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News for North Carolina Hospitals
from the Health Law Attorneys of Poyner Spruill LLP

PPACA's Expansion of Medicaid in Light of the Supreme Court's Decision in *National Federation of Independent Business* — What Does the Future Hold?

by Wilson Hayman

On June 28, 2012, the U.S. Supreme Court issued its much-anticipated decision in *National Federation of Independent Business v. Sebelius*, No. 11-393 (U.S. June 28, 2012). In a sharply divided opinion, a majority of the court upheld the constitutionality of the individual mandate to purchase "minimum essential" health insurance coverage in the Patient Protection and Affordable Care Act of 2010, as amended (PPACA) as a valid exercise of Congress's taxing power. The decision has been applauded by many sectors of the health care industry including the American Hospital Association. The PPACA attempts to address the anomaly that while the right to receive necessary health care has been recognized in EMTALA and other legislation, that right is directly contradicted by the lack of funding for such treatment for the approximately 50 million Americans without health insurance.

However, Chief Justice Roberts, writing for the majority in *National Federation*, also concluded that the PPACA's proposed Medicaid expansion violated the U.S. Constitution by threatening states with the loss of all their existing Medicaid funding if they decline to comply with the expansion. In a new doctrinal development, the court held that this was "a shift in kind, not merely degree" in the Medicaid program and was unconstitutionally coercive to the states. It noted that the expansion would transform Medicaid from a program that required states to cover only certain discrete categories of needy individuals - such as pregnant women, children, needy families, the blind, the elderly and the disabled - to one that requires the states to meet the health care needs of the entire nonelderly population having an income below 133 percent of the poverty level. For the average state, the loss of the federal portion of its entire Medicaid funding would represent more than 10 percent of the state's overall budget. In short, while the federal government may apparently still condition the receipt of new funding on a state's acceptance of new conditions, the court held that the federal government may not "withdraw existing Medicaid funds for failure to comply with expansion requirements." The court concluded the PPACA went beyond Congress's well-established power to create incentives to a whole new level of undue influence or compulsion that was not constitutionally acceptable. The fact that the PPACA provided that the federal government would pay 100 percent of the costs covering the newly eligible beneficiaries in the expanded Medicaid program through 2016, decreasing to no less than 90 percent in subsequent years, did not change this conclusion.

The severability clause found in 42 U.S.C. § 1303 of the Social Security Act provides that if any portion of that chapter should be found invalid, then the remainder shall not be affected. For this reason and based on its reading of the underlying congressional intent, the court upheld the remainder of the reforms included in the PPACA. Because the states could not be penalized for failing

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Increase in HIPAA Enforcement Activity Continues and Spreads to States

by Elizabeth Johnson

Recent activity by the U.S. Department of Health and Human Services (HHS) signals a significant and sustained uptick in HIPAA enforcement and associated penalties. First, the agency has pursued random audits, the results of which it intends to use to build an ongoing audit program and protocol. That protocol will support HHS's efforts to comply with the HITECH Act, which made such audits mandatory. The audits cover the HIPAA Privacy, Security, and Breach Notification Rules to evaluate covered entities' compliance with their provisions. The results of the first 20 audits have been published, and indicate that the majority of findings (65%) pertain to incomplete implementation of the Security Rule. Eighty percent of those were attributable to health care providers, as opposed to health care clearinghouses or health plans. The audits intentionally target covered entities of various types and sizes and this pilot phase will continue through 2012. The initial audit protocol was recently published by HHS and is available at www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/index.html.

Around the same time, on June 26, 2012, HHS announced its most recent HIPAA enforcement settlement. The target entity was the Alaska Department of Health and Human Services (DHHS), marking HHS's first HIPAA enforcement against a state agency. The action followed a security breach Alaska DHHS reported involving a stolen USB drive that may have contained ePHI. HHS's wide-ranging investigation uncovered multiple reported shortcomings, and the resultant settlement included an agreement to implement a corrective action plan and pay a settlement amount of $1.7 million.

Prior to that, on April 17, HHS announced that it settled a HIPAA violation alleged against Phoenix Cardiac Surgery, P.C. That case was the first significant HIPAA enforcement action involving a physician practice. The practice agreed to pay a $100,000 settlement amount and implement a corrective action plan to come into full HIPAA compliance under agency oversight. The compliance review followed an individual complaint to HHS regarding the practice's use of an Internet-based, publicly available calendar that revealed individually identifiable health information. Significantly, and like the action against Alaska DHHS, many of the violations cited were not directly related to the initial complaint, signaling the type of comprehensive evaluation that has become increasingly common when HHS pursues a compliance review after a complaint or security breach.

Multiple HIPAA resolutions have been reached with HHS in recent years, including settlement payments from $865,000-$2.25 million and one civil monetary penalty of $4.3 million. These actions provide a clear picture of the results HIPAA covered entities can expect if a security breach or an individual complaint causes the agency to investigate and uncover general failure to implement the many dozens of provisions contained in the Privacy, Security, and Breach Notification Rules.

HIPAA enforcement by states also has continued to escalate. Just a few weeks prior to releasing its own audit protocol, HHS published the materials it used to train state attorneys general on their newly-obtained right to enforce HIPAA. That material is available at www.hhshipaasagtraining.com/module0.php. To date, at least four states have pursued HIPAA enforcement actions, the most recent having been settled by Massachusetts for $750,000. Covered entities should anticipate the trend of increased state enforcement will continue as reported security breaches, HHS audits and individual complaints continue to uncover compliance problems signaling that pursuing such enforcement is often fruitful.

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The Risks of Misclassification of Employees as Independent Contractors

by Steve Rowe and Danielle Barbour

The misclassification of employees as independent contractors creates significant risks to employers. Recently the US Department of Labor and the Internal Revenue Service have significantly increased their enforcement efforts in this area.

The IRS uses guidelines in its determination as to whether an individual is an employee or an independent contractor. The primary test is whether the company has control over the worker; however, the IRS looks at a number of factors.

In September 2011, the US Department of Labor and the IRS signed a memorandum of understanding in an effort to jointly increase policing of worker misclassification. The IRS is concerned with lost employment taxes and retirement plan qualification issues. The Department of Labor's concerns include the failure of the employer to make required contributions to Social Security. Pursuant to this memorandum of understanding, the Department of Labor will refer wage and hour investigation information involving IRS employment tax compliance issues to the IRS. The IRS will, in turn, share employment tax referrals provided by the Department of Labor with state and municipal taxing authorities, that have agreements with the IRS. The Department of Labor and IRS will also share training materials and meet regularly to discuss ways to improve the partnership between the agencies.

On September 22, 2011, the IRS launched a voluntary worker classification settlement program. The program provides taxpayers with an opportunity to voluntarily reclassify their workers as employees for future tax periods with limited federal employment tax liability for the past nonemployee treatment. In order to participate in the program, the taxpayer must meet certain eligibility requirements, apply to participate, and enter into a closing agreement with the IRS. It is important to note, however, that the closing agreement with the IRS will not cut off any potential liability the employer faces based on employee misclassification with other agencies such as the North Carolina Industrial Commission and the North Carolina Department of Commerce Division of Employment Security.

The consequences of misclassifying employees are substantial. The employer could be liable for unpaid payroll taxes, claims based on employees being denied participation in benefit plans, and possible out-of-pocket liability for workplace injuries suffered by the worker due to the absence of coverage under a workers' compensation insurance policy.

It is further important to note that only employees are covered under Title VII of the Civil Rights Act of 1964 (Title VII). The courts have had to decide cases, including those involving physicians, regarding whether or not the plaintiff was an employee or an independent contractor for purposes of determining whether or not the individual could pursue a claim under Title VII. In the case of *Cilecek v. Inova*, Dr. Cilecek claimed that he was terminated because of his testimony in a former employee's sexual harassment suit in violation of Title VII. The trial court granted judgment in favor of Dr. Cilecek's employer, and Dr. Cilecek appealed. In reviewing the matter, the United States Court of Appeals for the Fourth Circuit, the Federal Circuit in which North Carolina is located, considered the following factors in determining whether Dr. Cilecek, who was performing emergency room medical services at a hospital, was an employee or an independent contractor: (1) the control of when the doctor worked, how many hours he worked, and the administrative details incident to his work; (2) the source of instrumentalities of the doctor's work; (3) the duration of the relationship between the parties; (4) whether the hiring party had the right to assign additional work to the doctor or to preclude the doctor from working at other facilities or for competitors; (5) the method of payment; (6) the doctor's role in hiring and paying assistants; (7) whether the work was part of the regular business of the hiring party and how it was customarily discharged; (8) the provision of pension benefits and other employee benefits; (9) the tax treatment of the doctor's income; and (10) whether the parties believed they had created an employment relationship or an independent contractor relationship. After reviewing these factors, the Court of Appeals concluded that Dr. Cilecek was an independent contractor. As a result, he was not entitled to pursue his claim under Title VII.

It is critical that every employer, including hospitals and medical practices, carefully scrutinize all its independent contractor arrangements and agreements. It is highly recommended that employers obtain advice of experienced legal counsel in regard to such analysis and the formulation of a course of action in the event of a misclassification.

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PPACA's Expansion of Medicaid

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to participate in the Medicaid expansion by losing all their Medicaid funding, some states may choose not to participate. The decision thus renders the Medicaid expansion optional but still available to any state that is willing to participate.

In this light, what does the future hold for health care reform? As a result of the Supreme Court's decision, the Medicaid program is now at the center of the debate about health care reform and PPACA. We do not yet know whether the administration will approach Congress to correct the constitutional failing by further legislation, and the outcome of such an attempt is not at all clear. The November election ensures that the debate and uncertainty will continue. Nor can we predict how many states will choose to opt out of the expanded Medicaid program, though several governors have expressed such an intent. Given the recent developments with our own Medicaid program and the competitive political climate, North Carolina's participation in Medicaid expansion is by no means clear.

Even with the high level of federal funding for new Medicaid beneficiaries, there may be nondoctrinaire reasons for financially strapped states to consider opting out. For instance, some states anticipate that the expansion will encourage substantial numbers of currently eligible persons to apply for Medicaid as well. Since the new funding assists only states with newly eligible beneficiaries, this development would result in an increased financial burden borne only by the states. In addition, some states may wait for HHS to promulgate guidance on opting out, in a desire "to read the fine print" and learn exactly what they are getting into.

What will be the result of states opting out of the Medicaid expansion? Obviously, there will be persistent and large numbers of uninsured and the problems that result. Any goal approaching universal coverage will not be realized in those jurisdictions. Some have described the effect of nonparticipation by states as creating a "Medicaid Doughnut Hole" for people who do not qualify for Medicaid or a private health plan. There is a tremendous state variation in the current adult eligibility under Medicaid – from below 25 percent to more than 200 percent of the federal poverty level. Moreover, the subsidies for health information exchanges are not available to individuals who are below 100 percent of the federal poverty level. If a low Medicaid-eligibility state opts out of the expansion and does not cover childless adults or others, it may create a coverage gap for those who are ineligible for either Medicaid or the federal tax credits. Their income would be higher than the state's current level of eligibility but lower than the 100 percent needed to qualify for exchange subsidies.

With all the other provisions of PPACA coming into effect over the next few years, it is very hard to determine how the court's holding on the Medicaid expansion will affect hospitals. The upholding of the individual mandate will hopefully result in an increase in the number of insured patients and a reduction in uncompensated "charity" care. But along with the new uncertainty around North Carolina's participation in the Medicaid expansion, which would certainly be a blow to North Carolina hospitals, are the reductions in disproportionate-share hospital funding that continue in effect and the substantial reductions in federal reimbursement that are slated to occur in the future under PPACA. Surely the only thing that is certain as a result of the *National Federation* decision is continuing uncertainty in the near future for our hospitals and other health care providers.

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