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BACKGROUNDER

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The Obamacare Challenge: The Questions Before the Supreme Court and Their Portents for Congress

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Abstract

Next week, the Supreme Court will hear challenges to Obamacare (the Patient Protection and Affordable Care Act) centered on the constitutionality of the legislation's individual mandate and Medicaid expansion. From a legal perspective, the Court's decision will serve as a significant precedent with respect to what limits, if any, still apply to congressional authority—fundamentally, whether the federal government remains one of limited powers. From a health policy perspective, for every possible outcome—including the Supreme Court either upholding or striking down the totality of the PPACA—Congress will have to take some kind of action in response. Congress's best course is to repeal the PPACA, or what remains after the Court has done its work, and then adopt real, patient-centered reforms like those put forward in The Heritage Foundation's Saving the American Dream.

This paper, in its entirety, can be found at **http://report.heritage.org/bg2669**

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The Supreme Court will soon hear three cases challenging features of the Patient Protection and Affordable Care Act (PPACA), popularly known as "Obamacare."[1] Across three days of oral argument, the Court will consider four broad legal questions:

- Whether the Anti-Injunction Act prohibits parties from challenging the minimum coverage provision, or individual mandate, at this time;
- Whether Congress exceeded its constitutional authority in enacting the minimum coverage provision—that is, whether the individual mandate is unconstitutional;
- Whether, if the mandate to purchase minimum coverage is unconstitutional, the mandate can be severed from the rest of the PPACA such that portions of the statute remain in effect; and
- Whether Congress's threat to withhold all federal funding under Medicaid, the single largest grant-in-aid program, in order to impose onerous conditions on the States that it could not impose directly constituted "coercion"

Talking Points

- Next week, the Supreme Court will hear arguments on whether Congress exceeded its constitutional authority by including in Obamacare an individual mandate to buy coverage and onerous Medicaid changes that states must accept to avoid losing all federal Medicaid funding.
- If the Court strikes the mandate, the question of its severability from the other provisions will be determined by how the Court applies its standard test: "whether the statute will function in a *manner* consistent with the intent of Congress."
- From a health policy perspective, for every possible outcome—including the Supreme Court either upholding or striking down the totality of the PPACA—Congress will have to take some kind of action.
- Congress's best course is to repeal the PPACA, or what remains after the Court has done its work, and then adopt real, patient-centered reforms like those put forward in *Saving the American Dream*.

and thereby exceeded Congress's enumerated powers and violated basic principles of federalism.

Answers to these questions will determine whether all, some, or none of the PPACA will remain in force after the Supreme Court's decision.

This paper does not attempt to provide a comprehensive analysis of either the legal arguments for each question, which the parties and *amici* have briefed in exhaustive detail, or all of the health policy issues in the PPACA, which could easily rival in size the book-length legislation itself. Rather, it describes the decision process that the Court will follow, maps the interrelationships among the questions the Court will consider, and examines the legal and policy consequences of various potential outcomes. The focus is more on how the Court *might* rule and less on how it *should* rule with respect to these questions, along with the implications of the possible outcomes.

While there are correct answers to these questions, how the Court actually will rule is unclear. What is clear, however, is that for every possible outcome—including the Supreme Court either upholding or striking down the totality of the PPACA—Congress will have to take some kind of action in response. Thus, the simplest and cleanest solution for the next Congress is to repeal the bill, immediately re-enact any non-controversial provisions, and then begin work on crafting better, patient-centered, and market-based health system reforms like those put forward in The Heritage Foundation's entitlement-reform plan, *Saving the American Dream*.[2]

Applicability of the Anti-Injunction Act

The first question for the Supreme Court is whether the challenge to the individual mandate is barred by the Anti-Injunction Act (AIA). The AIA provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed."[3] In effect, the AIA prohibits most lawsuits challenging a tax before the tax has been paid, requiring instead that the tax be paid and the taxpayer then sue for a refund.

Even if the Court ignores the fact that the primary challenge is to the mandate itself and not to the penalty, it cannot ignore that the penalty is just that: a penalty, not a tax. Even the federal government, which has alternated its position on whether the penalty is or is not a tax based upon little more than which position was more advantageous to its circumstances at the time, has conceded that the AIA "is not within the category of tax penalties" that trigger the AIA's bar.[4] In their briefs, both the challengers to the PPACA and the Obama Administration agree that the AIA does not prevent the Court from considering the legal challenge to the individual mandate.

Notwithstanding the rare unanimity of the parties on this point, some speculate that the Court may rely on the AIA to avoid answering the controversial question of the mandate's lawfulness, an outcome that may particularly appeal to Chief Justice Roberts, who generally favors judicial minimalism. This is, of course, little more than tea-leaf reading, but there are reasons to believe that the leaves do not portend this outcome. First and foremost, the legal arguments in support of the AIA bar are weak, and the Court (particularly the Chief Justice) is unlikely to bend the law to avoid a controversial ruling. Second, as a practical matter, a ruling that the AIA prevents a judgment now only delays the inevitable and creates uncertainty in the interim.

In the unlikely event that the Court determines that the AIA prevents it from hearing a legal challenge to the mandate, there are several possible legal outcomes. The Court may still reach the question of whether Congress has exceeded its authority under the Spending Clause in placing onerous requirements on the states as conditions of receiving Medicaid funds, and a decision on that issue could lead the Court to strike down the entire statute, including the mandate. Even if the AIA blocks the mandate challenge for

1. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).
2. Stuart M. Butler, Alison Acosta Fraser, and William W. Beach, eds., *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity*, The Heritage Foundation, 2011, at *http://www.heritage.org/research/reports/2011/05/saving-the-american-dream-the-heritage-plan-to-fix-the-debt-cut-spending-and-restore-prosperity*.
3. 26 U.S.C. § 7421(a).
4. Brief for Petitioners (Anti-Injunction Act) at 6, U.S. Dep't. of Health & Human Serv. v. Florida, No. 11-398 (Feb. 2012).

now, that would not preclude a future legal challenge being brought by a plaintiff who had paid the tax in 2015.

In the far more likely event that the Court finds that the AIA does not apply, the Court likely will turn next to consideration of the individual mandate.

The Individual Mandate

The second question before the Supreme Court is whether Congress exceeded its authority under Article I of the Constitution in enacting the individual mandate. The mandate requires that every individual lawfully present in the United States (subject to a few narrow exceptions) must maintain "minimum essential coverage" beginning in 2014 or pay a penalty.[5]

Answering this question will require the Court to assess the limits of Congress's authority under the Commerce Clause and Necessary and Proper Clause.[6] If the Court finds that the minimum coverage provision is constitutional, this result is likely to have drastic legal effects far beyond the case at hand or even the health care market. Never before has Congress attempted to force Americans to purchase a product. As the Eleventh Circuit explained in its decision striking down the mandate:

> Even in the face of a Great Depression, a World War, a Cold War, recessions, oil shocks, inflation, and unemployment, Congress never sought to require the purchase of wheat or war bonds, force a higher savings rate or greater consumption of American goods, or require every American to purchase a more fuel efficient vehicle.[7]

In the face of extraordinary (or even ordinary) circumstances, how much easier would it be for Congress to achieve results if desired action could be compelled rather than merely financially induced or cajoled? As the Eleventh Circuit correctly observed, "Few powers, if any, could be more attractive to Congress than compelling the purchase of certain products."[8]

Even compared to the broad view of congressional authority under the Commerce Clause that prevails today, a decision legitimizing the use of mandates would constitute a seismic shift that would inevitably have an impact on cases far beyond health care. History demonstrates that when the Court accepts broad claims of congressional authority in one context, Congress unsurprisingly responds by passing more legislation based on its newfound power.[9] Contrary to the Justice Department's suggestion that health care (as opposed to the relevant market, health insurance) is somehow "special," the government has failed to elaborate a convincing limiting principle that would prevent Congress from imposing other purchase requirements.

A decision that strikes down the mandate, by contrast, while of tremendous importance to the operation of the PPACA, could have differing effects on the Court's Commerce Clause jurisprudence depending on how the Court arrives at such a conclusion. Should the Court rule narrowly, the decision could simply mean that the Court does not wish to extend its precedents any further. That would delete the mandate but leave undisturbed the Commerce Clause jurisprudence status quo. Alternatively, it is possible that the Court could rule more broadly, walking back prior Commerce Clause precedent, but it need not do so in order to find the mandate unconstitutional.

However, if the Supreme Court rules that the minimum coverage provision is unconstitutional, it will then need to consider whether that provision is severable from the remainder of the PPACA.

Severability

The question of severability is perhaps the knottiest of the four questions before the Court in this case. The fact that the PPACA lacked a severability clause does not answer the question; courts commonly infer severability unless doing so would be contrary to Congress's intent. (That said, the Court will likely weigh the fact that a prior version of the bill contained a severability clause, which was removed from the version that became the PPACA.)

5. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 1501(b); 26 U.S.C. § 5000A(a) & (e).
6. The Justice Department also makes a fainthearted argument based upon Congress's taxing authority; however, Congress and the President argued persuasively prior to passage that the penalty is not a tax, and no court to review the case has accepted government's post-hoc rationalization to the contrary.
7. Florida v. U.S. Dep't. of Health & Human Serv, 648 F.3d 1235, 1289 (11th Cir. 2011).
8. *Id.*
9. *See* Horace Cooper, *Upholding Constitutionality of Individual Mandate Would Set a Dangerous Precedent*, National Center for Public Policy Research National Policy Analysis No. 626 (Aug. 2011), *available at* http://www.nationalcenter.org/NPA626.html.

The lower courts have come to a number of different conclusions regarding severability, which range from striking down only the mandate and allowing the remainder of the statute to stand to striking down the statute in its entirety. While the Supreme Court will have the advantage of reviewing these decisions, it will ultimately apply its standard test: "whether the statute will function in a *manner* consistent with the intent of Congress."[10] In framing this inquiry, the Court has sometimes asked the question as bluntly as whether "the legislature [would] have preferred what is left of its statute to no statute at all."[11]

As a practical matter, the Court has three basic options regarding severability, each of which presents legal and technical difficulties for the Court.

Option #1: The Court could find that the mandate is severable, strike down just that provision, and leave the rest of the statute standing. The problem for the Court with this approach is that even the Obama Administration concedes that at least some of the other provisions rely on the mandate and that these provisions would be counterproductive to Congress's goals if left standing.

Option #2: The Court could find that the mandate is severable but that other provisions of the statute will not operate as Congress intended in the absence of the mandate. The problem for the Court with this approach will be determining how and where to draw the line in striking some additional provisions but not others.

Option #3: The Court could find that the individual mandate cannot be severed from the remainder of the PPACA and strike down the law in its entirety.

Each alternative has serious implications for health care policy in Congress.

Option #1: Only the individual mandate falls.

The challengers, the Obama Administration, and health policy experts across the political spectrum agree that the PPACA's provisions requiring guaranteed issue of coverage and banning the application of pre-existing condition exclusions depend on the individual mandate. Were the Court to strike only the individual mandate, leaving in place these other provisions, that decision would, as the government explained to a lower court, "inexorably drive [the health insurance] market into extinction" by allowing individuals to delay obtaining health insurance until they are actually sick.[12] Accordingly, it is doubtful that the Court would find that the PPACA, shorn only of the mandate, would operate in the manner that Congress intended.

The Court could reason, however, that because the provisions most closely linked to the mandate do not, like the mandate, take effect until January 1, 2014, the political branches will have sufficient time to amend the statute to avoid any anticipated harmful effects. Of course, such an outcome would force the political branches into a renewed and bruising debate over the disposition of the remainder of the legislation, with a date certain for the onset of massive disruption in the health care system should they fail to act.

Option #2: The Court strikes down the mandate and related provisions.

Although the Court may be pursuaded, if it strikes down the mandate, also to strike one or more related provisions, there is no clear and compelling logic for how and where the Court should draw a line dividing the severable provisions from those that are not. The health policy implications of the Court's decision will vary depending upon its approach to carving up the PPACA. Indeed, attempting to divide severable from non-severable provisions inevitably presents the Court with a number of competing rationales, none of which is inherently clearer or cleaner than the others.

Even the Obama Administration's approach to severability, which concedes that a few provisions closely related to the mandate would have to fall with it, highlights the difficulties that the Court would face in drawing the severability line. The Administration allows that, "if the Court invalidates the minimum coverage provision and concludes that there are no impediments to its reaching the question of severability, it should invalidate only the guaranteed-issue and community-rating provisions that take effect in 2014 as non-severable."[13]

However, even this approach is logically inconsistent in two different respects. Thus, it is a good starting

10. Alaska Airlines, Inc. v. Brock, 480 U.S. 678, 685 (1987).
11. Ayotte v. Planned Parenthood of Northern New England, 546 U.S. 320, 330 (2006).
12. Memorandum in Support of Defendants' Motion to Dismiss at 45–46, Florida v. U.S. Dep't of Health & Human Serv., No. 3:10-cv-91-RV/EMT (June 16, 2010).
13. The provisions specified in the government's severability brief as "non-severable" are 42 U.S.C. 300gg(a)(1), 300gg-1, 300gg-3, and 300gg-4(a) and (b).

point for examining the difficulties the Court will face in determining severability.

Understanding the "Guaranteed-Issue" Provisions.

Despite assertions to the contrary, the PPACA's imposition of a guaranteed-issue requirment (meaning that coverage must be issued to all qualified applicants) on insurers and employer plans will not, in and of itself, "inexorably drive [the health insurance] market into extinction." In fact, Congress imposed guaranteed issue on all employer group coverage in 1996 as part of the Health Insurance Portability and Accountability Act (HIPAA).[14]

Employer plans collectively account for 90 percent of all private health care coverage, and since that market has not collapsed in the intervening 15 years, guaranteed issue *per se* is clearly not the main issue.[15] Nor is the PPACA's prohibition on varying premiums based on enrollee health status or prior receipt of medical care an issue, as HIPAA also imposed those restrictions on group coverage.

The real issue is the way Congress, in the PPACA, changed the rules governing pre-existing condition exclusions in connection with guaranteed issue of coverage. In crafting HIPAA, Congress took the sensible and balanced approach of limiting the application of pre-existing condition exclusions in the group market only to those enrollees without prior coverage.[16] Under HIPAA, those who play by the rules—i.e., enroll in employer coverage when it is offered and maintain that (or other creditable) coverage—are rewarded by being protected from the application of pre-existing condition exclusions when obtaining new coverage. Only those who decline offers of employer coverage and then seek coverage later when they need it are penalized by being subject to pre-existing condition coverage exclusions.

In the PPACA, rather than simply extending HIPAA's sensible employer group rules to individual health insurance coverage (the remaining 10 percent of the private market), Congress instead replaced HIPAA's balanced approach with a blanket prohibition on the use of pre-existing condition exclusions under any circumstances, coupled with an individual mandate to buy health insurance. Thus, the individual mandate was included in the PPACA, in the first instance, to limit the damage from Congress's policy blunder of imposing a total ban on pre-existing condition exclusions under any circumstances.

The Justice Department's attempt to use this error to arrogate unto Congress the constitutional authority to enact the law—i.e., arguing that the mandate is somehow "necessary and proper" to avoid the negative effects that might otherwise flow from the operation of the community-rating and guaranteed-issue requirements—is constitutional hubris on stilts. The Necessary and Proper Clause, when utilized in conjunction with the Commerce Clause, permits laws carrying into execution Congress's authority to regulate interstate commerce. It does not give Congress license to blunder boldly so that it can lay claim to greater authority to "fix" the problem it created. And to satisfy the Necessary and Proper Clause, even where the law is legitimately carrying into execution Congress's authority to regulate interstate commerce (which the PPACA does not), the law must still be *proper*—that is, constistent with the letter and spirit of the Constitution. The PPACA, which admits to no limiting principle and which is inconsistent with any reasonable conception of limited and enumerated powers, clearly fails this test.

The mandate was also intended to achieve Congress's goal of near-universal coverage while enabling it to include a number of other provisions in the legislation that will operate contrary to that goal by increasing coverage costs. This leads to the first problem with the logic of the Administration's severablity postition.

The Administration argues that if the mandate is invalidated, the Court must also strike the blanket prohibition on the application of pre-existing condition exclusions starting in 2014. Yet the Administration excludes from its list of non-severable provisions the related prohibition on applying pre-existing condition exclusions to children, which took effect in September 2010.

That change has already produced the kinds of harmful results—premium increases and the refusal of

14. For a further discussion, see Edmund F. Haislmaier, "The Right Way to Limit Pre-Existing Condition Exclusions," Heritage Foundation *The Foundry*, September 22, 2010, at *http://blog.heritage.org/2010/09/22/the-right-way-to-limit-pre-existing-condition-exclusions/*.

15. The most recent Census data show that, of the 175 million Americans in 2010 with private health insurance coverage, 159.1 million (89 percent) have employer-group coverage and 18.9 million (11 percent) have individually purchased coverage. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2011 Current Population Survey," Employee Benefit Research Institute *Issue Brief* no. 362, September 2011, Figure 1, p. 5.

16. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 100 Stat. 2548.

insurers to offer new "child only" policies—that the government cites as reasons why the broader prohibition on pre-existing condition exclusions cannot be severed from the mandate.[17] Thus, the only apparent rationale for not also striking the prohibition on pre-existing condition exclusions for children is that the provision has already taken effect, but to imply that the Court should look to when different provisions take effect as a guide to severability is not an inherently more logical approach either.

Implications of Striking the "Community-Rating" Provisions

The second problem with the Administration's severability logic comes when it argues that the Court should also treat the so-called community-rating provisions as non-severable.

If left standing, those provisions will undoubtedly produce significant premium increases for many individuals, most notably young adults whom actuaries project will face premium spikes of 35 percent to 45 percent.[18] Absent an individual mandate to obtain coverage, that will almost certainly result in many more uninsured, as young adults are generally healthy, typically have lower incomes, and have long been the age cohort least inclined to obtain coverage and thus with the highest uninsured rate. Increasing the number of uninsured is clearly contrary to Congress's stated intent of achieving "near-universal coverage." Leaving these provisions in place would therefore create a statute that does not operate in a manner that Congress intended.[19]

Yet, if the Court accepts the Administration's argument that it should strike one set of provisions (community rating) that will, absent the individual mandate, increase premiums and thereby result in more uninsured, then there is no reason for the Court not also to strike other provisions that will have the same effect. By logical extension, the Court should then also strike any other provision that will increase premiums, since, according to the economic literature on which the Congressional Budget Office (CBO) bases its coverage estimates, every 1 percent increase in health insurance premiums produces a 0.35 percent decrease in health insurance coverage.[20]

Under that logic, the Court should also strike at least the following six provisions as well:

- **The Prohibition on Annual Dollar Limits on Coverage.** In 2014, the PPACA will prohibit health insurers and employer health plans from imposing "annual limits on the dollar value of benefits for any participant or beneficiary."[21] The principal effect of this provision will be to eliminate current "limited benefit," or "mini-med," plans, usually offered by low-wage employers such as restaurants and nursing homes for whom it is uneconomical to offer full-benefit coverage. Some states, such as Tennessee, have also used limited benefit plans to expand coverage.

  The second most prevalent plan type that will be affected by this provision are employer-sponsored "health reimbursement arrangements" (HRAs) that have an annual reimbursement limit on the insurance coverage offered in conjunction with an HRA. Surveys in 2007 and 2008 estimated that 5 million to 5.5 million individuals were enrolled in HRA plans. In theory, the combination of the individual mandate and the new subsidies, which also take effect in 2014, will induce affected individuals to obtain replacement coverage when they lose their current limited benefit or HRA coverage.

  Currently, over 4 million individuals are covered by plans

17. A survey of state insurance departments one year later found that in 39 states, at least one insurer had stopped writing new child-only policies and that in 17 states, there were no longer any insurers offering such coverage. Michael B. Enzi, "Ranking Member Report: Health Care Reform Law's Impact on Child-Only Health Insurance Policies," U.S. Senate Committee on Health, Education, Labor and Pensions, August 2, 2011, at *http://www.help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%202,%202011.pdf* (March 7, 2012).
18. For a further discussion of the "community rating" provisions, see Edmund F. Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets," Heritage Foundation *WebMemo* No. 3111, January 20, 2011.
19. Pub. L. No. 111-148, § 1501(a)(2)(D).
20. For information on the price elasticity of demand for health insurance coverage, see Congressional Budget Office, "CBO's Health Simulation Model: A Technical Description," October 2007. See also Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Health Insurance?" *Journal of Public Economics*, vol. 88, nos. 7–8 (2004), pp. 1273–1293.
21. § 2711 of the Public Health Service Act (42 U.S.C. 300gg-11), *added by* § 1001(5), and amended by § 10101, of Pub. L. No. 111-148.

that, come 2014, will be in violation of the PPACA's prohibition on annual limits.[22] Without the individual mandate, a larger share of those individuals will not obtain replacement coverage, thus increasing the number of uninsured. That effect is likely to be greatest among those losing coverage whose household incomes exceed the upper income threshold for the new coverage subsidies.

- **The Comprehensive Coverage Requirement.** This provision imposes on plans offered by health insurers in the individual and small group markets (both in and outside the new exchanges) the "essential health benefit" requirements established under a separate section of the PPACA.[23] Congress instructed the U.S. Department of Health and Human Services (HHS) to define and periodically update the essential health benefits package. To date, HHS has not proposed regulations specifying the initial design of the essential health benefits package and has only issued "bulletins" outlining the approaches that it is considering. Given that the statute requires coverage for categories of benefits not typically included in most current health plans, it is likely that the eventual package of required benefits will increase premiums for many individuals who currently have group or individual health insurance coverage.

  Any premium increases that result will, absent the individual mandate, cause some share of individuals with affected plans to drop their coverage, thereby increasing the number of uninsured.

- **Limitations on Cost-Sharing.** This provision imposes on group health plans the restrictions on enrollee cost-sharing established elsewhere in the PPACA.[24] Reducing cost-sharing will, in turn, increase plan premiums and cause some individuals to lose or drop coverage.

- **The Preventive Care Coverage Requirement.** This provision requires employer plans and group and individual health insurance plans sold by commercial insurers to cover specified "preventive services" without any enrollee cost-sharing.[25] This will increase premiums for affected plans in three ways:

  First, mandated reductions in enrollee cost-sharing will require plans to pay more of the costs for services they already cover, shifting those costs from patients to premiums.

  Second, prohibiting enrollee cost-sharing for specific services will induce greater use of those services, further increasing premiums.

  Third, premiums will also increase to the extent that plans are required to cover benefits or services that were previously excluded or subject to plan limitations.

  Indeed, the federal government estimates that this provision alone will cause premiums to increase by 1.5 percent, on average.[26] This, too, will result in individuals losing or dropping coverage, thereby increasing the number of uninsured.

- **The "Minimum Loss Ratio" Requirement.** Starting in 2011, the PPACA imposed new "minimum loss ratio" regulations that require health insurers to spend at least 80 cents of every dollar in

22. Total enrollment in plans granted waivers is 4,039,774. Lists of those waiver recipients, with enrollment figures, can be found at *Annual Limits Policy: Protecting Consumers, Maintaining Options, and Building a Bridge to 2014*, U.S. Department of Health and Human Services, at *http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html*.
23. The comprehensive coverage requirement is found in Public Health Service Act § 2707(a), 42 U.S.C. 300gg-6(a). The essential health benefit provision is found in Pub. L. No. 111-148, § 1302(a).
24. The requirement to limit cost-sharing is found in § 2707(a) of the Public Health Service Act § 2707(a), 42 U.S.C. 300gg-6(a). The specified limits on cost-sharing are in Pub. L. No. 111-148 § 1302(c).
25. Public Health Service Act § 2713, 42 U.S.C. 300gg-13.
26. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 137 (proposed July 19, 2010), pp. 41726-41760, at *http://edocket.access.gpo.gov/2010/pdf/2010-17242.pdf*.

premiums on claims or "activities that improve health care quality."[27] Because high-deductible health insurance plans sold in conjunction with health savings accounts (HSAs) are designed to have lower claims costs than low-deductible plans and yet have many of the same fixed administrative costs, many HSA-qualified high-deductible plans will be unable to meet the new minimum loss ratio requirements and will have to be discontinued. These plans are attractive to individuals and employers specifically because of their lower premiums, and their loss will lead some individuals to drop coverage altogether, particularly in the absence of an individual mandate to purchase more expensive replacement coverage. This, too, will increase the number of uninsured.

- **The Tax on Insurance Premiums.** Starting in 2014, the PPACA imposes an annual and escalating "fee" on health insurers.[28] Because the "fee" is assessed in proportion to each insurer's share of total U.S. health insurance premium income, its economic effect is the same as that of an excise tax. Indeed, the statute states that it is to be treated as an excise tax under the Internal Revenue Code and may not be deducted as a business expense against corporate income taxes by insurers. Consequently, this fee will be fully passed on to consumers by insurers in the form of higher premiums.

  There is, however, an important difference between this fee structure and that of a traditional excise tax. Under a traditional excise tax, the amount paid by the consumer is the same for each unit taxed, and the revenue to the government thus rises or falls with fluctuations in sales of items subject to the tax or in the prices of those items if the tax is a percentage of the price. By contrast, total revenue from the insurance premium fee is fixed by statute, and the amount paid by each consumer will rise or fall based on fluctuations in the total number of consumers purchasing coverage. To the extent that fewer individuals purchase health insurance in the absence of a mandate to do so, premiums for the remaining insured individuals will increase further, and this will, in turn, induce more individuals to drop coverage. Striking down this provision, however, would also undermine Congress's attempt to achieve a neutral budget score.

All six of the foregoing provisions will increase the cost of health insurance and, absent an individual mandate to buy coverage, will result in more uninsured—an outcome that is clearly contrary to Congress's stated goal of expanding coverage.

However, should the Court take Congress at its word that achieving "near-universal coverage" was its intent in enacting the PPACA, the Court should look to strike not only provisions that, absent the mandate, would *increase* the number of uninsured, but also those provisions that, absent the mandate, would *fail to reduce* the number of uninsured as Congress intended. That logic could lead the Court to treat at least two other, major provisions as non-severable from the individual mandate.

- **The Medicaid Expansion.** The PPACA expands Medicaid to require coverage of all non-elderly adults and children with household incomes below 138 percent of the federal poverty level.[29] Health economists have long observed that some individuals do not enroll in health care coverage even when the coverage is offered at no charge. In particular, this phenomenon occurs in Medicaid and the Children's Health Insurance Program (CHIP). But Congress expected that the individual mandate would also serve to counter that effect. According to the Congressional Budget Office, as a result of the requirement for individuals to obtain insurance, "those who would be eligible for Medicaid (whether under current law or because of

27. For a further discussion of the effects of the PPACA's minimum loss ration regulations on HSA plans, see Alyene Senger, "Side Effects: If You Like Your HSA, Get Ready to Lose It," Heritage Foundation *The Foundry*, February 24, 2012, at *http://blog.heritage.org/2012/02/24/side-effects-if-you-like-your-hsa-get-ready-to-lose-it*. For a discussion of the other harmful effects of the PPACA's minimum loss ration regulations, see Edmund F. Haislmaier, "Effects of the PPACA's Minimum Loss Ratio Regulations," Testimony before Committee On Energy and Commerce, Subcommittee on Health, United States House of Representatives, September 15, 2011, at *http://www.heritage.org/research/testimony/2011/12/effects-of-the-PPACAs-minimum-loss-ratio-regulations*.
28. Pub. L. No. 111-148 § 9010, *amended by id*. § 10905, and *amended by* Pub. L. No. 111-152 § 1406.
29. Social Security Act § 1902(a)(10)(A)(i), 42 U.S.C. 1396a, *amended by* Pub. L. No. 111-148. § 2001.

the expansion) and who would otherwise be uninsured would be more likely to enroll in that program."[30]

If the mandate is struck down, it can be expected that fewer individuals will enroll in Medicaid than projected by CBO and others. While that might reduce the legislation's costs, it would also entail a failure of congressional intent to reduce the number of uninsured individuals.

- **The New Insurance Subsidies.** The PPACA provides subsidies for the purchase of coverage through health insurance exchanges by individuals with household incomes between 138 percent and 400 percent of the federal poverty level.[31] These new subsidies and the individual mandate, taken together, will lead a projected 24 million individuals to enroll in exchange coverage by 2019, according to CBO.[32]

  Absent an individual mandate to obtain coverage, fewer individuals will enroll in subsidized exchange coverage. This effect is likely to occur predominantly among single individuals earning 300 percent to 400 percent of the federal poverty level, for whom the cost of coverage *after* subsidies will still be $3,000 to $4,000 per year, and among couples earning 250 percent to 400 percent of the federal poverty level, for whom the cost of coverage *after* subsidies will still be $3,000 to $5,500. Again, this may marginally reduce costs, but it will also likely result in fewer insured indviduals than Congress expected or intended.

Yet another severance rationale is offered in an *amicus* brief filed by the American Hospital Association, joined by the National Association of Public Hospitals and Health Systems, the Federation of American Hospitals, and the Association of American Medical Colleges.[33] The hospitals argue that if the Court strikes the mandate, it must also strike provisions in the PPACA that cut federal funding to hospitals. Specifically:

- **Medicaid and Medicare Disproportionate Share Hospital (DSH) Payment Cuts.** For a number of years, Congress has provided supplemental payments in the Medicaid and Medicare programs to so-called disproportionate share hospitals (DSH). Those are hospitals that treat a disproportionate share of low-income patients and are presumed to have substantial costs associated with providing uncompensated care to indigent, uninsured individuals.

  Because Congress anticipated that the PPACA's Medicaid expansion, new subsidies, and individual mandate would result in near-universal health insurance coverage, the legislation also cuts Medicaid and Medicare DSH payments.[34] The hospitals argue that:

  Without the mandate, but with the DSH cuts, hospitals serving the most vulnerable populations would be stripped of billions of dollars in funding, with a reduced prospect of income from privately insured patients to offset it. The safety net might not survive. Congress could not have intended that result—and in fact, the statutory text and legislative history make clear that it did not.[35]

- **Medicare Payment Cuts.** Congress was determined to achieve a budget-neutral CBO score for the first 10 years of the PPACA. Thus, to "pay for" the PPACA's Medicaid expansion and new subsidies, it included in the legislation not only various taxes and fees, but also a set of provisions reducing Medicare hospital payments. The hospitals note that CBO estimates that those provisions collectively will reduce Medicare funding of hospitals

30. Congressional Budget Office, "Selected CBO Publications Related to Health Care Legislation, 2009–2010," December 2010, p. 85, *at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12033/12-23-selectedhealthcarepublications.pdf.
31. Internal Revenue Code of 1986 § 36B, 26 U.S.C. 32B, *amended* by Pub. L. No. 111-152, § 1001.
32. Congressional Budget Office, "Selected CBO Publications Related to Health Care Legislation, 2009–2010," December 2010, p. 23.
33. Brief for The American Hospital Association as Amici Curiae in Support of Neither Party on Severability, Florida v. Dep't of Health and Human Serv., No. 11-393 and 11-400, (January 6, 2012).
34. § 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)), *amended by* § 2551(a)(4) and §10201(e)(1) of Pub. L. No. 111-148, and § 1203(a) of Pub. L. No. 111-152, and § 1886 of the Social Security Act (42 U.S.C. 1395ww), *amended by* § 3133 of Pub. L. No. 111-148, and § 1104 of Pub. L. No.. 111-152.
35. American Hospital Association, *op. cit*.

by $156 billion. They argue that they agreed to those cuts "on the express understanding that the individual mandate would help the hospitals offset their losses" and cite various congressional and administrative statements to support their contention. They conclude:

> In a world with no mandate, the subsidies would remain in place, but they would not be fully utilized because fewer uninsured individuals—some 18 million fewer—would seek coverage. Healthcare providers thus would suffer a substantial reduction in Medicare reimbursements without *anyone* receiving the offsetting benefit those cuts were designed to fund.[36]

Were the Court to accept the economic linkage of the hospitals' argument that costs imposed by the PPACA on health system stakeholders were linked—in what the hospitals term a "grand bargain"—to projected increases in stakeholder revenue derived from the individual mandate, it would wander even further into the severability thicket. To be logically consistent, the Court would need to strike still more provisions as non-severable. The same argument can be made for also striking the PPACA's new medical device excise tax, its new federal premium tax on private insurers, and the mandatory "contributions" it imposes on drug companies. Congress clearly intended that all those measures would capture a portion of projected new revenues accruing to stakeholders as a result of the PPACA's expanding their customer base through the individual mandate.

Furthermore, while obviously self-serving, the hospitals' brief also points out another major issue in the passage of the PPACA: Congress intended the package to be budget neutral. While critics correctly pointed out that the legislation's "budget neutrality" was an artificial contrivance limited to the first 10 years scored by CBO (a fact now confirmed as CBO updates its baseline to reflect additional years), it is undeniable that this balancing act guided Congress's crafting of the legislation. Because Congress was set on achieving a neutral CBO score, the PPACA's provisions are intricately intertwined in this way. This severely complicates the task of picking and choosing which provisions will stand and fall without creating a piece of legislation that "Congress would not have enacted."[37]

Option #3: The entire statute falls.

Given the complexities and difficulties involved in trying to determine the severability of particular provisions, the Court may be tempted to embrace the third option of simply striking down the entire statute. This would largely relieve Congress of the burden of rushing to address a health policy mess left by a ruling that strikes down portions of the statute.

It also has the virtue of hewing to congressional intent. For a number of reasons, it should be plain that Congress would not have passed the PPACA without the mandate. In both the House and the Senate, there was not a vote to spare, suggesting that even small changes would have put the legislative compromise necessary to pass the bill in jeopardy.

Proponents of the PPACA have stated clearly and repeatedly that the mandate is essential to the broader legislative scheme and, in particular, to achieving the stated legislative goals of near-universal coverage and ensuring coverage for those with pre-existing conditions while achieving a neutral budget score from the Congressional Budget Office. Shorn of its central provision, which is necessary to make the numbers add up, the PPACA could not operate in a manner consistent with Congress's intent.

Yet wholesale invalidation begs the objection that such action would discard other sections of the legislation that are logically extraneous to the mandate and coverage of pre-existing conditions. For example, Title VII amends the Food, Drug, and Cosmetic Act to provide a new pathway for approval of so-called biosimilar or generic biologic medicines, and Title X includes provisions that affect only the Indian Health Service. Indeed, both of these titles were free-standing bills with broad bipartisan support before being grafted onto the PPACA, and both have already taken effect. The response to this objection is obvious: If the Court were to strike down the entire statute, Congress would surely re-enact those provisions.

The Medicaid Expansion

The final issue before the Court is whether the additional conditions imposed by the PPACA as part of its Medicaid expansion—conditions made under threat of withholding all

36. *Ibid.* Emphasis in original.
37. Alaska Airlines, Inc. v. Brock, 480 U.S. at 685.

Medicaid funding from non-complying states—constitute coercion and therefore exceed Congress's enumerated powers and violate the principles of federalism. The Court could avoid this issue, however, if it finds that the mandate is unconstitutional and decides that the PPACA's expansion of Medicaid is non-severable from the mandate.

Implications of Upholding the Medicaid Expansion

Upholding the PPACA's Medicaid expansion would require that the Court effectively abandon the limitation on coercion through spending recognized in *South Dakota v. Dole* and other decisions. While Congress currently frequently operates as if there were no such limitation, the removal of even the pretense of a limitation on the requirements that the federal government may impose on states would further upset the federal–state balance in favor of the federal government and embolden Congress to interfere further in questions of state and local concern.

As a practical matter, upholding the Medicaid expansion would profoundly undermine what remains of state autonomy and sovereignty in two ways.

First, the sheer scale of Medicaid, especially after the PPACA, puts the states in a suboordinate position in relation to the federal government. Medicaid is already a substantial and growing fiscal burden on states. States currently spend 20 percent of their general fund tax revenues on their Medicaid programs. Even before the PPACA's Medicaid expansion takes effect in 2014, the cost to states for their share of Medicaid (in its current form) is projected to grow to over 25 percent of state revenues in 2013.[38] Not surprisingly, state lawmakers are already concerned that funding obligations for Medicaid are steadily crowding out other budget items. The PPACA's Medicaid expansion will only make that problem worse.

The CMS Chief Actuary projects that the Medicaid expansion will add over 23 million individuals to the program's rolls.[39] That represents a 38 percent increase, boosting enrollment from 61 million to 84 million individuals. Although the legislation provides that federal taxpayers will pay the entire benefit costs of the Medicaid expansion in the first three years, state taxpayers will be on the hook for 5 percent of the added costs in 2017, increasing to 10 percent by 2020 and thereafter—and there is no guarantee that the federal government will maintain funding at promised levels. Yet even that relatively small state share will impose at least $22 billion in new costs on states between 2014 and 2020.[40]

States will also incur at least another $11 billion in additional administrative costs for Medicaid over the same period. Furthermore, the extra federal funding will apply only to enrollees that meet the new eligibility standards; the states will still have to pay their normal (higher) share of the costs for enrollees who would have qualified under pre-PPACA rules.

Second, the PPACA's changes in Medicaid's basic operational structure directly undermine state autonomy. The PPACA strips states of much of their remaining operational control of Medicaid. It stipulates that Medicaid eligibility will be determined by the new health insurance exchanges.[41] Furthermore, it requires states to accept the decisions of the exchanges as final, leaving states unable to reject even erroneous eligibility determinations.[42] The exchanges will be operated either directly by the federal government or, in states that establish their own exchanges, under federal rules and supervision.

The PPACA effectively reduces the states to the roles of tax collectors and administrative contractors for what is essentially, in all but name, a federal program. Should the Court uphold the PPACA's changes in Medicaid, nothing would prevent Congress from imposing similar changes on other programs with shared federal and state funding.

Implications of Striking Down the Medicaid Expansion

Should the Supreme Court strike down the PPACA's Medicaid expansion, the effect on other federal spending programs would be determined by the decision's precise

38. Edmund F. Haislmaier, "Quantifying Costs to States of Noncompliance with the PPACA's Medicaid Expansion," Heritage Foundation *Backgrounder* No. 2640, January 12, 2012.
39. Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, April 22, 2010, Table 2.
40. Edmund F. Haislmaier and Brian C. Blase, "Obamacare: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010.
41. Pub. L. No. 111-148 § 1311(d)(4)(F).
42. New § 1943(b)(1)(B) of the Social Security Act, *added by* Pub. L. No. 111-148 § 2201.

reasoning. While such a decision would prompt a healthy reexamination of federal spending programs, it might not call into question the constitutionality of other programs.

The Court could craft an opinion that draws a distinction between this case and potential challenges to other federal programs, based on two unique features of the PPACA and Medicaid.

First, the PPACA mandates that individuals obtain health insurance and then mandates that states expand Medicaid to meet much of that new demand. The Court might reason that such an arrangement is qualitatively more coercive than other, previous amendments to federal statutes governing Medicaid and similarly structured programs.

Second, Medicaid is seven times larger than the next biggest program jointly funded by the federal and state governments. Its sheer size puts it in a different category from similarly structured, though much smaller, programs. In this way, a decision that strikes down the PPACA's Medicaid expansion could be quite narrow, with little impact on other programs.

However, even if the Court invalidated the Medicaid expansion in a way that limited its usefulness as precedent for other, similar programs, such a ruling would likely force Congress to reconsider the design and operation of Medicaid as it currently exists. From a health policy perspective, such a reevaluation might actually produce some positive and long-overdue fundamental reforms in the program.

Conclusion

From a legal perspective, these cases will have implications far beyond the PPACA and will serve as a significant precedent with respect to what limits, if any, still apply to congressional authority—fundamentally, whether the federal government remains one of limited powers. From a policy perspective, unless the entire PPACA is struck down, Congress will have significant work to do in addressing what remains.

The Supreme Court's decision is important, both as a legal matter and in defense of limited government, but it will not, by itself, achieve good health care policy. Accordingly, legislators should not be counting on the Court to save them from themselves. The necessary and best course of action for Congress is therefore to repeal the PPACA, or what of it remains after the Court has done its work, and to achieve real, market-based reforms like those put forward in *Saving the American Dream*.

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