

## HEALTH LAW

**Kirsten A. Lerch & Stephen F. Johnson<sup>†</sup>**

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### INTRODUCTION

At the federal level, legal challenges to the Patient Protection and Affordable Care Act (“ACA”) continued although the litigation focus has shifted from the individual mandate to the employer mandate and concerns about religious exemptions. The settlement of the “improvement standard” case of *Jimmo v. Sebelius* resulted in significant changes to the Medicare system, clarifying that coverage would not be denied based on the absence of potential for improvement or restoration. At the state level, the New York Secure Ammunition

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<sup>†</sup> 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. Johnson is also an Associate with Gale Gale & Hunt, LLC; J.D., Fordham University School of Law; B.A., State University of New York College at Geneseo. This Article addresses recent developments in New York State and federal health law from July 1, 2012, to June 30, 2013.

and Firearms Enforcement Act led to amendments in many areas of New York Law, including the addition of reporting requirements for mental health professionals and the expansion of Kendra's Law. The Court of Appeals decided *Dupree v. Giugliano* and *Kowalski v. St. Francis Hospital & Health Centers*, which explored the issue of a sexual relationship between a patient and a physician and whether it fell within the realm of medical malpractice and the limitations of a hospital's duty to a patient who presents to the emergency department, respectively. *Joyer-Pack v. State of New York* and *Jacobs v. U.S. et al.* each discuss the necessity of expert evidence in medical malpractice cases. Lastly, we are beginning to see more cases which interpret the regulations implementing the Medical Indemnity Fund ("MIF")—one case in particular provides some context for the "delivery admission" aspect of the birth-related neurological injury.

## I. NEW YORK STATE CASE LAW

### A. New York State Court of Appeals

#### 1. Dupree v. Giugliano

In *Dupree v. Giugliano*,<sup>1</sup> the Court determined that a sexual relationship between a patient and doctor constituted medical malpractice. The Court of Appeals affirmed the appellate division's ruling, which denied the defendant physician's motion to set aside the jury verdict and the plaintiff's motion to set aside the jury verdict in part, and modified the order of the appellate division by vacating the award for punitive damages.<sup>2</sup>

The plaintiff commenced a medical malpractice suit against her family practice physician for allegedly exploiting her sexually during treatment for depression, leading to the demise of her marriage and causing her to suffer twelve years of anguish.<sup>3</sup> The defendant treated the plaintiff for stress and depression and prescribed antidepressant medication, recommended lifestyle modifications, and referred her to a therapist for counseling.<sup>4</sup> Approximately seventeen months after first treating with the defendant, the parties commenced a sexual relationship. The affair lasted nine months until the parties mutually

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1. 20 N.Y.3d 921, 924, 982 N.E.2d 74, 74, 958 N.Y.S.2d 312, 313-14 (2012).

2. *Id.*; *Dupree v. Giugliano*, 87 A.D.3d 975, 978, 929 N.Y.S.2d 305, 308 (2d Dep't 2011).

3. *Dupree*, 20 N.Y.3d at 922-23, 982 N.E.2d at 74, 958 N.Y.S.2d at 313; *Dupree v. Giugliano*, 2009 N.Y. Slip Op. 50697(U), 1 (Sup. Ct. Suffolk Cnty. 2009).

4. *Dupree*, 20 N.Y.3d at 922, 982 N.E.2d at 74, 958 N.Y.S.2d at 313.

agreed to end it. The plaintiff admitted the affair to her husband, who subsequently commenced divorce proceedings.<sup>5</sup> The plaintiff argued at trial that her romantic feelings toward the defendant were due to “‘eroticized transference’—a medical phenomenon in which the patient experiences ‘near psychotic attraction’ to a treating physician, which the patient is powerless to resist.”<sup>6</sup> The jury found in favor of the plaintiff, with the plaintiff being comparatively at fault twenty-five percent, and awarded compensatory and punitive damages.<sup>7</sup>

The Court rejected plaintiff’s argument that it was improper to charge the jury on comparative fault because she lacked the requisite capacity and volition with respect to her participation in the affair.<sup>8</sup> The Court reasoned that the mismanagement of plaintiff’s medical condition by the defendant physician did not negate comparative fault and pointed to the nine-month duration of the affair during which time both parties sought out repeated sexual encounters.<sup>9</sup> The Court noted that “the jury might, as it obviously did, reasonably discount the expert’s testimony that plaintiff was wholly without volition in the matter.”<sup>10</sup> As such, it held that the trial court did not err in charging the jury on comparative fault.<sup>11</sup>

Moreover, the Court of Appeals upheld the jury’s finding of liability against the defendant physician for medical malpractice.<sup>12</sup> The Court explained that, to establish a case against defendant for medical malpractice, “‘the challenged conduct [must] constitute medical treatment or *bear a substantial relationship*’ to the physician’s treatment of the patient.”<sup>13</sup> It noted that the defendant referred her to a therapist and also made modifications to the plaintiff’s antidepressant

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5. *Id.*

6. *Id.* at 923, 982 N.E.2d at 74, 958 N.Y.S.2d at 313.

7. *Id.*

8. *Id.*; *Dupree*, 2009 N.Y. Slip Op. 50697(U), at 2 (Plaintiff argued that her situation was similar to the “inherent compulsion” concept discussed in the educational context in that the eroticized transference during treatment with the defendant physician disabled her will and control of her own actions) (citing *Verduce v. Board of Higher Education*, 9 A.D.2d 214, 192 N.Y.S.2d 913 (1st Dep’t 1959); *Smith v. J.H. West Elementary School*, 52 A.D.3d 684, 861 N.Y.S.2d 690 (2d Dep’t 2008)).

9. *Dupree*, 20 N.Y.3d at 924, 982 N.E.2d at 74, 958 N.Y.S.2d at 314.

10. *Id.*

11. *Id.* at 922, 982 N.E.2d at 74, 958 N.Y.S.2d at 313.

12. *Dupree*, 2009 N.Y. Slip Op. 50697(U), at 3-5 (Defendant argued that plaintiff’s action was one to recover damages for seduction or alienation of affections, which were no longer actionable in New York State, rather than a claim for medical malpractice.).

13. *Dupree*, 20 N.Y.3d at 924, 982 N.E.2d at 74, 958 N.Y.S.2d at 313 (citations omitted).

medications due to her complaints of decreased libido.<sup>14</sup> The Court also cited the substantial testimony at trial regarding the transference phenomenon and the defendant physician's duty to manage this issue as a mental health provider.<sup>15</sup> The Court reasoned that "[h]ere, where defendant was prescribing a course of treatment for plaintiff's mental health problems, including medication and counseling, a jury might reasonably conclude that the sexual relationship was substantially related to and, in fact, interfered with the treatment so as to constitute medical malpractice."<sup>16</sup>

The Court also held that the physician defendant's conduct did not warrant a jury charge of punitive damages as there had been no evidence that the doctor maliciously or willfully caused plaintiff's transference and injuries.<sup>17</sup> The Court explained that punitive damages are only warranted when there is an existence of "aggravation or outrage, such as spite or 'malice,' or a fraudulent or evil motive on the part of the defendant, or such a conscious and deliberate disregard of the interest of others that the conduct may be called willful or wanton."<sup>18</sup> As such, the Court vacated the award of \$166,000 for punitive damages.<sup>19</sup>

## 2. *Kowalski v. St. Francis Hospital & Health Centers*

The *Kowalski* case is instructive for hospitals with respect to the limitations and boundaries of a hospital's duty to a patient who presents to the emergency department ("ED").

In *Kowalski v. St. Francis Hospital & Health Centers*, the Court of Appeals examined a hospital's duty in relation to an intoxicated patient who left the ED without being discharged and subsequently was hit by a car.<sup>20</sup> The Court affirmed the lower court's order granting defendants' motions for summary judgment.<sup>21</sup>

The intoxicated plaintiff was brought to the defendant ED by a friend for admission into the detoxification facility at a hospital called

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14. *Id.* at 923, 982 N.E.2d at 74, 958 N.Y.S.2d at 313.

15. *Id.* at 923-24, 982 N.E.2d at 74, 958 N.Y.S.2d at 313.

16. *Id.* at 924, 982 N.E.2d at 74, 958 N.Y.S.2d at 314.

17. *Id.*

18. *Dupree*, 20 N.Y.3d at 924, 982 N.E.2d at 74, 958 N.Y.S.2d at 314 (citing *Prozeralik v. Capital Cities Commc'ns*, 82 N.Y.2d 466, 479, 626 N.E.2d 34, 42, 605 N.Y.S.2d 218 (1993)).

19. *Id.*

20. 21 N.Y.3d 480, 483-84, 995 N.E.2d 148, 149, 972 N.Y.S.2d 186, 187 (2013).

21. *Id.* at 486, 995 N.E.2d at 151, 972 N.Y.S.2d at 189.

“Turning Point.”<sup>22</sup> The plaintiff had a high blood-alcohol content with garbled speech and red eyes. However, he was alert and able to walk. The plaintiff was seen by the defendant ED physician and was accepted into the Turning Point program. While awaiting transfer to the detox facility and approximately four hours after arriving at the hospital, the patient removed his IV and advised a nurse that he was catching a ride home in a taxi. In response, the nurse implored plaintiff to call a friend for a ride, and he agreed. The nurse left to inform the ED physician that the patient wanted to leave. When she returned the plaintiff was gone. The nurse asked the ED physician if she should call the police and the physician said “no” but notified hospital security of the incident. The plaintiff left the hospital unescorted and was subsequently hit by a car an hour or two later. The plaintiff had previously visited the hospital (he had been admitted to the hospital a month before due to suicidal thoughts and had been put on a “one-to-one watch”); however, this record was not reviewed at the time of his ED visit.<sup>23</sup>

Plaintiff commenced a negligence and medical malpractice action against the defendant hospital and the ED physician and her group.<sup>24</sup> Plaintiff argued that the defendants’ duty to retain him arose from a common law duty of care and cited to his previous admission for suicidal thoughts.<sup>25</sup>

The *Kowalski* Court held that an emergency room doctor and hospital did not have a duty to prevent an intoxicated patient who voluntarily sought treatment at the hospital, from leaving the hospital.<sup>26</sup> The Court explained that the fact that plaintiff patient expressed suicidal thoughts a month ago did not justify confinement. It reasoned that common law allows for the restraint of an individual whose mental state might make them a danger to themselves or others only in “extreme circumstances” and relied upon a previous Court of Appeals case, *Warner v. State*, which explained that

[t]he common law recognized the power to restrain, summarily and without court process, an insane person who was dangerous at the moment. The power was to be exercised, however, only when ‘necessary to prevent the party from doing some immediate injury either to himself or others’ and ‘only when the urgency of the case

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22. *Id.* at 484, 995 N.E.2d at 149, 972 N.Y.S.2d at 187.

23. *Id.*

24. *Id.* at 484, 995 N.E.2d at 150, 972 N.Y.S.2d at 188.

25. *Kowalski*, 21 N.Y.3d at 486, 995 N.E.2d at 151, 972 N.Y.S.2d at 189.

26. *Id.* at 483, 995 N.E.2d at 149, 972 N.Y.S.2d at 187.

demands immediate intervention.<sup>27</sup>

The Court pointed to Mental Hygiene Law section 22.09, which addresses the situation of an intoxicated person presenting to a hospital for treatment and a hospital's obligation to retain the patient.<sup>28</sup> It noted the distinction in the statute between an intoxicated person who sought treatment voluntarily and without objection<sup>29</sup> and one who presented to the hospital for treatment "with his or her objection."<sup>30</sup> The Court explained that only in the latter situation did the law provide that the patient be "retained for emergency treatment" and only if the examining physician "determines that such person is incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or others."<sup>31</sup> It reasoned that, since plaintiff presented to the hospital for detoxification treatment voluntarily, the hospital had no obligation under the Mental Hygiene Law to retain the patient for emergency treatment.<sup>32</sup>

Furthermore, since the Mental Hygiene Law explicitly laid out the circumstances when confinement by the hospital was indicated and when it was not, the Court reasoned that "[t]o restrain plaintiff on these facts would have exposed defendants to liability for false imprisonment."<sup>33</sup> The Court, therefore, held that defendants had no right to restrain the plaintiff and hence no duty to do so.<sup>34</sup>

### 3. James v. Wormuth

In *James v. Wormuth*,<sup>35</sup> the Court of Appeals considered whether expert testimony was needed to demonstrate a prima facie case of medical malpractice where a guide wire was intentionally left in the patient during a lung biopsy. During the procedure, a guide wire became dislodged and the defendant surgeon was unable to locate it after a twenty-minute manual search.<sup>36</sup> The surgeon ended the procedure and informed plaintiff that he was unable to locate the wire

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27. *Id.* at 485, 995 N.E.2d at 150, 972 N.Y.S.2d at 188 (citing *Warner v. State*, 297 N.Y. 395, 401, 79 N.E.2d 459, 462 (1948)).

28. *Id.*

29. N.Y. MENTAL HYG. LAW § 22.09(d) (McKinney 2011).

30. N.Y. MENTAL HYG. LAW § 22.09(e) (McKinney 2011).

31. *Kowalski*, 21 N.Y.3d at 485, 995 N.E.2d at 150, 972 N.Y.S.2d at 188. N.Y. MENTAL HYG. LAW § 22.09(e) (McKinney 2011).

32. *Kowalski*, 21 N.Y.3d at 486, 995 N.E.2d at 150, 972 N.Y.S.2d at 188.

33. *Id.* at 486, 995 N.E.2d at 151, 972 N.Y.S.2d at 189.

34. *Id.*

35. 21 N.Y.3d 540, 543; 545, 997 N.E.2d 133, 134; 136, 974 N.Y.S.2d 308, 309; 311 (2013).

36. *Id.* at 543, 997 N.E.2d at 134, 974 N.Y.S.2d at 309.

and that he had concluded it was best to leave the wire due to the risks of prolonging the procedure. Within the next two months, plaintiff returned to the defendant surgeon complaining of pain which she attributed to the existence of the wire. Defendant surgeon performed a second operation and removed the wire after locating it with a special x-ray machine.<sup>37</sup> Plaintiff sued the case on a theory of *res ipsa loquitur*, arguing that there was sufficient evidence that a jury could infer the existence of negligence since there was no medical reason to leave the wire inside plaintiff.<sup>38</sup> The trial court granted a direct verdict for the defense, and the appellate division affirmed the dismissal in a 3-2 decision.<sup>39</sup>

Before the Court of Appeals, plaintiff argued that expert testimony was unnecessary, that *res ipsa loquitur* applied as the fact the wire was left behind establishes liability, and further that the guide wire should be treated as a foreign object.<sup>40</sup> The Court disagreed and affirmed the appellate division for two chief reasons: 1) the surgeon made a decision using his professional judgment that the wire should be left inside the plaintiff which required expert testimony to assist the jury, and 2) plaintiff failed to establish all the elements of *res ipsa*, specifically, plaintiff failed to establish that the defendant surgeon had exclusive control of the instrumentality.<sup>41</sup> Moreover, the Court determined that because the surgeon intentionally left the wire behind, this case was distinguishable from those cases of a foreign object.<sup>42</sup>

#### 4. Gray v. Williams

In *Gray v. Williams*, the question was whether expert evidence was necessary to prove a lack of informed consent claim in a medical malpractice action.<sup>43</sup> In *Gray*, plaintiff underwent a colonoscopy performed by defendant surgeon, during which plaintiff sustained a perforation of the rectosigmoid junction.<sup>44</sup> Plaintiff subsequently commenced a suit in medical malpractice, with causes of action including negligent performance of the procedure, negligent post-procedure care, and a cause of action for lack of informed consent.<sup>45</sup>

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37. *Id.* at 543-44, 997 N.E.2d at 134, 974 N.Y.S.2d at 309.

38. *Id.* at 544, 997 N.E.2d at 135, 974 N.Y.S.2d at 310.

39. *Id.* at 545, 997 N.E.2d at 135, 974 N.Y.S.2d at 310.

40. *James*, 21 N.Y.3d at 545, 997 N.E.2d at 136, 974 N.Y.S.2d at 311.

41. *Id.* at 547, 997 N.E.2d at 137, 974 N.Y.S.2d at 312.

42. *Id.* at 548, 997 N.E.2d at 138, 974 N.Y.S.2d at 313.

43. *See generally* 108 A.D.3d 1085, 969 N.Y.S.2d 334 (4th Dep't 2013).

44. *Id.* at 1085, 969 N.Y.S.2d at 335.

45. *Id.* at 1086, 969 N.Y.S.2d at 335.

Defendants won a motion for summary judgment on the lack of informed consent claim<sup>46</sup> and received a “no cause” on the remaining two claims at trial. Plaintiff appealed, and the appellate division reversed the grant of summary judgment.<sup>47</sup>

The appellate division found that the defendant had met his initial burden for summary judgment by submitting evidence which demonstrated that he had informed the plaintiff of the risks associated with her procedure and that plaintiff had acknowledged her understanding of those risks.<sup>48</sup> However, the appellate division found that plaintiff met her burden of showing that there was a genuine issue of material fact because her affidavit raised questions as to what a reasonable person would have done in the circumstances and questions as to whether the informed consent was qualitatively insufficient.<sup>49</sup> It would appear that expert evidence is not necessary to demonstrate what a reasonably prudent person would do in like circumstances to maintain a cause of action premised upon lack of informed consent.

## II. NEW YORK STATE LEGISLATION

### *A. Impact of the Secure Ammunition and Firearms Enforcement Act on Mental Health Law*

On January 15, 2013, Governor Andrew Cuomo signed into law the New York Secure Ammunition and Firearms Enforcement (“SAFE”) Act.<sup>50</sup> The purpose of the Act is to reduce gun violence by strengthening rules regarding access to firearms and ammunition.<sup>51</sup> The legislation impacts much of New York law, including, but not limited to, amendments in criminal procedure law, correction law, education law, penal law, and mental hygiene law.<sup>52</sup>

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46. A claim for lack of informed consent requires that plaintiff demonstrate the medical provider failed “to disclose to the patient such alternatives thereto and the reasonably foreseeable risks and benefits.” N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney 2012). In addition, it must be established that a reasonably prudent person in the patient’s position would not have undergone the treatment or diagnosis if he had been fully informed and that the lack of informed consent is a proximate cause of the injury or condition for which recovery is sought. N.Y. PUB. HEALTH LAW § 2805-d(3) (McKinney 2012).

47. *Gray*, 108 A.D.3d at 1086, 969 N.Y.S.2d at 335.

48. *Id.* at 1086, 969 N.Y.S.2d at 335-36.

49. *Id.* at 1086-87, 969 N.Y.S.2d at 336.

50. Act of January 15, 2013, ch.1, 2013 McKinney’s Sess. Laws of N.Y. 1 (codified at N.Y. MENTAL HYG. LAW §§ 7.09, 9.47, 9.48, 9.60, 13.09, 33.13, 9.46 (McKinney 2013)).

51. See Guidance Document from NYS Office of Mental Health: New York Secure Ammunition and Firearms Enforcement Act (NY SAFE Act) (2013), *available at* [http://www.omh.ny.gov/omhweb/safe\\_act/guidance.pdf](http://www.omh.ny.gov/omhweb/safe_act/guidance.pdf) [hereinafter “OMH Guidance”].

52. *Id.* N.Y. EDUC. LAW §2801(b) (McKinney 2012).

With respect to N.Y. Mental Hygiene Law, the Act seeks to guard against dangerous or unstable people possessing guns and thus tightens provisions with respect to gun ownership by individuals with mental health illnesses.<sup>53</sup> SAFE amends N.Y. Mental Hygiene Law sections 7.09, 9.47, 9.48, 9.60, 13.09, and 33.13, and adds a new section, 9.46.<sup>54</sup> In addition, the Act amends section 18, chapter 408 of the laws of 1999 constituting “Kendra’s Law.”<sup>55</sup>

Section 9.46 of the Mental Hygiene Law creates new mandatory reporting requirements for mental health professionals.<sup>56</sup> These requirements became effective on March 16, 2013.<sup>57</sup> For purposes of the legislation, a mental health professional includes a physician, psychologist, registered nurse, or licensed clinical social worker.<sup>58</sup> Specifically, the law provides that

when a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others,<sup>59</sup> he or she shall be required to [make a] report, as soon as practicable, to the director of community services or the director’s designee.<sup>60</sup>

After receiving the report, if the community services official agrees with the professional’s assessment, the official then reports “non-clinical identifying information”<sup>61</sup> to the Division of Criminal Justice Services (“DCJS”).<sup>62</sup> The identifying information provided is then used by the DCJS in determining whether a license should be suspended or

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53. NY Secure Ammunition and Firearms Enforcement (SAFE) Act of 2013, S2230-2013 Memo, 236th Sess. (2013), *available at* <http://open.nysenate.gov/legislation/bill/S2230-2013>.

54. Secure Ammunition and Firearms Enforcement Act §§ 19, 20, 21, 22, 23.

55. *Id.*; *see also infra* note 69 and accompanying text.

56. N.Y. MENTAL HYG. LAW § 9.46 (McKinney 2013).

57. *Id.*

58. *Id.* at § 9.46(a).

59. According to the N.Y.S. Office of Mental Health, this standard requires a clinical determination that the individual’s clinical state creates either: “(a) a substantial risk of physical harm to the person, as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm.” OMH Guidance, *supra* note 51 at 2 (citing N.Y. MENTAL HYG. LAW § 9.01).

60. N.Y. MENTAL HYG. LAW § 9.46(b); *see also* OMH Guidance, *supra* note 51.

61. MENTAL HYG. § 33.13. This information can consist of the patient’s name, date of birth, race, sex, Social Security Number and/or address. *See* OMH Guidance, *supra* note 51.

62. MENTAL HYG. § 9.46(b).

revoked, whether the individual is ineligible for a license or is no longer permitted to possess a firearm under state or federal law, and whether there is a basis to require the individual to surrender his or her firearm.<sup>63</sup>

Section 9.46 provides that a mental health professional will not be expected to make a report if it would endanger the professional or potential victims.<sup>64</sup> Further, with respect to potential liability for the mental health provider, the statute dictates that “[t]he decision of a mental health professional to disclose or not to disclose . . . when made reasonably and in good faith, shall not be the basis for any civil or criminal liability.”<sup>65</sup>

According to the New York State Office of Mental Health, the disclosure of clinical information without the patient’s consent to the Director of Community Services is not a violation of the Health Insurance Portability and Accountability Act (“HIPAA”) privacy rule.<sup>66</sup> It notes that the statute *requires* the mental health professional to make this disclosure<sup>67</sup> and the privacy rule allows disclosure of protected health information without the consent of the patient when the disclosure is “required by law” and it complies with the requirements of the law.<sup>68</sup>

Finally, the Act expands Kendra’s Law and extends the law through 2017.<sup>69</sup> Kendra’s Law permits a mentally ill person to be subject to court-ordered assisted outpatient treatment (“AOT”) if a proper showing has been made that the individual is unlikely to survive safely in the community without supervision and has a history of lack of compliance with treatment.<sup>70</sup> The SAFE Act extends the individual’s initial court-ordered AOT from six months to one year,<sup>71</sup> mandates an evaluation for the need for continuing AOT prior to expiration of an AOT order,<sup>72</sup> requires an AOT order to follow an individual from one county to another if the individual changes his or her residence,<sup>73</sup> and dictates that an assessment be conducted to determine whether AOT is

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63. *Id.*; see also OMH Guidance, *supra*, note 51.

64. MENTAL HYG. § 9.46(c).

65. *Id.* at § 9.46(d).

66. 45 C.F.R. § 164.512(a)(1) (2012).

67. MENTAL HYG. § 9.46(b).

68. 45 C.F.R. § 164.512(a)(1); see also OMH Guidance, *supra* note 51.

69. New York Secure Ammunition and Firearms Enforcement Act 2, 37, 2013 N.Y. LAWS S2230.

70. MENTAL HYG. § 9.60(c)(3)-(4).

71. *Id.* at § 9.60(j)(2).

72. *Id.* at § 9.47(b)(5).

73. *Id.* at § 9.47(b)(6).

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indicated when an “inmate committed from a state correctional facility from a hospital in the department of mental hygiene to the community” is going to be discharged.<sup>74</sup>

It will be interesting to see the effects of this legislation and whether it results in any litigation. There is some concern in the mental health community that the new reporting requirements and sharing of a patient’s clinical information will lead to the deterioration of the therapeutic relationship inasmuch as the patient may be deterred from discussing suicidal or homicidal thoughts with his or her mental health provider for fear of being reported to the authorities.<sup>75</sup>

### B. Medical Indemnity Fund Case Law Update

The Medical Indemnity Fund (MIF) regulations continue to be renewed every ninety days via Emergency Regulations.<sup>76</sup> Since the last *Survey*, only two published cases have interpreted the provisions and regulations of the MIF. The first is *Joyner-Pack v. State of New York*,<sup>77</sup> and the second is *Jacobs v. United States*.<sup>78</sup>

#### I. Joyner-Pack v. State of New York

In *Joyner-Pack*, the Court of Claims reviewed a proposed settlement under CPLR Article 12.<sup>79</sup> The suit was to be settled for \$4,000,000, with \$2,000,000 constituting past pain and suffering and \$2,000,000 in “Fund damages,” representing a 50/50 split.<sup>80</sup> Of the past pain and suffering damages, \$915,359.88 was to be deposited in a managed settlement trust, and \$800,000 was to fund a periodic structured settlement. Plaintiff’s attorneys’ fees totaled \$559,640.12, of which \$275,000 was to be paid by defendants for the attorneys’ fees based on the “Fund damages.”<sup>81</sup>

The application of the Fund to this case is interesting due to the facts. The claimant was born in February 2002 with

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74. N.Y. CORRECT. LAW § 404(3) (McKinneys 2014).

75. See TG Branfalt Jr., *Mandatory Reporting Provision of the SAFE Act Raises Concerns in the Mental Health Community*, LEGIS. GAZETTE (March 11, 2013), available at <http://www.legislativegazette.com/Articles-Editors-Picks-c-2013-03-11-82942.113122-Mandatory-reporting-provision-of-the-SAFE-Act-raises-concerns-in-the-mental-health-community.html>.

76. See generally N.Y. COMP. CODES R. & REGS. tit. 10, § 69-10 (2013).

77. 38 Misc. 3d 903, 957 N.Y.S.2d 810 (N.Y. Ct. Cl. 2012).

78. No. 08-8061, 2012 U.S. Dist. LEXIS 162767 (S.D.N.Y. Nov. 13, 2012).

79. *Joyner-Pack*, 38 Misc. 3d at 904, 957 N.Y.S.2d at 811.

80. *Id.*

81. *Id.* at 905, 957 N.Y.S.2d at 811.

tracheobronchomalacia, a condition that affects the airway structures and the resulting airflow in and out of the lungs.<sup>82</sup> A tracheostomy was performed on March 2, 2002, and the claimant suffered periods of apnea and bradycardia until he developed a respiratory infection in late May 2002.<sup>83</sup> The claimant's condition worsened, and an MRI was scheduled for June 6, 2002. However, during sedation, the claimant's airway collapsed, causing severe respiratory distress and cardiopulmonary arrest. This led to hypoxic ischemic encephalopathy, a seizure disorder, and spastic quadriplegia.<sup>84</sup> During this entire time, the claimant remained a patient at University Hospital of Brooklyn-Downstate Medical Center.

The allegations of medical malpractice stemmed from the May and June treatment, which was several months after the claimant's birth. Pursuant to the regulations of the MIF, a "qualified plaintiff" is a patient who "has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or . . . has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefor."<sup>85</sup> The birth-related neurological injury is

an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only.<sup>86</sup>

As a preliminary matter, the court considered whether it had the power to determine whether an infant was qualified within the meaning of the MIF.<sup>87</sup> The court noted that admission into the Fund was a determination made by the Fund administrator, but cited section 2999-j(6)(a) and stated that this regulation implicitly requires a decision by the court regarding qualification.<sup>88</sup> Moreover, regulations promulgated by the New York State Department of Health anticipate that the court

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82. *Id.* at 905, 957 N.Y.S.2d at 812.

83. *Id.* at 905-06, 957 N.Y.S.2d at 812.

84. *Joyner-Pack*, 38 Misc. 3d at 906, 957 N.Y.S.2d at 812.

85. N.Y. PUB. HEALTH LAW § 2999-h(4) (McKinney 2011).

86. *Id.* § 2999-h(1).

87. *Joyner-Pack*, 38 Misc.3d at 909, 957 N.Y.S.2d at 814.

88. *Id.* at 909, 957 N.Y.S.2d at 814 (citing N.Y. PUB. HEALTH LAW §§ 2999-j(6)(a), (7)).

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will make a finding on whether a plaintiff or claimant is qualified and defer to the court to make this finding.<sup>89</sup>

The court went on to reason that, due to an incentive on the part of the parties to characterize damages as “Fund damages,” the court will often be the gatekeeper to the Fund, a duty which must be balanced against the determination of whether a settlement is in the infant’s best interests.<sup>90</sup> These two tensions were mitigated in this particular case as the State of New York was represented in the action by the Office of the Attorney General.<sup>91</sup> The Attorney General took the position that it did not have the ability to determine whether a case falls within the purview of the MIF, which the court interpreted as a waiver of any concerns about application of the MIF to the current case.<sup>92</sup> Consequently, the court found that it had the power to determine that the claimant was qualified and that since it was a “colorable” argument, the claimant’s case properly belonged in the MIF. I note that the court limited its opinion somewhat, stating that its conclusion was “solely for the purposes of the present action” and was in part based on the fact that the State of New York was a party to the action.

Another interesting aspect in the *Joyner-Pack* case was one provision in the proposed Infant Compromise Order (“ICO”), which concerned certain payments to be made to the claimant’s mother and natural guardian.<sup>93</sup> This provision provided that the claimant’s guardian was to receive payments for the claimant’s care and maintenance, payments for services rendered by the guardian, payments for the claimant’s clothing and shoes, and \$72,000 for an automobile and the cost of car insurance.<sup>94</sup> After noting that settlement funds generally belong to the infant alone and should not be used to “pay for the necessities of life for which parents are responsible,” the court determined that the payments were permissible here.<sup>95</sup> Although the claimant’s parent/guardian was unable to show financial hardship with the specificity required, a rigid application of the law would not serve the best interests of the claimant.<sup>96</sup> The evidence before the court showed that the claimant will forever remain “entirely dependent on his family or on institutional caregivers for every aspect of his life” and was

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89. *Joyner-Pack*, 38 Misc.3d at 909-10, 957 N.Y.S.2d at 814-15.

90. *Id.* at 910, 957 N.Y.S.2d at 815.

91. *Id.* at 911, 957 N.Y.S.2d at 815-16.

92. *Id.* at 911, 957 N.Y.S.2d at 816.

93. *Id.* at 912-13, 957 N.Y.S.2d at 817.

94. *Joyner-Pack*, 38 Misc. 3d at 913, 957 N.Y.S.2d at 817.

95. *Id.* at 913, 915, 957 N.Y.S.2d at 817, 818.

96. *Id.* at 914, 957 N.Y.S.2d at 818.

at the developmental level of a four-month old child. Thus the payments would “aid his family in caring for him in his home.”<sup>97</sup> The court granted the ICO.

2. *Jacobs v. United States et al.*

In *Jacobs v. United States. et al.*, a proposed settlement agreement was submitted in July 2011.<sup>98</sup> Following a determination that supplemental documents needed to be submitted, the court directed the parties to brief whether the case was subject to the MIF.<sup>99</sup> In February 2012, the court determined that the case was, in fact, subject to the MIF since the infant was born via emergency cesarian section due to unrelieved fetal bradycardia, which produced metabolic acidosis.<sup>100</sup> The infant was diagnosed with hypoxic ischemic encephalopathy due to sustained fetal bradycardia.<sup>101</sup>

Interestingly, the proposed settlement agreement in this case allocated twenty-five percent of the total settlement amount to the MIF, which differs from *Joyner-Pack* and the only other published case that applies the MIF.<sup>102</sup> The court did not provide much illumination on this point, stating that this amount “appears to be fair, reasonable and adequate and in harmony with the purpose of the MIF.”<sup>103</sup> Further, the “[twenty-five percent] allocation to the Fund reflects a fair, reasonable and adequate reduction in the settlement amount for the defendants, leaving a reasonable, fair and adequate amount in the non-Fund portion of the settlement fund to provide for the infant’s needs not covered by the Fund.”<sup>104</sup>

It will be interesting to see how the regulations of the Fund are applied to various cases going forward. It appears that there is some leeway in determining what percentage of “Fund Damages” is appropriate. Further, although the trial courts presumably retain the ability to modify the percentage negotiated by the parties, we have yet to see a published case where this has occurred.

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97. *Id.* at 914, 957 N.Y.S.2d at 818.

98. 2012 U.S. Dist. LEXIS 162767, at \*3 (S.D.N.Y. Nov. 13, 2012).

99. *Id.* at \*3-4.

100. *Id.* at \*4, 7.

101. *Id.* at \*9.

102. *Id.* at \*24; *Joyner-Pack*, 38 Misc. 3d 903, 904, 957 N.Y.S.2d 810, 811; *Mendez v. N.Y. & Presbyterian Hosp.*, 34 Misc. 3d 735, 738, 934 N.Y.S.2d 662, 664 (Sup. Ct. Bronx Cnty. 2011).

103. *Jacobs*, 2012 U.S. Dist. LEXIS 162767, at \*60.

104. *Id.*

## III. FEDERAL CASE LAW

A. *Jimmo v. Sebelius*

In last year's *Survey*,<sup>105</sup> the U.S. District Court case *Jimmo v. Sebelius*<sup>106</sup> was analyzed in relation to the Medicare "Improvement Standard."<sup>107</sup> By way of a brief update, the Centers for Medicare and Medicaid Services ("CMS") denied making coverage decisions based on the "Improvement Standard,"<sup>108</sup> but ultimately settled the case on January 24, 2013.<sup>109</sup>

The settlement agreement mandates changes to the Medicare system and is aimed at ensuring that claims are properly adjudicated in accordance with Medicare policy and that Medicare beneficiaries receive the coverage to which they are entitled.<sup>110</sup> The terms of the settlement agreement are intended to clarify the existing Medicare policy that coverage will not be denied based on the absence of the potential for improvement or restoration.<sup>111</sup>

To achieve this goal, CMS will update the program manuals used by Medicare contractors and conduct an educational campaign and a

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105. See Kirsten A. Lerch & Stephen F. Johnson, *2011-2012 Survey of New York Law: Health Law*, 63 SYRACUSE L. REV. 805 (2013).

106. See *Jimmo v. Sebelius*, No. 5:11-cv-17, 2011 U.S. Dist. LEXIS 123743 (D. Vt. Oct. 25, 2011).

107. Lerch & Johnson, *supra* note 105, at 818 (The Medicare "Improvement Standard" refers to the claim made by plaintiffs that Medicare limited coverage for home health care, skilled nursing home stays, and outpatient therapies to patients who showed an improvement in their condition. Plaintiffs maintained that under this practice, coverage of skilled care was denied to beneficiaries whose conditions had plateaued or who were medically stable or needed services for maintenance only. *Jimmo*, 2011 U.S. Dist. LEXIS 123743, at \*4-5); see Gill Deford et al., *How the "IMPROVEMENT STANDARD" Improperly Denies Coverage to Medicare Patients with Chronic Conditions*, 43 CLEARINGHOUSE REV. 422, 423 (2010); see also Robert Pear, *Settlement Eases Rules for Some Medicare Patients*, N.Y. TIMES (Oct. 22, 2012) <http://www.nytimes.com/2012/10/23/us/politics/settlement-eases-rules-for-some-medicare-patients.html>.

108. Centers for Medicare & Medicaid Services, *Jimmo v. Sebelius Settlement Agreement Fact Sheet* [hereinafter *Settlement Agreement Fact Sheet*], available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf>.

109. See generally Order Granting Final Approval of Settlement Agreement, *Jimmo*, 2011 U.S. Dist. LEXIS 123743, available at <http://www.medicareadvocacy.org/wp-content/uploads/2013/01/Order-Granting-Final-Approval.012413.pdf>.

110. Settlement Agreement, *Jimmo*, 2011 U.S. Dist. LEXIS 123743 [hereinafter *Settlement Agreement*], available at <http://www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf>; *Settlement Agreement Fact Sheet*, *supra* note 108.

111. Settlement Agreement, *supra* note 110, at 8-12; *Settlement Agreement Fact Sheet*, *supra* note 108.

claims review.<sup>112</sup> The updated manuals will clarify that coverage of therapy “does not turn on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care.”<sup>113</sup> CMS will undergo an educational campaign for contractors, adjudicators, providers, and suppliers to clarify its policy on the improvement of a Medicare patient in relation to coverage.<sup>114</sup> Lastly, CMS will review a random sample of coverage decisions to determine trends and issues, including a review of individual claim determinations that may not have been made in accordance with the principles set forth in the settlement agreement.<sup>115</sup> Per the settlement agreement, the manual revisions and educational campaign must occur prior to January 23, 2014.<sup>116</sup>

The *Jimmo v. Sebelius* settlement agreement is a significant development for Medicare beneficiaries as they will have greater assurances that their coverage determinations will not be made based on the potential for their condition to improve. Implementation of the above measures pursuant to the settlement agreement will hopefully obviate the need for any further “Improvement Standard” litigation.

### B. Challenges to the Affordable Care Act

As expected, there continues to be litigation that challenges the legality of the Affordable Care Act (“ACA”). These challenges can be grouped into several broad categories: religious challenges, challenges surrounding how the law was passed, and challenges as to how the law will operate. Rather than have this segment constitute an exhaustive review of the litigation, we have chosen one or two representative cases which exemplify these broad categories.

#### 1. Religious Challenges

In *Hobby Lobby Stores, Inc. v. Sebelius*,<sup>117</sup> two for-profit corporations (Hobby Lobby Stores, Inc. and Mardel, Inc.) owned by a single family moved for preliminary injunctive relief in respect to

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112. Settlement Agreement, *supra* note 110, at 14, 19; *Settlement Agreement Fact Sheet*, *supra* note 108.

113. Settlement Agreement, *supra* note 110, at 10-11; *Settlement Agreement Fact Sheet*, *supra* note 108.

114. See Settlement Agreement, *supra* note 110, at 14; see also *Settlement Agreement Fact Sheet*, *supra* note 108.

115. Settlement Agreement, *supra* note 110, at 20, 21; *Settlement Agreement Fact Sheet*, *supra* note 108.

116. *Settlement Agreement Fact Sheet*, *supra* note 108.

117. 723 F.3d 1114 (10th Cir. 2013).

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certain regulations<sup>118</sup> that implemented the ACA.<sup>119</sup> Specifically, one provision of the ACA mandates that employer-based group health care plans cover certain types of preventive health services.<sup>120</sup> Another provision provides that the plans must provide coverage of “preventive care and screenings” for women, which have been defined to include “all FDA approved contraceptive methods [and] sterilization procedures.” At issue here were four of the twenty FDA-approved contraceptive methods, which the family objected to due to the fact that they prevent uterine implantation of a fertilized egg.<sup>121</sup>

Plaintiffs contended that these regulations, which require that employers provide certain contraceptive services as part of their employer-sponsored health care plan, forced them to violate their religious beliefs and violated the Free Exercise Clause of the First Amendment and the Religious Freedom Restoration Act (“RFRA”).<sup>122</sup> Although there are certain exceptions for some organizations and religious employers from this contraceptive-coverage requirement, as well as for some “grandfathered” health care plans,<sup>123</sup> the two for-profit organizations did not fall within any of these exceptions.<sup>124</sup>

The District Court denied the motion finding that the corporations had not demonstrated a likelihood of success on the merits.<sup>125</sup> The Tenth Circuit reversed and determined that the for-profit corporations could be considered a “person exercising religion” for the purposes of the RFRA and that the Appellants had demonstrated a likelihood of success on the merits.<sup>126</sup> The case was remanded to the District Court to determine whether a preliminary injunction was appropriate.<sup>127</sup>

In contrast, the plaintiffs in *Conestoga Wood Specialties Corp. v. Sebelius*<sup>128</sup> had similar arguments but received a different result. In *Conestoga*, plaintiffs moved for a preliminary injunction to enjoin certain regulations implementing the ACA.<sup>129</sup> Among other allegations,

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118. 42 U.S.C. § 300gg-13 (Supp. V 2012); 29 U.S.C. § 1185d (Supp. V 2012); *Hobby Lobby Stores, Inc.*, 723 F.3d at 1120-21.

119. *Hobby Lobby Stores Inc.*, 723 F.3d at 1120.

120. 42 U.S.C. § 300gg-13 (Supp. 2012); 29 U.S.C. § 1185d (Supp. 2011).

121. *Hobby Lobby*, 723 F.3d at 1124–25. The family did not object to providing the other sixteen FDA-approved contraceptive methods. *See Id.*

122. *Id.* at 1120-21.

123. *Id.* at 1123-24.

124. *Id.* at 1124.

125. *Hobby Lobby*, 723 F.3d at 1145.

126. *Id.* at 1129, 1145.

127. *Id.* at 1147.

128. 724 F.3d 377 (3d Cir. 2013).

129. *Id.* at 380.

the Complaint alleged that the regulation, which requires group health plans and health insurance issuers to cover contraceptives, violates the RFRA and the Free Exercise Clause of the First Amendment.<sup>130</sup> The District Court denied the request for a preliminary injunction, which was appealed to the Third Circuit. On appeal, the court focused on whether a for-profit secular corporation was able to “engage in religious exercise under the Free Exercise Clause of the First Amendment and the RFRA.”<sup>131</sup> It ultimately determined the answer in the negative and affirmed the District Court’s denial of the motion.<sup>132</sup>

In *Roman Catholic Archdiocese of New York v. Sebelius*,<sup>133</sup> five New-York-area Roman Catholic entities challenged the mandate that group health insurance plans cover certain preventative services, including contraception, sterilization, and related counseling.<sup>134</sup> Plaintiffs alleged that this regulation violated the Establishment, Free Exercise, and Free Speech clauses of the First Amendment, the RFRA, and the Administrative Procedures Act.<sup>135</sup> Two of the plaintiffs’ claims were dismissed for lack of standing; however, the District Court allowed the remaining plaintiffs’ claims to stand. The case remains pending.

In *Liberty University v. Lew*,<sup>136</sup> plaintiffs challenged two provisions of the ACA: the employer mandate and the individual mandate.<sup>137</sup> Plaintiffs alleged these two provisions violated Articles I and IV of the Constitution, Amendments I, V, X of the Constitution, and the RFRA.<sup>138</sup>

The individual mandate requires that applicable individuals obtain health care coverage, which meets the minimum essential coverage

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130. *Id.*

131. *Id.* at 381.

132. *Id.*

133. 907 F. Supp.2d 310 (E.D.N.Y. 2012).

134. *Id.* at 312-13.

135. *Id.* at 313.

136. 733 F.3d 72 (4th Cir. 2013).

137. *Id.* at 7-8. The District Court upheld the constitutionality of both provisions, and the Fourth Circuit remanded with instructions to dismiss for lack of jurisdiction due to the Anti-Injunction Act. *Id.* at 9. The Supreme Court granted plaintiffs’ petition for certiorari, vacated the Fourth Circuit’s judgment and remanded for reconsideration in light of the Supreme Court decision in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012). *Id.* at 8.

138. *Liberty Univ.*, 733 F.3d at 98-99. Plaintiffs also challenged certain regulations that require coverage for all FDA-contraceptive methods (45 C.F.R. § 147.130(a)(1)(iv) (2012)), however these regulations were first raised on remand and thus the Fourth Circuit refused to consider them. *Id.* at 104.

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requirements, or pay a shared responsibility payment.<sup>139</sup> The employer mandate refers to the requirement that an “applicable large employer” must provide affordable health care coverage to full-time employees and dependents or will be subject to an assessable payment if it fails to do so.<sup>140</sup> The amount of the assessable payment differs depending on whether the employer provides health care coverage which does or does not meet the minimum essential coverage requirement.<sup>141</sup> An employee can obtain an “applicable premium tax credit” or “a cost-sharing reduction” if the employer fails to offer employee “affordable” coverage providing “minimum value” and the employee’s income falls between 100% and 400% of the poverty line.<sup>142</sup>

Plaintiffs argued the employer mandate exceeded Congress’ Commerce Power.<sup>143</sup> The court disagreed and reasoned that employers, by their very nature, are engaged in economic activity.<sup>144</sup> As such, the Commerce Power here is regulating existing activity.<sup>145</sup> This differs from the determination by the Supreme Court in *National Federation of Independent Business v. Sebelius*<sup>146</sup> in regards to the individual mandate, where the Court found that the commerce power could not be used to create activity and then regulate it. Thus, the Fourth Circuit held that, although the individual mandate could not be upheld as an exercise of the Commerce Power, the employer mandate could.<sup>148</sup>

Plaintiffs next contended the Taxing and Spending Clause does not provide power for Congress to enact individual and employer mandates.<sup>149</sup> The court dismissed this argument, finding that the Supreme Court had already addressed this issue in regards to the individual mandate and the same reasoning applied to the employer mandate.<sup>150</sup>

Plaintiffs argued that the individual and employer mandates violated their Free Exercise rights as these provisions force them to violate their religious belief, that “they should play . . . no part in facilitating, subsidizing, easing, funding, or supporting . . .

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139. 26 U.S.C. § 5000A(a)-(b) (2012).

140. 26 U.S.C. § 4980H(a)-(b) (2012).

141. *Liberty Univ.*, 733 F.3d at 85.

142. *Id.* at 84-85.

143. *Id.* at 91.

144. *Id.* at 93.

145. *Id.*

146. 132 S. Ct. 2566 (2012).

148. *Liberty Univ.*, 733 F.3d at 95.

149. *Id.*

150. *Id.*

abortions.”<sup>151</sup> Plaintiffs contended that the “minimum essential coverage” regulation could cause it to be subjected to significant penalties and substantial financial hardship.<sup>152</sup> In addition, the Liberty University plaintiff contended it was a Christian educational institution and it considered abortion to be murder and morally repugnant, except where necessary to save the life of the pregnant mother.<sup>153</sup>

The court disagreed with plaintiffs’ contentions, finding that the Free Exercise Clause does not compel Congress to exempt religious practices where the law is a valid and neutral law of general applicability as it is here.<sup>154</sup> Furthermore, there was no violation of the RFRA as there was no “substantial burden” on religious beliefs.<sup>155</sup> This was because the ACA provided exceptions for certain plans which cover abortion services in limited circumstances and plans which do not cover abortion services at all.<sup>156</sup>

Plaintiffs’ argument that the individual and employer mandates violated the Establishment Clause and their Fifth Amendment Equal Protection rights was also rejected. Specifically, plaintiffs argued that the religious conscience exemption<sup>157</sup> discriminated against their religious beliefs as it only applied “to sects that conscientiously oppose all insurance benefits, provide for their own members, and were established before December 31, 1950.”<sup>158</sup> The court disagreed and determined that this exception made no “explicit and deliberate distinctions” between sects and that it had a secular purpose, which satisfied the requisite legal standard.<sup>159</sup> In addition, there was no excessive entanglement with religion.<sup>160</sup> Plaintiffs’ contentions regarding the health care sharing ministry exception<sup>161</sup> were similarly dismissed as it made no attempt to distinguish between particular religious groups.<sup>162</sup>

Lastly, the court determined that the Fifth Amendment was not violated because the exceptions are “rationally related to the

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151. *Id.* at 99.

152. *Id.* at 86.

153. *Liberty Univ.*, 733 F.3d at 86.

154. *Id.* at 99.

155. *Id.*

156. *Id.* at 100.

157. 26 U.S.C. 5000A(d)(2)(A).

158. *Liberty Univ.*, 733 F.3d at 101.

159. *Id.* at 101-02.

160. *Id.* at 102.

161. 26 U.S.C. § 5000A(d)(2)(B).

162. *Liberty Univ.*, 733 F.3d at 102.

Government's legitimate interest in accommodating religious practice while limiting interference in the Act's overriding purposes."<sup>163</sup>

## 2. Passage Concerns

In *Sissel v. U.S. Department of Health & Human Services*,<sup>164</sup> plaintiff raised concerns regarding the individual mandate and the Origination Clause of the U.S. Constitution.<sup>165</sup> The Origination Clause states that "All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may propose or concur with Amendments as on other Bills."<sup>166</sup>

The procedural history of the ACA is detailed in the court's decision, but in brief it is as follows. A bill was passed in the House of Representatives that concerned amendments to the IRS code.<sup>167</sup> Once the bill arrived in the Senate, the substance of the Bill was deleted and the text of the ACA was inserted in its place.<sup>168</sup> This bill passed the Senate and was sent back to the House of Representatives, where it was ultimately passed and then signed into law by the President.<sup>169</sup> In essence, plaintiff's argument is that the individual mandate of the ACA is a tax, which makes the ACA a bill for raising revenue. Moreover, plaintiff contends the individual mandate was first introduced in the Senate, and thus, the entire ACA is in violation of the Origination Clause and should be declared unconstitutional on this basis.<sup>170</sup>

The court rejected this challenge in a decision published on June 28, 2013. The court found that although the text of the ACA was inserted in HR 2590 by the Senate, this is consistent with the past practice of the two houses. In addition, a bill which incidentally raises revenue is not a "Bill[] for raising Revenue" as interpreted by Origination Clause jurisprudence. Here, the ACA's purpose is to expand health insurance coverage and any revenue that is raised is incidental to this purpose.<sup>171</sup> Thus, the ACA is neither a "Bill[] for raising Revenue" and even if it is construed as such, it clearly originated

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163. *Id.* at 102.

164. 951 F. Supp. 2d 159 (D.D.C. 2013).

165. *See generally id.* In the first iteration of the Complaint, plaintiff alleged that individual mandate was a violation of the Commerce Clause. Following the decision in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012), the plaintiff amended his complaint to add an Origination Clause challenge. *Id.* at 163.

166. U.S. CONST. art. I, §7, cl. 1.

167. *Sissel*, 951 F. Supp. 2d at 161.

168. *Id.*

169. *Id.*

170. *Id.* at 167.

171. *Id.* at 168-69.

in the House of Representatives. Consequently, the Origination Clause does not require the invalidation of the ACA.<sup>172</sup> Defendant's motion to dismiss for failure to state a claim upon which relief may be granted was granted.<sup>173</sup>

### 3. ACA Operation

At least one case has challenged the ACA on the basis that it required impermissible delegation of congressional authority to the Independent Payment Advisory Board. In *Coons v. Geithner*, plaintiff contended that in passing the ACA, Congress exceeded its Commerce Clause power (Count I), the implied power inherent in the Necessary and Proper Clause (Count II), the federal Taxing Power (Count III), the Fifth and Ninth Amendments by restricting plaintiffs' medical autonomy (Count IV), the Fourth, Fifth and Ninth Amendments through a violation of privacy (Count V), that Congress violated separation of powers by establishing the Independent Payment Advisory Board (Count VII), and that the Arizona state health law pre-empted the ACA (Count VIII).<sup>174</sup> Following the decision in *National Federation of Independent Business*, Counts I and II were dismissed as moot and Count III was dismissed on the merits. Regarding Count VII, the District Court disagreed with plaintiffs' contentions and dismissed the delegation claim, stating that all that was required was that Congress "clearly delineate the general policy, the public agency which is to apply it, and the boundaries of the delegated authority", which was accomplished.<sup>175</sup> Although there was initially a question as to whether the remaining counts would survive in light of *National Federation of Independent Business*, plaintiffs' remaining claims were ultimately dismissed in December 2012.<sup>176</sup>

In *Pruitt v. Sebelius*, plaintiffs challenged the employer mandate of the ACA by arguing that it exceeded the Commerce Clause, and challenged an IRS rule that provides that subsidies are available to anyone enrolled in a qualified health plan through an exchange.<sup>177</sup> More specifically, plaintiffs claimed that the IRS rule was ultra vires, arbitrary and capricious, unconstitutional as it applies to the employees

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172. See *Sissel*, 951 F. Supp. 2d at 174.

173. *Id.* at 163.

174. No. CV-10-1714, 2012 U.S. Dist. LEXIS 124196, at \*5-6 (D. Ariz. Aug. 31, 2012) (citations omitted).

175. *Id.* at \*5-6.

176. *Coons v. Geithner*, No. CV-10-1714, 2012 U.S. Dist. LEXIS 180306, at \*14 (D. Ariz. Dec. 20, 2012).

177. No. CIV-11-30-RAW, slip op. at 6 (E.D. Okla. Aug. 12, 2013).

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of the State of Oklahoma, and a violation of the Tenth Amendment.<sup>178</sup> Defendants moved to dismiss the action on the basis of lack of standing and ripeness.

As it relates to the IRS Rule claim, the ACA provides that each state shall establish an “American Health Benefit Exchange.”<sup>179</sup> A state may decline to establish an exchange and if so, the Federal Government may establish an exchange instead.<sup>180</sup> The ACA provides premium assistance subsidies for individuals enrolled in “an Exchange established by the State under section 1311 [42 U.S.C. 18031] of the ACA” but makes no mention of exchanges created by the Federal Government.<sup>181</sup> The IRS Rule at issue states that subsidies are available to individuals “enrolled in one or more qualified health plans through an Exchange.”<sup>182</sup> According to plaintiffs, the IRS Rule expands the availability of subsidies to individuals who live in states which declined to create a State Benefit Exchange and instead had the Federal Government create one.<sup>183</sup> Since the ACA only provides that subsidies are available to those who live in States that created an Exchange, the IRS rule is *ultra vires* since it goes beyond that which was authorized by statute.<sup>184</sup>

In addition, plaintiffs claim that the availability of the premium assistance subsidy triggers the assessment penalty on employers, since the penalty only applies where at least one employee enrolls in a plan through an Exchange for which an applicable premium subsidy is allowed or paid.<sup>185</sup> Consequently, the IRS has usurped the right of the States to determine whether awards of premium tax credits or assessments of the large employer tax be made, a right which was granted by Congress. The Court dismissed the *ultra vires* contention on the basis of lack of standing and dismissed the claim that the Rule was unconstitutional as applied to the employees of Oklahoma.<sup>186</sup> However, the court declined to dismiss the claim that the IRS usurped the right of the States to determine whether tax credits or assessments should be made, and declined to dismiss the claim that the IRS rule is arbitrary

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178. *Id.* at 24.

179. 42 U.S.C. § 18031(b) (2012).

180. 42 U.S.C. § 18041(c) (2012).

181. 26 U.S.C. § 36b(c)(2)(A)(I) (2013).

182. 26 C.F.R. 1.36B-2(a)(1) (2013).

183. *Pruitt*, No. CIV-11-30-RAW, slip op. at 5.

184. *Id.* at 6.

185. *Id.* at 27.

186. *Id.* at 20.

and capricious.<sup>187</sup> The court requested additional briefing on whether the Anti-Injunction Act barred consideration of the Tenth Amendment issue.

As many of the above cases were dismissed on technical grounds or are in the process of being appealed, it seems likely that litigation surrounding the ACA will continue for some time into the future.

#### CONCLUSION

Looking ahead, the impact of the SAFE Act on the mental health system in New York State will be more fully realized, including any gaps in its reporting requirements or litigation in response to patient privacy. In addition, in the following year CMS will finish implementing changes to the Medicare review system pursuant to the *Jimmo v. Sebelius* settlement agreement. As to the litigation challenges surrounding the ACA, continued litigation seems likely. Ultimately, the Supreme Court may have to weigh in to settle these contentious concerns. Lastly, we look forward to any additional cases fleshing out the interpretations of the MIF regulations, specifically for cases where the trial court modifies the percentage of the verdict or settlement which are “Fund damages.”

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187. *Id.* at 30.