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Balch Fast Forward

Emerging Developments and How They Should Inform
Your Business Strategy in 2013

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At Balch & Bingham, we know that a comprehensive and dynamic business strategy is key to a sustainable competitive advantage. A business leader's daily tasks can make it challenging to find time to consider the ever-changing external threats and opportunities that you consider as you formulate your business strategy.

Our mission is to help you manage threats and capitalize on opportunities, particularly as they arise from a changing regulatory landscape or litigation developments. As we begin 2013, there are three industries that are being redefined. Each will benefit from such strategic thinking. Changes in the Energy, Financial Services and Health Care industries, when approached with an effective and insightful strategy, hold exciting opportunities.

In this forecast, you will find our expectations and thoughts for those three industries in 2013, the ways in which emerging developments will affect them and, most importantly, what leaders in those industries should be doing in order to adapt and excel when confronted with the realities that 2013 (and beyond) will bring. We hope that you will find these thoughts useful in setting your future path.

As always, we welcome your feedback, and wish you the best of luck this year.

Alan T. Rogers
Managing Partner

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ENERGY

The Presidential and Congressional elections have resulted in another four years of divided federal government. We expect little Congressional action on energy or environmental policy in 2013. It is likely, however, that the Obama administration will remain aggressive in its pursuit of energy and environmental policy agendas through continuing efforts to expand and defend federal jurisdiction. Specifically, we expect federal energy, environmental and natural resource agencies to press such initiatives through administrative action. Where the federal government grows, the states typically yield. Many states are already concerned about the increasing influence and initiatives of federal agencies, however, and are pushing back and defending their jurisdictional authority. This federal versus state battle over jurisdiction and regulatory authority will continue through 2013, and likely through the balance of the President's second term. In many instances, these battles will be resolved by the Courts.

In light of this backdrop, where the rule makers are engaged in drawing lines of jurisdictional authority, we are advising our clients to identify their allies, form coalitions and joint defense arrangements, organize their resources, and proactively engage the issues. Foundational legal issues of authority, including the role of agencies, the role of courts and the reach of the commerce clause will all be engaged in the coming year. The federal versus state jurisdictional battle will be fought on multiple fronts.

States have come to understand that low cost electricity is a major asset to attracting and keeping jobs. States have also come to understand that most federal policies and initiatives in both the energy and environmental arenas tend to increase power prices where they have been historically low. The following are some insights on how the "Federalism" issue may manifest itself and drive resolution of key issues in the coming year.

The U.S. Environmental Protection Agency and the Environmental Community Will Continue Their Efforts to Push Coal Off the Regulatory Cliff

President Obama's first term in office saw an unprecedented attack on the coal industry — from mining to disposal and beyond — than had ever before been launched. New surface-top mining disputes; continued enforcement actions against electric utility industries and other coal-burning sources; draconian emission standards for coal-fired sources; and the potential for more stringent effluent and ash disposal standards all point to one very clear conclusion: without adaptation, domestic reliance on coal as a fuel source has arrived at the beginning of the end. Further, by attacking the electric utility industry directly — one of the largest coal-using industries — the administration casted its enforcement net in an even wider, more profound, and more economically debilitating way.

The next four years will likely see more of the same: continued attacks on the extraction and use of coal. The President no longer needs to appease "energy voters" to ensure reelection. Instead, he can now focus his efforts on strengthening proposed and soon-to-be proposed regulations in a manner that will facilitate the increased regulation on coal and coal-related industries. For instance, expect the EPA to extend the proposed New Source Performance Standards (NSPS) for carbon dioxide and other greenhouse gases for new electric utility units to existing/modified units (as was proposed during the election campaign). Further, coal ash disposal regulations — which have been looming on the regulatory horizon for quite some time — could classify coal ash refuse as a hazardous waste, thus severely restricting the reclamation and disposal of this material. Further expect EPA to issue restrictive effluent standards and section 316(b) regulations governing cooling water intake structures under the Clean Water Act. Both of these water-related regulations will impact the electric utility industry, and the effects will trickle down to the coal industry as well. Finally, expect more severe restrictions on surface-top mining — the coal "cradle" — because the administration will likely attempt to turn agency guidance (previously struck down by a federal district court) into agency regulations.

Admittedly, some in the regulated community disagree. Specifically, they believe that President Obama and his administration will not have the resources necessary to continue to pursue all of the President's initial policy goals, including the enforcement efforts against coal and coal-related industries such as the electric utility industry. In an internal budget-related memo recently released by the EPA employees' union, EPA's Deputy Assistant Administrator of the Office of Enforcement and Compliance stated that even criminal enforcement, normally immune to budget cuts, would be required to focus its efforts on a smaller number of "high impact cases." EPA's current budget is approximately $8.4 million, and although the Senate proposed to maintain the agency's funding at approximately the same level for 2013, the House proposed allocating only $7.1 million.

With fewer resources potentially at EPA's disposal, it is understandable why some believe the agency will be forced to prioritize its initiatives over the next four years and beyond. Nevertheless, because President Obama's administration has attacked coal and the electric utility industry more aggressively than any other administration, the EPA will likely keep its anti-coal agenda as a top priority in the President's next term. We can also expect that well-funded environmental activists groups will be pursuing the same goals as EPA in this regard.

The Federal Energy Regulatory Commission Will Continue to Move Ahead With its New Transmission Policies in Order No. 1000

It is unclear what major new initiatives FERC will pursue during 2013. Increased coordination between the natural gas and electricity industries continues to be a priority for the agency, but thus far, FERC has elected to stay it hand as the industries demonstrate their attention to the issue. Given the

current administration's reelection, FERC may decide to advance some of the measures that it has considered, but so far refrained from adopting, to promote the development of wind and solar generation. This may possibly include attempts to force the consolidation of regional electric utility systems and balancing areas.

In any event, FERC continues to move ahead with Order No. 1000, which forces "nonincumbent" transmission developers upon existing transmission planning processes and imposes new transmission coordination and cost allocation requirements. In the Southeast and other areas, the Order is expected to do little more than create inefficiencies in transmission planning and present new harms and risks to consumers. For example, the North Carolina Utilities Commission reported in the fourth quarter of 2012 that Order No. 1000's nonincumbent developer requirements "would pose new kinds of risks to North Carolina's electric consumers." The risks identified include, "raising costs to customers" and the possibility that a merchant developer would: "abandon its project mid-stream"; "build a project in a substandard or inherently unreliable manner, or fail to maintain line"; and "fail to take appropriate actions to promptly restore service after an outage." Appeals of Order No. 1000 are before the U.S. Court of Appeals for the D.C. Circuit, but the court is not expected to rule until 2014. Utilities will continue to work upon developing their compliance filings to Order No. 1000 throughout 2013, with the implementation of Order No. 1000's requirements – subject to court action – likely to become effective in 2014.

Litigation in New Jersey and Maryland May Define the Role of States in Procuring New Electric Generation Capacity

In 2007, the PJM Independent System Operator implemented its capacity-market model, the "Reliability Pricing Model" (RPM), designed to create long-term price signals to attract investments in generation needed to maintain reliability in the region. Generators participating in the PJM market are required to bid their capacity into the RPM auction, and generators whose bids clear the auction are paid the clearing price.

Over time, some have criticized the RPM as not providing adequate initiatives for new needed generation, in part because of a fear that developers would not be able to recover the significant costs incurred in building new generation. Seeking to remedy the need for new generation in their respective jurisdictions, Maryland and New Jersey each initiated programs whereby generation developers selected through an RFP process would be awarded fixed-rate contracts for new generation. Because all generation must bid into the RPM auction, subject to a few discrete exceptions, the contracts awarded in these state programs required the selected generators to clear the auction. Once cleared, the relevant contracts (referred to as "Contracts for Differences") would require local utilities to pay the generators the difference between the auction clearing price and the fixed contract rate if

the auction clearing price was lower and required the generators to pay the difference if the clearing price was higher.

These state programs precipitated litigation on multiple fronts. The incumbent utilities in New Jersey and Maryland objected to being forced to bear the risk of low auction clearing prices. Other generators felt that this program created an undue preference for the selected generators, which could bid into the auction at the lowest possible price, assured that they would be able to recover their costs because of the Contracts of Differences. At base, these disputes center around whether states can enact programs designed to be independent of the FERC-approved RTO market rules while operating in the RTO markets.

The question is still disputed. PJM changed its auction rules so that a generator selected in this program must bid into the auction at a price based on its cost of new entry — which prevents the submission of an intentionally low bid. FERC identified these changes as necessary to ensure that the state elected generators are not given an undue preference through undue advantage. FERC's order on this matter is currently on appeal before the U.S. Court of Appeals for the Third Circuit. Meanwhile, challenges in U.S. District Courts in New Jersey and Maryland focus on the validity of the state programs. It is expected that the case in New Jersey will go to trial in the coming year, with the Maryland case to follow.

The outcome of these cases could have a strong bearing on the ability of the states within PJM (and in regions with RTOs generally) to control the process of acquiring adequate generation to serve their citizens. If the courts rule to strike down the programs, the states within PJM (and within other RTOs) may see their ability to ensure that adequate generation is built within their jurisdictions severely curtailed. At that point, FERC may become the primary entity that establishes the rules for new generation development.

Smart Grid Will Continue to Develop and Evolve

"Smart Grid" is becoming a more widely used term, even among the general population, but its meaning and expected impact continue to evolve. Clearly, the Smart Grid is progressing beyond the installation of smart meters and updated transmission and distribution system equipment. The Smart Grid will continue to transform the electric industry, especially through developments on the "edge" of the system. In particular, the utilization of distributed energy resources, advanced energy storage and microgrids will receive greater emphasis, particularly as Hurricane Sandy focused governmental policies and customer attention on enabling the electric grid to better withstand, endure and recover from major adverse events. In that regard, the Smart Grid will further employ automated, remote management and controls to respond rapidly to changing conditions. The Smart Grid will also be seen

as the primary catalyst to bring smaller, dispersed "green" resources to the grid to help satisfy policy goals and future electricity demands. Accordingly, both incumbents and new players will need to monitor relevant legislative, regulatory and policy developments impacting the Smart Grid as well as the related rapidly changing technical standards landscape.

Dodd-Frank Act Impacts on Energy-Related Products

On July 21, 2010, President Obama signed the Dodd-Frank Wall Street Reform and Consumer Protection Act into law. Title VII of the Dodd-Frank Act established a comprehensive new regulatory framework for swap transactions. The Dodd-Frank Act broadly defined the term "swap" to include certain types of options on commodities (including certain electricity and gas products). The Dodd-Frank Act required the Commodity Futures Trading Commission to further define the term swap and to develop a regulatory oversight process for the swaps market.

Since 2010, the CFTC has issued more than 40 final rules, including rules that define the types of agreements that are subject to the CFTC's jurisdiction and the applicable record keeping, reporting and position limit requirements. In the wake of these final rules, the energy industry (through various industry groups and representatives) requested certain clarifications from the CFTC to better understand how to apply the new Dodd-Frank Act requirements.

As the energy industry waits for these clarifications, it has needed to move forward with implementation activities because of the current and approaching compliance deadlines. To further complicate the energy industry's implementation efforts, many of the agreements impacted by the new requirements are also subject to the jurisdiction of the FERC. Due to the overlapping CFTC and FERC jurisdictions, Congress required two Memorandums of Understanding (MOUs) regarding their scope of jurisdiction and information sharing activities, which were required to be executed by January 2011. Congress required these MOUs because it foresaw the inefficiencies, inconsistencies and confusion that would result from the CFTC and FERC not agreeing to and documenting these understandings upfront. However, these MOUs have never been executed, and without having these MOUs in place, the CFTC has issued a majority of the final rules to implement the Dodd-Frank Act. Unfortunately, for the energy industry, it is currently unclear if or when these necessary MOUs will ever be executed.

Despite this lack of clarity, we are recommending that our clients in the energy industry review their agreements (including but not limited to power purchase and sale agreements, transmission services agreements, emission agreements and fuel procurement agreements) to determine if they contain provisions that may be subject to the CFTC's new jurisdiction. We are actively working with our clients to assist in these reviews and to develop the necessary Dodd-Frank Act compliance programs around the impacted transmissions.

FINANCIAL SERVICES

The aftershocks of the financial crisis that gripped the U.S. financial services industry from 2007 – 2009 continue as banks struggle to determine how to deploy their financial, technological and human resources to best address the avalanche of new laws, rules and regulator initiatives. The Dodd-Frank Act is a significant, but by no means the sole, source of the burgeoning regulatory burden for banks.

In the new world of banking, challenges come from many different directions and in a myriad of forms as regulators and other policy makers strive to avoid a repeat performance and to address behaviors that they believe contributed to the crisis. Among the key challenges facing bankers will be the phase-in of enhanced capital and liquidity requirements, which will not only impact the balance sheet of banks but also the types of products and services many banks offer. Perhaps on the other end of the regulatory spectrum are what many policy-makers may view as the "wages of sin," taking the form of a far more aggressive regulator, the CFTC, with the power to mandate behaviors that are consumer-centric rather than just to prohibit behaviors that fail to follow specific rules.

Against this backdrop, it will be necessary for banks to keep abreast of the breakneck pace of changes in the regulatory, legal and business environment in which they must survive and, hopefully, prosper. As just one example of developments worth following are the challenges being mounted against the use of mandatory arbitration clauses in consumer agreements. While consumer-protection groups and other typical opponents of mandatory arbitration continue to work the court system, doubtless they will soon have a powerful ally in CFTC.

Banks Will Be Required to Hold More Capital and Be More Liquid

The financial shocks that hit the worldwide economy over the past several years caused major problems at most banks, including numerous failures. In the United States, Congress does not want taxpayers ever again to make up shortfalls in bank capital, nor does it want to jeopardize the FDIC insurance fund further. For their part, the banking supervisors do not want to have to gear up again for the labor-intensive type of regulation required when banks are in distress.

The initial response of the federal banking regulators was to propose in the summer of 2012 new rules that would require that U.S. banks phase-in the new international "Basel III" capital rules, beginning in January of 2013. The new rules (in excess of 600 pages) are difficult even to read, let alone to implement, and by many estimates would require most banks to hold about three times more basic capital than is now the case.

The reaction of the banking industry to the proposed capital rules was swift and negative. Community banks argued that Basel III would make it harder for them to lend to small businesses by mandating that such loans be rated as risky, which would correspondingly require higher levels of capital.

Similarly, all banks are concerned that the new rules would require that compliance staffs compute complex risk weights for one of their mainstay products, residential mortgage loans. The effect of the new rules, say banks, would be to exacerbate an already sputtering economic recovery, or to drive borrowers to non-banks not subject to the new rules. The new rules would be especially punitive for banks holding the riskiest of all assets: past-due loans.

In November 2012, the U.S. banking regulators announced that they would not hold financial institutions to the January 2013 deadline for first-step implementation, even though several other countries (among them Canada, China, Mexico and Switzerland) are planning to meet the deadline. The Federal Reserve says it is trying to respond to the concerns of bankers and is still working as hard as possible to complete the rule-making process.

Another source of heightened concern for bankers is a liquidity rule that would mandate that banks hold enough easy-to-sell assets to survive a 30-day financial shock that is even more extreme than the 2007-2009 financial crisis. This "stress test" would assume a global recession and a 5% drop in Gross Domestic Product, as well as an unemployment rate of 12% and a 50% drop in stock prices.

Although the exact timing and form of the new capital and liquidity requirements cannot be predicted, it is inevitable that significant changes will have to be made in bank balance sheets. Banks that wish to remain independent will have to work hard and smart to identify avenues to obtain and sustain sources of capital, including the riskiest form of capital to investors, common stock. Increasingly banks also will have to consider the capital requirements for their businesses when engaging in strategic planning.

Several provisions of the JOBS Act ("Jumpstart Our Business Startups") passed by Congress in April 2012 might help banks cope with the reality that they may soon be on a hunt for new capital. First, the law increased the number of stockholders a company may have — from 500 to 2,000 — before it must register its securities with the Securities and Exchange Commission. This change might make it easier for privately-held banks and bank holding companies to bring in new investors without triggering the expensive reporting and other compliance requirements that come with SEC registration. The JOBS Act also allows banks and bank holding companies that are already public to de-register if they have fewer than 1,200 stockholders. Critics note, however, that a possible consequence of these new provisions might be that some investors will be reluctant to invest if their shares will not be easily sold on a stock exchange.

Another noteworthy JOBS Act provision directs the SEC to ease the restrictions on solicitations and advertising in private sales of securities. SEC Rule 506 currently allows sales of securities without SEC registration in any dollar amount to an unlimited number of "accredited investors" and up to 35 non-

accredited investors, but only so long as there are no general solicitations or advertising used. This has had the effect of limiting the ability of banks to reach out to potential investors who do not already have a relationship with the bank or its investment bankers. Consistent with its directive under the JOBS Act, the SEC proposed a rule in August 2012 that would ease the restrictions by allowing general solicitations and advertising, but only if the securities are sold to accredited investors. The rule has not yet been finalized. Indeed, one member of Congress accused former SEC Chairman Mary Schapiro of purposely leaving her office in December of 2012 without bringing the proposed rule to a vote because of pressure from groups (the Consumer Federation of America for example) that fear that the new rule would make investors more vulnerable to fraud.

The JOBS Act passed with unusually broad bipartisan support, which suggests that the SEC likely will receive considerable pressure to finalize and implement the rule without much more delay.

In light of the foregoing realities and concerns, decision makers should expect:

- The capital lines of the balance sheets of banks and bank holding companies will have to get larger. This will be true even if the rules are expressly applied only to larger banks, because regulators will find it difficult to think of smaller banks as less risky.
- More capital will be required for business borrowers and for residential mortgage loans (which as described below might also be more limited in their terms because of new consumer protection rules).
- Banks will be forced to increase their focus on products and services that do not generate risky assets, such as investment services, insurance services and other services that generate non-interest income.
- Compliance staff or vendors will be required to calculate and monitor new and more complex capital rules.
- Relationships with investment bankers and other investor intermediaries will become a higher priority for bank management.
- Banks will continue to be more restricted than they were pre-crisis in their payment of dividends.
- Banks with strong capital positions will be the most likely to use their capital for acquisitions.
- De novo bank creation will remain low, because it is so difficult to raise the necessary start-up capital.

Consumer Protection Will be as Pervasive a Regulatory Paradigm as Safety and Soundness

It is not a coincidence that U.S. Senator Elizabeth Warren (D-Mass.) emerged as a leader in banking regulation policy from relative obscurity as a Harvard Law School bankruptcy law professor. Her attitude that the banking industry has been hostile to consumers and must change its ways is emerging as a commonly-held view among policy-makers. Every scandal that emerges in the banking industry, from LIBOR-rigging to risky investments by the "London Whale," only reinforces the notion that bankers' interests are not aligned with those of consumers and that the industry needs more regulation designed to protect its customers. Senator Warren gained the notoriety that ultimately contributed to her election to the Senate through her championing of the Consumer Financial Protection Bureau. That agency, which was created by the Dodd-Frank Act in 2010, will dramatically change the landscape for how banks will do business in the years ahead.

The CFPB is in charge of new regulations that will significantly affect mortgage and consumer lending. More ominous, however, is the entirely new approach to regulation that the new agency represents. No longer will banks be able to rely on "fine print" to manage the risk of consumer complaints. The CFPB's approach is one of fairness, not unlike that for consumer products regulated by the Consumer Products Safety Commission. With the CPSC, no amount of disclosure, or perhaps even reliance on the common sense of the consumer, will save a company from an expensive recall of a product that in fact causes injuries. Likewise for banks, if the CFPB has jurisdiction, no amount of disclosure in a customer agreement will protect a bank in the case of a fee or practice that the CFPB deems to be "unfair."

The CFPB's regulatory jurisdiction is limited to banks with $10 billion or more in assets. However, we predict that the banking-only supervisors, such as the Federal Reserve, the FDIC and state banking supervisors, will apply many of the same fairness concepts to smaller banks.

"Unfair" residential mortgage loan structures contributed significantly to the 2007-2009 financial crisis. Therefore, these loans are certain to get more attention from the CFPB in 2013 and beyond. Congress has already instructed the CFPB to create a category of "qualified mortgages" that are "fair" and protect lenders who make these loans from certain types of liability in lawsuits by the borrowers. The General Accounting Office has determined that since 2010 the underwriting and terms and conditions of residential mortgage loans have become greatly homogenized, and that almost every loan made in 2010 and 2011 met Congress's definition of "qualified mortgage."

In the years ahead, the industry will seek once again to introduce some variability into mortgage loans, in order to enhance profits. The challenge will be to determine whether the CFPB will provide protection from liability for these new types of loans. Some banks will not be willing to risk the legal liability that might come from offering mortgages that are not expressly protected from liability.

These banks will see lower profitability from their mortgage lending. Clearly, banks will need advice, internally or externally, as to exactly how to apply the CFPB's regulations in this area.

The fairness of checking account fees also will be an area ripe for debate, and thus for further regulation. Because of the tremendous infrastructure required to offer checking account and other deposit services, is it really "fair" for consumers to expect free checking accounts? On the other hand, at what level do overdraft charges make an otherwise free checking account unfair? The CFPB and other banking regulators will likely be looking to differentiate between banks that apply an "us versus them" attitude and banks that approach their business strategies with a sense of "shared values" with their customers, where both sides benefit from the pricing of goods and services.

The CFPB (and other banking regulators) will also increasingly be in the business of protecting populations using financial services, in addition to home mortgage borrowers, that are perceived as "vulnerable." These vulnerable populations include the elderly, military personnel and students. This will change the way banks design and market new products, and will also affect banks differently according to the demographics of their customer base. For example, banks located in areas with older populations likely will have to provide heightened training to employees regarding the proper use of powers of attorney and in dealing with customers in nursing home and similar facilities.

Even those who would not normally be considered vulnerable will be entitled to the CFPB's protections if they are using a financial product or service that is new to the market. For example, a CFPB representative told Congress in 2012 that while new technology that allows consumers to use their smartphones to make payments at merchants may add convenience, it also raises the question of whether consumers can get adequate disclosures about the terms and conditions of these transactions when a single click is all that is needed to make such payments.

Another way that the CFPB might differ from traditional banking regulators is its willingness and ability to collaborate and share information with other regulators, as well as with private consumer groups. For example, the agency has signaled that it will actively cooperate with nonprofits and community groups engaged in protecting the elderly. Likewise, it has announced that it will share consumer complaint data that it receives with state agencies, state attorneys general, local agencies and congressional offices, and will accept such information from them as well.

Finally, the CFPB is likely to borrow an enforcement tool from the toolbox of the SEC as a means of ensuring the behavior it desires from banks: bring a legal action against an alleged wrongdoer, and then make sure it is very well publicized so as to deter others from similar behavior. The agency used this technique in 2012 in its first public enforcement action when it ordered Capital One to refund approximately $140 million to two million customers who it determined had been misled into buying

credit card "add-on products." That enforcement action also shows that the CFPB will hold banks responsible for the actions of the third parties they use to offer their products and services, who were in that case the vendors who staffed Capital One's call centers.

In light of the foregoing realities and concerns, decision makers should expect:

- "Is this fair?" will be as important a question to ask in designing and offering banking products as the question "Are we operating in a safe and sound manner?"
- New consumer financial products will have to be measured against guidance from the CFPB as to how much protection is offered from liability to customers.
- Banks will have to adopt a mindset that they may be viewed as responsible to protect those populations that might be considered vulnerable because they are not physically, financially or intellectually able to fend for themselves, as well as those populations not otherwise vulnerable, but which are using financial products or technology that is new to the marketplace.
- Regulators will increasingly "gang up" on banks to protect consumers.

Arbitration May Not Always be Available as a Means to Resolve Customer Disputes

For most of the past twenty years, banks and other financial service providers have sought to use arbitration and other alternatives to courtroom litigation in order to resolve disputes with customers. Today approximately 50% of deposit agreements include an arbitration clause. The percentage is even higher in separate agreements for the use of online banking, debit cards, and credit cards.

While faster and often less expensive than traditional litigation, arbitration comes with some tradeoffs. Arbitrations require payments to the arbitration service and to the arbitrator. Arbitrators also have the reputation of looking for an equitable or a "split the baby" resolution rather than applying technical legal doctrines to bar recovery. Most importantly, in most cases, there is no appeal available from an adverse ruling from an arbitrator. Notwithstanding the tradeoffs, banks generally have continued to view arbitration clauses in their customer agreements as beneficial. One effect of arbitration clauses is that they sometimes can make it more difficult for plaintiffs to bring class actions. The courts have generally been kind to banks in these battles, due in part to the Federal Arbitration Act, which is designed to facilitate private dispute resolution.

Attacks on arbitration clauses are not likely to subside, however, and more likely will increase. President Obama and many other Democrats dislike mandatory arbitration provisions, believing that all consumers should have their "day in court" regardless of agreements to the contrary. The same Dodd-Frank legislation that President Obama and the Democrat-controlled Senate crafted to reform Wall Street also spoke to arbitration clauses in consumer agreements. First, Dodd-Frank provides that

arbitration clauses are not allowed in home mortgage agreements. Second, Dodd-Frank mandates that the CFPB conduct a study on consumer arbitration in regards to financial services. The CFPB is then empowered to issue regulations regarding the limits or conditions of use of arbitration clauses, including even prohibiting them entirely if it is "in the public interest and for the protection of consumers." Just think of what Senator Elizabeth Warren will say about arbitration from her new perch as a member of the Senate Banking Committee.

Meanwhile, opponents of arbitration clauses continue to challenge such clauses in a variety of circumstances, particularly in the context of class actions. Some lower courts have held, for example, that it was "unconscionable" to require consumers to arbitrate claims for some class actions because the costs and legal fees for their individual cases would overwhelm any recovery they might receive. The U.S. Supreme Court, in *AT&T Mobility LLC v. Concepcion*, overruled these lower-court decisions in 2011, rejecting the "unconscionability" argument and ruling that if the arbitration clause was drafted appropriately, the arbitrator – rather than the courts – could decide on the enforceability of the arbitration clause. There likely will be future challenges, however, and doubtless the opponents of the use of arbitration clauses in consumer class actions will seek to limit the Supreme Court's ruling to the particular facts of the *Concepcion* case.

Opponents of arbitration clauses have launched another attack that the Supreme Court has agreed to hear in 2013. The case is a class action brought by a group of merchants against American Express for alleged violations of the federal antitrust laws. The new challenge is based on the assertion that mandatory arbitration is against "public policy" because it essentially immunizes wrongdoing and thereby prevents the "vindication of rights." The Supreme Court's ruling in this case will be anxiously awaited and closely scrutinized. But, it should be noted that it is possible that the ruling may be somewhat narrow rather than broad-reaching given that the challenge requires a balancing of policies behind the federal antitrust laws with those behind the Federal Arbitration Act. A determination by the Court that the federal antitrust laws effectively override the Federal Arbitration Act may not have much impact on other challenges that are not based on federal law or that are based on a different set of federal statutes.

In light of the foregoing realities and concerns, decision makers should expect:

- Proponents of arbitration clauses in consumer agreements will continue to be avid "court watchers" as it is likely that opponents will continue challenges to such clauses in a number of different venues and contexts.
- The CFPB will likely weigh in on mandatory arbitration in consumer agreements, and not in a way that will encourage its use.

HEALTH CARE

All Americans are faced with exploding health care costs and an increasingly complex maze of regulations affecting the delivery and receipt of medical care. The following discussion identifies anticipated legislative, regulatory and judicial activity in the health care arena, with a focus not only on 2013, but also what the next five to ten years hold in store.

The Economic Realities

The perfect storm approaches in the next decade. There are four components of the Medicare Trust Funds: Part A—the entitlement based generally on individuals being 65 years of age or older or handicapped); Part B—the indirect insurance product for physician services and outpatient care funding for which comes, in part, from individuals' Social Security payments); Part C—the Medicare HMO product now sometimes referred to as Medicare Advantage); and Part D—the Medicare Drug Program that is also an indirect insurance product funded, part, from Social Security payments. Putting aside any political rhetoric, the facts are that these components are all expending money faster than they can recoup it. Even with the savings associated with the Patient Protection and Affordable Care Act (PPACA), Medicare Part A will be insolvent by 2024. Furthermore, the true expenditures of Part B and Part C are difficult to evaluate because Congress has consistently "kicked the can down the road" and avoided the implementation of the sustainable growth rate (SGR) to physician fees. This most recently occurred on December 31, 2012, when to avoid the "fiscal cliff," Congress once again deferred the implementation of the SGR until January 1, 2014. Implementation of the SGR would have triggered an across the board reduction in physician fees of almost 31%.

Complicating this situation further are shifts in our population. Census figures reflect that the population aged 65 and older continue to be the single fastest growing component of the American public with the "Baby Boomer" (i.e., those individuals born between 1946 and 1964) wave in the offing. The 2010 Census indicates that the population aged 65 and older grew by 5,276,231 and now accounts for 15.1% of the American public, while the population aged 45 to 64 grew by 19,536,809 and now accounts for 31.5% of the American public. Indeed, between 2000 and 2010, almost as many people entered these demographics as joined the actual population (24,813,040 versus 27,623,632). Consider also the complication that the population of 25 to 44 year olds, who will bear a significant portion of the burden of our country's finances, *shrunk* by almost 3,000,000 during the same time period.

Contrast this information with recent data from the American Medical Association. The Association of American Colleges' Center for Workforce Studies, among others, currently predicts physician shortages by 2025 of 46,000 primary care physicians and 41,000 general surgeons. These figures assume the SGR will not be implemented; if it is, the anticipated shortages likely will be greater. The figures do not

include any analysis if the current "caps" on medical school education slots (which, by the way, are subsidized by the federal government) are contracted.

The root causes of unwieldy health care costs appear to be manifold. Fraud seems pervasive, if the investigative and enforcement action of agencies like the Office of Inspector General are any indication. Overutilization of health care resources is a common refrain, and one that usually invokes a comparison of Americans' freedom of choice with other countries that control closely the consumers' access to care and reimbursement (e.g., Canada and Japan). Yet, countries like Japan, Canada and the Netherlands have achieved longer life spans and lower rates of infant mortality at a fraction of the cost of the American system. Administrative costs of reimbursing health care (i.e., the administrative costs and profits of the insurance companies) are also markedly higher in the United States than in other countries, prompting PPACA's imposition of a Medical Loss Ratio (MLR) on all insurers that "caps" the amount of non-medical dollars that insurance companies may spend administering health insurance. In actuality, the root causes are likely multiple deficiencies in design, consumption and access to medical care.

In sum, more Americans are aging as a percentage of the population as a whole. The United States has insufficient funds, insufficient health care providers, and insufficient training programs for new health care providers. Medicare is financially unstable. The 2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance [Part A] and Federal Supplementary Medical Insurance [Part B] Trust Funds (2012 Medicare Trust Report) bluntly summed up the current situation as follows. Importantly, these observations assume the implementation of the savings and increased income associated with PPACA:

> The Trustees project that HI [Part A] tax income and other dedicated revenues will fall short of HI expenditures in all future years under current law. The HI trust fund does not meet either the Trustees' test of short-range test of financial adequacy or their test of long-range close actuarial balance.

The numbers themselves are harbingers of a crisis that will occur in the next decade. The United States has already reached the precipice of financial insolvency for the Medicare program even with the cost savings measures and new taxes associated with PPACA. Furthermore, it may be naïve to believe that the nation can either work or tax itself out of this situation. The Medicare program is itself a millstone around the neck of the country's economy, and private insurance is continuously being pressured to increase reimbursement to augment the Medicare and Medicaid dollars that are insufficient to support most hospitals. Yet, Medicare is also a political "third rail" that may remain untouched until it literally collapses of its own weight.

Any number of realistic and philosophic questions might arise from these facts alone: Should my son or daughter pursue medical school? Why provide unlimited medical coverage to our elderly? Given the economic reality, were tax cuts in the last decade prudent? Indeed, are any tax cuts prudent? Who is to believe that a medical reimbursement system established in 1965, before the majority of the modern treatment modalities existed, could possibly be accurate? Aren't there alternative health care delivery mechanisms to the health insurance system such as a single provider of Medicare services like the VA Health System? Why place any limit on the number of immigrants coming to the country if they are tax paying contributors (i.e., taxpayers) to an economic system that cannot survive without dramatic increases in revenue? What is the fate of the political party in power on the day that Medicare finally collapses, leaving bills that can only be partially paid?

Planning for the Next Decade

As the business leaders of our country, it is incumbent upon us to help plan for the next decade. Some trends are unique to health care — the Office of Inspector General continues to report an extraordinary annual return on investment of $1,601 for each $1 invested in antifraud investigations. Others are not. For example, private insurance does and will continue to subsidize hospitals and health care systems that border on collapse from reduced Medicare and Medicaid reimbursement. Meanwhile, individual employers should ensure that their respective workforces are as healthy as possible through, for example, on-site clinics and properly incentivized wellness campaigns. Such measures will be one of the few controlled means of reducing health care insurance premiums.

The following thoughts address only a few of the trends anticipated for the next decade. Nor are they intended to be all-inclusive or prioritized. Nevertheless, they should help guide your planning for the future.

- Anticipate Increased Emphasis on Managed Care. The 2012 Medicare Trust Report indicates that almost 25% of Medicare beneficiaries currently receive medical care coverage through managed care products also known as health maintenance organizations or Medicare Advantage plans. Essentially, these plans permit Medicare beneficiaries to select an insurance plan for coverage on a year-by-year basis with specific "opt in" periods. Once a plan is selected, it is difficult, although not impossible, for a Medicare beneficiary to change plans until the following annual "opt in" period. Often, but not always, the Medicare drug coverage is combined with a plan's offerings. For plans selected by Medicare beneficiaries, the federal government then pays over to the individual plans the anticipated annual Medicare costs of the beneficiaries, and the individual Medicare Advantage plan is financially responsible for ensuring the Medicare beneficiaries receive the care when needed. Currently, there is some "modeling" of the monies paid over to the individual Medicare Advantage plans (e.g., if a beneficiary is diabetic, there is some increase in financial compensation) although this "modeling" is

still elementary. In addition, the Medicare Advantage plans are currently subsidized by the federal government to accept this pricing structure. **Anticipate** that there will be increased emphasis on the use of these conduits to the Medicare population. The attraction of these products is that the risk of loss associated with runaway Medicare costs is shifted from the federal government and its administrators to the insurance plans willing to accept the responsibility for providing care to those Medicare beneficiaries who "opt in" to their respective plans. Neither political party can afford to be holding the Medicare "bomb" when it explodes.

- Expect Friction between Insurers and the Federal Government. Currently, these Medicare Advantage plans are subsidized by the federal government after a number of insurance companies left the market in the 1990's when they were financially unable to provide the care needed by the exploding Medicare population. How long this subsidization, initiated by President George W. Bush and perpetuated by President Obama, will continue is unknown. What is clear, however, is that the existence of these Medicare Advantage plans has the effect of transferring the political association with the impending failure of Medicare from the shoulders of an individual political party to the shoulders of independent insurance companies that do not depend on local, state or national elections for continued operation. While continued expansion of Medicare Advantage plans throughout the United States can be anticipated, **expect** that, as costs and the number of covered beneficiaries continue to rise, there will be increased tension between the insurance industry and the federal government as insurers seek additional compensation to provide health coverage while holding the ultimate threat of not accepting any new contract during the next coverage period, in which case all the beneficiaries would return to the status quo.
- Recognize the Impact of Medical Loss Ratios. As noted above, PPACA established, effective in 2011, MLR's for insurance companies in the United States. The goal is to increase the amount of direct health benefits provided as part of health insurers' operations. Although there are some idiosyncrasies to the statute and intermediate regulations, large insurers must essentially retain no more than 15% of premiums for administrative costs and profit, and small insurers must essentially retain only 20% of premiums for administrative costs and profit. In order to bolster profits in the face of this new legislation, **recognize** that insurance companies will, in the next two or three years, continue to diversify into areas such as quality assurance, software and staffing organizations that service the overall delivery of health care services. These unregulated companies (the MLR's apply to the administrative costs associated with the delivery of the health insurance program alone) may be able to ensure that the insurance companies continue to post profits of the type that have been experienced to date.
- Take Steps to Ensure a Healthy Workforce. Despite increased pressure on employers to provide insurance to their employees and despite the fact that private insurance will continue to subsidize hospitals and physicians that are faced with shrinking federal reimbursement, **employers can control**

their employees' health care costs in a number of ways. Higher deductible plans (both for annual deductibles and per procedure or visit deductibles) are increasingly popular. (See, "The Prevalence and Cost of Deductibles in Employer Sponsored Insurance: A View from the 2012 Employer Health Benefit Survey" published by the Kaiser Family Foundation.) Furthermore, the simple step of ensuring a healthier work force by encouraging daily exercise, sponsoring smoking and tobacco cessation workshops, encouraging healthier food selections (e.g., should the soda machine on the third floor be filled with bottled water instead?), the use of on-site clinics for larger employers (or a shared clinic among smaller employers), on-site flu vaccinations and the like will lead to a more productive workforce and less expensive insurance costs. The avoidance or, indeed, delay of a single hospital admission will more than pay the costs associated with this program. Furthermore, organizations like the American Heart Association are willing — at a cost of pennies on the dollar — to work in conjunction with employers in the development of these programs.

- Anticipate Varied Attempts to Seek Additional Tax Revenues. The Medicare numbers are stark. Without additional revenues (in addition to the multiple layers of taxation already included in PPACA), the current Medicare system will fail in the next decade. The alternatives of cutting significant reimbursement to medical providers or raising the Medicare qualifying age are political suicide. The former would lead to widespread rebellion in the health care industry that, as noted above, is already unable to meet the medical needs of our population. The latter would lead to an immediate rejection of the politicians by the elderly population that regularly votes and that is an increasingly larger and larger segment of the American public (i.e., less than 10% of the American public in 1960 and more than 15% today). **Anticipate** new and varied methods of taxation from the local level (e.g., modifying property taxation to exclude from taxation only direct hospital resources used in the delivery of hospital care and not broad brush exclusions based on the tax-exempt status of the landowner) to the federal level (e.g., increased taxation of the perceived "wealthy" in America or cost sharing for Medicare benefits utilized by the affluent).

- Anticipate Attacks Against the Tax-Exempt Industry. One apparent target of additional tax revenues appears to be tax-exempt hospitals and health care systems themselves. At the prodding of Congress, the Internal Revenue Service has recently redesigned the Form 990, the informational return filed by tax-exempt entities, and this year added the new Schedule H for licensed hospitals. This Schedule H analyzes, among other data, the community spending by tax-exempt hospitals and hospital systems. **Anticipate** that these new tools and initiatives will lead either to additional direct taxation or indirect taxation through annual commitments by licensed tax-exempt hospitals to return funds to the public by relieving governmental burdens to spend on community needs that affect health care. Given the new Community Health Needs Assessments (CHNAs) that are to be completed by every tax-exempt licensed hospital in the United States for fiscal years commencing after March 23, 2012, **anticipate** that the specific commitments to community resources will be extraordinary. Early CHNAs address minutia such as availability of fresh food, the proximity and number of liquor

stores and school violence within the service areas of the individual hospitals. The need to address each issue of course is important, but perhaps only tangentially related to health care. In addition, tax-exempt hospitals have enjoyed and made good use of the ability to borrow funds through tax-exempt financings (i.e., financings that are made more attractive as investors do not pay tax on returns from properly qualified bonds) where interest rates for needed capital are extraordinarily low. If this financing mechanism were attacked in an effort to secure more tax revenues, it would negatively affect the tax-exempt hospital industry's access to capital and, therefore, the ability to continue to upgrade equipment and plants. As the tax-exempt hospital industry composes the vast majority of the health care delivery system in the United States, the repercussions would be staggering. Nevertheless, **anticipate** that this funding mechanism will be challenged in the future.

- Anticipate Consolidation of the Health Care Industry. Given the financial pressures in the industry, **anticipate** further consolidation by and among health care providers. The days of the solo practitioner and the single community hospital are numbered as the ability to access capital and to address the maze of regulatory requirements require the financial strength traditionally achieved by more substantial organizations.

- Preserve Community Hospitals. In addition to the more broad-based financial pressures on the health care industry, many of the subsidies for sole community hospitals and disproportionate share hospitals will be reduced or terminated as part of the PPACA trade off for increasing the number of insured individuals in the United States and the concomitant expansion of Medicaid funding for the poor. Community hospitals are often the backbone of small communities as they frequently represent the area's largest employer. In addition, the presence of a community hospital is one of the few mandatory social components necessary to attract and keep local employers and their workforces. **Anticipate** that, in the absence of extraordinary local measures, community hospitals will either close or become outposts for larger metropolitan health care systems that will ensure that the local hospital is nothing but a triage location and "feeder" of patients for the benefit of the metropolitan health care system. **For small community hospitals, the time to develop local solutions is now**, whether the solution is the conversion of the local facility to governmental status with tax support or to facilitate the consolidation of the local hospital with a larger metropolitan system that will, in consideration for the development of a new "tertiary care feeder hospital," guarantee the perpetuation of a functioning hospital in the local community.

- Anticipate Increased Federal and State Prosecution. As noted above, the current annual "return on investment" for fraud and billing violations by Office of Inspector General prosecutors involved in the health care arena is a staggering 1600%. For those providers involved in the delivery of health care, **anticipate** a continuation of this activist law enforcement and anticipate the need to ensure that all operations are consistent with federal and state regulatory requirements. **The time for robust and thorough corporate compliance programs and regular self-audits is now.** While both corporate

compliance programs and self-audits have long been considered to be voluntary and, indeed, there is no mandatory requirement for either except in a few subsections of the health care industry (e.g., Accountable Care Organizations, a new effort by the federal government to shift additional patients into the managed care model), both robust corporate compliance programs (with complete and active Board supervision and management and extraordinary Board education) and self-audits should be considered to be an essential and integral requirement of operation.

- Consider the Potential Expansion of Medicaid. Since the Supreme Court's June 28, 2012 ruling in *National Federation of Independent Business v. Sebelius*, there has been a national debate on whether individual states should accept the additional federal funds for Medicaid expansion under PPACA. Much of the debate has focused on ongoing efforts to attack the fundamentals of PPACA that were adopted — albeit just barely — by the President and Congress. To be clear, PPACA is no panacea. According to the terms of the Medicare Trust Fund itself, it has, at best, staved off insolvency from the previously projected 2016-2017 time frame to 2024. However, PPACA and its new proposed regulations are a reality. As noted above, the trade-offs for expanded national insurance include contractions in reimbursement for small community hospitals and disproportionate share hospitals that already face a dire financial situation. **Recognizing that each state will need to make a decision that best meets the needs of its respective populations, states should consider accepting the additional federal dollars that are tied to Medicaid expansion.**

- The Concepts of Health Insurance Benefits and Employment Compensation Will be Unbundled. Wage controls, favorable tax policy and other mid-20th Century phenomena made health insurance a standard part of employee compensation. Beginning in the early 1970's, employers, insurers and providers have strained to preserve the status quo through cost containment measures (e.g., the Certificate of Need programs, the changes in the reimbursement system moving from a cost-based reimbursement arrangement to a per procedure reimbursement, the imposition of a strict physician fee schedule) with Congress, CMS (the Centers for Medicare & Medicaid Services and formerly known as the Health Care Financing Administration) and state regulators adding operational and service requirements and limiting or controlling plant and service expansion options over time. By mid-2013, all but the smallest employers should have decided whether to offer to all full-time employees and their dependents affordable, minimum essential coverage. Effective January 1, 2014, the alternative is to pay a non-deductible tax of $167.67 monthly for each full time employee or to pay a non-deductible tax of $250 monthly for each employee for whom offered coverage is unaffordable, each tax assessment being triggered by the certification of a state health care exchange through which at least one full time employee has obtained coverage with premium assistance. By 2018, a 40% non-deductible excise tax will apply to all non-exempt "Cadillac plans" (total cost per capita exceeds $10,200 annually for an individual or $27,500 for family coverage), and it is projected that 60% or more of large employers will adopt cost-saving changes to avoid this taxation. Accordingly, **anticipate** that, over the next five years, a substantial portion of the population presently insured

through their employers will be turning to government or to government-administered insurance exchanges for coverage and **anticipate** that many other employees will be unhappy with the type and amount of employer provided health insurance. Furthermore, anticipate pressure on employers to convert full-time employment positions to part-time in order to avoid some of the more onerous insurance provisions contained in PPACA. The end result of these changes will be the uncoupling of many health insurance programs from traditional employment compensation models.

These are but a few of the predictions for Health Care in the next decade. While the long-term viability of our health care delivery system will require significant remodeling or anticipated increases in revenue sources (i.e., taxes) or both as suggested by the 2012 Medicare Trust Report, the health care industry as a whole continues to be a significant contributor to our country's gross domestic product. Job opportunities — particularly for lower level providers of health care such as physician assistants and nurses — will abound in the health care industry and a functioning, healthy hospital or hospital system will always be a cornerstone to community stability and growth. Filling the need for educated, competent providers and maintaining community hospitals will become increasingly difficult in the next decade. In some locations, the loss of both providers and hospitals should be anticipated.

CONTRIBUTING AUTHORS AND EDITORS

Energy

Emily Crawford - www.balch.com/ecrawford

Piyanka Ghosal - www.balch.com/piyanka-ghosal

Scott B. Grover - www.balch.com/sgrover

P. Stephen Gidiere III - www.balch.com/sgidiere

K.C. Hairston - www.balch.com/kchairston

Lyle D. Larson - www.balch.com/llarson

James L. Noles, Jr. - www.balch.com/jnoles

Leonard C. Tillman - www.balch.com/ltillman

Andrew W. Tunnell - www.balch.com/atunnell

S. Chris Still - www.balch.com/cstill

Jesse S. Unkenholz - www.balch.com/junkenholz

Financial Services

R. Alan Deer - www.balch.com/adeer

Gregory C. Cook - www.balch.com/gcook

Richard L. Pearson - www.balch.com/rpearson

Stephen A. Yoder - www.balch.com/syoder

Health Care

R. Pepper Crutcher, Jr. - www.balch.com/pcrutcher

Cavender C. (Chris) Kimble - www.balch.com/ckimble

Michel M. Marcoux - www.balch.com/mmarcoux

J. Hobson Presley, Jr. - www.balch.com/j-hobson-presley

Philip Sprinkle - www.balch.com/psprinkle