Patient Protection and Affordable Care Act: Challenges and Issues

I. Background:

Federal health care reform has been a contentious issue since it was signed by President Obama in 2010. After months of struggling to pass legislation aimed at reforming the current system, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010. However, within minutes of the bill becoming law, the PPACA was challenged by 13 state attorney generals jointly filing a lawsuit alleging the new law violated the Constitution. This suit was filed in the U.S. District Court of Pensacola, FL. The National Federation of Independent Business and 7 additional states joined the suit as co-plaintiffs. Of the 20 states involved, all but Louisiana, Nevada, and Mississippi had Republican attorney generals at the time. The suit was filed on the grounds of the PPACA violating Articles I and IV and the 10th Amendment of the Constitution. Virginia’s attorney general filed a separate suit and 33 other states continue to consider legislation to nullify the federal individual mandate for their state citizens.

In addition to the constitutional challenges faced by the PPACA, the new law will also face technical challenges upon implementation, particularly with the implementation of the state-level health insurance exchanges. These insurance exchanges will become fully operational in 2014.

As the PPACA continues to roll-out, employers should be in the habit of closely monitoring the additional requirements, and re-adjusting their current system as necessary.

The following websites were used in creating this report. As the state of the PPACA continues to evolve, these websites should provide a good overview and analysis of the changes.

http://healthcarelawsuits.org/
http://www.ncsl.org/?tabid=18906
www.healthlawandlitigation.com
http://www.familiesusa.org/health-reform-central/about-the-new-law/
http://www.progressivestates.org/node/24961

III. Implementation Issues

In addition to the legal and state legislation challenges that the PPACA faces, there are also technical aspects of the law that will require heavy research and study of best-practices. In particular, the health insurance exchanges that each state will be required to run will necessitate significant structural reform. This report highlights several of the most pressing issues, and gives a recommendation for each. The research for this section of the report is taken from a report by the CommonWealth Fund, titled Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues, authored by Timothy S. Jost of Washington and Lee University School of Law.

Health Insurance Exchanges

The exchanges are expected to play a major role in the purchase and sale of health insurance once they become fully operational in 2014. As of July 2011, the following states had enacted exchange establishment legislation: California, Colorado, Connecticut, Hawaii, Illinois, Maine, Maryland, Nevada,
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The Commonwealth Fund has issued a report that identifies difficult issues that the states and the federal government face in implementing these exchanges. These issues include:

1) Governance of the exchanges
2) Adverse selection against and within the exchanges
3) How to make self-insured plans compatible with the exchanges
4) Making the exchanges attractive to employers
5) Exercise of regulatory authority in certification of health plans that can participate in the exchanges
6) How to make descriptive and evaluative information available to the consumers
7) How to decide eligibility determinations under the Affordable Care Act
8) Reducing administrative costs and attracting funding

Below lists a brief summary of each issue, and what the Commonwealth Fund recommends as a solution. For more information on any of the below, as well as further discussion of healthcare issues under the new system, see http://www.commonwealthfund.org/ and search for the report Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues.

1) How should the state exchanges be governed?

Current state exchanges either function within existing state departments’ agencies or have been created as independent public entities. The California Health Benefits Exchange is an independent agency governed by a five member board, including one appointee of the California Secretary of Health and Human Services, two members appointed by the governor, one by the Senate Committee on Rules, and one by the Speaker of the Assembly.

- Some exchange functions could be handled readily by a private entity, such as operating a web portal and processing enrollments or premium payments. Such functions can be outsourced to private entities under the ACA. Other functions, such as certifying that a health plan operates in the interests of qualified individuals, are inherently governmental. Exchanges may also exercise governmental discretion in determining eligibility for premium subsidies or Medicaid.

- The U.S. Constitution limits the ability of Congress to delegate legislative decisions to other branches of government, and in particular to delegate governmental authority to private entities. That being said, it is rare for courts to hold a delegation invalid.

- A publicly run exchange would be subject to a considerable number of state administrative and government operations laws. California, for example, requires public employees to perform tasks that can be performed “adequately and competently” by civil servants.
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- It is important that the exchanges have the agility to react quickly to changes in insurance markets. States may want to apply their administrative procedure acts somewhat flexibly to exchanges.

- But public law governing administrative agencies exists to ensure transparency, accountability, and public participation in the governance of public agencies and to avoid corruption and patronage. Therefore, it is appropriate that some public law provisions apply to exchanges.

- A private entity might face additional responsibilities under federal law. On the other hand, it will usually make sense for an exchange to outsource largely nondiscretionary, mechanical functions competitively available in the private sector. Examples include premium billing, collection, reconciliations systems; enrollment and case installation services; data processing; customer relations management.

Agency or Board operated?

In most states, it is unlikely that the exchange will fit within an existing government agency. Although the exchange must coordinate closely with the state insurance department or commissioner, it should not be housed in the insurance department. It is also unwise to house it in the Medicaid department, since many participants will not be on Medicaid and will have different needs than Medicaid participants.

Recommendation: In each state, the exchange should be placed in an independent agency, which should be explicitly exempted, as necessary, from the requirements of specific state administrative law or government operations requirements. The governing board of the exchange could represent interested parties, state agencies with which the exchanges must work, and persons with relevant expertise. Management, on the other hand, should be apolitical and professional. Exchanges should outsource services for which competitive markets exist and for which performance can be readily monitored.

2) Preventing adverse selection

Adverse selection is the greatest threat facing exchanges. As long as individual or small-group coverage is readily available outside the exchange, the potential exists for healthy individuals and groups to purchase insurance disproportionately outside the exchange. If the exchange becomes essentially a high-risk pool, the exchange will become unattractive to insurers while coverage through the exchange will become unaffordable to individuals and employers.

The ACA permits both an individual and a group health insurance market to continue to exist outside the exchange, leaving open the possibility of adverse selection against the exchange if lower-risk subscribers can find less expensive coverage elsewhere. Fortunately, a number of ACA provisions will discourage adverse selection. It should be noted that although the ACA does not allow the federal government to

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1 Some of these include, section 5000A(a) of the Internal Revenue Code, created by section 1501 of the ACA, which requires individuals to have “minimum essential coverage”; the fact that most of the insurance reforms imposed
require individuals or employees to purchase insurance through the exchange, it does not prohibit the states from imposing additional requirements on the outside market to discourage adverse selection, or even to move to eliminate the outside market altogether. This could be done by requiring all insurance sales in the individual and small-group market to be done through the exchange. However, this would raise the issue of eliminating coverage for undocumented aliens, because the healthcare statute prohibits unlawful aliens from purchasing insurance through the exchange. In place of an act this severe, states could regulate the individual and small group markets identically inside and outside the exchange. These requirements should be applied generally to plans outside the exchange to ensure a level playing field and to discourage those plans from offering lower cost and lower quality. Most importantly, the same marketing and benefit design provisions should apply both within and outside the exchange to deter non-exchange plans from marketing their plans or structuring their benefits to attract better risk. Lastly, insurance regulators should monitor grandfathered plans closely to make sure they are not “lemon dropping,” that is, encouraging high-cost enrollees to move to the exchange.

Coordination of the market inside and outside the exchange to avoid adverse selection will be particularly problematic in states in which the federal government operates the exchange because the state either has declined to do so or has failed to establish an exchange itself. Adverse selection will be an additional threat in those states because the federal government will have little regulatory authority over the outside market.

**Adverse Selection Within the Exchange**

Another significant risk that must be considered in designing exchanges is that of adverse selection among insurers within the exchange. There is considerable evidence that higher risk enrollees (older enrollees and enrollees with health problems) will not be evenly distributed among all types of health plans within the exchange. Higher-risk enrollees have traditionally tended to prefer PPOs with large networks as opposed to HMOs with tighter networks. Enrollees with serious chronic illnesses want access to a wide range of specialists and treatments. Higher-risk enrollees also prefer plans with lower cost-sharing obligations. Finally, higher-risk enrollees are less likely to elect to leave more expensive plans for less-expensive plans during open-enrollment periods, particularly if they have an established relationship with a particular provider or professional who is only available through their current plan.

Particular features of the ACA make the problem more acute. The ACA prohibits health plans from charging individual enrollees higher premiums on the basis of health status. A health plan will nevertheless have to set its premiums to cover its costs, therefore health insurance issuers with unhealthier enrollees will have to raise their premiums for all members, driving away healthier enrollees. Moreover, in all plans, issuers must treat all individual and all small-group enrollees, respectively, as members of single risk pools (or as members of a combined risk pool if the state elects to combine individual and small-group pools), so adverse selection against a plan could raise the premiums for all plans offered by a particular insurer.

The problems of risk selection both against and within the exchange are supposed to be addressed by the ACA reinsurance and risk-adjustment programs. For the years 2014 through 2016, exactions will be collected from health insurance issuers and group health plans and paid to reinsured high-risk
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individuals. This program will address risk selection only in the individual and not in the small-group market, and lasts only three years.

In the long run, therefore, the key to protecting the exchange against adverse selection, and to retaining a range of products within the exchange that will appeal to different populations, will be the ACA’s permanent risk-adjustment program. The program is designed to move funds from health plans and insurers with lower-actuarial risk enrollees to plans and insurers with higher-actuarial-risk enrollees. The risk adjustment program applies inside and outside the exchange, to both the individual and the small-group market, although not to self-insured or grandfathered plans. Health insurance plans will still vary in cost according to the richness of their coverage, but the risk-adjustment program should diminish the degree to which the premium and tier placement of a plan is linked to the risk profile of its population.

Finally, risk selection is a dynamic game. The capacity must exist for a rapid and flexible response. State enabling exchange legislation must task the exchange with continually and actively monitoring the insurance market to detect signs of adverse selection. It must also establish close coordination between the exchange and the entity responsible for risk adjustment to ensure an effective response to risk selection when it occurs.

Recommendations: To the extent possible, state regulation of the individual and small-group market outside the exchange should be identical to corresponding regulation inside the exchange. Some states may be able to eliminate the market outside the exchange. HHS should design a sophisticated but practical risk-adjustment system that states can use to discourage adverse selection against and within the exchange among participating and nonparticipating insurers.

3) How to make the exchanges work for employers

While the discussion of exchanges focuses largely on how the exchanges should serve individual consumers, the relationship between insurers and employers and employee groups is just as important. Exchanges are required under section 1311(d)(2)(A) to make qualified health plans available to qualified employers. Indeed, the ACA requires states to provide “for the establishment of a Small Business Health Options Program (in this title referred to as a ‘SHOP Exchange’) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small-group market in the State.”

For exchanges to succeed, they must be attractive to small employers. In most states, exchanges will need to enroll employees of small employers as well as individuals to reach a large enough pool of enrollees to overcome adverse selection issues, achieve administrative efficiencies, and create an attractive market for insurers. Exchanges must, therefore, actively market themselves to small employers and to brokers and agents who serve small employers. Exchanges should contract with navigators who are known and trusted by small businesses and their owners, and should do so well in advance of January 1, 2014, so that the exchanges will have small employers ready to join as soon as they open.

Exchanges must be capable of relieving small employers of responsibility for basic benefit management services, like online enrollment, automated billing and collection, electronic disbursements and reconciliation, the handling of employee additions and removals and plan selection, and other related functions. They should also be able to assist employers in applying for the small business tax credit and to assist with the management of COBRA continuation coverage, 125 cafeteria plan, health savings or
Further Recommendations: Exchanges should offer employers the option of an aggregated bill covering the premiums of all employees. The exchange should assume the task of allocating premiums among the various insurers and plans chosen by individual employees. Employers should be able either to pay a fixed percentage of the premium for a specified level of coverage, with the employee covering the remainder of the premium, or to charge employees a premium share based on category and richness of coverage and, if desired, on tobacco use and involvement in wellness-incentive programs. Employers could also offer greater support to lower-income employees.

4) The extent of the regulatory role of the exchanges

Certifying Qualified Health Plans
The scope of the regulatory authority of exchanges is a potential source of significant controversy. The ACA permits the exchange to offer only “qualified health plans.” Qualified health plans must meet all of the regulatory requirements imposed by the ACA on health insurance issuers in the individual and group market, but must also meet additional requirements imposed by ACA sections 1301 and 1311(c), including marketing, network adequacy, accreditation, and quality-improvement requirements. In addition, the exchange may certify plans for participation only if it “determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates.” The ACA further provides that the exchange may not refuse to certify a plan because it is a fee-for-service plan, may not impose price controls, and may not exclude plans that provide excessive end-of-life care. Section 1311 also provides that exchanges must require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plans available through the Exchange.

Further Recommendations: Exchanges must use their certification power to ensure that health plans meet the statutory requirements for qualification and that plans do not impose unreasonable premium increases on their members. Legislation authorizing state exchanges should under no circumstances require exchanges to admit all insurers in the market, but should at least give exchanges the option of being an active purchaser. Exchanges should decide whether to take a more inclusive or exclusive approach to insurer participation based on the conditions in their own state and local markets. Exchanges should use their regulatory authority to lower prices and increase value to the extent that the competitive conditions in their markets allow. Exchanges should also standardize and limit the range of plan choices available within each tier to stimulate competition based on price and value.

5) The exchanges as a source of descriptive and evaluative information

Exchanges should make information describing the benefits and limitations of available health insurance plans readily and easily accessible. To permit accurate selection among health plans through the exchange Internet portal, health plans should be contractually bound by information they disclose on their websites. Exchanges should develop rating systems that permit accurate comparison of the value
of competing health plans, and satisfaction survey programs that pay particular attention to the opinions of plan members who have serious health problems or financial problems related to their health needs. When conducting their evaluations, exchanges should be attentive to the opinions of employers as well as individuals.

6) The exchanges and public subsidy eligibility determinations

Many individuals and families who approach the exchange will need financial assistance to purchase health insurance. Medicaid eligibility expands dramatically under the ACA, with Medicaid assistance available for individuals and families with incomes up to 133 percent of poverty. Children up to the age of 19, and in many states up to age 21, will be eligible for Medicaid or CHIP. In all but two states, children are eligible for CHIP if their families have incomes of 200 percent of poverty or less, with 22 states providing coverage above that level. Individuals and families with incomes above Medicaid and CHIP eligibility levels but at 400 percent of poverty or less will be eligible for premium tax credits and cost-sharing reductions. In some families, children will receive Medicaid or CHIP while the parents receive premium tax credits. States may also supplement the federal premium tax credits available through the exchange.

It is vitally important that the ACA vision of a seamless, coordinated, efficient, electronic system be implemented for processing applications for tax credits, cost-reduction subsidies, Medicaid, and CHIP if the exchanges—and the ACA itself—are to succeed. That success will require creative interpretation and application of certain provisions of the ACA that create barriers to implementation of an efficient eligibility system. It is equally important, if not more so, that the subsidy determination process not stand in the way of unsubsidized individuals. For millions of individuals who are not entitled to subsidies, the market outside the exchange will continue to be readily available. Those individuals must be able to avoid completely the subsidy application process if they choose to do so, or face only a minimally burdensome screening if they choose to apply, so that they do not face any impediments to purchasing insurance through the exchange rather than through the outside market.

Further Recommendations: Although the Affordable Care Act includes extensive provisions describing how eligibility for premium tax credits, cost-sharing reductions, Medicaid, and CHIP are to be determined, the allocation of responsibility for making such determinations remains unclear and contradictory. The statute should be implemented in such a way as to permit an individual to apply initially either to the exchange or to the state Medicaid agency. Either entity must then make certain that the individual is signed up for the appropriate program. The exchange and the Medicaid and CHIP programs should facilitate electronic applications without the need for paper documentation. Interim assistance should be readily available in cases where eligibility cannot immediately be determined. The reconciliation requirements of the statute should be interpreted so as not to defeat the purpose of providing assistance to those who need it. Exchanges should see it as their responsibility to ensure the continued enrollment of eligible individuals and families for tax credits or public programs, rather than holding individuals responsible for continually having to work at maintaining their own eligibility.

7) Administrative costs and funding of the exchanges

To be successful, exchanges must be able to offer insurance plans that provide at least as much value for money as insurance plans available in the non-exchange market. Because all plans offered by exchanges must be certified as qualified health plans, they are likely to be of high quality. In the end, however, the premium charged by a plan will be a key factor in determining whether or not individuals and employers
purchase insurance inside or outside the exchange, particularly for families and employers who are not eligible for the tax credit. Unless a state requires the market outside the exchange to abide by the same rules as qualified health plans inside the exchange, or unless the exchanges are extraordinarily sensitive about imposing extra costs on qualified health plans, plans inside the exchange may have to charge higher premiums than those outside. Moreover, exchanges themselves will not be without cost. They are responsible for establishing eligibility for Medicaid and for premium tax credits, as described above. They are supposed to contract with “navigators,” organizations that can help inform the public about the availability of qualified health plans and financial assistance and can help enroll individuals in qualified plans. Exchanges will have a substantial role in creating, collecting, managing, and distributing information and in rating participating plans. The exchanges will also have regulatory responsibilities that will require resources.

The states will receive planning grants from the federal government to get underway, but must fully support the exchanges after 2014. Exchanges may also be able to apply for federal grants to develop new enrollment systems, either directly or through the states in which they operate. The ACA further recognizes that exchanges may receive funding from external sources on an ongoing basis. To the extent that the exchanges assist in processing applications for Medicaid and other state health programs, they should be reimbursed by the state, which in turn should be reimbursed by the federal government for the federal share of those administrative costs. Beyond this reimbursement, however, it is unlikely that states will choose to subsidize exchanges.

**Reducing Administrative Costs**

However exchanges are funded, they must be able to reduce the costs to insurers or to enrollees by at least enough to offset their own cost. For subsidized enrollees, exchange coverage will be attractive because they will not be faced with the full cost of the insurance. Most employers and many middle- and upper-income families will not receive subsidies, however, so exchanges will have to find alternative approaches to lowering costs to purchasers.

One approach:

- Motivate insurers to offer premiums within the exchange that are lower than those available outside it by providing them with an exchange market large enough for competitive forces to drive down premiums
  - Insurers could then reduce premiums if the exchange were able to lower their administrative costs, making it less expensive for insurers to offer coverage within the exchange than outside it
  - If exchanges can lower the administrative costs incurred by purchases, and in particular by employers, purchasing through the exchange might be attractive even if nominal premiums charged are the same or slightly higher than non-exchange premiums

This being said, most exchanges to date have not been able to reduce administrative costs significantly in the development stages.

Exchanges could perform a number of administrative functions that could further lower insurer costs, including processing applications for coverage and for subsidies, billing enrollees and employees for premiums, providing financial reconciliation, paying commissions, providing Web site development and maintenance, marketing and outreach, and broker and human resources training. By affording continuity of coverage when employees change jobs, exchanges can reduce insurer marketing costs. By creating greater transparency, exchanges can make insurers’ administrative costs more visible,
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thus creating additional pressure on insurers to lower them.

An exchange can also reduce employers’ costs by taking over some of the functions of administering and maintaining insurance policies, which employers would otherwise have to either handle themselves or contract out.

The most contentious cost-saving measure that exchanges may attempt is limiting or eliminating insurance agents’ and brokers’ commissions. Agent and broker commissions can account for 10 to 15 percent of the health insurance premium in the individual market, perhaps even more in the first year of a policy.

Implementation Issues and recommendations for employers

The following list is adapted from an article by Maureen M. Maly, of Faegre & Benson LLP. It can be found at http://www.shrm.org/hrdisciplines/benefits/Articles/Pages/AfterOneYear. This basic checklist is designed to highlight the issues employers should be focusing on moving through the second year of federal healthcare reform.

1. **Understanding the big picture.** If health care reform withstands the legislative, judicial, and political challenges it currently faces, then the landscape will be substantially different by 2014. Health insurance exchanges will be in place where individuals can purchase health care coverage, some with subsidies, and individuals and employers will be subject to health insurance coverage mandates. It will be important for employers to understand how the new exchanges work, which employees will qualify for subsidies, and which individuals and employers will be subject to the health insurance coverage mandates.

2. **Modeling costs post-2014.** Employers should be modeling their costs under various alternatives in 2014. One alternative might be to stop providing major medical insurance. This would mean sending employees to the new health insurance exchanges for coverage and paying the no coverage penalty of $2,000 per full-time employee (assuming at least one such employee obtained a subsidy for exchange coverage). Another alternative would be to keep providing coverage. However, in that case, employers will want to consider whether they need to make changes to the cost and quality of their coverage to avoid penalties that will apply if an employer’s coverage is considered unaffordable or low value. Of course, cost is not the only factor driving health insurance coverage decisions, and employers will also want to consider other factors, such as competitiveness, employee productivity, and morale.

3. **Getting ready for new reporting and disclosure requirements.** Health care reform contains a number of new reporting and disclosure requirements that will begin taking effect in the next three years, including a new requirement to report the value of health insurance coverage on Form W-2, new mini-summaries of health coverage (both effective in 2012), and new cost and coverage reporting requirements (effective in 2014). Although we are still waiting for guidance on the specifics of these requirements, employers should begin alerting their systems and administration personnel that these new obligations will be coming soon.

4. **Updating plan documents and contracts.** Most employers made a number of changes to their health plan documents in 2010 to comply with some of the new health care reform
requirements, such as covering adult children to age 26, eliminating lifetime limits on essential benefits, and notifying plan participants about grandfathered status if a plan decided to become a grandfathered plan. Employers should make sure that their plan documents and summary plan descriptions accurately reflect all of the changes they made. In addition, as employers renew contracts with service providers to benefits plans, they should consider whether the contracts require changes for health care reform, such as new claims processes, incorporating revisions to the internal process and external review, new indemnification provisions, etc.

5. **Monitoring developments.** The constitutionality of the individual mandate provisions of health care reform continues to be challenged in courts all over the country, and courts have come to differing decisions. Experts are in widespread agreement that this issue will be resolved by the Supreme Court. The only issue is how soon that will happen. And, even if the Supreme Court finds the individual mandate provision unconstitutional, the fate of the rest of the healthcare reform provisions is unclear. Health care reform has also faced legislative challenges and although it is unlikely to be repealed in its entirety under the current administration, there are likely to be some changes, such as repeal of the broader Form 1099 filing requirement. Employers should continue to monitor these developments closely.

### II. Constitutional and Legislative Challenges to the PPACA

The PPACA has come under attack by both public and private lawsuits, as well as state legislation. This report will look first at what provisions of health care reform are being challenged in the courts, and on what constitutional grounds. Next, the state legislation aimed at limiting the reach of the PPACA will be discussed and summarized, with examples from several states cited.

**Key ACA Provisions Challenged**

Collectively the litigation raises constitutional challenges to four provisions of the ACA.

- **Individual responsibility** – The law’s requirement that beginning January 1, 2014, non-exempt individuals either maintain health insurance coverage (termed “minimum essential coverage”) or pay a penalty in the form of a tax.
- **Medicaid expansion** – The law’s requirement that states participating in Medicaid expand their programs, beginning January 1, 2014 to cover non-elderly persons with incomes below 133 percent of the federal poverty level (FPL), including individuals previously ineligible for federally assisted Medicaid benefits.
- **Insurance market reforms** – Federal reforms aimed at curbing certain practices by health insurers, specifically: reforms that require insurers and self-insured group plans to issue and renew health insurance coverage without regard to the health status of individuals or groups, and to offer coverage that is not subject to annual or lifetime limits and that complies with certain other requirements.
- **Employer responsibility** – The law’s minimum employer contribution responsibilities in the case of employers that either offer no plan or a plan with inadequate subsidies, with contribution responsibilities tied to the number of employees that qualify for a subsidy.
These provisions are most commonly challenged under the Commerce Clause, Taxation Power, and the Ninth and Tenth Amendments.

Grounds of Challenges

1) Minimum essential coverage (the individual mandate) and the Commerce Clause

In passing the individual mandate provision through the legislature, Congress and the federal government have relied on the argument that the power to do so is grounded in the Commerce Clause. The Commerce Clause provides that Congress shall have ‘Power to regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes’. Case law has provided that Congress has the power to regulate: 1) the use of channels of interstate commerce; 2) to protect the instrumentalities of interstate commerce, or persons or things in interstate commerce; and 3) those activities that substantially affect interstate commerce.

The third prong of the above test is the most relevant to the individual mandate. The constitutionality of the PPACA turns on whether or not the individual mandate can be seen as a regulation of activities that substantially affect inter-state commerce. It is undisputed that Congress may regulate insurance under the Commerce Clause; the key question is whether the individual mandate is a legitimate use of Congressional powers under the Clause. The argument in opposition states that a decision not to engage in a contractual relationship (opting NOT to buy health insurance) has nothing to do with interstate commerce – regulation of inactivity does not constitute commerce. No Supreme Court case to date has directly addressed the regulation of inactivity. Case law of the 20th century featured a broad interpretation of Congressional authority to regulate under the Commerce Clause, but decisions in the last two decades have limited the reach of Congress’s power under the Clause.

2) Individual mandate and the Taxation Power

An alternative constitutionality argument in support of the individual mandate is that the minimum coverage provisions are justified by Congress’s expansive power to tax for the general welfare. The Constitution provides that ‘the Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the…general Welfare”. Congress uses the taxation power argument as a secondary option to its claims under the Commerce Clause. All of the District Courts which have, to date, considered the issue, have rejected the argument that the mandate is supported by the Taxation clause, preferring instead the argument under the Commerce Clause.

In State of Florida v. U.S. Department of Health and Human Services (see below for further details), the judge concluded that the penalty was not a tax because: 1) Congress did not describe it as a tax, as can be evidenced by its earlier use of such language, which it later discarded in favor of different language. Congress opted instead to call the fee a penalty. 2) Congress did not state in the Act that it was exercising its taxing authority to impose the individual mandate and penalty; it instead relied exclusively on its power under the Commerce Clause; 3) The Act does not mention any revenue generating purpose that is to be served by the individual mandate and penalty, even though such a purpose is required. The judge found that Congress did not intend to impose a tax when it imposed the penalty. All courts to date have concluded that the penalty is not a tax.

2 In the Fifth Circuit, the test of tax validity is ‘whether on its face the tax operates as a revenue generating measure and the attendant regulations are in aid of a revenue purpose’.
The first of three Federal Appeals Courts found the individual mandate constitutional in June 2011. Three judges heard the case. 1 Republican and 1 Democrat sat in the majority vote and found the individual mandate a valid exercise of legislative power by Congress under the Commerce Clause. In the same month, the Sixth Circuit Court of Appeals also upheld the individual mandate, also citing the Commerce Clause.

3) Coercing and Commandeering the states; Violation of the Tenth Amendment

Coercion and commandeering of the states has been suggested under two components of PPACA.

Medicaid: In the Florida case, the state plaintiffs argued that the Act drastically expanded and altered the Medicaid program to such an extent they could not afford the newly imposed costs. The defense did not deny that the Act would significantly alter and expand the Medicaid program, but rather emphasized that the states’ participation in Medicaid under the Act is, as it always has been, entirely voluntary. The defense also noted that Congress expressly reserved the right to alter and amend the Medicaid program and has done so numerous times in the past. The states’ countered that because of the enormous costs involved in the program, they did not actually have the freedom to opt out and that, by imposing this requirement, Congress was coercing and commandeering the states. This count was dismissed by the judge.3

Health Benefit Exchanges: These exchanges allow individuals and small businesses to leverage their buying power to obtain competitive prices. The Act provides that these exchanges will be set up and operated by the states, or by the federal government if the states opt not to do so. In the Florida case, the states argued that, although in theory they had a choice, in practice, the Act forced them to operate the exchange under threat of removing or curtailing their regulatory powers, and thus constituted coercion and commandeering in violation of the Ninth and Tenth Amendments. This claim was dismissed by the judge.

Employer Mandate: In Thomas More, the states argued that the employer mandate interferes with the states’ sovereignty as large employers, as well as the performance of government functions, and is therefore in violation of Article I and the Ninth and Tenth Amendments. The employer mandate requires large employers (including states, in their capacities as large employers) to offer and automatically enroll employees in federal-approved insurance plans or else face substantial penalties and assessments. The judge in Thomas More stated that healthcare benefits should be treated no differently than other aspects of compensation and conditions of employment that the Supreme Court has already held that Congress may regulate and mandate against the states (such as wages, hours, overtime pay, etc.). This thereby invalidated the Tenth Amendment claim.

As of May 2011 there are two distinct state-based federal court challenges and several other private party suits with judges’ rulings:


3 Although it has been discussed, in the form of the Dole coercion theory: “in some circumstances the financial inducement offered by Congress might be so coercive as t pass the point at which pressure turns into compulsion”. Dole v. South Dakota.
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- On January 31, 2011 Federal District Judge Roger Vinson declared the federal health care overhaul unconstitutional, siding with 26 states that sued to block it, saying that people can't be required to buy health insurance by 2014 or face penalties. He went a step further than a previous ruling against the law, declaring the entire thing unconstitutional if the insurance requirement does not hold up.

- Attorneys for the administration had argued that the states did not have standing to challenge the law and that the case should be dismissed. The final step will almost certainly be the U.S. Supreme Court.

  - Judge Henry Hudson in August 2010 declined to dismiss the suit. He issued a ruling declaring the individual mandate unconstitutional on December 13, 2010. The appeal by the Administration was heard by the U.S. Court of Appeals for the 4th Circuit on May 10. Hudson stopped short of voiding the entire law, ruling just the individual mandate provision to be in violation of the Constitution.

  - On October 7, Judge George Steeh dismissed this case, stating that choosing not to obtain health insurance coverage qualified as an example of "activities that substantially affect interstate commerce", thereby ruling the act to be constitutional. The court concluded that Congress had the power to impose obligations on individuals who claimed not to participate in interstate commerce because the obligations were components of broad schemes regulating interstate commerce. 4
  - Plaintiffs appealed to the U.S. Court of Appeals for the 6th Circuit.

- **Liberty University v. Geitner**
  - A private party suit by Liberty University was rejected in the U.S. District Court for the Western District of Virginia on November 30; the judge issued a 54-page ruling that granted the government’s request to dismiss the case. The judge found that there was a rational basis for Congress to conclude that individuals’ decisions about how and when to pay for health care are activities that in the aggregate substantially affect the interstate health care market. He also concluded that forgoing insurance is far from inactivity, but rather an economic decision to pay for health care services later, out of pocket, rather than now, through the purchase of insurance. Thus, he concluded the Act to be constitutional.

- **US Citizens Assoc. v. Sebelius**

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4 The court pointed to Congress’s emphasis in the legislative findings that it had enacted the Health Care Reform Act to address a national crisis – tens of millions of Americans without insurance, and out of control medical costs on the national level. Congress stated that how Americans choose to pay for health care services has a direct and substantial impact on the interstate health care market. Second, the minimum coverage provision is essential to the Act’s larger regulation of the interstate business of health insurance. In effect, the individual mandate addresses cost shifting in the market.
Patient Protection and Affordable Care Act: Challenges and Issues

- In another private party suit, the U.S. District Court for the Northern District of Ohio on November 22 allowed part of a lawsuit challenging the constitutionality of the health reform law to move forward.
- Dismissing three claims brought by the U.S. Citizens Association, Judge David Dowd agreed to hear arguments that the law’s individual mandate violates the Constitution’s interstate commerce clause. The rejected claims asserted that the law violated plaintiffs’ freedom of association guaranteed by the First and Fifth Amendments, the due-process clause of the Fifth Amendment and plaintiffs’ right to privacy.

Cases to Repeal the Healthcare Law

State Legislative Efforts at Reforming the PPACA

Filing lawsuits is the first of two options that states and private parties are using to counter the PPACA. There are also plenty of separate state legislative reform initiatives, with some members of at least 45 state legislatures having proposed legislation to limit, alter or oppose selected state or federal actions. In general, many of the opposing measures, in 2010 and 2011:
Patient Protection and Affordable Care Act: Challenges and Issues

- Focus on not permitting, implementing or enforcing mandates (federal or state) that would require purchase of insurance by individuals or by employers and impose fines or penalties for those who fail to do so.
- Seek to keep in-state health insurance optional, and instead allow people to purchase any type of health services or coverage they may choose.
- Contradict or challenge policy provisions contained in the 2010 federal law.

The language varies from state to state and includes statutes and constitutional amendments, as well as binding and non-binding state resolutions. For 2011, there are several new approaches:
- Several states considered bills that would prohibit state agencies or officials from applying for federal grants or using state resources to implement provisions of the Affordable Care Act, unless authorized to do so by adopted state legislation.
- 16 states considered measures to create an "Interstate Freedom Compact," joining forces across state lines to coordinate or enforce opposition.
- Several states are considering bills that propose the power of "nullification," seeking to label the federal law "null and void" within the state boundaries.

[Map of 2009-2011 State Legislation Opposing Elements of Federal Health Reform]

- Enacted in 17 states; Laws in 15 states; Pending ballot questions in 4 states

Legend:
- Legislation, signed/adopted
- Legislation passed; approved by voters in 2010
- Legislation filed in 2011
- Filed; did not pass in 2011

See NCSL report for states with multiple filed legislation.
Examples of state legislative action

Signed laws and binding resolutions for ballot questions

Alabama - HB 60, passed House and Senate; enacted without governor's signature, June 9, 2011.
- Would oppose elements of federal health reform, providing by constitutional amendment that residents may provide for their own health care, and that "a law or rule shall not compel any person, employer, or health care provider to participate in any health care system." This amendment requires voter approval or disapproval on the November 6, 2012 ballot.

Florida - H 1193, passed House and Senate; signed by the governor as Chapter No. 2011-126, June 2, 2011.
- By state statute, prohibits a person from being compelled to purchase health insurance except under specified conditions including dangerous occupation, voluntary enrollment in public benefits or contracts between private parties.

Florida - S 2, passed Senate and House; sent to the secretary of state, 5/4/2011.
- Joint resolution proposes a State Constitutional amendment to prohibit laws or rules from compelling any person, employer, or health care provider to participate in any health care system, permit any person or employer to purchase lawful health care services directly from health care provider, or permit health care provider to accept direct payment from person or employer for lawful health care services. This amendment requires voter approval or disapproval on the November 6, 2012.

Texas - SB 7, passed Senate, passed House, 96y-48n, 6/27/2011; signed by the governor, July 19, 2011.
State market reform act; includes an interstate health care compact, allowing Texas to partner with other states to ask the federal government for control — both fiscal and governmental — over Medicare, Medicaid and commercial coverage; also directs state officials to seek a waiver from Washington to operate Medicaid with a federal block grant ballot.
Non-binding resolutions, adopted 2011

Colorado - HR 1010, Adopted non-binding House-only resolution, citing the 10th Amendment, requests the U.S. Congress to repeal the individual mandate required by PPACA; also strongly encourages Congress to "recognize individual states' efforts to reform health care by grandfathering any state laws, regulations, or practices intended to contain costs, improve quality, increase consumerism, or otherwise implement health system reform concepts.

Passed, but vetoed by governors

Idaho - H 298, passed House and Senate; vetoed by governor, 4/20/2011.
- Would have provided that no person within the State shall be compelled to participate in a government health insurance program not authorized by the State; provides that the Affordable Care Act shall not be enforced, administered or enacted by the State and no department, agency or political subdivision shall accept or expend moneys related to the implementation of discretionary provisions of the Act, such as exchanges and insurance consumer protections.

Minnesota - S 760, passed Senate and House; vetoed by governor, May 24, 2011.
- Would have opposed selected provisions of the ACA, by declaring that the public policy of the state "is that every person within the state of Minnesota is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty." Also would provide that no state official or employee "shall act to impose, collect, enforce, or effectuate any penalty" related to ACA mandates for coverage.