Health Care Reform and the Patient Protection and Affordable Care Act

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I. INTRODUCTION AND HISTORY OF HEALTH CARE REFORM

A. History of Health Care Reform Leading Up to the PPACA

B. The Patient Protection and Affordable Care Act

1. The Patient Protection and Affordable Care Act, P.L. 111-148 ("PPACA," "Affordable Care Act," "ACA," "Health Care Reform" or the "Act"), signed into law on March 23, 2010, purports to overhaul the entire health care system within the United States, making it the most expansive health care reform statute in the history of the nation.

2. The responsibility for enforcement and the development of future guidance rests primarily with the Department of Health and Human Services ("HHS" or the "Secretary") and Department of Labor ("DOL").

3. Substantial authority also rests with the Internal Revenue Service ("IRS"), which is responsible for assessing taxes and penalties for non-compliance and which will implement new reporting and disclosure requirements.

II. OVERVIEW OF PPACA

A. Provisions Effective Now

1. *Small Business Health Insurance Tax Credits*
   Businesses with less than 25 employees with average annual earnings of less than $50,000 will be eligible for a tax credit of up to 35% of the employer's contribution to the employees' health coverage. Small non-profit organizations may receive up to a 25% credit.

B. Provisions Effective For First Plan Year Beginning On or After September 23, 2010

1. *Removal of Lifetime Limits*
   Plans/policies are prohibited from imposing lifetime dollar limits on essential health benefits.

   a. Essential health benefits include at least the following general categories of coverage:

      1. ambulatory patient services;
      2. emergency services;
      3. hospitalization;

4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventative and wellness services and chronic disease management, and
10. pediatric services, including oral and vision care.

2. *Phasing Out of Annual Limits*
   Group health plans and insurance policies must phase out annual limits on coverage for essential health benefits. For plan years beginning on or after September 23, 2010, but before September 23, 2011, the annual limit is $750,000; for plan years beginning on or after September 23, 2011, but before September 23, 2012, the annual limit is $1,250,000; for plan years beginning on or after September 23, 2012, but before January 1, 2014, the annual limit is 2,000,000 (different rules apply for grandfathered plans). For plan years beginning on or after January 1, 2014, all annual limits on essential benefits must be removed.

3. *Removal of Pre-Existing Condition Exclusions for Children*
   The Act includes new rules preventing health plans from denying coverage to children under the age of 19 due to a pre-existing condition.

4. *Prohibitions on Rescissions*
   The Act prohibits group health plans from rescinding an individual's coverage, except in the case of fraud, or intentional misrepresentation of a material fact. A rescission is defined as a retroactive cancellation or discontinuance of coverage. Cancellations of coverage that have only prospective effects, or that are retroactive due to a failure to pay required premiums will not be treated as rescissions and will continue to be legal, including situations where a plan does not cover ex-spouses (subject to COBRA continuation coverage provision) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage. Affected individuals must be given at least 30 days prior notice before coverage is rescinded.

5. *Patient Protections*
   If a non-grandfathered plan requires designation of a primary care physician, participants must be able to designate any participating primary care physician or pediatrician. If OB/GYN benefits are offered under a non-grandfathered plan, participants must be allowed to see the specialist

without a referral or prior authorization (and services rendered by the provider must be treated as rendered by a primary care physician). If emergency benefits are offered under a non-grandfathered plan, the plan cannot require pre-authorization or any limitation on services provided out of network that is more restrictive than in-network benefits.

6. *Extension of Coverage to Adult Children*
   Under the new law, if a plan provides coverage for dependent children, the plan must offer coverage to the dependent child until they turn 26-years-old, even if the child no longer lives with the parent, is married, is no longer in school or is not a dependent on the parent's tax return. In the case of grandfathered health plans, the plan does not have to provide coverage to an adult child eligible for other employer sponsored coverage (unless it is the employer sponsored coverage of the other parent) until 2014. Guidance suggests that definition of "child" for purposes of PPACA is same as the definition of "child" found in Section 152(f)(1) of the Internal Revenue Code, which includes biological children, step-children, adopted children (including those children placed for adoption) and eligible foster children.

7. *Coverage of Preventative Services*
   Non-grandfathered health plans must cover certain preventive services without charging a deductible, co-pay, or coinsurance.

8. *Internal Claims and Appeals Procedures and External Appeals*
   Non-grandfathered health plans must provide participants with enhanced appeal rights for claim denials, which include an external review process. The effective dates for the standards related to internal claims and appeals procedures and external appeals have been extended to allow time for additional guidance. See Technical Release No. 2011-01 attached.

9. *Requirement for Nondiscrimination*
   Non-grandfathered insured plans may not discriminate in favor of highly compensated individuals, and will be subject to similar nondiscrimination testing rules that currently apply to self-insured plans.

10. *W-2 Reporting*
    The aggregate cost of employer sponsored health coverage (based on a methodology similar to that used for COBRA rates) was previously required to be reported on the employee's 2011 Form W-2 (to be provided in 2012). The value of coverage is not taxable. In Notice 2010-69, the IRS delayed this mandatory reporting requirement. The Notice states that employers will not be required to report this information for 2011.

11. *Over-the-Counter Drugs*
    Beginning January 1, 2011, tax-free reimbursements for over-the-counter drugs will no longer be permitted from health savings accounts ("HSAs"), flexible spending arrangements ("FSAs"), health reimbursement arrangements ("HRAs"), and Archer medical savings accounts, unless they are for insulin or prescribed by a physician. Reimbursement for over-the-counter medical devices and supplies, such as crutches, bandages, and blood sugar test kits, will continue to be permitted.

12. *Automatic Enrollment*
    Employers covered by the FLSA, with more than 200 full-time employees, that offer health coverage must automatically enroll all new full-time employees (if they are eligible), and continue the enrollment of current employees. Although this provision of the PPACA is technically effective for plan years beginning on or after September 23, 2010, the DOL has stated that compliance will not be required until regulations are issued.

C. Provisions Effective in 2012

1. *Uniform Summary Documents*
   A four page uniform summary of benefits and coverage explanation must be developed and provided to participants no later than March 23, 2012.

2. *Summaries of Material Modifications*
   Beginning in 2012, summaries of material modifications must be provided at least 60 days prior to any plan changes (including benefit improvements).

D. Provisions Effective in 2013

1. *Medicare Taxes*
   For taxable years beginning on or after January 1, 2013, individuals earning over $200,000 in wages annually ($250,000 for a joint return) will be assessed an additional Medicare tax of 0.9%. An additional Medicare tax of 3.8% will also be applied on net investment income for these individuals.

E. Provisions Effective in 2014

1. *Prohibiting Discrimination Due to Pre-Existing Conditions or Gender*
   All pre-existing condition limitations must be eliminated for plan years beginning on or after January 1, 2014. In addition, in the individual and small group market, the law eliminates the ability of insurance companies to charge higher rates due to gender or health status.

2. *Elimination of Annual Limits on Coverage*
   All annual dollar limits on the amount of coverage an individual may receive for essential health benefits must be eliminated for plan years beginning on or after January 1, 2014.

3. *Limited Waiting Periods*
   Waiting periods for coverage may not extend beyond 90 days.

4. *Ensuring Coverage for Individuals Participating in Clinical Trials*
   Beginning in 2014, non-grandfathered plans will be prohibited from dropping or limiting coverage because an individual chooses to participate in a clinical trial to treat cancer or any other life-threatening diseases.

5. *Cost-Sharing Limits*
   For plan years beginning on or after January 1, 2014, non-grandfathered plans are prohibited from imposing cost-sharing with respect to essential benefits packages in excess of the out-of-pocket limits applicable to high-deductible health plans (currently $5,950 for individual coverage and $11,900 for family coverage). In addition, employers with 100 or less employees (considered to be in the small employer market) are prohibited from imposing deductibles in excess of $2,000 for individual coverage and $4,000 for family coverage.

6. *Establishing Health Insurance Exchanges*
   Starting in 2014, individuals who do not have employer sponsored health coverage will be able to buy insurance directly from a health insurance exchange. Exchanges will offer a choice of health plans that meet certain benefits and cost standards.

7. *Increasing the Small Business Health Insurance Tax Credit*
   Beginning in 2014, the small business tax credit for qualified small businesses and non-profit organizations is increased to up to 50% of the employer's contribution for health coverage for small businesses, and up to 35% for small non-profit organizations.

8. *Making Care More Affordable*
   Beginning in 2014, tax credits which are supposed to make it easier for the middle class to afford health insurance will become available for people with incomes above 133% and below 400% of the federal poverty level ($43,000 for an individual or $88,000 for a family of four in 2010) who are not eligible for or offered other affordable coverage. These individuals may also qualify for reduced cost sharing (e.g. copayments, coinsurance, and deductibles).

9. *Employer "Play or Pay" Penalties*
   (1) Effective January 1, 2014, employers that employ an average of at least 50 employees during the previous calendar year and do not offer minimum essential coverage to full-time employees are subject to an annual federal tax assessment for any month in which any full-time employee is enrolled in an exchange and receives the federal tax premium (discussed above). The penalty is equal to $2,000 annually (indexed for inflation) times the total number of all full-time employees (excluding the first 30 employees), and is paid monthly. (2) There is also an annual federal tax assessment for employers that employ an average of at least 50 full-time employees during the prior calendar year and do not offer minimum essential coverage for any month in which any full-time employee is enrolled in an exchange and receives the federal premium tax credit or cost-sharing reduction. The employee must qualify for a premium tax credit or cost-sharing reduction because the employee's share of the premium exceeds 9.5% of income, or the employer contributes less than 60% towards the cost of coverage. The assessment is equal to the lesser of $3,000 annually times the number of full-time employees receiving the tax credit or cost-sharing reduction, or $2,000 annually times the total number of all full-time employees (excluding the first 30 employees). This penalty is also paid monthly.

10. *Increasing Access to Medicaid*
    Individuals who earn less than 133% of federal poverty level (approximately $14,000 for an individual and $29,000 for a family of four in 2010) will be eligible to enroll in Medicaid.

11. *Individual Responsibility*
    Beginning in 2014, individuals who can afford coverage will be required to obtain basic health insurance coverage or pay a fee to help offset the cost of caring for uninsured Americans. If affordable coverage is not available to an individual, he or she will be eligible for an exemption.

12. *Employee Free Choice Vouchers*
    Employees who cannot afford the coverage provided by their employers (because the employee premium is between 8.0% - 9.5% of the employee's household income) will have the option of taking whatever funds their employers would have contributed to their health coverage and purchasing coverage through one of the exchanges.

F. Effective 2018

1. *"Cadillac" Plan Tax*
   For plan years beginning on or after January 1, 2018, a 40% excise tax will be imposed on the value of employer provided health care above indexed single and family limits and related job risk. For insured plans the tax will be imposed on the insurer and for self-insured plans the tax will be imposed on the employer. For multiemployer plans, the limit will be based on family limits. As of today, the family limit value for low risk jobs is $27,500 and the limit for high risk jobs is $30,950. These amounts will be increased for inflation.

G. Grandfathered Plans and Impact of PPACA Provisions on Grandfathered Plans

1. Overview

a. Certain group health plans and health insurance coverage in existence as of March 23, 2010 are subject only to certain provisions of the health care reform for as long as "grandfathered status" is maintained.

b. Grandfathered health plan coverage is defined as coverage provided by a group health plan, or a health insurance insurer, in which an individual was enrolled on March 23, 2010.

c. A group health plan or health insurance coverage does not cease to be grandfathered merely because one or more individuals enrolled on March 23, 2010 cease to be covered, provided that the plan or group health insurance coverage has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). See 29 C.F.R. §2590.715-1251.

2. Grandfathered Health Plans are Exempt from Some of the Act's Requirements

a. Grandfathered health plans are not subject to the following health care reform requirements:

1. Coverage of preventative care
2. Coverage of children eligible for other employer-sponsored health plans
3. Appeals process
4. Nondiscrimination
5. Patient protections
6. Reports to HHS

7. Participation in clinical trials
8. Limitation on cost sharing
9. Nondiscrimination in Health Care

b. Grandfathered health plans are required to comply with all other provisions of the reform legislation including:

1. Prohibition on denying coverage to children based on pre-existing conditions
2. Prohibitions on rescissions of coverage
3. Eliminating lifetime limits on coverage
4. Phasing out annual limits on coverage
5. Extending coverage to adult children

3. How Grandfathered Status is Lost

a. Elimination of Benefits. Under the interim final regulations, a group health plan will lose its grandfathered status if it eliminates all or substantially all benefits to diagnose or treat a particular condition. This includes the elimination of any element that is necessary to diagnose or treat a condition. For example, if a benefit package provides benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs, and subsequently eliminates benefits for counseling, the benefit package is treated as having eliminated all or substantially all benefits for that mental health condition. 26 CFR §54.9815-1251T(g)(1)(i); 29 CFR §2590.715-1251 (g)(1)(i); 45 CFR §147.140(g)(1)(i).

b. Increase in Percentage of Cost-Sharing or Co-Insurance Requirements. Under the final interim regulations, any increase in a percentage cost-sharing requirement will cause a group health plan to lose its grandfathered status. For instance, if a group health plan increases its coinsurance percentage from 20 percent to 25 percent, the amendment will cause the plan to lose its grandfathered status. The reason for this requirement, as explained in the preamble, is that co-insurance automatically increases for inflation so no other adjustments are necessary. 26 CFR §54.9815-1251T(g)(1)(ii); 29 CFR §2590.715-1251(g)(1)(ii); 45 CFR §147.140(g)(1)(ii).

c. Increase in Fixed-Amount Cost Sharing Requirements. Under the final interim regulations, a group health plan will lose its grandfathered status if it increases any fixed amount cost-sharing requirement (other than a copayment), by more than "medical inflation" plus 15 percent. 26 CFR §

54.9815-1251T(g)(1)(iii); 29 CFR §2590.715-1251(g)(1)(iii); 45 CFR §147.140(g)(1)(iii).

d. Increase in Copayment Requirements. Under the interim final regulations, any increase in a copayment will cause a plan to lose its grandfathered status, if the total increase in the copayment, measured from March 23, 2010, exceeds the greater of (a) $5 increased for medical inflation; or (b) medical inflation plus 15 percent. 26 CFR §54.9815-1251T(g)(1)(iv); 29 CFR §2590.715-1251(g)(1)(iv); 45 CFR §147.140(g)(1)(iv).

e. Decrease in Employer Contribution Rate. Under the interim final regulations, any decrease in an employer or employee organization's contribution rate toward the cost of coverage for any tier of coverage for any similarly situated class of individuals by more than 5 percentage points below the contribution rate in effect on March 23, 2010, would cause the plan to lose grandfathered status. For insured plans, the contribution rate is defined as the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. For self-insured plans, contributions by an employer or employee organization are calculated by subtracting the employee contributions towards the total cost of coverage from the total cost of coverage. For example, assume a group health plan provides two tiers of coverage – self only and family. The employer contributes 80 percent of the total cost of coverage for family coverage. If the employer reduces its contribution to 50 percent of the total cost of coverage for family coverage, the plan will lose its grandfathered status, even if it keeps the same contribution rate for self-only coverage. 26 CFR §54.9815-1251T(g)(1)(v); 29 CFR §2590.715-1251(g)(1)(v); 45 CFR §147.140(g)(1)(v).

f. Changes in Annual Limits. Finally, the interim final regulations, address the imposition of a new or modified annual limit by a group health plan or insurance coverage. The following three situations are addressed.

    1. A plan or health insurance coverage that, on March 23, 2010 did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.

    2. A plan or health insurance coverage that on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no

overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.

3. A plan or health insurance coverage that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

g. The plan must also maintain records documenting the terms in effect on March 23, 2010 and for subsequent years showing how changes comply with the restrictions.

h. Changes other than those described above will not cause a plan to lose its grandfathered status. For example, changes to premiums, changes to comply with statutory requirements, changes to voluntarily comply with provisions of the PPACA and changing third-party administrators will not violate any of the above rules.

4. Benefit Package Status

a. Grandfathered status under health care reform is determined, not on a plan basis, but rather on a benefit package basis. For plans with multiple benefit packages, this means that changes to each benefit package must be compared to the benefit package as offered on March 23, 2010.

b. Accordingly, if a particular benefit package ceases grandfathered status, it does not affect the grandfathered status of the other benefit packages.

c. Examples of separate benefit packages include high deductible health plan, preferred provider organization (PPO) plan option, HMO plan option . . .

5. *Notice*

    a. To maintain grandfathered status, a group health plan or health insurance coverage must provide written notice to the participants that the plan believes is a grandfathered health plan.

    b. The model notice provided by the agencies can be found at: http://www.dol.gov/ebsa/healthreform/

    c. Guidance on this issue by the Department of Labor has provided that including the model notice language with summaries of benefits, including summary plan descriptions is acceptable. The Departments are encouraging plan sponsors and issuers to identify communications in which disclosure of grandfathered status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage (SMM? New uniformed summary document?)

6. *Fully-Insured Collectively Bargained Health Plans*

    a. Health care reform regulations contain a special rule for health insurance coverage maintained pursuant to one or more collective bargaining agreements ratified before March 23, 2010. Pursuant to this rule, the plan will be considered to be a grandfathered health plan at least until the date on which the last agreement relating to the coverage that was in effect on March 23, 2010 terminates.

    b. Upon the expiration of the last collective bargaining agreement in effect on March 23, 2010, the determination of whether a plan is grandfathered will be made by comparing the terms of the coverage in effect at that time to the terms of coverage that were in effect on March 23, 2010.

7. *Retiree Only Plans*

    a. Health care reform does not apply to retiree only plans.

    b. There is no explicit definition of retiree only plans. However, the regulations provide that the Act's requirements do not apply to plans with less than two participants who are current employees.

    c. The degree to which the "retiree only" plan must remain separate and distinct in form from the "current employee" plan remains unclear.

III. Legal/Legislative Challenges

A. Florida v. U.S. Department of Health and Human Services, N.D., Fla., No. 3:10-cv-91

1. The focus of the state plaintiffs'[1] challenge to the Act is the requirement for individuals to purchase health insurance or pay a penalty ("individual mandate"). This requirement becomes effective in 2014.

2. The defendants filed a motion to dismiss and on October 14, 2010, Judge Roger Vinson denied defendants' motion, in part. Specifically, Judge Vinson declined to dismiss constitutional claims with respect to the individual mandate as well as plaintiffs' claim that the Medicaid program expansion under the Act is coercive, and thus, unlawful.[2]

3. Plaintiffs alleged that the individual mandate exceeded the powers granted Congress pursuant to the Commerce Clause. Under the Commerce Clause, Congress may regulate activities affecting interstate commerce. However, plaintiffs argued that the individual mandate does not regulate activity affecting interstate commerce; "instead, it seeks to impermissibly regulate economic inactivity."

4. Defendants asserted that the mandate is a tax sustainable under Congress' expansive power to tax for the general welfare. Further, according to defendants, plaintiffs' suit is barred by the Anti-Injunction Act [26 U.S.C. §7421(a)] which provides "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person . . .". The Judge found that Congress did not enact a "tax" when it imposed the penalty with respect to the mandate. The court, thus, determined that the Anti-Injunction Act did not apply.

5. In refusing to dismiss the individual mandate claim, Judge Vinson stated, "at this stage in the litigation, this is not even a close call." Judge Vinson further opined, "the power that the individual mandate seeks to harness is simply without precedent."

[1] Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North and South Dakota, Pennsylvania, South Carolina, Texas, Utah and Washington.

[2] The Judge dismissed the following claims: (a) the individual mandate violates due process; (b) the Act's requirements for the creation of health benefit exchanges is coercive and violates the 9th and 10th Amendments; (c) state sovereignty is violated by requiring states to provide health insurance on the same terms as large employers; and (d) the penalty in connection with the individual mandate is an unlawful direct tax. The Judge determined, in dismissing the first three claims, that those claims did not raise any constitutional issues. With respect to the fourth dismissed claim, the Judge found that the penalty is not a tax.

6. With respect to the Medicaid claim, plaintiffs argued that the Act drastically expands and alters the Medicaid program to such an extent that it will force them to "run their budgets off a cliff". Defendants responded that state participation in Medicaid is entirely voluntary.

7. According to the court, the plaintiffs must either accept the sweeping Medicaid changes or withdraw from the system completely (and lose federal funding) which could possibly leave the state's poorest citizens without coverage. The court, referencing South Dakota v. Dole, 483 U.S. 203 (1987), determined that the underlying question is whether Congress' action is so coercive to pass the point where permissible pressure turns into impermissible coercion. Judge Vinson found that the plaintiffs made a plausible claim that the Medicaid changes constituted impermissible Congressional coercion.

8. On November 4, 2010, plaintiffs and defendants filed their respective motions for summary judgment. According to the plaintiffs' motion, the individual mandate is unconstitutional and "cannot be severed" from the PPACA. Thus, plaintiffs argue that the Act, as a whole, "should be declared unconstitutional". The PPACA does not contain a severability clause.

9. On January 31, 2011, Judge Vinson found that the PPACA is unconstitutional. The Judge determined that the individual mandate did not meet constitutional muster and could not be severed from the rest of the Act.

B. Virginia v. Sebelius, E.D. Va., No. 3:10-cv-188

1. On August 2, 2010, Judge Henry Hudson denied the defendant's motion to dismiss Virginia Attorney General Ken Cuccinelli's challenge to the PPACA, specifically the individual mandate. The Judge, in allowing the case to continue, determined that there was no on-point precedent regarding constitutional authority to regulate "a person's decision not to purchase a product." The Judge stated, "While this case raises a host of complex constitutional issues, all seem to distill to the single question of whether or not Congress has the power to regulate – and tax – a citizen's decision not to participate in interstate commerce."

2. Similar to the state plaintiffs in the Florida challenge, the plaintiff in this case argued that because the law does not contain a severability clause, the Judge must strike down the PPACA in its entirety if the Judge strikes down the mandate to purchase coverage.

3. On December 13, 2010, Judge Hudson ruled in favor of the plaintiffs and found the individual mandate to be unconstitutional in that it exceeded the "constitutional boundaries of congressional power." He did not find the entire Act unconstitutional.

4. The decision has been appealed and is pending in the United States Court of Appeals for the Fourth Circuit.

C. Liberty University, Inc. v. Geithner, W.D. Va., No. 6:10-cv-00015

1. On November 30, 2010, Judge Norman K. Moon, unlike his Virginia counterpart, Judge Hudson, dismissed the plaintiffs' challenge to the Act with respect to the individual coverage requirement. The Judge concluded that the individual mandate is within the scope of Congress' powers under the Commerce Clause, "there is a rational basis for Congress to conclude that individuals' decisions about how and when to pay for health care are activities that in the aggregate substantially affect the interstate health care market."

2. This case is also pending on appeal in the Fourth Circuit.

D. Thomas More Law Center v. Obama, E.D. Mich., No. 2:10-cv-11156

1. On October 7, 2010, Judge George Caram Steeh dismissed the plaintiffs' claims with respect to the constitutionality of the PPACA. The core issue in this case, similar to those detailed above, was whether Congress has the authority to require virtually everyone to carry health insurance starting in 2014 or face a penalty.

2. Initially, the Judge determined that the Anti-Injunction Act was not applicable because the relief sought, "for the most part, [has] nothing to do with the assessment or collection of taxes." Instead, plaintiffs' demands were directed at "the requirement that individuals obtain health insurance."

3. Judge Steeh ruled that the Commerce Clause provided adequate authority for Congress to implement the individual mandate. The Judge rejected plaintiffs' argument that the Commerce Clause did not regulate the "inactivity" here – refusal to purchase health insurance. The Judge found that the failure to buy health insurance was not inactivity as the plaintiffs argued, but rather a decision to try to pay for health services later out of pocket rather than in the present, through the purchase of insurance. The Judge stated:

> Plaintiffs have not opted out of the health care services market because, as living, breathing beings, who do not oppose medical services on relegation grounds, they cannot opt out of this market. As inseparable and integral members of the health care services market, plaintiffs have made a choice regarding the method of payment for the services they expect to receive.

4. The Judge also emphasized the importance of the individual mandate in connection with the overall scheme of health care reform. The Act will prohibit insurers from refusing to cover individuals with pre-existing conditions and from setting eligibility rules based on health status or claims experience. According to the Judge:

> Without the minimum coverage provision, there would be an incentive for some individuals to wait to purchase health insurance until they needed care, knowing that insurance would be available at all times. As a result, the most costly individuals would be in the insurance system and the least costly would be outside it. In turn, this would aggravate current problems with cost shifting and lead to even higher premiums.

5. The case is on appeal in the Sixth Circuit.

E. U.S. Citizens Association v. Sebelius, N.D. OH., N0. 5:10-cv-1065

1. The plaintiffs allege that the Act is unconstitutional with respect to the mandate to purchase health insurance. On November 22, 2010, Judge David D. Dowd, Jr., relying heavily on the analysis of Judge Vinson in the Florida challenge, denied defendants' motion to dismiss.

2. Judge Dowd echoed what most commentators believe to be the end game for the various challenges, "this Court does not intend to write a lengthy opinion with respect to the defendants' motion to dismiss because the Court's decision will, in all likelihood, be without relevance by the time this case reaches the Supreme Court."

F. Baldwin v. Sebelius, U.S. No. 10-369, Cert. Denied (11/8/10)

1. On November 8, 2010, the Supreme Court determined that it would not review a District Court decision finding that plaintiffs (a California advocacy organization and an individual) lacked standing to challenge the PPACA.

The lower court held that the plaintiffs could only show a hypothetical threat of injury because the challenged PPACA provisions were years away from being implemented. See Baldwin v. Sebelius, S.D. Cal., No. 10-cv-1033 (case closed August 27, 2010). The case is on appeal in the Ninth Circuit.

G. State Amendments

1. Oklahoma and Arizona recently voted to amend their state constitutions to include "health care freedom" provisions which give individuals the right not to participate in any health care system. The amendments attempt to counter the individual man date under the PPACA, effective in 2014.

H. The New Congress

1. The 2012 elections produced a Republican controlled House of Representatives. On January 19, 2011, the House voted to repeal the PPACA. Only three Democrats backed the appeal.

2. On February 2, 2011, the Democrat controlled Senate voted down the repeal of the PPACA.