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In This Issue

Patient Protection and Affordable Care Act: An Economic Analysis

By *Chantel Sheaks*

Later this month, the U.S. Supreme Court will hear arguments on the validity of the nation's most comprehensive health reform law since Medicare was enacted. Most Americans know the Patient Protection and Affordable Care Act (PPACA) as the much debated legislation that will require them to face a penalty tax if they don't secure minimum healthcare insurance coverage by Jan. 1, 2014.

This provision, known as an individual mandate, was challenged for being unconstitutional almost immediately after the PPACA was signed in March 2010. While a myriad of court cases were filed in federal district courts across the country, many of these cases were dismissed on procedural grounds, but at least two were decided on a substantive level.

For example, several individuals without private healthcare insurance worked with the Thomas More Law Center, a national public interest law firm based in Ann Arbor, Mich., to file suit in the federal district court for the Eastern District of Michigan. Despite the challenge of the PPACA's individual mandate's constitutionality, the district court upheld the law, as did the Sixth Circuit Court of Appeals (jurisdiction over Michigan, Ohio, Tennessee and Kentucky), becoming the first circuit court to decide this issue.

During the same time, a notable case was filed by the attorney generals of 26 states (Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming) in the district court of Northern Florida. The district court determined that the individual mandate is unconstitutional, and because the provision is so integral to the PPACA, the entire statute is unconstitutional; especially because it does not contain a severability clause.

This case was appealed to the Eleventh Circuit (jurisdiction over Florida, Georgia and Alabama) which held that the individual mandate is unconstitutional, but that it is severable from the rest of PPACA. As such, the Eleventh Circuit only invalidated the individual mandate, but upheld the rest of the statute.

In a separate action, Virginia Attorney General Kenneth Cuccinelli also challenged PPACA's constitutionality. The Fourth Circuit Court (Virginia, Maryland, West Virginia, North Carolina and South Carolina) held that that state did not have standing to bring the case. In a separate case in Virginia, Liberty University, et al. v. Timothy Geithner, et al., the Fourth Circuit Court held that because the consequent penalty would not come into effect until 2015 at the earliest, the Tax Anti-Injunction Act (TAIA) precludes the court from hearing the case before a tax penalty is actually imposed.

Given the differences between the Circuit Courts, in December 2011, the Supreme Court announced that it will hear the cases on Monday, March 26, 2012. Oral arguments will be spread out over three days for an unprecedented six hours. The issues to be discussed include:

- Whether the TAIA prohibits the Court from hearing the case before the individual tax is actually imposed.
- Whether the individual mandate is constitutional and if so, whether it is severable from the rest of PPACA.
- And finally, whether the Medicaid expansion is permissible.

The following does not attempt a legal analysis of the issues, but instead it explores two potential economic scenarios that could result from legal maneuverings around the individual mandate.

First Scenario

The TAIA generally provides that an individual cannot bring an action in court to restrain the assessment or collection of any tax. The TAIA has been interpreted to prohibit a challenge to a tax before the tax is actually assessed. Assuming that the individual mandate penalty is a tax (which, in itself is a hotly debated topic), and the soonest the penalty could be assessed is 2015, the potential worst case scenario would be that the TAIA bars any lawsuit until at least 2015 and the Supreme Court ultimately rules (perhaps not until 2016 or 2017) that PPACA is unconstitutional.

From a purely economic perspective, this scenario would do little to lower healthcare costs, and could instead escalate costs with no sustainable improvement in quality or care. Why? Many of the very costly provisions become effective in 2014. For example, while the cost of establishing health insurance exchanges (either at the state or federal level) depends on the type of exchange, the benchmark is millions of dollars. The initial startup cost for the Connector in Mass. was $25 million, with an annual operating cost of $30 million, financed by a surcharge on health insurance premiums. Consider the cost if you multiply these amounts by 51, and then dissolve everything that has been established in 2016 or 2017 because the PPACA is ruled unconstitutional. This cost does not even include the required employer disclosures to employees and the government that start in 2013, 2014, and 2015, nor does it include the cost of compliance and enforcement for individuals, employers and the government.

Second Scenario

The second potential worst case scenario would develop if the Supreme Court were to rule that the individual mandate is unconstitutional, and that it is severable from the rest of the law. This would mean that individuals would not be required by law to obtain minimum health insurance coverage, but all of the other market reforms, employer mandates, and exchange mandates would remain in effect.

Unlike other criticism or support of the individual mandate, labeling this possibility as the second worst case scenario is not a political call, but a practical assessment. Specifically, this scenario would still require the rest of the law to be implemented. States and/or the federal government would be required to set up exchanges, but for the exchanges to work, insurers must *want* to offer coverage in the exchanges and a cross-section of healthy and not so healthy individuals need to *want* coverage. Without the individual mandate, the result could be no one showing up for the exchanges that were built. In short, striking the individual mandate but upholding the rest of PPACA, results in costly requirements for employers, insurers, and state and federal governments without necessarily increasing insurance coverage.

It's difficult to accurately predict what the Supreme Court will decide, but what *can* be predicted is that any decision that causes a delay on PPACA or effectively splits the baby will have a severe economic impact on the cost of healthcare coverage and will not likely improve the quality of care. To prevent needless spending, a swift decision needs to be made sooner than later.

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See the full press release here.

Xerox Secures a $676,500.00 Recovery in a Wrongful Death Case

By *Francesca M. Sollima*

Death cases always present a challenge. There needs to be a balance between the pecuniary interests of the next of kin and those of a health plan that has a subrogation interest, especially when there are limited proceeds available. In this case, Xerox filed a proof of claim with the probate court so that the decedant's estate was on notice of the ERISA plan's lien interest and then worked closely with counsel for the estate/next of kin to fairly distribute $2.2 million in settlement funds between the survival claim and the wrongful death claim. We particapted in a court mandated settlement conference and after much negotiation and discussion agreed that $1.2 million would be paid to the next of kin for their loss and that $1 million would be paid into the estate of the decedant. We also were able to successfully argue that the lien filed on behalf of the ERISA plan was to be paid before the other creditors of the estate. We argued that since the only funds paid into the estate were the settlement proceeds, the ERISA Plan had a constructive trust on those proceeds and a secured interest which therefore should be paid before the interests of general creditors.

Many attorneys will try to avoid repaying health plans in death cases by either not filing a survival claim or by allocating all the settlement proceeds to the wrongful death claim for the next of kin instead of the survival claim. In addition, many states have enacted survival statutes and wrongful death statutes which may limit the types of damages sought. Attorneys will try to use these statutes to defeat a health plan's right to be subrogated or reimbursed. Our people are experts at navigating this complex area and at securing the best recovery for both ERISA and non-ERISA Plans. By taking a cooperative approach, while maintaining a strong presence in the underlying case, we routinely and successfully resolve subrogation and reimbursement claims in death cases for our customers.

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Subrogation Success for Companies in Bankruptcy

By *Eva Brown*

According to the American Bankruptcy Institute, 164,925 businesses have filed for bankruptcy protection since 2009. Subrogation for benefit plans governed under ERISA can present unique challenges in the bankruptcy context.

When an employee covered by a health plan governed under ERISA is injured in an accident and settles a claim to which the plan is entitled to reimbursement, does the employee need to reimburse the plan if it has filed for bankruptcy protection? Typically, the employee's attorney takes the position that the company is bankrupt, so there is no legal entity to reimburse.

However, the plan's lien is considered to be a plan asset. ERISA does not contain a comprehensive definition of plan assets; instead we rely on Department of Labor (DOL) advisory opinions. DOL Advisory Opinion 93-14a provides:

[t]he assets of a welfare plan would include any property, tangible or intangible, in which the plan has a beneficial ownership interest. The identification of plan assets would therefore include consideration of any contract or other legal instrument involving the plan.

Therefore, if a company is in the midst of bankruptcy when the employee's case settles, the lien is an asset of the bankruptcy estate. This holds true for a bankruptcy filed under Chapter 7 or Chapter 11. Moreover, the bankruptcy trustee functions as a plan administrator pursuant to USC §§ 704(a)(11), 1106(a)(1).

Another scenario occurs where assets and liabilities are purchased during a Chapter 11 reorganization. Xerox was involved in case where the employee's claim settled after the bankruptcy was discharged. The overriding issue became providing proof that the plan's lien had not vanished into a bankruptcy black hole.

The entity which purchased the assets of the debtor company retained the same third party administrator to handle medical claims which streamlined contact with the new company. We obtained the purchase agreement which was approved by the bankruptcy court. The purchase documents were detailed and drafted to specifically include the acquisition of the health plan assets of the debtor company. The plan participant's attorney was provided the sale documents. The lien was successfully resolved without litigation.

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