Blitman&King LLP

Twenty-First Annual

LABOR AND EMPLOYMENT LAW SEMINAR March 7, 2011

HEALTH CARE REFORM (Grandfathered Status and Legal/Legislative Challenges)

Daniel R. Brice, Esq.

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HEALTH CARE REFORM
(Grandfathered Status and Legal/Legislative Challenges)

By: Daniel R. Brice, Esq.

I. INTRODUCTION AND OVERVIEW OF THE STATUTE

A. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, P.L. 111-148 ("PPACA", "HEALTH CARE REFORM" OR THE "ACT")

1. The PPACA, 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 and standards rests primarily with the Department of Health and Human Services ("HHS" or the "Secretary").

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. GRANDFATHERED STATUS

A. OVERVIEW

1. 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.

2. Grandfathered health plan coverage is defined as:

> Coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010.

3. 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.

B. GRANDFATHERED HEALTH PLANS ARE EXEMPT FROM SOME OF THE ACT'S REQUIREMENTS

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

a. Coverage of Preventative Care. Under Section 2713 of the Public Health Service Act ("PHSA") non-grandfathered plans must provide coverage (without cost sharing requirements) for certain immunizations and other preventative care services recommended by the United States Preventative Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration.

b. Coverage of Children Eligible for Other Employer-Sponsored Health Plans. For plan years beginning on or after September 23, 2010, plans must provide coverage to children under age 26. However, under Section 2714 of the PHSA and 29 C.F.R. 2590.17-2714 of the DOL regulations, until 2014, grandfathered plans do not have to provide such coverage if these children are eligible for other employer-sponsored health coverage.

c. Appeals Process. Under Section 2719 of the PHSA, non-grandfathered health plans must (a) have internal claims and appeal processes that incorporate ERISA claims and appeals procedures, (2) provide notice to participants of available internal and external claims processes, (3) allow participants to review their files, present evidence and testimony as part of the appeals process, and receive continued coverage during the appeals process, and (4) implement an external review process that meets state or HHS standards.

d. Nondiscrimination. Under Section 2716 of the PHSA, non-grandfathered fully-insured group health plans are subject to the nondiscrimination requirements of Code Section 105(h)(2) (which are already applicable to self-insured plans). This means that insured plans will not be able to discriminate in favor of "highly compensated individuals"

with respect to either eligibility to participate or benefits.

e. Patient Protections. Section 2719A of the PHSA, requires non-grandfathered plans to permit participants to select a participating primary care provider (or pediatrician in the case of a child), to provide direct access to obstetrical or gynecological care without a referral, and to provide out-of-network emergency services without increased cost sharing or prior authorization (if the plan provides emergency services).

f. Reports to HHS. Under Section 2715A of the PHSA, non-grandfathered plans are required to annually submit information to HHS regarding claims payment policies and practices, financial disclosures, data on enrollment and disenrollment, data on the number of claims denied, data on rating practices, information on cost sharing and payments for out-of-network coverage, information on participant rights, and any other information determined by the Secretary. In addition, under Section 2717 of the PHSA, non-grandfathered plans must report annually to enrollees and the Secretary of HHS whether the benefits under the plan satisfy certain standards relating to: (a) improving health outcomes through quality reporting, case management, care coordination, chronic disease management, and medication and care compliance initiatives; (b) activities to prevent hospital readmissions; (c) activities to improve patient safety and reduce medical errors; and (d) wellness and health promotion programs. However, these reports are not required until guidelines are issued by HHS.

g. (Effective January 1, 2014). Participation in Clinical Trials. Section 2709 of the PHSA prohibits group health plans from denying or dropping coverage because an individual chooses to participate in a clinical trial for cancer or another life-threatening condition.

h. (Effective January 1, 2014). Limitation on Cost Sharing. Section 2707 of the PHSA provides that annual out-of-pocket costs cannot exceed the limits for high deductible health plans (currently $5,950 for individuals and $11,900 for families). Out-of-pocket expenses include copayments, deductibles, co-insurance and any other expenditure required by a participant for a qualified medical expense with respect

to essential health benefits covered under the plan.

i. (Effective January 1, 2014). Nondiscrimination in Health Care. Section 2706 of the PHSA prohibits discrimination by group health plans and insurers against providers acting within the scope of their professional licenses and applicable state laws.

2. Grandfathered health plans are required to comply with all other provisions of the reform legislation. For example, grandfathered plans must still comply with the following requirements:

a. **Prohibition on Denying Coverage to Children Based on Pre-Existing Conditions.** The Act includes new rules preventing health plans from denying coverage to children **under the age of 19** due to a pre-existing condition.

b. **Prohibitions on Rescissions of Coverage.** 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. Affected individuals must be given at least 30 days prior notice before the rescission.

c. **Eliminating Lifetime Limits on Coverage.** Plans/policies are prohibited from imposing lifetime dollar limits on essential health benefits. Essential health benefits include at least the following general categories of coverage: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

d. **Phasing out Annual Limits on Coverage.** Group health plans and insurance policies must phase out annual limits on coverage. Beginning in 2014, these limits must be

eliminated completely.

E. **Extending Coverage to Young Adults.** Under the new law, young adults will be allowed to stay on their parents' plan until they turn 26 years old.

C. SIX DEADLY SINS

1. A plan may not violate any of the following rules if it wants to maintain its grandfathered status:

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 C.F.R. § 54.9815-1251T(g)(1)(i); 29 C.F.R. § 2590.715-1251(g)(1)(i); 45 C.F.R. § 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 C.F.R. § 54.9815-1251T(g)(1)(ii); 29 C.F.R. § 2590.715-1251(g)(1)(ii); 45 C.F.R. § 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. For this purpose "medical inflation" is defined as the Consumer Price Index for All Urban Consumers, unadjusted (CPI), published by

the DOL using the 1982-1984 base of 100. 26 C.F.R. § 54.9815-1251T(g)(1)(iii); 29 C.F.R. § 2590.715-1251(g)(1)(iii); 45 C.F.R. § 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 (as defined above) plus 15 percent. 26 C.F.R. § 54.9815-1251T(g)(1)(iv); 29 C.F.R. § 2590.715-1251(g)(1)(iv); 45 C.F.R. § 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 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 to contributes to 50 percent for family coverage, the plan will lose its grandfathered status, even if it keeps the same contribution rate for self-only coverage. 26 C.F.R. § 54.9815-1251T(g)(1)(v); 29 C.F.R. § 2590.715-1251(g)(1)(v); 45 C.F.R. § 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).

2. 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.

3. 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 Affordable Care Act and changing third-party administrators will not violate any of the above rules.

D. BENEFIT PACKAGE STATUS

1. Grandfathered status under health care reform is determined, not on a plan status, 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.

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

3. Examples of separate benefit packages include high deductible health plan, preferred provider organization plan option, HMO option...

E. NOTICE

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

2. The model notice provided by the agencies is as follows:

> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services

at www.healthreform.gov.]

3. Guidance on this issue by the Department of Labor has provided that including the model notice language with 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.

F. FULLY-INSURED COLLECTIVELY BARGAINED HEALTH PLANS

1. 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.

2. 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.

G. RETIREE ONLY PLANS

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

2. 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.

3. 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, 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.

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[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.

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."

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 plaintiff 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 religious 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., NO. 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 mandate 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 repeal.

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