UNITED STATES DISTRICT COURT

Northern District of Florida

Pensacola Division

Case No.: 3:10-cv-91-RV/EMT

State of Florida, et al.,
Plaintiffs,

Memorandum of Law

v.

U.S. Department of Health and Human Services, et al.
Defendants.

February 7, 2011

MEMORANDUM OF LAW IN SUPPORT OF INTERVENORS MOTION TO INTERVENE, INTERVENORS' MOTION TO ALTER JUDGMENT AND INTERVENORS MOTION FOR A PRELIMINARY INJUNCTION

Preliminary Statement

In 2003 at a campaign stop in Chicago, Barack Obama stated:

> "I happen to be a proponent of a single payer universal health care program. I see no reason why the United States of America, the wealthiest country in the history of the world, spending 14 percent of its Gross National Product on health care cannot provide basic health insurance to everybody. And that's what Jim is talking about when he says everybody in, nobody out. A single payer health care plan, a universal health care plan. And that's what I'd like to see. But as all of you know, we may not get there immediately." Breitbart.tv/obama-in-03-id-like-to-see-a-single-payer-health-care-plan/

Amy Chrozick, a reporter covering the campaign of Presidential Candidate Obama, reported that at a campaign stop in Albuquerque, NM on August 19, 2008:

> **Barack Obama** said he would consider embracing a single-payer health-care system, beloved by liberals, as his plan for broader coverage evolves over time.

> "If I were designing a system from scratch, I would probably go ahead with a single-payer system," Obama told some 1,800 people at a town-hall style meeting on the economy.
>
> A single-payer system would eliminate private insurance companies and put a Medicare-like system into place where the government pays all health-care bills with tax dollars.
>
> Many liberals have long embraced the coverage plan, saying it would cover everyone, take the profit out of health insurance and allow for greater efficiencies. Blogs.wsj.com/washwire/2008/08/19/obama-touts-single-payer-system/

It has often been well stated, *Quando aliquid prohibetur ex directo, prohibetur et per obliquum.* Given the Administration's acknowledged goal of a single payer, government controlled health care system and the need to eliminate private insurance to accomplish that goal, the increased cost burden under Health Reform provides clear and convincing evidence that the Government is trying to do indirectly what it cannot do directly, namely, prohibit purchase of private health insurance by destroying the employer based health care system. The Intervenors have come to this Court to defend and preserve employer based, private payer health care as it currently exists.

Statement of Facts

The health insurance market is sometimes referred to as private payer health insurance ("private insurance"). Millions of individual Americans pool their health care premiums in health insurance companies. The health insurance companies invest in income producing products thereby leveraging the premiums paid by their insureds. In addition, health insurance companies sell stock accumulating more capital. In these ways health insurance companies create a huge pool of health care dollars. This pool is used to reimburse health care providers for care, for investments in new medical machines, for

expansion of health care facilities and for the next generation of pharmaceuticals. This pool is projected to be $854,000,000,000 in 2009. See Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 1029 (2010) ("PPACA") as amended by the Health Care and Education Reconciliation Act of 2010, Pub L. 111-152, 124 Stat. 1029 (2010) ("HCERA"), PPACA at Sec. 1501, (a)(2)(B)

The health insurance industry is to health care what the stock market is to industry - the driving force behind expansion and innovation. If the health insurance industry disappears so do advances in medical care, medical machines, pharmaceuticals and bio-technological cures. But health care insurance is more than a pool of dollars. It is the means by which individuals protect their constitutional right to control their own health care. Without health insurance individuals will lose control of their health care.

In America today, 35% of people with health insurance have government paid health care. The remaining 65% have private insurance. Of this 65%, 59% participate in employer based health care plans. The Economic Case for Health Reform, Council of Economic Advisers (2009) at 3. (hereinafter "Eco Case for H.R.) Put another way, 90% of the health insurance market is supported by employer based health plans.

Congress played an active role in the creation of this employer based health care system. This began in 1974 when Congress passed the Employee Retirement Income Security Act (ERISA) Pub L. No. 93-406, 88 Stat. 829. Among ERISA's stated goals was to encourage employers to offer health care benefits. This encouragement is described by Fred Goldberg and Susannah Camic, Legal Solutions in Health Reform: Tax Credits for Health Insurance, O'Neill Institute for National and Global Health Law, Georgetown

University, (2009), oneillinstitute.org at 4. As a result, businesses began to compete for workers by offering compensation packages that included non-wage benefits such as health insurance. Eco Case for H.R. at 37. "Employers paid 82 percent of the cost of premiums for single coverage and 71 percent of the cost for family coverage, for workers participating in employer sponsored medical plans." Employee Benefits in the United States, March 2009, Department of Labor, Bureau of Labor Statistics, USDL: 09 – 0872 at 1. It was employer based health insurance that made quality health care affordable to the average working family.

Congress in adopting the PPACA is attempting to radically change the health care delivery system. PPACA (1) repeals important IRC exclusions and deductions supporting employer based health benefits; (2) imposes new, mandatory benefits which increase the cost of insurance and (3) imposes massive revenue offsets and fees on medical machine manufacturers, pharmaceutical companies, health insurance companies and employers who offer a health care benefit plan to their employees. These changes will directly impact employer based health care.

> These provisions will cost employers monetarily and increase employers' administrative burdens. Employers have many more compliance issues to monitor as a result of this legislation. Failing to comply with these requirements could result in additional expenses by way of substantial penalties.
>
> These provisions also have the potential to decrease employer-provided benefits. For example, employers will find it much more expensive to provide retiree benefits without the prescription drug coverage subsidy tax exemption and active medical benefits, with the threat of a 40 percent excise tax on health coverage beyond the stated threshold and with the new restrictions on plan terms, such as no lifetime limits or pre-existing condition exclusions. This extra cost may serve as a deterrent to providing some benefits. Joanna C. Kerpen, Enacted

Health Care Legislation: Effect on Employers, healthcarereform.com (March 26, 2010)

The cost of employer paid health insurance is currently about 8% of compensation costs. Eco Case for H.R. at 30. As insurance costs for employers increase, more and more employers will drop their health benefits. Canada began the nationalization of its health care delivery system in 1957. One of the first steps Canada took to institute a national system was to eliminate the tax exclusions for employers who offered health care benefits. "[T]he elimination of the tax exclusion for employer-sponsored supplemental insurance in Quebec-Canada, led to 'a decrease of about one-fifth in coverage by employer-provided supplementary insurance...but the increase in the non-group market offset only 10-15 percent of the decrease in coverage through an employer.'" Goldberg & Comic, supra., at 8 (citing Jason Furman, President Obama's senior economic policy adviser). Thus experience has taught us that many employees will not acquire health insurance on their own. Further, even for the 10 – 15% who do obtain health care coverage, there is no evidence that they were able to purchase anywhere near the level of coverage they enjoyed under their employer based plans.

The way PPACA and HCERA came to be drafted was described by the Democratic Majority on the Senate Committee on Health, Education, Labor and Pensions ("H.E.L.P. Committee"). On May 21, 2009 the H.E.L.P. Committee issued a Briefing Paper. The first page of that paper is attached as Exhibit A. In that paper the Democratic Majority states as follows:

> For the past year, Democratic Members and staff of the Senate Committee on Health, Education, Labor and Pensions – along with our colleagues at the Senate Finance Committee, the House of Representatives and the Administration

– have been laying groundwork and preparing legislation to reform the U.S. health care system. As we near the point of introducing legislation to achieve our vision, we issue this policy overview to lay out our priorities for the legislation.

The Democrats in Congress without public hearings or Republican participation drafted what became health care reform. After May 21st, the Democrats in Congress used their large majorities in the House and Senate to ram the legislation through without Republican support and despite polls showing Americans opposed Health Care Reform.

There are two principal justifications for the Federal Government taking over complete control of health care. The first is the "massive and spiraling cost of health care." What constitutes national health care costs is actually defined by the Organization for Economic and Co-operative Development ("O.E.C.D."). O.E.C.D. originated in 1948 as the Organization for European Economic Co-operation to help administer the Marshall Plan. Later, its membership was extended to non-European states. In 1961, it was reformed as O.E.C.D. Most O.E.C.D. members are high income economies with a high Human Development Index and are regarded as developed countries. *See* O.E.C.D., Wikipedia.com. Structured along the lines of the O.E.C.D. definition, the U.S. defines national health care costs as being comprised of the following:

1. Department of Defense Budget for all men and women in military uniform;
2. The Veterans Administration budget for health care for military veterans;
3. Workers Compensation;
4. Research and Development costs of all U.S. medical machine manufacturers, pharmaceutical companies and bio-medical research firms;
5. Construction of public hospitals;
6. Government paid health care including Medicare, Medicaid and the Children's Health Insurance Program (hereinafter "C.H.I.P.S.) ; and
7. Third party or private payer insurance expenditures. Karl Loren, Health Care Spending as Part of GDP --Historical, karlloren.com, 4/29/2009.

The major difference between the O.E.C.D. definition and the Government's definition regards No. 4 above. Other O.E.C.D. countries do not include R & D costs. Instead they include imports and exports of medical machines, pharmaceuticals and bio-technology. This makes sense since if a nation imports more than it exports, it increases health care costs. The U.S. Government, on the other hand, includes R & D costs but does not offset the costs with the value of exports of medical machines, pharmaceuticals and bio-technology products thereby over-inflating the cost of health care. .

When the Government talks about regulating the health care market under PPACA, it is talking about regulating only two of the seven major elements that comprise health care costs. And Medicare, Medicaid and C.H.I.P.S. are Government programs.

In 1992 national health care expenditures comprised 12.1% of Gross Domestic Product ("G.D.P."). According to the Kaiser Family Foundation national health care spending had risen to 15.3% by 2006. See Kaiser Family Foundation, Trends in Health Care Costs and Spending, March 2009. What was the contribution of private insurance to the increase in the percentage of G.D.P. devoted to health care between 1992 and 2006? The answer is not much. On November 12, 2009 Senator Max Baucus, Chairman of the Senate Finance Committee and one of the authors of Health Care Reform, issued a Report titled Call to Action – Health Reform 2009. *See* Finance.Senate.Gov. ("the Baucus Report") (The Cover Page and pages 3 & 4 are attached at B) At page 3 Senator Baucus in discussing the increase in third party premiums noted as follows:

> Why are premiums rising so fast? A recent synthesis of studies found that greater use of medical technologies is a driving force – contributing between 38 and 65 percent of health care cost increases. Other factors, including obesity,

> demographics, and productivity, also contribute to growth in the cost of health care.

Between 1988 and 2007 there have been two major "spikes" in health care premiums corresponding to the introduction of new medical machines. After each spike peaked, the growth of premium increases declined. After the spike in 1989 the growth rate declined to 1% by 1996 (lower than overall inflation and the increase in workers earnings). A second spike occurred between 2000 and 2003 as additional new technologies came on line. Once again after the spike the rate of growth declined and it is projected to continue to decline through at least 2012.

The Baucus' Report continues on page 4:

> Additionally, hospitals and clinics provide an estimated $56 million in uncompensated care every year to people without health insurance and those who have health coverage pay the bill through higher health care costs and increased premiums. A study of this "hidden tax" estimated that ten percent of California health care premiums are attributable to cost shifting due to the uninsured.

We know that between 1992 when health care costs were 12.1 % of G.D.P. and 2006 when health care costs were 15.3% of G.D.P., Workers Comp costs which had been declining until 2002 turned around and began to increase, the U.S. engaged in overseas military operations in Iraq and Afghanistan driving up health care costs for both the Department of Defense and the Veterans Administration, Medicare expenditures increased as the population grew older and Medicaid increased as more people were added to the program. But the biggest increase was Medicare Part D, The Prescription Drug Benefit Program. Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries. It was enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and went into

effect on January 1, 2006. As of the end of year 2008, the average annual per beneficiary cost spending for Part D, reported by the Department of Health and Human Services, was $1,517, making the total expenditures of the program for 2008 $49.3 Billion. Projected net expenditures from 2009 through 2018 are estimated to be $727.3 billion. *See* Medicare_Part_D at Wikipedia.com. The real increase in massive and spiraling health care costs is in Medicare including Medicare Part D. In a letter published in Politico.com, attached as Exhibit C, Senator Rockefeller states:

> When it comes to moving our health system forward and creating stability for the future, we need to think big. And let's fact it: The 800-pound gorilla is Medicare. Think Big About Medicare Fix by Sen. Jay Rockefeller, Politico.com, July 30, 2009 at 1.

Senator Rockefeller then goes on describe how Medicare is going broke and has to be saved. There are provisions in the PPACA dealing with Medicare and Medicaid. The Intervenors do not take issue with those sections at this time. But if Medicare and Medicaid are already Government programs, why does the Congress want to "reform" the entire health care system when everyone knows the 800 lb. gorilla is Medicare? This is explained by Andrew G. Biggs:

> A new consensus on entitlement reform has developed in Washington: rising per-capita health care spending is the only real crisis besetting the government's entitlement programs, while America's aging population and Social Security play minor roles at best. Some cite this view to shift the policy emphasis from entitlement cost control to the restructuring of the U.S. health sector, including private health care.
>
> ...
>
> Unfortunately, the new consensus has not spurred policymakers to restrain Medicare and Medicaid costs. Budget experts Neil Howe and Richard Jackson were the first to raise concerns about the policy implications of this new view. Writing for the Concord Coalition, they said that the new consensus "has all the hallmarks of a classic bait-and-switch." The new consensus claims that only fixing Medicare and

> Medicaid can close the fiscal gap, but doing so requires restructuring *all* health care provision – both public and private. But economy-wide health reform would increase costs for a long period before any savings were generated, in part because most comprehensive health care reform proposals make expanding insurance coverage a higher priority than holding the line on overall costs. During the interim, entitlement costs would only worsen. (emphasis in original)(footnotes omitted) Andrew Biggs, Entitlements: Not Just a Health Care Problem, 7 Pierce Law Review 195, 198 (2009)

And this is exactly what has happened. On April 22, 2010 Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services (herein after "CMS") issued a Report entitled Estimated Financial Effects of the "Patient Protection and Affordable Care Act" as Amended (hereinafter "Foster Report")(the cover page of that Report and pages 15 – 18 are attached as Exhibit D) The Foster Report estimates that as a result of PPACA national health expenditures would increase by $311 Billion for years 2010 through 2019. *Id.* at 15. Rather than reducing costs, PPACA as amended increases them.

The second rationale for the federal takeover of health care is that 45 million Americans are uninsured. See U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009 (hereinafter "Census Report"). Although the Census Report does indicate that 45.7 million Americans were uninsured, it notes further:

> Research shows health insurance coverage is underreported in the [Census Report] for a variety of reasons. Annual retrospective questions appear to cause few problems when collecting income data (possibly because the interview period is close to when people pay their revenue offsets). However, because health insurance coverage status can change over the course of a year, answering questions about this long reference period may lead to response errors. For example, some people may report their insurance coverage status at the time of their interview rather than their coverage status during the previous calendar year. Census Report at 20.

How many people were truly uninsured? Who knows but according to the Census Report 91% of children under 18 had health insurance, the largest percentage since 1987 when data was first collected, 89.2% of non-Hispanic whites, 80.9% of Blacks and 69.3% of Hispanics were insured. *Id.* at 22. Further, economic status had little to do with why many

people were uninsured. According to the Census Report, 8.2% of households earning $75,000 or more per year, 14.0% of households earning $50,000 or more per year and 21.4% of households earning $25,000 to $49,999 were uninsured. *Id.* at 25. Of family households earning less than $25,000, 75.5% had health insurance while only 24.5% were uninsured. *Id.* If 75% of the households earning less than $25,000 per year could afford some level of health insurance coverage, everyone earning above $25,000 could afford health insurance. They simply chose not to buy it. *See* Eco Case for H R at 30 (Free health care causes some to not buy health insurance).

The Intervenors Enjoy a Fundamental Right to Personal Security which Includes the Right to Control their Own Health Care.

There is a separate set of powers reserved under the 10th Amendment, those powers reserved to the People which neither the National Government nor the States can abrogate. These powers are often referred to a Fundamental Rights. *U.S. v. Oakland Cannabis Buyer's Coop*, 532 U.S. 483, 501 (2001); *Bowers v. Hardwick*, 478 U.S. 186, 190 - 191 (1986); *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)(fundamental principles of liberty and justice which lie at the base of all our civil and political institutions). Thus there is an overlay in the Tenth Amendment between the police powers of the state and the Fundamental Rights of the citizens. For example, we have public school systems but we also know that it is a Fundamental Right of Parents to direct the education of their children. *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925), *Meyer v. Nebraska*, 262 U.S. 390, 400 (1923).

Neither the Bill of Rights nor the 14th Amendment mark the outer limits of Liberty. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 848 (1992); *Richmond*

Newspapers, Inc. v. Virginia, 448 U.S. 555, 579 - 580 (1980)(noting that James Madison's efforts, culminating in the Ninth Amendment, served to allay the fears of those who were concerned that expressing certain guarantees could be read as excluding others). The Constitution protects basic rights and liberties that are not specifically enumerated in the Constitution. *Washington v. Glucksberg*, 521 U.S. 702, 720-721 (1997). The Supreme Court has never been called upon to decide if a person has a fundamental right to control their own health care although two Justices have expressed their opinion on the subject. *Id.* at 777 (Souter, J.)(there is a liberty right to determine medical need); *Id.* at 790 (Breyer, J.)(there is a right to personal control over professional medical advice); See also *Reno v. Flores*, 507 U.S. 292, 302 (1993) *Cruzan v. Director of Mo. Department of Health,* 497 U.S. 261, 281 (1990); *Moore v. E. Cleveland*, 431 U.S. 494, 503 (1977); *Eisenstadt v. Baird*, 405 U.S. 438, 450-452 (1972), *Slaughter House Cases*, 16 Wall. 36 (1873). As Judge Blackstone wrote in Book 1, Chapter 1:

> The absolute rights of every Englishman (which, takes in a political and extensive sense, are usually called their liberties) as they are founded on nature and reason, so they are coequal with our form of government; though subject at times to fluctuate and change: their establishment (excellent as it is) being still human. At some times we have seen them depressed by overbearing and tyrannical princes; at others so luxuriant as even to tend to anarchy, a worse state than tyranny itself, as any government is better than none at all. But the vigour of our free constitution has always delivered the nation from these embarrassments, and, as soon as the convulsions consequent on the struggle have been over, the balance of our rights and liberties has settled to it's proper level; and their fundamental articles have been from time to time asserted in parliament, as often as they were thought to be in danger. William Blackstone, *Commentaries on the Laws of England,* Volume 1, Of the Rights of Persons, University of Chicago Press, 1979, at 123.

It is these "fundamental articles", actually the absolute rights of Every Englishman, which we now call Fundamental Rights. And among these Fundamental

Rights is: "1. The right of personal security [which] consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation." Blackstone, *supra.*, at 125. Included in this Fundamental Right is: "4. The preservation of a man's health from such practices as may prejudice or annoy it." *Id.* at 130.

In *Abigail Alliance for Better Access to Developmental Drugs v. Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007)(Rogers, J. dissenting) Circuit Judge Rogers discussed whether or not there was a fundamental right to control your own health care:

> A review of this [Nation's] history demonstrates that this Nation has long entrusted in individuals those fundamentally personal medical decisions that lie at the core of personal autonomy, self-determination, and self-defense.
>
> The heritage of this right predates the Founding. Samuel Adams referred to the "duty of self preservation" as "the first law of nature". The common law's eminent commentator, William Blackstone, wrote of three "principal or primary articles" historically comprising "the rights of all mankind." First among these was "[t]he right of personal security...in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, [and] his health." Blackstone described the guarantee of "[t]he preservation of a man's health from such practices as may prejudice or annoy it." This right included the right to self-defense and the right to self-preservation. "For whatever is done by a man to save either life or member, is looked upon as done upon the highest necessity and compulsion."
>
> This principal is of early vintage, for "Anglo-American law starts with the premise of thorough-going self determination." Long before regulation of the efficacy of medications was contemplated by the federal government, courts recognized with "universal acquiescence" that "the free citizen's first and greatest right, which underlies all others," is "the right to the inviolability of his person, in other words, his right to himself. So too, this court has recognized "the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.' *Id.* at 716 – 717 (numerous citations omitted)

Later, Circuit Judge Rogers continued:

> [t]he most fundamental rights are those that no government of the people would contemplate abridging – it is doubtful that many courts or legislatures have discussed whether the government can determine whether we are allowed to

> breathe air, but this does not make our access to oxygen any less grounded in history. In considering whether the terminally ill patient's interest in self-preservation is protected by the Due Process Clause, the court overlooks the most fundamental evidence of the protection the [plaintiff} claims, namely that the words "life" and "liberty" are in the Due Process Clause itself. The right to life, and the asserted corollary right to attempt to preserve life, is not a second derivative species of "liberty" whose protection by the Constitution should be approached with skepticism. *Id.* at 722.

To the powerful arguments presented by Circuit Judge Rogers the Appellants would humbly add the immortal words of Thomas Jefferson in the Declaration of Independence, "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness." If life itself in an inalienable right, should not free men and women have the fundamental right to control their own health care so as to preserve their right to life?

While that fundamental right might not extend to purchasing marijuana, a drug not found to have any therapeutic value, or accessing assisted suicide, there can be no serious doubt that Americans enjoy a fundamental right to Personal Security which includes controlling their own health care.

The Right to Purchase Health Insurance is a Corollary of the Intervenors' Fundamental Right to Control their own Health Care.

In the modern world the way people control their own health care is to purchase health insurance. Without health insurance, people cannot control their own health care and what care they receive will be determined by others. Therefore Intervenors offer that a person's ability to purchase the health insurance of their choice is a fundamental right protected by the Constitution. This is a case of first impression in this Nation but it is not

the first time this issue has been considered. In *Chaoulli v. Quebec* (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35 the Supreme Court of Canada faced the question of whether the individuals ability to purchase health insurance is a fundamental right.

In Canada the *Canada Health Act*, the *Health Insurance Act*, and the *Hospital Insurance Act* limit access to private health services by removing the ability to contract for private health insurance to cover the same services covered by public insurance. The result is a virtual monopoly for the public health scheme. This effectively limited access to private health care except for the very rich, who can afford private care without need of insurance. At the same time Canadian law provides as follows:

> *Canadian Charter*
>
> **7.** Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> *Quebec Charter*
>
> **1.** Every human being has a right to life, and to personal security, inviolability and freedom.

The Plaintiff, Chaoulli, argued that the effective prohibition against purchasing third party or private payer health insurance violated his rights under the Canadian Charter and the Quebec Charter. The Attorney General of Quebec argued that the prohibition resulted from a desire to pool the financial resources available for health care. *Id.* at 31. The Attorney General further argued (a) that the protection of the right to freedom and life is limited to situations involving the administration of justice, (b) that the right asserted is economic and is not a fundamental right, and (c) that the appellants do not have standing. *Id.* at 34.

In its analysis the Court referred to one of its prior decisions.

> In *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, Sopinka J., writing for the majority, held that security of the person encompasses "a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress" (pp. 587-88). The prohibition against private insurance in this case results in psychological and emotional stress and a loss of control by an individual over her own health. *Id.* at 72-73

The court recognized that in adopting nationalized health care the legislature was setting social policy but concluded:

> The courts have a duty to rise above political debate. They leave it to the legislatures to develop social policy. But when such social policies infringe rights that are protected by the charters, the courts cannot shy away from considering them. The judicial branch plays a role that is not played by the legislative branch. *Id.* at 59.

Ultimately the court decided:

> Where a law adversely affects life, liberty or security of the person, it must conform to the principles of fundamental justice. This law, in our view, fails to do so. While the decision about the type of health care system Quebec should adopt falls to the Legislature of that province, the resulting legislation, like all laws, is subject to constitutional limits, including those imposed by s. 7 of the *Charter*. ...The government defends the prohibition on medical insurance on the ground that the existing system is the only approach to adequate universal health care for all Canadians. The question in this case, however, is not whether single-tier health care is preferable to two-tier health care. *Id.* at 67-68.

The Intervenors' argument in support of their right to purchase health insurance is even stronger than the argument of Canadian Plaintiff Chaoulli because of the differences in the legal systems. Under Canadian law and the international law of nations, citizens do not have fundamental rights. "An individual has no international legal rights nor remedies in the international legal order and is but an "incidental beneficiary" of rights and duties between state-parties." Louis Henkin, *The Philosophy of Human Rights*, in The

Philosophy of Human Rights, Milton E. Winston ed., Wadsworth Publishing Co., 1989 at 137-38 . In other words, in a country such as Canada or the United Kingdom a citizen only enjoys the rights Parliament gives to him or her. Citizens have no inherent rights of their own. This is why in *Chaoulli* the Supreme Court starts with a discussion of the Canadian Charter and the Quebec Charter to see what rights Chaoulli had been given under Canadian law. Under our Constitution rights are not "gifts" from the government but natural and inherent. It is in the difference in the legal systems that one must view the attempt of the American Government in the PPACA and HCERA to impose a Health Canada or a National Institute of Health (U.K. health system) medical system on the American People. Under a Parliamentary system, the government could merely strip the people of their right to control their own health care. The Canadian and British people had no constitutional protection of that right. In the United States the People have a place to go to protect their fundamental right to control their own health care, namely, this Court.

Without access to health insurance, only the very rich can provide for their health care. If control of a person's own health care is a fundamental right then access to private health insurance is a fundamental right. The one legal writer who has taken up the issue agrees.

> The [U.S.] Supreme Court has stated or assumed that the right to refuse medical treatment is a protected liberty interest. (citing *Cruzan v. Director, Missouri Dept. of Health,* 497 U.S. 261 (1990)) Similarly, the right to seek medical care might then conceivably be framed as a specially protected liberty interest. (citing *Alliance for Better Access to Cevelopmental drugs and Washigton Legal Foundation v. Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007)) This liberty interest, in turn, conceivably could form the basis for protecting a right to purchase health insurance to afford treatment. (citing *Chaoulli v. Quebec*)) Mark

A. Hall, The Constitutionality of Mandates to Purchase Health Insurance at 11, O'Neill Institute for National and Global Health Law, Georgetown University, 2009, oneillinstitute.org.

The Intervenors believe that the right to control their own health care is a fundamental right and know that it that without the ability to purchase health insurance, this fundamental right will be lost. Therefore, this Court must protect the right of the Intervenors to purchase health insurance through their employer so that they can continue to exercise their fundamental right to control their own health care.

The Changes in the Tax Code Combined with Mandates, Fees and Revenue Offsets Imposed Upon Health Care Providers, Health Insurers, Medical Device Manufacturers, Drug Companies and Employers Offering a Health Care Benefit to their Employees Unduly Burden the Intervenors' Right Control their Own Health Care.

The changes in the tax code combined with mandates, fees and revenue offsets imposed upon health care providers, health insurance companies, medical machine manufacturers, pharmaceutical companies and employers offering health care benefits to their employees threatens to force employers to eliminate health care benefits completely. See Firms Mulled Dropping Insurance Plan, Politico.com, May 7, 2010. (Attached at E) This will make the Intervenors' ability to purchase health insurance all but impossible. When that happens, the Intervenors will lose their fundamental right to control their own health care.

The supporters of health reform believe the use of the IRS Code to bring about health care reform is proper because under the Constitution there is no limit on the exercise of the taxing clause by Congress. *See Regan v. Taxation With Representation of Washington*, 461 U.S. 540, 547 (1983); *Sonzinsky v. U.S.*, 300 U.S. 506, 513 (1937). But

Congress' taxation power cannot be used in a way that burdens a fundamental right recognized in the Constitution's Bill of Rights and judicial interpretations by the U.S. Supreme Court. Mark A. Hall, supra., at 1; C. Hoke, Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles, 21 Hastings Constitutional Law Quarterly 489, 572 (1994); R. Briffault, Federalism and Health Care Reform: Is Half a Loaf Really Worse Than None?, 21 Hastings Constitutional Law Quarterly 611, 613-16 (1994); K.M. Sullivan, Unconstitutional Conditions, 102 Harvard Law Review 1413 (1989); L.A. Baker, Conditional Federal Spending After *Lopez*, 95 Columbia Law Review 1911 (1995); Tracy A. Kaye and Stephen W. Mazza, United States – National Report: Constitutional Limitations on the Legislative Power to Tax in the United States, 15 Michigan State Journal of International Law 481, 490 (2007)(citing *Murdock v. Pennsylvania*, 319 U.S. 105 (1943) and *Foilett v. McCormick*, 321 U.S. 573 (1944)).

> Even if a tax is levied expressly for the purpose of obtaining revenue, when it appears, "in the light of its history and present setting, that it is for a purpose which the Constitution does not permit the law making body to accomplish, the tax is invalid. *Helvering v. Davis*, 301 U.S. 619, 630 – 631 (1936)(citations omitted)

What are the burdens placed upon employers such as the Intervenors' employer who offer a health care benefit for their employees and health care insurers?

Mandates

Prior to PPACA there were very few federal mandates on health policies. States, however, have traditionally imposed mandates on insurers.

> The Council for Affordable Health Insurance (hereinafter "CAHI") issued a report in 2008 listing over 1900 state mandates applicable to individual and

small group policies....Estimates of costs imposed by such mandates vary greatly. CAHI has developed estimate ranges for each of the state mandates, ranging from less than 1% to between 5-10% of additional costs. While the costs of a specific mandate may be low, the accumulation of 40 – 50 mandates in a sate may price certain individuals out of the market. Critics of mandates note that mandates ultimately harm consumer health by ...raising the cost of health insurance and thus contributing to the number of uninsured Americans.

A growing number of states, recognizing that mandates are not cost-free, are requiring systematic review of either state mandates or of proposed mandate legislation. The Massachusetts Division of Health Care Finance and Policy, for example, estimated the total spending on the state's 26 mandated benefits at $1.32 Billion, or 12% of premiums for the one-year study (July 1, 2004 through June 30, 2005) Stephanie Kanwit, The Purchase of Insurance Across State Lines in the Individual Market at 9, O'Neill Institute for National and Global Health Law, Georgetown University, (2009), oneillinstitute.org. (footnotes omitted)

Even as states are reassessing the impact of mandates on accessibility to health insurance, the Government in PPACA and HCERA mandate seventeen (17) major additional health care benefits which must be offered by employers and health insurers. How much will these mandates add to premiums paid by employers and their employees is a unknown although industry analysts estimate it in the hundreds of billions of dollars. And any additional up tick in costs will drive more employers to drop health care benefits and more employees will lose their coverage.

Fees

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy. PPACA, at 1661 of 2409.

Ostensibly this $2 fee per every employee enrolled in an employer health plan is to support "Patient-Centered Outcome Research" under Sec. 6301. Since there were no hearings on PPACA or the HCERA the inconvenient fact that the type of research contemplated under Sec. 6301 is currently being done by the Agency for Healthcare Research and Quality (hereinafter "AHRQ") which is part of HHS was never brought to the public's attention. AHRQ focuses on the role of clinical care and the health care delivery system. As Carolyn M. Clancy, M.D., then Director, AHRQ stated in her testimony before the Joint Economic Committee of Congress on July 9, 2003:

> AHRQ's mission is to improve the effectiveness, quality, safety, and efficiency of health care services that patients receive. What is unique about our mission is that it encompasses both the evaluation of the effectiveness and quality of clinical services and the most effective and efficient ways to organize, manage, and safely deliver those services.

AHRQ has been doing this for 25 years at the public's expense as part of the HHS budget. There is no provision in PPACA or HCERA to close AHRQ. The $2 "fee" is just another way to drive up costs for employers who offer health care benefits.

Revenue Offsets

In addition to mandated benefits, there are new additional fees and revenue offsets. Most of the fees and revenue offsets are contained in Title IX of the PPACA. It has been estimated that the Revenue Provisions of PPACA and HCERA will add $500+ billion in expenses to insurers, employers and employees. Add in the $2 fee, mandatory benefits and the $311 Billion increase in costs and the total approaches $1 Trillion. If as noted above $56 Billion in uncompensated health care services increased insurance premiums by 10% in California (and presumably nationally), then how much of an

increase will $1 Trillion cause? And what will it do to the ability of employers and employees to continue to offer and pay for private health insurance?

The combined effect of the mandatory benefit provisions, fees and revenue offsets in the PPACA combined with the $311 Billion increase in health care costs will drive up the cost of health insurance to the point where employer health benefits will disappear and private insurance will become extinct. And when health insurance ends, the Intervenors' fundamental right to control their own health care ends with it.

The Intervenors Require Injunctive Relief Immediately

The Intervenors are asking the Court to enjoin the collection of the fees and revenue offsets levied under the PPACA and the HCERA. This very issue was taken up by this Court in its earlier Order on Motion to Dismiss, 10/14/2010:

> Congress did not state in the Act that it was exercising its taxing authority to impose the individual mandate and penalty; instead, it relied exclusively on its power under the Commerce Clause. U.S. Const. art I, § 8, cl. 3 ("[Congress shall have Power] To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes"). The Act recites numerous (and detailed) factual findings to show that the individual mandate regulates commercial activity important to the economy. Specifically, it states that: "The [individual mandate] is commercial and economic in nature, and substantially affects interstate ommerce" in that, inter alia, "[h]ealth insurance and health care services are a significant part of the national economy" and the mandate "will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services." Act § 1501(a)(1)-(2)(B)(C). It further states that health insurance "is in interstate commerce," and the individual mandate is "essential to creating ffective health insurance markets." Id. § 1501(a)(2)(F), (H). The Act contains no indication that Congress was exercising its taxing authority or that it meant for the penalty to be regarded as a tax. Although the penalty is to be placed in the Internal Revenue Code under the heading "Miscellaneous Excise Taxes," the plain language of the Code itself states that this does not give rise to any inference or presumption that it was intended to be a tax. See United States v. Reorganized CF&I Fabricators of Utah, Inc., 518 U.S. 213, 222-23, 116 S. Ct. 2106, 135 L. Ed. 2d 506 (1996) (citing to 26 U.S.C. § 7806(b), which provides that: "No inference, implication, or presumption of legislative construction shall be drawn or made by

reason of the location or grouping of any particular section or provision or portion of this title") Slip Opinion at 18.

PPACA at Title IX, Subtitle A – Revenue Offset Provisions imposes huge additional costs on health care, insurers and employers who offer health benefits. In addition to the argument that since Congress did not assert its Taxing authority in adopting the act, if this Court has ruled that PPACA is unconstitutional, why is there any need for revenue offsets? Since PPACA will not be implemented because it is unconstitutional there will be no added costs to offset.

This court declined to issue an injunction because it was confident that its declaratory judgment ruling would be sufficient to halt implementation of PPACA. The Intervenors challenge this presumption. Attached as F is an Order issued by District Court Judge Feldman holding the Government in Contempt for violating his earlier Order on Louisiana's drilling moratorium. In it he states that the Governments actions "provide clear and convincing evidence of the government's contempt of this court's preliminary injunction order." F at 7. Attached as Exhibit G is a letter four Democratic Senators published in Politico.com three days after this Court's Ruling indicating that because this Court's Order was an act of judicial overreach they will ignore the ruling. Finally attached at H is an Article by the Associated Press indicating that the insurance industry is proceeding with the overhaul despite this court's ruling because "if states don't act, the federal [HHS] could step in and run the new insurance markets." Everyone knows that the government has no intention of stopping or even slowing down the overhaul under PPACA despite this Court's ruling. That is why injunctive relief is necessary now.

The Intervenors are not challenging a statute taking effect in 2014. PPACA is changing health care today. Attached at I is an example of what is happening in the real world. On February 1, 2010 Aetna pulled its health insurance out of Colorado. Statistically we know that of the 22, 000 insureds losing coverage, 20,000 worked for small businesses with health benefits, most of those small business will not replace the health benefit, only 3,000 of the former insureds will buy insurance and the remainder will be uninsured. Those 17,000 employees and their families have lost their health care coverage and with it their fundamental right to control their own health care. This Court must act now before more Americans lose control of their health care..

Liars Lie and Honest Men Swear to the Truth of their Lies

The Intervenors watched for almost two years as Obama Administration representatives lied to the American People in order to justify Health Reform. But the Intervenors never dreamed that the Administration would lie to a District Court Judge.

The Intervenors never doubted that the Administration would get health care passed. Therefore they started their litigation in August, 2009 based upon the health care provisions in the Stimulus Act, The American Recovery and Reinvestment Act, P.L. 111 – 05 (2009)("ARRA"). At the heart of the litigation was a challenge to the Health Information Technology for Economic and Clinical Health Act, Title XIII of the ARRA. ("HITECH"). HITECH requires every health care provider ("HCP") to create an electronic health record ("EHR") for every person in the country, include in the EHR all the personal health information ("PHI") and send the EHR to the Department of Health and Human Services ("HHS"). The program is being implemented for HHS by the

Centers for Medicare and Medicaid Services. ("CMS"). The Intervenors claimed that since they were covered by a private plan of insurance under an employer benefit, HHS had no right to their PHI and that HITECH violated their Fundamental Right to Privacy.

In order to defeat the Intervenors standing in district court the Government not once but twice stated clearly to Judge Jones that HITECH was only capturing PHI on Medicare and Medicaid patients. Attached at J is the cover and page 12 of the Government's Brief and at K is the cover and page 8 of the Government's Reply Brief. Based upon this representation, Judge Jones dismissed the complaint.

As the statutes created by HITECH together with the provisions for implementation adopted in the Final Rule set forth in the Appendix hereto make abundantly clear, that representation was a flat out lie. But the U.S. Attorney could not know that. Given the length and complexity of Health Reform legislation he had to rely on HHS/CMS for his information. The same Administration Officials who lied to the American People lied to Judge Jones through the U.S. Attorney and since the U.S. Attorney was making the representation Judge Jones accepted it as Gospel. The Intervenors have no doubt that HHS/CMS will use the Government Attorneys appearing before this Court to lie again this time to avoid the Intervenors' application for relief.

Robert A. Heghmann
17 Deer Meadow Road
Durham, NH 03824
(603) 397 – 5018

Beatrice M. Heghmann
17 Deer Meadow Road
Durham, NH 03824
(603) 397 – 5018

APPENDIX

HITECH, Title XIII, Sec. 3000, 42 U.S.C. Sec. 300jj (13):

> ''(13) QUALIFIED ELECTRONIC HEALTH RECORD.—The term 'qualified electronic health record' means an electronic record of health-related information on an individual that—
>
> ''(A) includes patient demographic and clinical health information, such as medical history and problem lists; and
>
> ''(B) has the capacity—
>
> ''(i) to provide clinical decision support;
>
> ''(ii) to support physician order entry;
>
> ''(iii) to capture and query information relevant to health care quality; and
>
> ''(iv) to exchange electronic health information with, and integrate such information from other sources.

HITECH, Title XXX, Sec. 3001 (c) (3):

(3) STRATEGIC PLAN –

> (A) IN GENERAL – The National Coordinator shall, in consultation with other appropriate Federal agencies (including the National Institute of Standards and Technology), update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to the following:
>
> ii. The utilization of an electronic health record for each person in the United States by 2014. 42 U.S.C. Sec. 300-JJ-11 (c) (3) (a)(ii)

HITECH, Title XXX, Sec. 3002 (b)(2)(B):

> ''(B) AREAS REQUIRED FOR CONSIDERATION.—For purposes of subparagraph (A), the HIT Policy Committee shall make recommendations for at least the following areas:
>
> ''(iii) The utilization of a certified electronic health record for each person in the United States by 2014. 42 U.S.C. Sec. 300-JJ-12 (b)(2)(B) (iii)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
42 CFR Parts 412, 413, 422, and 495
CMS-0033-F
RIN 0938-AP78
Medicare and Medicaid Programs; Electronic Health Record Incentive Program
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Final rule.

Final Rule at 305 - 06:

We proposed that to satisfy the requirements of reporting on clinical quality measures under sections 1886(n)(3)(A)(iii) and 1903(t)(6)(C) of the Act for the 2011 - 2012 payment year, we would require eligible hospitals and CAHs to report on all EHR incentive clinical quality measures for which they have applicable cases, without regard to payer. We proposed that Medicare eligible hospitals and CAHs, who are also participating in the Medicaid EHR incentive program, will also be required to report on all Medicaid clinical quality measures for which the eligible hospital has applicable cases. We also proposed that to demonstrate an eligible hospital or CAH is a meaningful EHR user, the eligible hospital or CAH would be required to electronically submit information on each clinical quality measures for each patient to whom the clinical quality measure applies, regardless of payer, discharged from the hospital during the EHR reporting period and for whom the clinical quality measure is applicable. Although as proposed, we did not require clinical quality reporting electronically until 2012, we would begin clinical quality reporting though attestation in the 2011 payment year. We solicited comment on whether it may be more appropriate to defer some or all clinical quality reporting until the 2012 payment year. If reporting on some but not all measures in 2011 was feasible, we solicited comment on which key measures should be chosen for 2011 and which should be deferred until 2012 and why.

Comment: A commenter asked that we state the authority which provides us the ability to require EPs and hospitals to report on non-Medicare and Medicaid patients. (p. 328)

Response: Sections 1848(o)(A)(2)(iii) and 1886(n)(3)(A)(iii) of the Act broadly state that as a condition of demonstrating meaningful use of certified EHR technology, an EP, CAH or eligible hospital must "submit information" for the EHR reporting period on the clinical quality or other measures selected by the Secretary "in a form and manner specified by the Secretary." Likewise, section 1903(t)(6) of the Act states that demonstrating meaningful use may include clinical quality reporting to the States, and may be based upon the methodologies that are used in sections 1848(o) and 1886(n). This language does not limit us to collecting only that information pertaining to Medicare and Medicaid beneficiaries. Therefore, we believe that we have the authority to collect summarized clinical quality measures selected by the Secretary, with respect to all patients to whom the clinical quality measure applies, treated by the EP, eligible hospital, or CAH. We believe that the quality of care of our EP, eligible hospitals, and CAHs, as

well as the ability to demonstrate the meaningful use of certified EHR technology, is best reflected by the care rendered to all patients, not just Medicare or Medicaid beneficiaries.

Final Rule at 461-63:

5. Preclusion of Administrative and Judicial Review

We did not discuss preclusion of administrative and judicial review in our proposed rule. We are now including a discussion, in order to make the public aware of the preclusion. Also, the sections of this final rule discussing payments to Medicare Advantage (MA) organizations and CAHs both include a description of the preclusion, as well as accompanying regulation text. Therefore, while we believe statutory provisions on preclusion of review are self-implementing, below, we include a discussion of the preclusion of review that applies to EPs and eligible hospitals. We have also added regulation text to maintain consistency with the CAH and MA organization provisions. For EPs, section 1848(o)(3)(C) of the Act prohibits administrative or judicial review under section 1869, section 1878, or otherwise, of all of the following:

• The methodology and standards for determining EP incentive payment amounts.
• The methodology and standards for determining the payment adjustments that apply to EPs beginning with 2015.
• The methodology and standards for determining whether an EP is a meaningful EHR user, including: (1) the selection of clinical quality measures; and (2) the means of demonstrating meaningful EHR use.
• The methodology and standards for determining the hardship exception to the payment adjustments.
• The methodology and standards for determining whether an EP is hospital-based.
• The specification of the EHR reporting period, as well as whether payment will be made only once, in a single consolidated payment, or in periodic installments.

For eligible hospitals, section 1886(n)(4)(A) of the Act similarly prohibits administrative or judicial review under section 1869, section 1878, or otherwise, of the following:

• The methodology and standards for determining the incentive payment amounts made to eligible hospitals, including: (1) the estimates or proxies for determining discharges, inpatient bed-days, hospital charges, charity charges, and Medicare share; and (2) the period used to determine such estimate or proxy.
• The methodology and standards for determining the payment adjustments that apply to CMS-0033-F 463 eligible hospitals beginning with FY 2015.
• The methodology and standards for determining whether an eligible hospital is a meaningful EHR user, including: (1) the selection of clinical quality measures; and (2) the means of demonstrating meaningful EHR use.
• The methodology and standards for determining the hardship exception to the payment adjustments.
• The specification of the EHR reporting period, as well as whether payment will be made only once, in a single consolidated payment, or in periodic installments.

We note that the above listing may summarize or abbreviate portions of the statute. For precise language on the preclusion of judicial review, readers should always refer to the statute.

A

Briefing Paper for Meeting
of the
Senate Committee on Health, Education, Labor and Pensions

May 21, 2009

A New Vision for American Health Care:
Strengthening What Works and Fixing What Doesn't

Overview and Background

For the greater part of the last 100 years, Americans have sought ways to provide affordable and quality health insurance coverage to all our citizens. In this journey, we have achieved notable successes, including the creation of Medicare and Medicaid in 1965, the inception of the Children's Health Insurance Program in 1997, the expansion of prescription drug coverage for seniors in 2003, and more. We have also witnessed setbacks and defeats, including the failure of reform efforts during the Administrations of Presidents Harry Truman, Jimmy Carter and Bill Clinton.

In recent years, the drive to cover all Americans has been joined with the imperative to reform a health care system which consumes far more of our nation's resources than merited by the results produced. While the men and women who work in U.S. medicine perform miracles and wonders every day, our health care system wastes precious dollars to produce uneven results.

For the past year, Democratic Members and staff of the Senate Committee on Health, Education, Labor and Pensions – along with our colleagues at the Senate Finance Committee, the House of Representatives and the Administration – have been laying groundwork and preparing legislation to reform the U. S. health care system. As we near the point of introducing legislation to achieve our vision, we issue this policy overview to lay out our priorities for the legislation.

We begin with our goals for the improvement of American health care:

- Assuring reliable, high quality and affordable health insurance for all Americans
- Improving value by creating a higher quality, more efficient delivery system
- Building a new framework to enhance prevention and wellness
- Creating a durable structure of long term supports and services for seriously disabled Americans
- Rooting out fraud and abuse in the public and private health systems
- Establishing shared responsibility and paying appropriately and fairly for reform

B-1

CALL TO ACTION
HEALTH REFORM 2009
SENATE FINANCE COMMITTEE CHAIRMAN MAX BAUCUS (D-MONT.)

HEALTH REFORM 2009

November 12, 2008

U.S. Senator Max Baucus (D-Mont.)
Chairman, Senate Finance Committee

www.finance.senate.gov • Tel: 202-224-4515

B-2

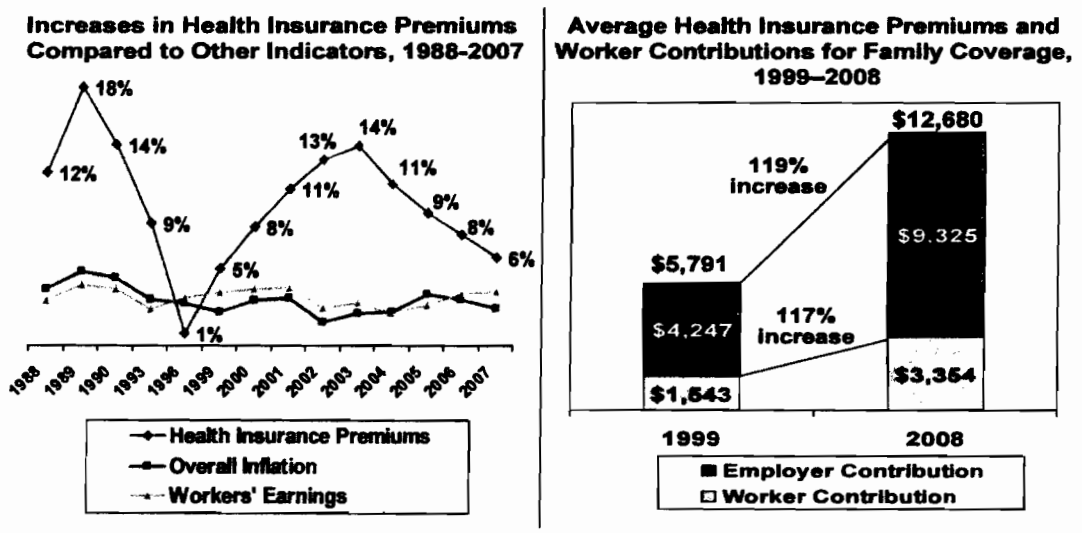
Cost— Growth in Health Care Spending is Unsustainable for Families, Businesses, and the Federal Government

American families are struggling to keep up with out-of-pocket costs for health care. American businesses are straining to absorb rising health care costs while staying competitive at home and around the world. Federal and state budgets — as well as taxpayers — are bearing an ever-increasing burden as entitlement programs such as Medicare and Medicaid consume a larger share of public expenditures.

Failure to address problems in the health care system could undermine current efforts to restore the economy. Ultimately, Congress cannot help American families' finances or address America's economic woes in a lasting, meaningful way without health care reform.

Even before the current economic crisis, working families and individuals found their health care in jeopardy as the cost of employer-sponsored coverage rose beyond the means of businesses — particularly small businesses — and workers alike. As Figure 1.2 shows, health insurance premiums have increased faster than wages and inflation for most years between 1988 and 2007. Premiums have increased 117 percent for families and individuals and 119 percent for employers between 1999 and 2008.

Figure 1.2. Illustrations of Health Insurance Premium Increases



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1988-2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2007.

Why are premiums rising so fast? A recent synthesis of studies found that greater use of medical technology is a driving force — contributing between 38 and 65 percent to health care cost increases.[17] Other factors, including obesity, demographics, and productivity, also contribute to growth in the cost of health care.

Additionally, hospitals and clinics provide an estimated $56 billion in uncompensated care every year to people without health insurance,[18] and those who have health coverage pay the bill through higher health care costs and increased premiums. A study of this "hidden tax" estimated that ten percent of California health care premiums are attributable to cost shifting due to the uninsured.[19]

Even if workers can afford their portion of a premium, employers may not be able to afford the rest. Because employers are the principal source of health insurance in the U.S., providing health benefits for more than 158 million people,[20] erosion in employer-sponsored coverage is a serious problem.

REAL PEOPLE, REAL REASONS FOR REFORM:
Phoenix Products, Inc., an Ohio firm, has operated for 31 years, growing from a youthful start-up company into an established business with 47 employees. As recently as 2003, Phoenix Products could afford to provide a comprehensive health plan at a reasonable cost. But as its employees grew older and health costs increased, the company had to dramatically alter the health plan benefit structure to keep providing any coverage at all. The company moved away from comprehensive benefits to a limited catastrophic coverage plan. Even then, premiums increased ten percent each year from 2003 to 2007.

Renewing coverage in 2008 cost the company 35 percent more than in 2007; the maximum increase allowed under Ohio law. Quotes from other plans were 2½ times higher than the current rate. The company is on the verge of losing its ability to offer insurance.

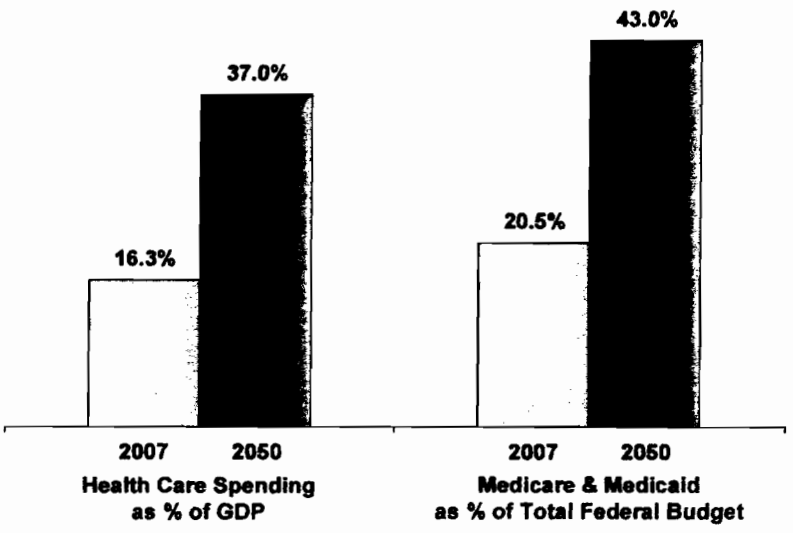
Small business owners have increasingly been forced to decide among several painful options to offset increasing health care costs — raising health insurance premiums, limiting raises or reducing bonus pay, eliminating family health benefits, or providing less-than-comprehensive health coverage.

The story of Phoenix Products (left), relayed to the Senate Finance Committee at a June 2008 hearing,[21] is far too common in the U.S. In 2000, 68 percent of small to mid-size businesses (3-199 workers) offered health benefits, but today that figure is 62 percent.[22]

As rising health care costs threaten the stability and competitiveness of American businesses, they threaten to destabilize the fiscal health of the country itself. Peter Orszag, Director of the Congressional Budget Office, has appropriately noted that rising health care costs represent the "single most important factor influencing the Federal Government's long-term fiscal balance."[23] The U.S. spends more than 16 percent of our gross domestic product (GDP) on health care — a much greater share than other industrialized nations with high-quality systems and coverage for everyone. By 2017, health care expenditures are expected to consume nearly 20 percent of the GDP (see Figure 1.3), or $4.3 trillion annually.[24] Spending for Medicare and Medicaid, due to many of the same factors found in the private sector, is projected to increase by 114 percent in ten years.[25] Over the same period, the GDP will grow by just 64 percent.

B-4

Figure 1.3. Health Care Spending Poses Long Term Challenges for U.S. Economy and Federal Budget



Sources: Keehan, "Health Spending Projections Through 2017"; CBO, The Long Term Budget Outlook (Dec. 2007)

States face fiscal challenges ALSO. On average, states already spend 22 percent of their budgets on Medicaid.[26] One effect of rising unemployment rates will be increased eligibility for and enrollment in Medicaid. Many state governments are struggling to meet balanced budget requirements.[27] In response, at least 29 states have already taken action to reduce their budget deficits for fiscal year 2009.[28] States face limited choices in trying to meet budget shortfalls; they can raise taxes or cut spending on Medicaid and other vital services.

Finally, in the 21st century, when the economies of the world are ever more interconnected, the strength of our health care system is increasingly important. Our international competitiveness depends on the health of our workforce. Although polls show that many Americans believe the U.S. health care system is better than other industrialized nations,[29] the numbers do not demonstrate this to be true.

As mentioned, the U.S. spends a greater percent of GDP and almost twice as much per person on health care compared to other major industrialized countries (see Figure 1.4).[30]

In a study of global health care systems, journalist and author T.R. Reid found startling cost differences with the U.S. In Japan's largely private system, the cost for magnetic resonance imaging (MRI) is less than $100, compared to $1,200 in the U.S. In Switzerland, home to profitable insurance companies and influential pharmaceutical companies, administrative costs represent 5.5 percent of total costs, compared to about 22 percent for coverage purchased in the private insurance market in the U.S.[31] While there must be a uniquely American answer to the question of containing health care costs, other countries demonstrate the possibility of success.

C-1

Press Room: Press Releases

July 30, 2009

SENATOR ROCKEFELLER OPED - THINK BIG ABOUT MEDICARE FIX- IN TODAY'S POLITICO

CHAIRMAN OF SENATE FINANCE COMMITTEE ON HEALTH CARE HIGHLIGHTS IMPORTANCE OF MEDPAC PROPOSAL ON 44TH ANNIVERSARY OF MEDICARE AND MEDICAID

Think Big About Medicare Fix

The current health reform debate in Congress is one of the most important of our lifetime. Powerful economic forces are at last aligned with the desperate needs of the American people. We have an opportunity to provide health care to millions of the uninsured and to strengthen essential employer-sponsored coverage. And we are driven to stabilize our health care system by reining in runaway costs — so that high-quality coverage is not only affordable for every American but also sustainable for the nation.

Cost containment has taken center stage in this debate, and with good reason. The American people are tired of spending more and more of our limited resources on health care and getting inconsistent and unreliable results. In order for reform to make a lasting difference in people's lives, it must not only expand coverage but also reduce costs — both out-of-pocket costs for American families and system-wide costs for American taxpayers.

Tinkering at the edges will not get us there. When it comes to moving our health system forward and creating stability for the future, we need to think big. And let's face it: The 800-pound gorilla is Medicare.

Forty-four years ago Thursday, President Lyndon B. Johnson transformed our health care system when he signed the Medicare and Medicaid programs into law. With Medicare, he promised the American people that every citizen would be protected "against the ravages of illness in his old age" — a pledge that growing old would no longer carry the threat of falling by the wayside.

In its first two years, Medicare signed up 20 million Americans. Today, it is part of our national DNA — a core promise from one generation to the next. More than 44 million Americans — 370,000 in my state of West Virginia — count on Medicare today for quality, affordable care.

But Medicare is growing at an alarming rate — and future increases will outpace workers' earnings and the overall economy. The trust fund that supports hospital, home health, skilled nursing and hospice care is projected to be insolvent in less than 10 years — by 2017.

This is not just a problem; it is a crisis and one we cannot afford to turn away from. What's more, because Medicare is such a powerful force, it drives prices and policies across the health care marketplace. So if left unaddressed, the current trajectory of rising Medicare costs will not only jeopardize the well-being of seniors and people with disabilities, it will send our entire health care system — and our national economy — into a downward spiral.

Yet the force and power of Medicare can also be harnessed in the other direction. If we successfully stem the tide of rising costs, with the same bold vision that led to Medicare's creation four decades ago, we can strengthen the program and lend stability to the entire system.

How do we do it? Not, in my view, by charging seniors more for less and not by arbitrarily picking winners and losers among health care providers.

When Medicare was first created, sole responsibility for determining payment rates was vested in Congress, based on the notion that Congress was best positioned to protect patients and ensure quality. But as Medicare coverage and provider reimbursement policies have become increasingly complex, and as the ranks of industry lobbyists have grown, Congress has been overwhelmed by the details, and the voices of seniors and individuals with disabilities have gotten lost in the noise.

Today, Congress too often overlooks or ignores clear evidence from health care experts about care and cost. Instead, we inconsistently and inefficiently enact a select few policies that may benefit a particular need or interest but have no rational relationship to preserving Medicare's future.

And many more expert policy recommendations are never even seriously considered. For example, we have seen clear data showing gross government overpayments to programs like Medicare Advantage. Yet time and again, proposals to fix these problems have been stopped by an insurance industry that profits from delay.

I believe we need to fundamentally change course and finally put expert evidence and advice at the forefront of health care decision making. We need to take the bold but relatively simple step of elevating the already

C-2

well-respected Medicare Payment Advisory Commission, created by Congress years ago to provide unbiased recommendations on care and payment.

I have brought legislation to the table in the Senate — the MedPAC Reform Act — that would modify MedPAC to make it an independent, transparent, executive branch agency with the basic authority to act on its own expert recommendations, after a full public vetting. I also have worked with the president and his advisers on a similar entity he has proposed, called the Independent Medicare Advisory Council, with the power to provide recommendations to the president.

Under my proposal, Congress would continue to provide strict oversight of the Medicare program — nothing short of a constitutional amendment could eliminate its power to do so. However, Congress and the special interests would no longer be an obstacle to much-needed reforms in Medicare.

Some opponents continue politicking Medicare to death, preferring the devil they know to the devil they don't. I urge them to think beyond their fear and to trust that — with a strong directive, independence from the special interests and clear oversight — an empowered, independent MedPAC is the answer to the future of Medicare.

To ignore Medicare's unsustainable future would be to leave a devastatingly weak link in our nation's health care infrastructure, and, frankly, that is not an option. Any reform that fails to address Medicare's solvency would be incomplete. Medicare's role in the health insurance marketplace is just too big. And the security it provides for our most vulnerable citizens is just too important.

Sen. John Rockefeller is chairman of the Senate Finance Subcommittee on Health Care.

http://www.politico.com/news/stories/0709/25580_Page2.html#ixzz0MkJE851T

###

Senator Jay Rockefeller | 531 Hart Senate Office Building | Washington, DC 20510 | 202-224-6472
E-mail Senator Rockefeller | Click here for more contact information.

D-1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of the Actuary

DATE: April 22, 2010

FROM: Richard S. Foster
Chief Actuary

SUBJECT: Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the Patient Protection and Affordable Care Act. We offer this analysis in the hope that it will be of interest and value to policy makers and administrators as they implement and monitor these far-reaching national health care reforms. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through fiscal year 2019 of selected provisions of the "Patient Protection and Affordable Care Act" (P.L. 111-148) as enacted on March 23, 2010 and amended by the "Health Care and Education Reconciliation Act of 2010" (P.L. 111-152) as enacted on March 30, 2010. For convenience, the health reform legislation, including amendments, will be referred to in this memorandum as the Patient Protection and Affordable Care Act, or PPACA.

Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Except where noted, we have not estimated the impact of the various tax and fee provisions or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our national health reform estimates will be available in a forthcoming memorandum by the OACT Health Reform Modeling Team.

Summary

The table shown on page 2 presents financial impacts of the selected PPACA provisions on the Federal Budget in fiscal years 2010-2019. We have grouped the provisions of the legislation into six major categories:

(i) Coverage provisions, which include the mandated coverage for health insurance, a substantial expansion of Medicaid eligibility, and the additional funding for the Children's Health Insurance Program (CHIP);

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;

(iv) Provisions aimed in part at changing the trend in health spending growth;

average premium level of about $240 per month would be required to adequately fund CLASS program costs for this level of enrollment, adverse selection, and premium inadequacy for students and low-income participants. (Except for those paying the $5 premium, individuals enrolling in a given year will pay a constant premium amount throughout their participation, unless trust fund deficits necessitate a premium increase. Premiums will vary by age at enrollment and by year of enrollment.)

In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases. This effect has been termed the "classic assessment spiral" or "insurance death spiral." The problem of adverse selection is intensified by requiring participants to subsidize the $5 premiums for students and low-income enrollees. Although Title VIII includes modest work requirements in lieu of underwriting and specifies that the program is to be "actuarially sound" and based on "an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period," there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.[13]

Immediate Insurance Reforms

A number of provisions in the PPACA have an immediate effect on insurance coverage. Most of these provisions, however, do not have a direct impact on Federal expenditures. (A discussion of their impact on national health expenditures is included in the following section of this memorandum.) Section 1101 of the PPACA authorizes the expenditure of up to $5 billion in support of a temporary national insurance pool for high-risk individuals without other health insurance. Section 1102 requires the Secretary of HHS to establish a Federal reinsurance program in 2010-2013 for early retirees and their families in employer-sponsored health plans. Participation by employers is optional, and the law authorizes up to $5 billion in Federal financing for the reinsurance costs. No other financing is provided, and reinsurance claims would be paid only as long as the authorized amount lasts. We estimate that the full amount of the authorizations for sections 1101 and 1102 would be expended during the first 1 to 3 calendar years of operation.

National Health Expenditure Impacts

The estimated effects of the PPACA on overall national health expenditures (NHE) are shown in table 5. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by $311 billion, or 0.9 percent, over the updated baseline projection that was released on June 29, 2009.[14] Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent

[13] An analysis of the potential adverse selection problems for the CLASS program was performed by a nonpartisan, joint workgroup of the American Academy of Actuaries and the Society of Actuaries. Their report was issued on July 22, 2009 and is available at http://www.actuary.org/pdf/health/class_july09.pdf .

[14] R. Foster and S. Heffler, "Updated and Extended National Health Expenditure Projections, 2010-2019." Memorandum dated June 29, 2009. Available online at http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/NHE_Extended_Projections.pdf.

in 2019, as the effects of the Medicare market basket reductions compound and as the excise tax on high-cost employer health plans becomes effective. The NHE share of GDP is projected to be 21.0 percent in 2019, compared to 20.8 percent under prior law.

The increase in total NHE is estimated to occur primarily as a net result of the substantial expansions in coverage under the PPACA, together with the expenditure reductions for Medicare. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, as noted above, an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the PPACA would increase NHE in 2019 by about 3.4 percent.

The PPACA will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates and the impacts of the Independent Payment Advisory Board can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues under the provision to permanently reduce annual provider payment updates by economy-wide productivity gains). Medicaid outlays for health care would increase under some provisions and decrease under others; excluding the coverage expansion, the overall higher level of such costs would lower total U.S. health expenditures in 2019 by about 0.1 percent.

The immediate insurance reforms in Title I will affect national health expenditures as well, although by relatively small amounts. We estimate that the creation of a national high-risk insurance pool will result in roughly 375,000 people gaining coverage in 2010, increasing national health spending by $4 billion. By 2011 and 2012 the initial $5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program; we anticipate that such increases would limit further participation. An estimated 2.7 million retirees and dependents would be affected by the Federal reinsurance program for early retirees with employer-sponsored insurance. Although the reinsurance program would increase Federal costs by the allotted $5 billion, we estimate that the impact on total national health expenditures would be negligible.

Beginning in 2010, qualified child dependents below age 26 who are uninsured will be allowed to enroll under dependent coverage. An estimated 485,000 dependent children will gain insurance coverage through their parents' private group health plans, increasing national health spending by $0.9 billion. These impacts are expected to persist through 2013. Additionally, because this provision would not expire when the Medicaid expansion, individual mandate, and Exchanges start in 2014, we anticipate that these individuals would continue to remain covered as dependents even though they may be newly eligible for other coverage. Finally, we did not estimate NHE coverage or cost impacts for the other immediate reform provisions, such as prohibiting limitations on pre-existing conditions or elimination of lifetime aggregate benefit

limits. We believe that each of these provisions would have only a relatively minor upward impact on national health spending.

Section 9001 of the PPACA places an excise tax on employer-sponsored health insurance coverage with a benefit value above specified levels (generally $10,200 for individuals and $27,500 for families in 2018, adjusted in 2019 by growth in the CPI plus 1 percentage point and by growth in the CPI thereafter).[15] The tax is 40 percent of the excess benefit value above these thresholds. We estimate that, in aggregate, affected employers will reduce their benefit packages in such a way as to eliminate about three-quarters of the excess benefit value. The resulting higher cost-sharing requirements for employees would have an initial impact on the overall level of health expenditures, reducing total NHE by an estimated 0.1 percent in 2019. Moreover, because health care costs will generally increase faster than the CPI, we anticipate additional, incremental benefit coverage reductions in future years to prevent an increase in the share of employer coverage subject to the excise tax. These further adjustments would contribute to a small reduction in the growth in total health care costs (but an increase in out-of-pocket costs) for affected employees in 2019 and later.[16] As mentioned earlier, the proportion of workers experiencing reductions in their employer-sponsored health coverage as a result of the excise tax is estimated to increase rapidly after 2019.

The health reform legislation, as enacted, imposes collective annual fees on manufacturers and importers of brand-name prescription drugs and on health insurance plans. In addition, the PPACA establishes an excise tax on non-personal-use retail sales by manufacturers and importers of medical devices. For manufacturers and importers of brand-name prescription drugs, the fee is $2.5 billion in 2011, increasing to a maximum of $4.1 billion by 2018, and then is set at $2.8 billion per year in 2019 and beyond.[17] For insurers, the annual fee is set at $8.0 billion starting in 2014 and rises to $14.3 billion by 2018; thereafter, the fee increases by the rate of premium growth. In each case, the total annual fee amount would be assessed on the specified industry as a whole; the share of the fee payable by any given firm in that industry would be determined based on sales (for manufacturers and importers of drugs) and on net premiums (in the case of insurers), with some limited exemptions. The excise tax on medical device sales is effective in 2011 and is set at 2.3 percent of first sales in each year. We anticipate that these fees and the excise tax would generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums, with an associated increase in overall national health expenditures ranging from $2.1 billion in 2011 to $18.2 billion in 2018 and $17.8 billion in 2019.

Although, compared to prior law, the *level* of total national health expenditures is estimated to be higher through 2019 under the PPACA, two particular provisions of the legislation would help reduce NHE *growth rates* after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans (with benefit thresholds indexed by the CPI plus 1 percent for 2019 and by the CPI thereafter) would exert a further decrease in NHE

[15] Higher thresholds apply in the case of qualified retirees and individuals in high-risk occupations. Additionally, a higher threshold applies for employers with above-average proportions of older and/or female workers.

[16] We have not included the excise taxes under this provision in the estimated financial effects of the PPACA shown in this memorandum. Similarly, the indirect impacts on Federal income taxes and social insurance payroll taxes are not shown.

[17] These fees are allocated to the Part B account of the Medicare Supplementary Medical Insurance trust fund.

growth rates of an estimated 0.05 percent in 2019 and slightly more than that for some years after. Although these growth rate differentials are not large, over time they would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As discussed previously, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

Underlying the overall moderate effects of the PPACA on NHE will be various changes by payer. Based on the net impact of (i) the substantial coverage expansions, (ii) the significant cost-sharing subsidies for low-to-middle-income persons, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, and (iv) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage, we estimate that overall out-of-pocket spending would be reduced significantly by the PPACA (a net total decline of $237 billion in calendar years 2010-2019).

Public spending would increase under the PPACA as a result of the expansion of the Medicaid program and additional CHIP funding but would be reduced by the net Medicare savings from the legislation. Private expenditures would decrease somewhat because of the net reduction in the number of persons with employer-sponsored health insurance and the reduced benefits for plans affected by the excise tax on high-cost employer coverage. The sizable growth in health insurance coverage through Exchange plans would also affect NHE amounts by payer. Prior to the PPACA, public expenditures (principally Medicare and Medicaid) were estimated to represent 52 percent of total NHE in 2019. Under the PPACA, the public share would be roughly 51 percent if health expenditures by Exchange plans are classified as private spending.[18]

Caveats and Limitations of Estimates

The Federal costs and savings, changes in health insurance coverage, and effects on total national health expenditures presented in this memorandum represent the Office of the Actuary's best estimates for the PPACA. Although we believe that these estimates are reasonable and fairly portray the likely future effects of this comprehensive package of health care reforms, they are

[18] The allocation of NHE *by payer* is based on the entity that is responsible for establishing the coverage and benefit provisions and that has the primary responsibility to ensure that payment is made for health care services. (Auxiliary analyses of NHE *by sponsor* are also prepared, based on the financing of health expenditures in the U.S.) Because all Exchange plans will be private plans, under the traditional NHE classification approach these expenditures would be considered private health insurance spending. However, the classification of health expenditures made by Exchange plans is complicated by three factors:

(i) The Exchanges will be government entities, with a role in setting minimum benefit standards, but they will not directly provide health insurance coverage. The same situation applies to the multi-State Exchange plans arranged by the Office of Personnel Management.

(ii) The Federal government, through the refundable tax credits and cost-sharing reductions, will subsidize a significant portion of Exchange plan premiums and cost-sharing liabilities.

(iii) The premium subsidies will vary between zero and 100 percent from one person to another, and the cost-sharing subsidies from zero to 80 percent on an insurance-value basis.

A more precise determination of the appropriate classification of the Exchange plan expenditures based on national health expenditure accounting principles will be conducted in the future.

POLITICO

E-1

Firms mulled dropping insurance plan

By: Jennifer Haberkorn
May 7, 2010 09:12 AM EST

Four large companies have weighed dumping their employees' insurance plans and paying a penalty to the federal government under the new health care law, a move that would be a substantial blow to the Democrats' health care overhaul.

AT&T, Verizon, Caterpillar and John Deere all prepared internal documents as the legislation was being considered that compared the costs of keeping coverage or paying the penalty, according to Fortune magazine.

Verizon told the magazine that it is not considering canceling plans. Other companies declined to comment.

It's unclear from the Fortune article whether the firms were serious about dropping the plans or whether they were just calculating the relative costs of doing so.

Critics of the health care plan had warned of the scenario, which would dismantle the employer-based health system that has dominated in the country for half a century and violate President Obama's pledge that people who like their current coverage could keep it.

"Even though the proposed assessments [on companies that do not provide health care] are material, they are modest when compared to the average cost of health care," according to a document prepared for Verizon, the magazine reported.

If many employers drop coverage, it would dramatically increase the cost of the overhaul plan.

If large employers do not provide coverage and at least one of their employees qualifies for a tax subsidy, the employer would have to pay a $2,000 penalty for every employee — not just those who get

E-2

POLITICO

subsidies.

The documents were pulled together last month for Democrats on the Energy and Commerce Committee, which prepared a hearing to examine the companies' public reports citing large write-downs because of tax breaks eliminated by the law.

The requesters, led by chairman Henry A. Waxman (D-Calif.), wanted all of the companies' internal documents related to health care costs. But the hearing was cancelled shortly after staff read the documents, according to Fortune.

Critics had warned that the health plan's requirements for most large employers — provide coverage or pay a penalty if employees end up with federal tax credits — would merely force employers to choose the cheaper option of paying the penalty.

AT&T, for instance, calculated that it spends $2.4 billion a year providing health insurance, but would only spend $600 million if it chose to pay the penalty.

Employers also are worried about being hit with the so-called "Cadillac" tax on insurance plans valued at more than $8,500 for an individual or $23,000 for a family. Verizon[1] expects the tax will cost $255 million a year.

Shortcuts To Links In Article

1. http://ezurl.co/7bf891

 F-1

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

HORNBECK OFFSHORE SERVICES, LLC, ET AL	CIVIL ACTION
VERSUS	NO. 10-1663
KENNETH LEE "KEN" SALAZAR, ET AL	SECTION "F"

ORDER & REASONS

Before the Court is the plaintiffs' motion for recovery of attorney's fees. For the following reasons, the motion is GRANTED.

Background

The facts of this case are well-known. As Deepwater Horizon's April 20, 2010 explosion gave way to a massive oil spill, the President of the United States formed a bipartisan commission—the National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling—and tasked it with investigating the facts and circumstances concerning the cause of the blowout. The President also ordered the Secretary of the Interior to conduct a thorough review of the Deepwater Horizon blowout and to report, within thirty days, "what, if any, additional precautions and technologies should be required to improve the safety of oil and gas exploration and production operations on the outer continental shelf." The results of this review were published on May 28, 2010 in an Executive Summary and Safety Report, and offered the appearance that it had been peer reviewed by a panel of scientists—a claim

 F 2

which was publicly repudiated by several of them.

Invoking this study, the Secretary of the Interior ordered a moratorium on all drilling at depths greater than 500 feet in the Gulf of Mexico. The plaintiffs in this case soon challenged the lawfulness of the moratorium. On June 22, 2010, this Court granted the plaintiffs' motion for a preliminary injunction and ordered the Administration not to enforce the moratorium:

> [Defendants] are hereby immediately prohibited from enforcing the Moratorium, entitled 'Suspension of Outer Continental Shelf (OCS) Drilling of New Deepwater Wells,' dated May 28, 2010, and NTL No. 2010-N04 seeking implementation of the Moratorium, as applied to all drilling on the OCS in water at depths greater than 500 feet.

In that Order, this Court found that the plaintiffs had established a likelihood of successfully showing that the Secretary's decision to issue a six-month blanket moratorium against all companies involved in deepwater drilling in the Gulf of Mexico was arbitrary and capricious and, therefore, unlawful. The government apparently notified operators that suspension notices issued under the first moratorium no longer had legal effect and ordered BOEMRE[1] personnel not to take action to enforce the moratorium. It is undisputed, however, that deepwater drilling activities did not commence after this Court's Order. Instead, over the next two weeks, the Secretary of Interior repeatedly affirmed his intention and resolve

---

[1] Bureau of Ocean Energy Management, Regulation and Enforcement.

 F-3

to impose a moratorium on deepwater drilling in the Gulf of Mexico.

The government appealed the Court's injunction Order, and sought a stay of the preliminary injunction pending appeal. On July 8, 2010, the U.S. Court of Appeals for the Fifth Circuit rejected a stay, over one dissent. Four days later, on July 12, 2010, the Interior Secretary issued a twenty-two page decision memorandum rescinding the first blanket moratorium and directing BOEMRE to withdraw the suspension letters issued under it; but the Secretary also ordered the agency to issue new blanket suspensions based on a second moratorium. The second moratorium disabled precisely the same rigs and deepwater drilling rigs and activities in the Gulf of Mexico as did the first one (although it superficially, rather than continue the 500-foot depth standard, purported to restrain all rigs that use subsea blowout preventers or surface blowout preventers on a floating facility); the second moratorium was to apply also through November 30, 2010, the same expiration date that the first moratorium anticipated. The government defended the new moratorium's justness, explaining that though similar (identical) in effect to the first, it addressed the technical concerns highlighted in the Court's first Order.

The second moratorium was then lifted on October 12, 2010, the same day the parties were to submit some additional briefing. Still, however, no drilling permits have been issued for activities barred by it as of this date. That was October. In November 2010,

 F-4

it also was exposed that an important White House official had changed the Safety Report before its public release, which created the misleading appearance of scientific peer review.[2]

The plaintiffs now move for reimbursement of their significant attorney's fees on two theories: first, under a civil contempt theory, and second under a common law claim of bad faith.

Law & Analysis

I.

Article III courts have inherent authority in cases of civil contempt to enforce their judicial orders through an assessment of attorney's fees. Cook v. Ochsner Found. Hosp., 559 F.2d 270, 272 (5th Cir. 1977); see In re Bradley, 588 F.3d 254, 263 (2009) ("If the purpose of the sanction is to coerce the contemnor into compliance with a court order, or to compensate another party for the contemnor's violation, the order is considered purely civil."). "Civil contempt can serve two purposes, either coercing compliance with an order or compensating a party who has suffered unnecessary injuries or costs because of contemptuous conduct." 588 F.3d at 263 (internal quotations and modifications omitted). The present motion centers on entitlement to compensation for the cost of the

---

[2] Even though the Office of the Inspector General found no conclusive evidence of wrongdoing on the part of the Department of Interior or its employees, at the hearing on the first moratorium, in response to a question by the Court, the government's answer then was wholly at odds with the story of the misleading text change by a White House official, a story the government does not now dispute.

government's conduct.

To establish civil contempt in this setting, the plaintiffs must show "by clear and convincing evidence: 1) that a court order was in effect, 2) that the order required certain conduct by the [government], and 3) that the [government] failed to comply with the court's order." Am. Airlines, Inc. v. Allied Pilots Ass'n, 228 F.3d 574, 581 (5th Cir. 2000). The evidence required to establish all three factors must be "so clear, direct and weighty and convincing as to enable the fact finder to come to a clear conviction, without hesitancy, of the truth of the precise facts of the case." Test Masters Educ. Servs., Inc. v. Singh, 428 F.3d 559, 582 (5th Cir. 2005) (internal quotations omitted); see Armstrong v. Exec. Office of the President, 1 F.3d 1274, 1289 (D.C. Cir. 1993) (finding contempt may lie only for the violation of the clear terms of a court's order).

The government does not credibly dispute, and the Court holds, that the formula's first two prongs are satisfied by clear and convincing evidence: the Court ordered a preliminary injunction, which required the government not to enforce the first moratorium and its associated suspensions. What remains to be resolved by this Court is whether the plaintiffs have established that the "the [government] failed to comply with the court's order," Am. Airlines, 228 F.3d at 581, by evidence "so clear, direct and weighty and convincing as to enable the fact finder to come to a

clear conviction, without hesitancy, of the truth of the precise facts of the case." Singh, 428 F.3d at 582.

II.

The plaintiffs' civil contempt claim focuses on the government's imposition of a second blanket moratorium hurriedly on the heels of the first; plaintiffs argue that moratorium amounts to a flagrant and continuous disregard of the Court's Order. But a finding of contempt of the preliminary injunction Order for that reason alone falls short. The plaintiffs read this Court's preliminary injunction Order too broadly; that Order emerged from the Court's finding that the plaintiffs were substantially likely to prove that the process leading to the first moratorium was arbitrary and capricious as a matter of law. As an answer to the plaintiffs' quarrel with the second moratorium, the government maintains that it merely met the Court's concerns and resolved each of the procedural deficiencies the Court found in the first.[3] Perhaps. Under these facts alone, then, the Court could not, at least not clearly and convincingly, find the government in contempt of the preliminary injunction Order. See Singh, 428 F.3d at 582 (finding standard not satisfied when district court simply expressed doubts about the sincerity of a party's compliance with

[3] The government's answer, however, is diminished by the Secretary's undisputed public statements of determination to ban deepwater drilling out of his concern for systemic dangers. These public statements were silent about addressing the Court's Order.

an injunction order).

There is, however, more to the story. The plaintiffs also stress that the government did not simply reimpose a blanket moratorium; rather, each step the government took following the Court's imposition of a preliminary injunction showcases its defiance: the government failed to seek a remand; it continually reaffirmed its intention and resolve to restore the moratorium; it even notified operators that though a preliminary injunction had issued, they could quickly expect a new moratorium. Such dismissive conduct, viewed in tandem with the reimposition of a second blanket and substantively identical moratorium and in light of the national importance of this case, provide this Court with clear and convincing evidence of the government's contempt of this Court's preliminary injunction Order. To the extent the plaintiffs' motion asserts civil contempt based on the government's determined disregard of this Court's Order of preliminary injunction, it is GRANTED.

III.

The Court concludes that the plaintiffs have established the government's civil contempt of its preliminary injunction Order by evidence "so clear, direct and weighty and convincing as to enable the fact finder to come to a clear conviction, without hesitancy, of the truth of the precise facts of the case." Singh, 428 F.3d at 582. Thus, the Court need not reach the plaintiffs' secondary bad

F-8

faith challenge.

The issue of quantum shall be referred to Magistrate Judge Wilkinson.

New Orleans, February 2, 2011

MARTIN L. C. FELDMAN
UNITED STATES DISTRICT JUDGE

G-1

POLITICO

Why we fight health reform rollback

By: Sens. Ben Cardin, Chuck Schumer, Sherrod Brown and Debbie Stabenow
February 3, 2011 04:41 AM EST

Americans have urged Congress to focus on job creation and boosting our economy. Unfortunately, the new House leadership — and now the Republicans in the Senate — started the year with a vote to roll back the health care law that has benefited millions of Americans.

Along with our Democratic colleagues in the Senate, we plan to review individual provisions in the law that may not work as intended. But we are not willing to allow a wholesale rollback of health care reform that could take away popular benefits from American families, jeopardize the health and well-being of millions and add more than a trillion dollars to the deficit.

We will not allow any such effort to pass the Senate. Nor do we believe that acts of judicial overreach — like Monday's court ruling in Florida, which deviates from other courts' judgments on the new law — will stand.

Hard-working Americans should be able to get the quality medical care they need to stay healthy, prevent illnesses and get the treatment their doctors recommend. As of Jan. 1, the Affordable Care Act makes sure that happens.

If health reform is rolled back, seniors would no longer see the price of brand-name prescription drugs cut in half when they fall into the Medicare Prescription Drug Gap or "doughnut hole." They would no longer be eligible for new Medicare improvements, like free cancer screenings and annual checkups with their doctor.

If health reform is rolled back, many people in their early 20s, now able to stay on their parents' insurance through age 26, would lose coverage.

6-2

POLITICO

If health reform is rolled back, many children with pre-existing conditions, such as children who beat leukemia, could again be barred from getting health coverage.

If health reform is rolled back, small businesses would no longer be able to pool together to get better rates on health insurance.

We are fighting for middle-class families and small businesses — not to protect the profits of big insurance companies.

We're looking out for small companies like Halliday Technologies in Plain City, Ohio, which has concerns about double-digit increases on premiums. The new law requires health insurance companies to spend at least 80 percent to 85 percent of premiums on health care and quality improvements for patients, rather than on overhead and administrative costs. As long as the law is intact, Halliday Technologies and other small businesses nationwide can be assured that the bulk of their premium dollars are going to patient care — not insurance company CEOs.

We're looking out for business owners like Mark Hodesh, who runs a small home and garden shop in Ann Arbor, Mich. The new law gave a tax cut to help them provide insurance for employees. So Hodesh was able to hire a new employee, expand his business and make 2010 his busiest year ever. If the health care law is repealed, small businesses' savings and employees could be put in jeopardy.

We're looking out for cutting-edge health care innovators, like Vaccinex in Rochester, N.Y., that are doing lifesaving research on cancer and other diseases. Under the new law, Vaccinex already has received nearly $750,000 in grants to aid its work in pioneering new approaches to multiple sclerosis and cancerous tumors.

We're looking out for the 25 million women

a-3

POLITICO

covered by Medicare nationally — 400,000 in Maryland alone — who can now receive preventive services like mammograms, pelvic exams and Pap tests with no co-payments or deductibles.

Mark Seigel, chairman of the Maryland section of the American Congress of Obstetricians and Gynecologists, says the Affordable Care Act will help women win battles against deadly cancers by making testing and early detection more available and less costly. He knows that when cancer is detected in the early stages, the patient's treatment and recovery are much shorter. If the health care law is rolled back, access to these lifesaving screenings would very likely be at risk.

While the new House leaders have made it their highest priority to roll back health reform, the four of us will fight in the Senate any effort to take away the health benefits that American families currently enjoy.

Turning back the clock on health care would give insurance companies a happy new year. But it would be disastrous for middle-class families, seniors and small businesses.

Sen. Ben Cardin (D-Md.) serves on the Senate Finance and Budget Committees. Sen. Chuck Schumer (D-N.Y.) is vice chairman of the Senate Democratic Caucus. Sen. Sherrod Brown (D-Ohio) is on the Appropriations Committee. Sen. Debbie Stabenow (D-Mich.) serves on the Budget Committee and the Health Care Subcommittee of the Finance Committee.

Shortcuts To Links In Article

H-1

YAHOO! NEWS PRINT Back to story

Too big to stop? Obama's overhaul lumbers on

AP Associated Press

By RICARDO ALONSO-ZALDIVAR, Associated Press
Wed Feb 2, 3:28 pm ET

WASHINGTON – President Barack Obama's health care law has too much momentum for one judge to stop it. Most insurers, hospital executives and state officials expect they'll keep carrying out the overhaul even after a federal judge cast its fate in doubt by declaring it unconstitutional.

[Related: Other states may follow 'Obamacare' ruling in Fla.]

"It's still the law of the land," said William Hoagland, vice president for public policy at health insurer Cigna. "We'll continue to proceed with its requirements, and (the ruling) will not slow that down. We have no other choice until this thing is resolved one way or the other." Insurers spent millions to block passage of the law.

Health care accounts for about one-sixth of the economy, and many players in the sprawling sector have a love-hate relationship with Obama's remake. There's dissatisfaction with core provisions, and a sense that parts may be unworkable. But at the same time, it's seen as a way to start addressing problems of cost and quality.

"I don't think people are going to hit the stop button," said Paul Keckley, executive director of the Deloitte Center for Health Solutions, a research arm of the consulting firm. "You probably don't make the big bets right now, but you make the incremental investments in case you have to make the big bets six or 12 or 18 months down the road. Everyone proceeds with an informed approach."

Monday's ruling by U.S. District Judge Roger Vinson in Florida had been expected to go against the Obama administration. But the scope of the decision in a lawsuit by 26 of the 50 states took some by surprise.

Vinson struck down the entire law after saying its requirement that nearly all people have health insurance was unconstitutional. A different judge who reached the same conclusion in a separate case voided the individual insurance requirement and left everything else in place.

H-2

The administration plans to appeal both rulings. Judges in two other cases have upheld the law. It's generally expected that the U.S. Supreme Court will get the last word, but that could take a year or two more.

During that time, the government will write thousands of pages of federal rules covering hospitals, doctors, states, insurers and others. Among the topics are new models for hospitals and medical practices to band together, and rules for operating state insurance markets called for in the law. It adds up to thousands of jobs and tens of millions of dollars.

Florida Republican Gov. Rick Scott said Tuesday he plans to put the brakes on the state's role in putting the law into place, but not everyone feels that states can afford to sit on the sidelines.

"The ruling does not change the urgent need for state-based reforms, nor should it derail efforts in the states targeted at fixing a broken and unsustainable system," said Alabama state Rep. Greg Wren. A Republican who says he agrees that the law is unconstitutional, Wren is nonetheless helping to lead a national task force on implementing it.

Presuming that the Supreme Court will ultimately rule against the law "is too risky a strategy," said Wren. For example, if states don't act, the federal Health and Human Services Department could step in to run the new insurance markets in their backyards.

According to preliminary figures compiled by the National Conference of State Legislatures, lawmakers have introduced more than 250 bills relating to states' role in the overhaul. About 50 propose challenges to the law or say states should refrain from carrying out particular provisions. More than 70 deal with insurance changes, and more than 40 address how to establish the state markets where people can buy coverage.

After trying to block passage of the law, insurers might have to defend the requirement that people must get coverage. Not only that, the industry wants stiffer penalties for those who don't enroll.

Starting in 2014, the law bars insurers from turning away people with medical conditions. Unless there's a way to force as many healthy people as possible into the pool, premiums could rise sharply.

Without the mandate that the judge in Florida ruled unconstitutional, "it's a house of cards," said Cigna's Hoagland.

H-3

Associated Press writer Bill Kaczor in Tallahassee, Fla., contributed to this report.

I-1

SERFF Tracking Number:	*AETN-126957602*	*State:*	*Colorado*
Filing Company:	*Aetna Life Insurance Company*	*State Tracking Number:*	*258051*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Individual*		
Project Name/Number:	*Individual Market Withdrawal/*		

Filing at a Glance

Company: Aetna Life Insurance Company
Product Name: Individual
TOI: H21 Health - Other
Sub-TOI: H21.000 Health - Other
Filing Type: Form

SERFF Tr Num: AETN-126957602
SERFF Status: Closed-Approved
Co Tr Num:

Author: Gloria Barnes
Date Submitted: 12/21/2010

State: Colorado
State Tr Num: 258051
State Status: Approved
Reviewer(s): Shirley Taylor
Disposition Date: 01/20/2011
Disposition Status: Approved
Implementation Date:

Implementation Date Requested: 02/01/2011

General Information

Project Name: Individual Market Withdrawal
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Gloria Barnes
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
Individual Market Withdrawal

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 01/20/2011
State Status Changed: 01/20/2011
Created By: Gloria Barnes
Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Gloria Barnes, PRODUCT & REGULATORY AFFAIRS CONSULTANT
980 Jolly Road
Mail Stop U13N
Blue Bell, PA 19422

BarnesG1@aetna.com

856-309-1423 [Phone]
215-775-6078 [FAX]

Filing Company Information

I - 2

Aetna Life Insurance Company
2625 Shadelands Drive
Walnut Creek, CA 94596

Aetna

Mary V. Anderson
Counsel
Law & Regulatory Affairs, F948
(925) 948-4207
Fax: (925) 948-4210

December 21, 2010

VIA FACSIMILE & SERFF
(801) 538-3829

John Postolowski
Insurance Commissioner
Division of Insurance
Colorado Department of Regulatory Agencies
1560 Broadway, Suit 850
Denver, CO 80202

Re: Aetna Life Insurance Company
Withdrawal from the Individual Market
NAIC Number: 001-60054
FEIN Number: 06-6033492

Dear Commissioner Postolowski;

Aetna Life Insurance Company ("Aetna") has determined it can no longer meet the needs of its customers while remaining competitive in the Colorado individual health insurance market. As a result, please consider this letter as formal notification that Aetna will stop offering and will withdraw its individual policies from the Colorado market effective February 1, 2011.

Subject to your Department's review and approval of our Plan of Withdrawal, Aetna will mail the 180-day discontinuance notices to individual policyholders and covered persons on or about February 1, 2011. Aetna will also provide the 180 day notice of discontinuance to the insurance commissioner in each state in which an affected individual is known to reside.

Aetna will discontinue coverage under existing individual health policies consistent with C.R.S. § 10-16-201.5(1)(d)(II) and will no longer have any individual health policies as of August 1, 2012.

Aetna is aware and understands that under Colorado law, Aetna is prohibited from re-entering the individual health market for a period of 5 years after the date of notice to the Department.

We will be in touch with your staff to finalize Aetna's Plan of Withdrawal and discuss any additional details. Should the Department have any questions regarding Aetna's withdrawal from this market, do not hesitate to call me at the number shown above.

Sincerely,

Mary V. Anderson
Counsel

Attachments

cc: Shirley Taylor
Bob Ferm

I-4

AETNA LIFE INSURANCE COMPANY
PLAN OF WITHDRAWAL FROM INDIVIDUAL MARKET IN THE STATE OF COLORADO

Summary

Aetna Life Insurance Company ("Aetna") has made the decision to discontinue selling individual health products in the State of Colorado effective February 1, 2011 as it believes that it can no longer meet the needs of its customers while remaining competitive in the market. As of December 1, 2010, Aetna provides coverage to approximately 22,400 insureds through policies issued to Colorado individuals and families.

All individual policyholders and covered persons will be provided with at least 180-days notice of the discontinuance. Aetna intends to send written notifications beginning on or about February 1, 2011. As illustrated below, Aetna will continue to renew existing individual policies through one more renewal period after the expiration of the 180-days notice period. Depending on the plan's anniversary date, a plan may or may not receive a full twelve (12) month coverage period. The following outlines the renewal and coverage period for existing individual health insurance plans:

- For plans with anniversary dates on or between February 1, 2011 and July 31, 2011, we will renew each plan for a further twelve (12) month period and coverage will cease at the end of the renewal period.
  - For example, if a plan's anniversary date is on April 1, 2011, there will be one further renewal period of twelve months and coverage will end on March 31, 2012.

- For plans with anniversary dates on or between August 1, 2011 and January 31, 2012, we will renew each plan until July 31, 2012. Effective August 1, 2012, all coverage under the plans will end.
  - For example, if a plan's anniversary date is on September 1, 2011, the plan will receive one further renewal until July 31, 2012.

Although we expect that all insureds are residents of Colorado, Aetna will also provide the 180 days discontinuance notice to the insurance commissioner in each state in which an affected individual is known to reside.

Proposed Communications Schedule

Communication to policyholders, covered persons, brokers and insurance commissioners of each state in which affected individuals are known to reside will begin on or about February 1, 2011.

I-5

AETNA LIFE INSURANCE COMPANY
PLAN OF WITHDRAWAL FROM INDIVIDUAL MARKET IN THE STATE OF COLORADO

Proposed Communications

- **Letters to Individual Policyholders and Covered Persons**
  On or about February 1, 2011, Aetna will mail notices of discontinuance to individual policyholders and covered persons at least 180 days prior to the date of discontinuance of their coverage. The proposed policyholder letter template is attached as Attachment A. Aetna will also mail follow-up letters to the policyholders as they go through the final renewal of the plans. The proposed final renewal letter template is attached as Attachment B.

- **Broker Communications**
  Aetna will notify brokers of the discontinuance of individual products. The brokers will be provided access to sample letters sent to their customers. The proposed broker communication is attached as Attachment C.

- **Communications to Aetna Account Managers**
  Aetna will provide account managers with appropriate talking points to help ensure that they have the necessary tools and understanding to address customer inquiries that may arise, and to facilitate a smooth withdrawal process.

Customer Service

Aetna's customer service representatives will be briefed and provided with talking points to address member inquiries that may arise, including how to contact CoverColorado.

J-1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BEATRICE M. HEGHMANN and ROBERT A. HEGHMANN, Plaintiffs, v. KATHLEEN SEBELIUS, Secretary, Department of Health and Human Services, NANCY-ANN DEPARLE, Director, White House Office of Health Reform, and CHARLENE FRIZZERA, Administrator, Centers For Medicare and Medicaid Services, Defendants.	09 Civ. 5880 (BSJ)

Government's Motion to Dismiss the Amended Complaint Pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6)

PREET BHARARA
United States Attorney for the
Southern District of New York
Attorney for Defendant

BENJAMIN H. TORRANCE
Assistant United States Attorney
86 Chambers Street
New York, New York 10007
Telephone: 212.637.2703
Fax: 212.637.2702
E-mail: benjamin.torrance@usdoj.gov

– Of Counsel –

J-2

Indeed, plaintiffs' complaint establishes no basis for the conclusion that they will sustain any injury at all. As detailed above, the HITECH Act does not make electronic health records mandatory for private health care providers. PHS Act § 3006 (as amended by the HITECH Act § 13101, codified at 42 U.S.C. § 300jj-16). To the contrary, even if the government were to make electronic health record technology available to the public,[5] the statute expressly says that it does not require private entities to adopt or use this EHR technology. 42 U.S.C. § 300jj-17(d). Even Medicare and Medicaid providers, while receiving incentives to adopt EHRs, are not required to do so. HITECH Act §§ 4101–4102, 4201 (amending 42 U.S.C. §§ 1395w-4, 1395w-23, 1395ww, 1396b).[6]

Plaintiffs' complaint does not allege that they use any federally provided health care, or even Medicare or Medicaid. Compl. ¶¶ 2, 4. They therefore assert no injury under the statutes they cite. And even if the statutes could be read as plaintiffs assert, they cannot meet the heightened burden of establishing causation and redressability—two of the three elements of constitutional standing—when third parties are regulated:

> When . . . a plaintiff's asserted injury arises from the government's allegedly unlawful regulation (or lack of regulation) of *someone else*, much more is

---

[5] EHR technology will be made available to the public unless the HHS Secretary determines that the needs of providers are being met through the marketplace. 42 U.S.C. § 300jj-17(a).

[6] Although plaintiffs' complaint alleges that "[e]very health care provider is being required to acquire and implement Health Information Technology designed by the Office of Health Reform and HHS," Compl. ¶ 12, that assertion (unaccompanied by any citation) directly contradicts the statutes plaintiffs complain of, and deserves no weight from this Court. *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1949–50 (2009) (court need not accept "legal conclusions" or "legal conclusion couched as factual allegation" (internal quotation marks omitted)); *Leeds v. Meltz*, 85 F.3d 51, 53 (2d Cir. 1996) ("bald assertions and conclusions of law will not suffice" to defeat a motion to dismiss); *GVA Market Neutral Master Ltd. v. Veras Capital Partners Offshore Fund, Ltd.*, 580 F. Supp. 2d 321, 326 (S.D.N.Y. 2008) ("mere 'conclusions of law or unwarranted deductions' need not be accepted" on motion to dismiss (quoting *First Nationwide Bank v. Gelt Funding Corp.*, 27 F.3d 763, 771 (2d Cir. 1994))).

K-1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

BEATRICE M. HEGHMANN and ROBERT A. HEGHMANN, Plaintiffs, v. KATHLEEN SEBELIUS, Secretary, Department of Health and Human Services, NANCY-ANN DEPARLE, Director, White House Office of Health Reform, and CHARLENE FRIZZERA, Administrator, Centers For Medicare and Medicaid Services, Defendants.	09 Civ. 5880 (BSJ)

Government's Reply Memorandum in Support of Its Motion to Dismiss the Amended Complaint Pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6)

PREET BHARARA
United States Attorney for the
Southern District of New York
Attorney for Defendant

BENJAMIN H. TORRANCE
Assistant United States Attorney
86 Chambers Street
New York, New York 10007
Telephone: 212.637.2703
Fax: 212.637.2702
E-mail: benjamin.torrance@usdoj.gov

– Of Counsel –

K-2

B. Effect of the HITECH Act

Plaintiffs contend that the government offers "misrepresentations" of the effect of the HITECH Act. Pls.' Mem. at 5–6. They claim that "every Health Care Provider in the United States [is] required to create an [electronic health record] for every person in the United States. . . . The legal obligation of every health care provider to create an EHR for everyone in the U.S. including the Plaintiffs exists today." But they cite no statutory provision or other law to support this claim, which directly contradicts the HITECH Act. As clearly stated in 42 U.S.C. § 300jj-16—entitled "*Voluntary* application and use of adopted standards and implementation specifications by private entities" (emphasis added)—

> Except as provided under section 13112 of the HITECH Act [governing health care providers contracting with the government], nothing in such Act or in the amendments made by such Act shall be construed—
>
> (1) to require a private entity to adopt or comply with a standard or implementation specification adopted under section 300jj-14 of this title [regarding adoption of electronic health record standards]; or
>
> (2) to provide a Federal agency authority, other than the authority such agency may have under other provisions of law, to require a private entity to comply with such a standard or implementation specification.

Other provisions reinforce the voluntary nature of adoption of electronic health records. 42 U.S.C. §§ 300jj-16(b), 300jj-17(d). The entire premise of plaintiffs' argument is thus contradicted by the statute itself. Similarly, plaintiffs state—again, without benefit of any citation—that Medicare-participating providers "must create an EHR for every patient even the private payer patients." Pls.' Mem. at 6. But in fact, the Act provides financial incentives for Medicare- and Medicaid-participating providers to adopt electronic health records, but does not mandate EHR adoption by such providers. HITECH Act §§ 4101–4102, 4201 (amending 42 U.S.C. §§ 1395w-4, 1395w-23, 1395ww, 1396b).