GROOM LAW GROUP

January 21, 2011

MEMORANDUM

RE: 2010 Ends with a Flurry of Health and Welfare Guidance

The agencies in charge of implementing the Patient Protection and Affordable Care Act (PPACA) finished off a historic year of health care reform with a flurry of December guidance. Much of this was good news for plans—for example, the Internal Revenue Service (IRS) delayed the applicability of new nondiscrimination rules for insured plans until after it issues regulations and issued favorable guidance concerning FSA/HRA debit cards. In addition, DOL, in consultation with the other agencies, issued some helpful Frequently Asked Questions (FAQs) on PPACA, and added a few wellness program and mental health parity FAQs to the mix. The Department of Health and Human Services' (HHS) contribution included guidance on the Early Retirement Reinsurance Program (for which there are still $4 billion in funds remaining), guidance regarding the annual waiver limit program, and a new notice requirement. In addition, HHS issued a Request for Information regarding how group health plans and group health insurers can utilize "value-based insurance design" in the coverage of preventive services. Meanwhile, on Capitol Hill, Congress was busy enacting legislation to extend various tax provisions that would otherwise have expired.

The new year is already off to an interesting start, with the newly elected Republican majority in the House of Representatives initiating its efforts to repeal the PPACA through its bill entitled the "Repealing the Job-Killing Health Care Law Act" and various courts weighing in on PPACA constitutional challenges. Please read on for details of the developments below and our forecast for 2011.

I. IRS Guidance

A. Over-the-Counter Drugs/FSA and HRA Debit Cards

PPACA amended the Internal Revenue Code (Code) to provide that expenses incurred for over-the-counter (OTC) medicines and drugs may only be reimbursed from an employer-sponsored health plan (including a health flexible spending arrangement (FSA) or health reimbursement account (HRA)) if the participant obtains a prescription (or the medicine or drug is insulin). Similarly, a distribution from a health savings account (HSA) for an OTC medicine or drug only may be treated as a tax-free "qualified medical expense" if one of these requirements is satisfied.

Last September, the IRS issued Notice 2010-59, which, among other things, provides generally that "prescription" for this purpose means "a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state." In addition, Notice 2010-59 provides that, effective for expenses incurred on or after a short transition period ending January 15, 2011, FSA and HRA debit cards may not be used to

purchase OTC medicines and drugs (except in the case of a "90% pharmacy"). According to Notice 2010-59, this prohibition was because "[c]urrent debit card systems are not capable of substantiating compliance" with the new requirements.

On **December 23, 2010**, the IRS issued Notice 2011-5, which modifies Notice 2010-59 with respect to the use of FSA and HRA debit cards. Notice 2011-5 provides that FSA and HRA debit cards may continue to be used to purchase OTC medicines and drugs at or from certain types of entities so long as certain requirements are satisfied. For example, Notice 2011-5 provides that FSA and HRA debit cards may continue to be used at drug stores and pharmacies, non-health care merchants that have pharmacies, and mail order and web-based vendors that sell prescription drugs, if, among other things: the prescription is presented to a pharmacist, the pharmacist dispenses the medicine or drug in accordance with applicable law and assigns an Rx number, the pharmacy retains records of the Rx number and certain other information and makes it available to the employer upon request, and the debit card system accepts OTC medicine or drug charges only if an Rx number has been assigned. Notice 2011-5 also allows FSA and HRA debit cards to continue to be used to purchase OTC medicines and drugs at other vendors that have health care related Merchant Codes so long as certain requirements are satisfied.

B. Insured Group Health Plan Nondiscrimination Rules

On September 20, 2010, the IRS issued Notice 2010-63 requesting comments on the PPACA change applying certain Code section 105(h) nondiscrimination rules to insured group health plans and providing certain information regarding penalties. In response, the IRS received numerous comments requesting guidance detailing the meaning of the reference in Public Health Service Act (PHSA) section 2716 to applying rules "similar to" certain rules in Code section 105(h). Among other things, the comments requested the issuance of simplified testing rules and safe harbors.

On **December 22, 2010**, the IRS issued Notice 2011-1, which states generally that the IRS, along with the Departments of Treasury, Labor, and Health and Human Services (the "Agencies"), have determined that compliance with the nondiscrimination rules applicable to insured plans should not be required, and no sanctions should be imposed, until after a regulation or other guidance of general applicability has been issued. Further, Notice 2011-1 states that the Agencies anticipate that any new guidance will not apply until plan years beginning a specified period after its issuance, and that before the beginning of those plan years, insured group health plans will not be required to file IRS Form 8928 to report excise taxes resulting from violations of the new rules. Notice 2011-1 also requests additional public comments on various specific issues raised in comments submitted in response to Notice 2010-63. Among other things, Notice 2011-1 requests comments by March 11, 2011 on –

- the application of the "benefits" nondiscrimination rules to the rate of employer contributions toward the cost of coverage (or required employee contributions) and the duration of eligibility waiting periods;

- potential safe harbor and unsafe harbor designs; and

- the application of the nondiscrimination rules to "expatriate" and "inpatriate" coverage.

C. Relief on PPACA $500,000 Compensation Deduction Limit

PPACA restricts the deductibility of compensation paid by certain health insurers to an individual to $500,000 per year. On **December 22, 2010**, the IRS issued Notice 2011-02, which generally limits the companies affected by this provision to traditional health insurers. We posted a summary of this guidance to the Groom Law Group website on December 28, 2010. www.groom.com/resources-557.html. The summary provides some background on the original PPACA provision and describes the relief in the IRS Notice.

II. DOL Frequently Asked Questions

On **December 22, 2010**, the Department of Labor (DOL) released the fifth set of FAQs pertaining to the PPACA, bringing the total number of PPACA FAQs to 37. All five sets of FAQs are posted to the DOL and HHS websites. www.dol.gov/ebsa/faqs/faq-aca5.html; www.hhs.gov/ociio/regulations/implementation_faq.html. Officials from DOL, HHS and Treasury/IRS refer to these FAQs as "subregulatory guidance," and agency officials have stated that they view these FAQs as an effective way to efficiently address the numerous questions and comments they receive, many in response to interim final regulations that have been issued. In addition to PPACA implementation, this fifth set of FAQs also addresses HIPAA nondiscrimination rules as applied to wellness programs and issues under the Mental Health Parity and Addiction Equity Act. Highlights of these new FAQs follow.

A. PPACA

The new PPACA FAQs contain some welcome news for employers concerning the effective dates of two PPACA requirements-- automatic enrollment and the 60-day advance notice of material modification. First, the agencies clarified that the automatic enrollment rule, which will require an employer with more than 200 full-time employees to automatically enroll new full-time employees in the employer's health benefits plan and continue enrollment of current employees, will not be effective until regulations are issued by DOL and Treasury. The FAQ states that this rulemaking will be completed by 2014, and DOL will solicit comments regarding current auto-enrollment practices in developing these regulations.

The agencies also clarified the effective date for a new 60-day notice rule of plan changes. PPACA requires health plans to issue a new summary of benefits, based on a model to be developed by the Secretary of HHS, starting in 2012. PPACA also requires that plans provide participants a 60-day advance notice of material modifications to this summary. In the FAQ, the agencies clarified that the 60-day notice requirement would not apply until the summary of benefits requirement itself applies. The FAQs say the agency will issue regulations that address the requirements for the summary of benefits document, which will be effective for employers no later than March 23, 2012.

On the topic of grandfathered plans, a new FAQ provides that if a deductible or out-of-pocket limit is based on a percentage-of compensation formula, and an employee's compensation increases, the employee could face a higher out-of-pocket limit, but that change would not cause

the plan to relinquish grandfather status. This rule does not apply to copayments. The earlier sets of FAQs contain a number of other rules addressing various fact patterns and how those fact patterns impact a plan's grandfathered status. In addition, on November 17, 2010 the agencies also issued an amendment to the Interim Final Rules for Grandfathered Health Plans which provides that, in certain cases, a group health plan can change insurers without impacting grandfathered status.
http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=24413&AgencyId=8&DocumentType=2

Finally, the new FAQs provide some clarification regarding the question of whether a plan can impose requirements that vary based on age without violating the age 26 dependent coverage requirements under PPACA. Specifically, an FAQ states that a plan can impose distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children, (for example, a copayment for any participant under age 19, not just dependents). While this FAQ is helpful, it leaves open the question of whether a plan with distinctions that apply to participants who are below a certain age are prohibited (i.e., below the age that would be realistic for an employee or a spouse).

Remaining FAQs address reasonable medical management techniques in the context of preventive care services and the ability of an insurer to screen children for alternative coverage options in the individual market prior to offering child-only coverage.

B. HIPAA Wellness Program Rules

DOL also issued FAQs pertaining to the HIPAA nondiscrimination and wellness program rules. These FAQs generally do not include new or different information from what DOL has said previously on wellness programs, but do summarize the rules and some frequently asked questions in one place.

Generally, the HIPAA nondiscrimination regulations, issued in 2006, provide that a group health plan cannot discriminate among plan participants based on a health factor. See 29 CFR 2590.702 (corresponding language in Treasury and HHS regulations). However, the regulations provide an exception for "wellness programs" that meet certain criteria, including that the limit of any reward under the program be 20% of the cost of employee coverage, the program be reasonably designed to promote health, qualification for the program be offered at least annually, and, where a participant is medically incapable of meeting a health standard, the program offer a reasonable alternative way to earn the reward (and the plan is required to disclose the availability of this alternative standard).

The new guidance summarizes these rules and distinguishes between wellness programs that base a reward on a health status (in which case the above rules apply) or base a reward on mere participation, regardless of health status (in which case the above rules do not apply). The FAQs provide examples of both types of programs. For example, providing a reward for achieving a low cholesterol count would be considered a wellness program based on a health status, while providing a reward for attending a monthly health seminar would not. The FAQs clarify that a

plan may offer both types of programs, but only the rewards based on achieving a health status are subject to the HIPAA wellness rules or the 20% limit.

The FAQs also state that, where an employer operates a wellness program as an employment policy that is separate from its group health plan, the program will not be subject to the HIPAA nondiscrimination and wellness rules. The FAQs give examples of employers who subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage walking, pay for gym memberships, or ban smoking in employer facilities. The FAQs caution that other state or federal laws could apply though. (We note that employers also should consider whether offering these programs, particularly when more robust, may be ERISA-covered benefits, which then could be subject to the HIPAA nondiscrimination and wellness rules.)

Finally, the FAQs note that the 20% limit under the current HIPAA nondiscrimination and wellness rules will be raised to 30% in 2014 under PPACA (and the Secretary of HHS has discretion to raise the limit to 50%). This means that plans may be able to provide a greater reward under health-based wellness programs that meet the HIPAA nondiscrimination and wellness requirements. DOL says it is considering what "accompanying consumer protections may be needed to prevent [these programs] from being used as a subterfuge for discrimination based on health status" and says that additional guidance is expected in 2011.

C. Mental Health Parity and Addiction Equity Act

The FAQs also address the Mental Health Parity and Addiction Equity Act. These FAQs clarify the application of two exemptions from the rules—the "small employer" exemption and the "cost" exemption—and address the medical necessity disclosure requirement in the context of medical and surgical benefits.

"Small employers" are exempt from the parity rules. The FAQs make clear that, although there were changes to the definition of "small employer" for other purposes under PPACA, group health plans of employers that are subject to ERISA and the Code (i.e., self-funded and insured plans of private employers, including churches) are exempt from the parity rules if they have 50 or fewer employees, regardless of any state insurance law that may define small employer differently. Nonfederal governmental plans, on the other hand, are subject only to the PHSA, which defines a small employer as one that has 100 or fewer employees.

The FAQs also provide an interim enforcement safe harbor regarding the cost exemption under the parity rules. Under the cost exemption, a plan that has an increased cost of at least two percent during the first plan year of compliance can obtain an exemption for the second plan year by following the exemption procedures under the Mental Health Parity Act regulations issued in 1997. http://www.dol.gov/ebsa/faqs/faq_consumer_mentalhealthparity.html. The FAQ notes that calculations of increased costs should include increases in a plan's share of cost-sharing, and non-recurring administrative costs should be amortized. The FAQ confirms that even a plan that obtains the exemption for the second plan year must comply with the parity rules for the third plan year, but could claim the exemption for the fourth plan year if the plan incurs an increased cost of at least one percent in the third plan year. As a practical matter, most plans are likely to conclude that these requirements are too burdensome to take advantage of this exemption.

The FAQs also address the broad medical necessity disclosures required under the parity rules. The parity rules require that the criteria for medical necessity determinations made under a plan or health insurance coverage *with respect to mental health or substance use disorder benefits* must be made available by the plan administrator or health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request. The FAQs further provide that medical necessity criteria *for medical and surgical benefits* must be disclosed upon request under ERISA's claims procedure rules, including to the participant or a provider or other individual acting on behalf of the participant as an authorized representative. This disclosure obligation is very broad, and plans may have to change their existing procedures to accommodate this requirement.

Note that an earlier FAQ pertaining to mental health parity provides an enforcement safe harbor under which the Agencies will not take enforcement action against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications—an office visit sub-classification and all other outpatient items or services—for purposes of applying the financial requirement and treatment limitation parity tests http://www.dol.gov/ebsa/faqs/faq-mhpaea.html. This enforcement safe harbor has provided additional flexibility to plans in applying the rules and allows additional plans to pass the parity tests.

III. HHS Guidance

A. Early Retiree Reinsurance Program

On **December 30, 2010**, HHS updated the "Common Questions" section of www.errp.gov, the website devoted to the Early Retiree Reinsurance Program (the ERRP). Among the highlights of this update is the announcement that, as of December 30, over $4 billion dollars remained available for claims reimbursement. This is welcome news, as it was widely feared that the $5 billion appropriated for the ERRP would be disbursed quickly, leaving many plans without an opportunity to participate.

Plan sponsors that have not yet applied to the program still have time; applications are reviewed on a continuing basis. The ERRP began accepting claims reimbursement requests from approved plan sponsors on October 25, 2010. Specific procedures and requirements for claims reimbursement can be found at www.errp.gov.

HHS also has issued several new FAQs regarding the ERRP on its website. Significantly, one of the FAQs permits plan sponsors with a retiree-only plan that was spun off from a plan that also includes active employees to file a new application for the ERRP for the retiree-only plan, but also continue to submit claims for the period during which the retirees were in the blended plan. Also, a plan sponsor may use the reimbursements under the ERRP to reduce participant contributions or its own health benefit costs for either the original plan and/or participants in the original plan, the new plan and/or participants in the new plan (so long as an ERRP application has been filed for that plan), or both. If a plan sponsor uses funds to reduce its own health benefit costs, it must comply with the maintenance of contribution requirement as applied to the plan for which the plan sponsor is reducing its costs.

B. Waiver Program for Limited Benefit Plan, including Notice Requirement

On **December 9, 2010**, HHS issued additional guidance related to how a plan may request a waiver of the annual limit requirements under the PPACA.

Annual Waiver Required Notice

The new guidance discusses the notice requirement for "limited benefit" or so-called "mini-med" plans that have received a waiver of the annual limit requirements. These plans must provide notice to current and eligible participants informing them that the plan does not meet the minimum annual limits requirement under PPACA and has received a waiver of the annual limits requirements. The notice must use the model language in the OCIIO guidance (see OCIIO Guidance 2010-1B) http://www.healthcare.gov/center/regulations/guidance_limited_benefit_2nd_supp_bulletin_120910.pdf and the model language must be prominently displayed and be in 14-point bold type.

For plan or policy years beginning before February 1, 2011, the notice must be distributed within 60 days of December 9, 2010, which means that the notice must be distributed on or before Monday, February 7, 2011. For plan or policy years beginning on or after February 1, 2011, the notice must be provided as part of any informational material, such as, open enrollment materials, and in any plan or policy documents, such as, summary plan descriptions.

Sale of New Limited Benefit Plan Policies including to Group Health Plans

OCIIO also issued guidance (see OCIIO Guidance 2010-1C) http://www.healthcare.gov/center/regulations/guidance_limited_benefit_3rd_supp_bulletin_120910.pdf that provides two limited exceptions to the rule under PPACA that insurers may not issue new policies that do not meet the annual limit requirements. The first limited exception relates to the sale of State-mandated individual policies. The OCIIO guidance provides details about when new sales of those policies are permitted. The second limited exception will be of greater interest to plan sponsors. HHS will allow group health plan sponsors that had a policy that received a waiver of the annual limit requirements to purchase a new policy after the date of the guidance (December 9, 2010) from a different insurer that also has obtained a waiver of annual limit restrictions. Without this exception, plan sponsors would have been unable to purchase new policies that had met the waiver requirement, (for example, if their prior insurer stopped offering this coverage).

C. Request for Information - Preventive Care Value-Based Designs

On **December 28, 2010**, HHS issued a Request for Information regarding how group health plans and health insurance issuers can utilize "value-based insurance design" in the coverage of preventive services. 75 Fed.Reg. 81544. Comments are due February 28, 2011.

PPACA generally requires non-grandfathered group health plans and health insurance issuers offering individual or group insurance coverage to provide coverage for certain preventive services without imposing any cost-sharing on the participant. However, plans are permitted to impose reasonable medical management techniques, and PPACA expressly permits HHS to

develop guidelines to allow group health plans and health insurance issuers to utilize "value-based insurance designs" for providing preventive care coverage.

HHS generally considers value-based insurance design to be plan designs that provide incentives for consumers to encourage the use of higher-value providers, treatments, and services. An example of a value-based insurance design is a design under which a copayment for services performed at an in-network ambulatory surgery center is waived, where a copayment for the same service at an in-network outpatient hospital setting is imposed. The plan is providing the preventive care coverage with no cost-sharing, but only in certain settings, and directing participants to a "higher value" provider. See DOL Q:1 in the FAQs About Affordable Care Act Implementation, Part V.

The December 28 Request for Information asks for comments on how plans and insurers are using value-based insurance design, including information on best practices for recommended preventive services. In addition, HHS asks fourteen specific questions, including questions on what consumer protections should be adopted in value-based insurance design guidelines to ensure access to care.

IV. Legislative Extension of Expiring Tax Provisions

After much speculation and debate, the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (the Tax Extenders Act) was passed by Congress and then signed into law by President Obama on **December 17, 2010**. Among its many provisions, the Tax Extenders Act includes a two-year extension on the increased limits for employer educational assistance programs, transit passes, and dependent care assistance.

A. Educational assistance program

The Tax Extenders Act extends the income exclusion for fees receiving up to $5,250 of employer-provided undergraduate and graduate educational assistance under Code section 127 through December 31, 2012. This provision had been scheduled to sunset as of December 31, 2010.

B. Transit Pass

The Tax Extenders Act also extends the parity requirement for employer-provided transit benefits under Code section 132(f), which were added by the American Recovery and Reinvestment Act of 2009. Therefore, effective January 1, 2011, the monthly fringe benefit exclusion limit for qualified parking, transportation in a commuter highway vehicle, and any transit pass will remain the same (i.e., $230 per month) through December 31, 2011 (IRS Rev. Proc. 2011-12 § 2.06). Without this extension, the monthly exclusion for commuter transit benefits would have been reduced to $120 per month, effective January 1, 2011.

C. Dependent Care Assistance

Finally, the Tax Extenders Act extends two important dependent care assistance provisions until December 31, 2012. First, for purposes of the income exclusion under the dependent care assistance program, the deemed earned income of a spouse who is a full-time student or who is incapable of self-care will remain at $250 per month for one qualifying individual and $500 per month for two or more qualifying individuals. These rates would have decreased to $200 and $400, respectively, effective January 1, 2011. Second, the Tax Extenders Act extends the increase in the maximum child care expenses that qualify for the dependent care tax credit from $2,400 for one child and $4,800 for two or more children to $3,000 and $6,000, respectively.

V. Legislative Attempts to Repeal the PPACA

During the campaign leading up to the 2010 elections, Congressional Republican leaders stated that they planned to repeal PPACA if they regained the Congressional majority. After Republicans officially took control of the House of Representatives in early January 2011, the Republican House leadership immediately scheduled a vote to repeal PPACA and entitled the bill the "Repealing the Job-Killing Health Care Law Act" (H.R. 2). On **January 19, 2011**, the House passed that bill by a vote of 245 to 189.

Because Democrats are still in control of the Senate, it is unlikely that H.R. 2 will be brought to a vote in the Senate. Nevertheless, Senate Republicans likely will try to add amendments to repeal PPACA to other, unrelated legislation being considered by the Senate. This could result in a number of procedural skirmishes as Republicans try to force a vote on an amendment to repeal PPACA. In any event, President Obama will undoubtedly veto any bill repealing PPACA if such legislation somehow makes it through both the House and Senate. In addition, such a Presidential veto could not be overridden in Congress. Thus, repeal of PPACA is very unlikely while President Obama is in office.

Although the focus of Congressional Republicans in the early part of 2011 likely will be on repealing and replacing PPACA, House committees also will hold oversight hearings on implementation of various portions of PPACA. In conjunction with these hearings, Congressional Republicans likely will introduce bills in an attempt to "defund" provisions of PPACA, but it is likely that such efforts generally will run into the same legislative roadblocks as total repeal efforts. It also is likely that attempts will be made to repeal or otherwise modify certain specific provisions of PPACA.

VI. Court Challenges to the PPACA

Not surprisingly, there were a number of constitutional challenges to PPACA that were filed in various federal district courts, and the courts came to differing conclusions as to the constitutionality of the law.

A. *Virginia v. Sebelius* Holds That PPACA's Individual Mandate Is Unconstitutional

In the most well-publicized case, *Virginia v. Sebelius* (Case No 10-cv-00188), a federal judge in the Eastern District of Virginia ruled on **December 12, 2010** that PPACA's individual mandate provision (§ 1501) – which requires most Americans to purchase health insurance by 2014 or pay a penalty – was unconstitutional. The court held the imposition of an individual mandate to purchase insurance exceeded Congress' power under the Commerce Clause of the Constitution. The Obama Administration argued that, because every individual will, at some point, need health care and because a large portion of the uninsured population in America consumes billions of dollars in uncompensated care, decisions on how to finance that care were economic and, accordingly, fell under the Commerce Clause. The court rejected this argument, however, finding that "[a]n individual's personal decision to purchase—or decline to purchase—health insurance from a private provider is beyond the historical reach" of the Constitution, and that "[n]o specific[ ] constitutional authority exists to mandate the purchase of health insurance."

The court also rejected the Administration's argument that the individual mandate was a tax, and thus a valid exercise of Congress's taxation power under the Constitution. The court determined that the individual mandate was not a tax because it was intended to penalize individuals who fail to obtain insurance, rather than to raise revenue.

Noting that PPACA did not contain a "severability" clause, which would allow other provisions of PPACA to remain intact even if one provision was struck down by a court, Virginia asked that the court invalidate PPACA in its entirety. The court refused to do so, however, and stated that its ruling invalidated only the individual mandate provision (§ 1501) – and "directly dependent provisions which make specific reference to Section 1501." Although there are few specific references to Section 1501 in PPACA, the law nonetheless references Section 1501's individual mandate to maintain minimum essential coverage – or uses the term "minimum essential coverage" – in several key provisions that affect employers or their plans, including:

- The requirement that plans provide a Summary of Benefits (discussed earlier);
- The "pay or play" provisions that require employers either to provide affordable health coverage to employees or to pay certain penalties;
- The employer mandate to provide employees with free choice vouchers in order to purchase coverage under a state exchange;
- The "Cadillac plan" excise tax provisions under Code § 4980I, under which the tax will be assessed on a plan that provides minimum essential coverage if the cost of the plan exceeds certain threshold dollar limits; and
- Code § 162(m)(6), which will apply only to covered health insurance providers offering minimum essential coverage beginning in 2013.

B. Two District Courts Have Dismissed Lawsuits Challenging PPACA's Constitutionality

The ruling in *Virginia v. Sebelius* stands in contrast to the decisions of two other district courts that have addressed the constitutionality of PPACA. In late November, the U.S. District Court for the Western District of Virginia dismissed a lawsuit filed by Liberty University challenging, among other things, PPACA's individual mandate, which the university alleged was an improper exercise of congressional authority under the Commerce Clause of the Constitution. The court disagreed, and in its opinion dismissing the lawsuit, concluded that Congress, in fact, had a rational basis to conclude that an individual's decision regarding when – and how – to pay for health care is indeed an activity that "in the aggregate substantially affects the interstate health care market." (*Liberty University v. Geithner*, Case No. 10-cv-00015 (W.D. Va.)).

Similarly, in October, a judge in the Eastern District of Michigan dismissed a lawsuit challenging the constitutionality of PPACA's individual mandate. The court ruled that PPACA's individual mandate regulated interstate commerce, and that, accordingly, Congress acted within the scope of its authority under the Commerce Clause. (*Thomas More Law Center v. Obama*, 10-cv-11156 (E.D. Mich.)). Both cases are on appeal, with briefing and oral arguments expected in 2011.

C. The Next Battleground: Florida

The largest lawsuit challenging PPACA has been consolidated in Florida, with 20 states joining the legal action initiated by the Florida Attorney General. (*Florida v. Department of Health and Human Services*, Case No. 10-cv-91). Among other issues, the states are challenging the constitutionality of the individual mandate and allege that the Medicaid expansion required by PPACA exceeds Congress' power under the Constitution by impermissibly "coercing" states to accept such an expansion. In October, the court dismissed some of the claims brought by the plaintiffs, but allowed the key constitutional claims to survive. In December, the court held lengthy oral argument on the remaining constitutional challenges, and a decision is expected in the near future.

Regardless of the outcome in the Florida action, it is certain that Courts of Appeals will soon hear the constitutional challenges to PPACA, and it is possible that the issue could be decided by the U.S. Supreme Court.

* * *

We anticipate that the agencies will continue to issue PPACA guidance in 2011 at a steady pace, and we are committed to providing you with timely updates on all significant developments. In the meantime, if you have any questions, please contact your regular Groom attorney or any of the attorneys listed below:

Jon W. Breyfogle	jbreyfogle@groom.com	(202) 861-6641
Jenifer A. Cromwell	jcromwell@groom.com	(202) 861-6329
Elizabeth T. Dold	edold@groom.com	(202) 861-5406
Thomas F. Fitzgerald	tfitzgerald@groom.com	(202) 861-6617

Anu Gogna	agogna@groom.com	(202) 861-2602
Lonie A. Hassel	lhassel@groom.com	(202) 861-6634
Cheryl Risley Hughes	chughes@groom.com	(202) 861-0167
Christine L. Keller	ckeller@groom.com	(202) 861-9371
Tamara S. Killion	tkillion@groom.com	(202) 861-6328
Mark C. Nielsen	mnielsen@groom.com	(202) 861-5429
Allison B. Rogers	arogers@groom.com	(202) 861-0162
William F. Sweetnam, Jr.	bsweetnam@groom.com	(202) 861-5427
Christy A. Tinnes	ctinnes@groom.com	(202) 861-6603
Brigen L. Winters	bwinters@groom.com	(202) 861-6618