.Y.S. 7854, 237th Sess. (2014).

Law by adding a new subdivision 9-b to prohibit the identification, charging, reporting and investigation of medical professional misconduct based "solely on . . . treatment . . . that is . . . not universally accepted by the medical profession."[109] The proposed legislation passed both houses and was awaiting review by Governor Cuomo as of June 30, 2014.[110]

The Office of Professional Medical Conduct ("OPMC") is responsible for investigating physicians, physician assistants and specialist assistants in New York State to ensure that New York patients receive appropriate medical care. The legislation would codify the existing policy of the OPMC that it will not identify, investigate or charge a practitioner based solely on their use of a treatment modality that is currently not universally accepted by the medical community.[111] A particular concern in the medical field, which drove this legislation and is reflected in the language of the proposed legislation, is medical treatment of Lyme and tick-borne diseases that may not be universally accepted in the medical community.[112]

The reasoning behind the proposed legislation is that science and, in turn, the medical profession continues to evolve. Thus, "it is important that the OPMC maintains a flexible, case-specific, investigations policy – particularly where new treatments and acceptance by the medical community do not align."[113] The bill stands for the proposition that medical treatment is to be analyzed on a case-by-case basis and practitioners are given discretion with respect to the treatment they employ in their patients. In addition, the legislation encourages innovations in patient treatment rather than disincentivizing physicians

109. N.Y.A. 7558B, 237th Sess. (2014); N.Y.S. 7854, 237th Sess. (2014); *see also* Memorandum In Support of S.7854 (2014), *available at* http://open.nysenate.gov/legislation/bill/S7854-2013.

110. By way of an update, the bill was signed by Governor Cuomo on December 17, 2014, after agreement by the legislature regarding an amendment to the legislation to "address 'certain technical implementation flaws that would limit (the state's) ability to conduct an inquiry or investigation into a certain category of complaints thereby putting the public at risk.'" John Ferro, *Cuomo signs bill safeguarding Lyme treatments*, POUGHKEEPSIE J., Dec. 18, 2014, at 1, *available at* http://www.poughkeepsiejournal.com/story/news/health/lyme-disease/2014/12/18/cuomo-signs-lyme-disease-bill/20576915/.

111. Memorandum from Dennis Graziano, OPMC Director, to every staff member of the Office of Professional Medical Conduct (June 15, 2005), *available at* http://www.lymediseaseassociation.org/index.php/state-activities/new-york/1053-ny-doctor-protection-memorandum; *see also* Memorandum In Support of S7854 (2013), *available at* http://open.nysenate.gov/legislation/bill/S7854-2013.

112. John Ferro, *Cuomo signs bill safeguarding Lyme treatments*, POUGHKEEPSIE J. at 1; Memorandum In Support of S7854 (2013), *available at* http://open.nysenate.gov/legislation/bill/S7854-2013.

113. Memorandum In Support of S7854 (2013), *available at* http://open.nysenate.gov/legislation/bill/S7854-2013.

who might otherwise employ them but will not due to fear of OPMC repercussions. Though, it should be noted that employing these medical treatments is not without limitations for medical providers. Rather, the non-universally accepted status of the treatment cannot be the *sole reason* for an investigation, charges, and punishment.[114]

C. Prescription Drug Monitoring

On August 27, 2013, new state regulations took effect requiring physicians and pharmacists to consult a prescription drug database prior to prescribing any controlled substances to their patients. The new requirements are part of the Internet System for Tracking Over-Prescribing Act ("I-STOP"), passed unanimously by the legislature in 2012.[115] While New York has had a prescription database in place since 1973, the legislature found that the system was under-utilized and instead formulated mandatory duties for physicians and pharmacists who prescribe controlled substances in an attempt "to minimize medication errors and reduce the possibility of 'doctor shopping' and over-prescribing."[116]

The new regulations require physicians and pharmacists to consult the I-STOP system no more than twenty-four hours prior to prescribing schedule II, III, or IV substances.[117] Practitioners are required to document the consultation in the patient's chart or, alternatively, provide a specific explanation for why the search was not performed.[118] A practitioner may only prescribe a controlled substance without consulting I-STOP if he cannot reasonably consult the system in a timely manner, there is no other practitioner available to access the system, and the prescription is not for more than a five-day supply.[119] Practitioners must also be careful to enter prescription information into the system not more

114. *Id.* Per a June 15, 2005, memorandum from the director of OPMC to its staff members, "so long as a treatment modality effectively treats human disease, pain, injury, deformity or physical condition, the recommendation or provision of the modality does not, by itself, constitute professional misconduct." Memorandum from Dennis Graziano, OPMC Director, to every staff member of the Office of Professional Medical Conduct (June 15, 2005), *available at* http://www.lymediseaseassociation.org/index.php/state-activities/new-york/1053-ny-doctor-protection-memorandum.

115. N.Y.S. 7637, 235th Sess. (2012).

116. N.Y.C.R.R. tit. 10, § 10 (2013) ("Although the PMP has been in existence for decades, practitioners have never been required to consult it, and very few have used it. From February of 2010 through March of 2013, out of approximately 115,000 practitioners, only about 4,400 had used the PMP for a total of approximately 407,000 searches.").

117. 10 NYCRR 80.63(c)(1).

118. *Id.*

119. *Id.* § (c)(2)(vii)(a)-(c).

than twenty-four hours after the substance was delivered to the patient.[120] The new regulations do not establish any specific new penalties for practitioners who fail to consult I-STOP when required. Practitioners are still, however, subject to any general penalties outlined in New York statutes for willful violations of the Public Health Law.

There are several exceptions to the I-STOP requirements. For instance, physicians prescribing methadone or other controlled substances for treatment of addiction need not consult the system.[121] Additionally, there is no need to consult I-STOP if a practitioner is prescribing a medication solely for use on the premises of an institutional dispenser, such as a mental health facility.[122] Further, practitioners prescribing a controlled substance for use in an emergency department of a general hospital or a hospice are not required to consult I-STOP.[123]

Moving forward, it will be interesting to see whether failure to follow these I-STOP regulations will impact medical malpractice litigation. It is conceivable that patients who become addicted to controlled substances could paint a practitioner's failure to properly consult I-STOP as evidence of malpractice.

III. FEDERAL CASE LAW

A. Challenges to the Affordable Care Act—An Update

The highest-profile developments in health law over the last year were religious-based challenges to the ACA. These challenges have taken two forms, depending on the identity and characteristics of the plaintiff. First, we have seen numerous challenges filed by private corporations challenging the ACA under both the First Amendment's Free Exercise Clause as well as the Religious Freedom Restoration Act ("RFRA"). This branch of religious-based confrontations resulted in a Supreme Court decision and was the most prominent of the legal threats to the ACA over the past year. Second, there have been challenges to the ACA brought by non-profit religious organizations alleging that the Act's contraception mandate violates the First Amendment. This branch of cases has not yet reached the Supreme Court and has produced varying outcomes in district and circuit courts around the country.

120. *Id.* § 80.71(e).
121. *Id.* § 80.63(c)(2)(ii).
122. 10 NYCRR 80.63(c)(2)(iv).
123. *Id.* § 80.63(c)(2)(v)-(vi).

Perhaps the highest-profile Supreme Court decision since the last update was *Burwell v. Hobby Lobby Stores, Inc.*[124]Hobby Lobby, a privately-held corporation specializing in retail sales of arts and crafts supplies, challenged the ACA's contraception mandate, alleging that it violated the company's rights under the RFRA and Free Exercise Clause.[125] They specifically objected to the portion of the ACA that required employers to provide contraceptive coverage to their employees or face fines of $100 per day for each employee.[126] Hobby Lobby estimated that these fines would result in cumulative penalties of $475 million per year.[127] Alternatively, Hobby Lobby could refuse to provide any insurance to its employees at all and incur annual penalties of $2000 per employee.[128] The suit was initially filed in the Western District of Oklahoma where the court refused to issue a preliminary injunction.[129] Hobby Lobby then appealed to the tenth circuit who issued an en banc ruling reversing the district court and issuing a preliminary injunction.[130] The government then appealed and the Supreme Court agreed to hear the case in November 2013, consolidating it with a similar religious-based challenge from the third circuit.[131]

The Court issued its ruling on June 30, 2014. Justice Alito, writing for a five to four majority, held that the RFRA exempted Hobby Lobby from the ACA contraception mandate.[132] The RFRA provides that the government may "substantially burden a person's exercise of religion only if it demonstrates that application of the burden" is both "in furtherance of a compelling governmental interest" and "is the least restrictive means of furthering that compelling governmental interest."[133] In other words, the RFRA requires courts to apply strict scrutiny to religious challenges to neutral laws of general applicability. The Court found that Hobby Lobby's reasons for refusing to provide contraceptive coverage were religious in nature.[134] Further, the Court rejected the

124. 134 S. Ct. 2751 (2014).

125. *Id.* at 2759.

126. 26 U.S.C. § 4980D(b)(1) (2014).

127. *Burwell*, 134 S. Ct. at 2775-76.

128. *Id.* at 2776, 2014 U.S. LEXIS 4505, at *64.

129. Hobby Lobby Stores, Inc. v. Sebelius, 870 F. Supp. 2d. 1278 (W.D. Okla. 2012).

130. Hobby Lobby Stores, Inc. v. Sebelius, 723 F.3d 1114, 1147 (10th Cir. 2013).

131. Sebelius v. Hobby Lobby Stores, Inc., 134 S. Ct. 678, 678 (2013) (consolidating *Hobby Lobby* with the factually and legally similar *Conestoga Wood Specialties Corp. v. Sebelius*, 134 S. Ct. 678 (2013) (involving a wood furniture fabricator based in Pennsylvania and owned by a Mennonite family where plaintiffs' objections to the ACA and their legal theories are substantially similar to those in *Hobby Lobby*)).

132. *Burwell*, 134 S. Ct. at 2785.

133. 42 U.S.C. § 2000bb-1(b) (2014).

134. *Burwell*, 134 S. Ct. at 2776.

government's argument that a $2000 annual penalty for not providing any health insurance was minimally burdensome to Hobby Lobby and other similarly situated corporations.[135] The majority also rejected the government's argument that there were no less-burdensome alternatives to mandating that employers with religious objections provide employees with contraception through their health insurance plans.[136] Rather, the Court found that the government assuming the costs of contraceptive coverage "would certainly be less restrictive to the plaintiffs' religious liberty, and [the government] has not shown . . . that this is not a viable alternative."[137] The Court based its opinion solely on the "least restrictive" prong of the RFRA and did not address whether the government was advancing a "compelling governmental interest." It also did not address the plaintiffs' claims pursuant to the Free Exercise Clause.

While *Hobby Lobby* may have gained the most attention over the last year, a separate branch of religious-based challenges to the ACA's contraceptive mandate may result in equally high-profile developments in the future. In contrast to *Hobby Lobby*, these cases involve plaintiffs who are non-profit religious organizations. Although the plaintiffs in these cases are distinct from those in *Hobby Lobby*, their claims are substantially similar and are based on the RFRA and Free Exercise Clause.

Perhaps the most significant of these non-profit cases was the Eastern District of New York decision in *Roman Catholic Archdiocese of New York v. Sebelius*.[138] While numerous courts around the country have issued temporary injunctions exempting non-profit religious organizations from the ACA contraceptive mandate, this case appears to be the first federal case to issue a permanent injunction on the issue.[139] The case was filed by six organizations affiliated with the Roman Catholic Church in the New York City area alleging that the mandate

135. *Id.* at 2776-77 (stating that "it is far from clear that the net cost to the companies of providing insurance is more than the cost of dropping their insurance plans and paying the ACA penalty. Health insurance is a benefit that employees value. If the companies simply eliminated that benefit and forced employees to purchase their own insurance on the exchanges, without offering additional compensation, it is predictable that the companies would face a competitive disadvantage in retaining and attracting skilled workers.").

136. *Id.* at 2780-81.

137. *Id.* at 2780.

138. 987 F. Supp. 2d 232 (E.D.N.Y. 2013).

139. *Id.* at 245 (citing Zubik v. Sebelius, 983 F. Supp. 2d 576 (W.D. Pa. 2013), for the proposition that "only one district court has ruled on whether the Mandate violates the RFRA as applied to religious non-profits; that court entered a preliminary injunction in two related actions, enjoining enforcement of the Mandate against non-profit Catholic entities similarly situated to the plaintiffs here.").

violated their rights under the RFRA, the Administrative Procedures Act, and the Establishment, Free Exercise, and Free Speech clauses of the First Amendment.[140] The plaintiffs moved for summary judgment on their RFRA claims and the district court issued a ruling in December 2013.[141] Like the Supreme Court in *Hobby Lobby*, the district court found that the contraceptive mandate created a substantial burden on the plaintiffs' religious liberties.[142] What is most interesting about *Roman Catholic Archdiocese*, however, is that the court ventured into territory that the Supreme Court avoided in *Hobby Lobby*. Specifically, the district court addressed whether the mandate satisfied the RFRA's "compelling governmental interest" standard, a discussion that the majority in *Hobby Lobby* avoided.[143] The court rejected the government's argument that the mandate was necessary to further the dual interest of "the promotion of public health, and ensuring that women have equal access to health-care services."[144] Rather, the district court held that the myriad of exceptions to the health care mandate made it unlikely that the mandate actually furthers the dual interests the government advanced.[145] Moving forward, it will be interesting to see whether this formulation is endorsed in subsequent non-profit challenges to the ACA.

CONCLUSION

Although Governor Cuomo has signed Program Bill #57 and Bill A07558B/S.7854 into law since the close of the *Survey* period, the long-term effects of these laws remain largely unseen due to administrative delay and other setbacks. On the federal level, we anticipate that various challenges to the ACA will continue, leaving several prominent provisions of that law in doubt. On the federal level, we anticipate that various challenges to the ACA will continue, leaving several prominent provisions of that law in doubt.

140. *Id.* at 236-37.
141. *Id.* at 236-37.
142. *Id.* at 252.
143. *Roman Catholic Archdiocese*, 987 F. Supp. 2d at 252-53.
144. *Id.* at 253.
145. *Id.* at 253.