THE FUTURE OF HEALTH CARE REFORM REMAINS IN FEDERAL COURT

Jonathan H. Adler

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Jonathan H. Adler
Johan Verheij Professor of Law
Director, Center for Business Law & Regulation
Case Western Reserve University School of Law

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Abstract
National Federation of Independent Business v. Sebelius did not mark the end of litigation challenging the Patient Protection and Affordable Care Act (PPACA) against constitutional attack. To the contrary, PPACA litigation continues apace and could well increase in the years to come as federal agencies seek to implement the health care reform law. This essay provides a brief overview of how continuing litigation in federal court will affect the implementation – and perhaps even the ultimate viability – of Congress’s latest and most ambitious health care reform effort. Topics discussed include legal challenges to the availability of tax credits in federally run health insurance exchanges and a requirement that group health plans cover contraception, and prospective challenges to the Independent Payment Advisory Board and revisions to the individual mandate penalty.
The Future of Health Care Reform Remains in Federal Court

Jonathan H. Adler*

In *National Federation of Independent Business v. Sebelius* a closely divided Supreme Court upheld nearly all of the Patient Protection and Affordable Care Act (PPACA) against constitutional attack.1 Perhaps most significantly, the Supreme Court upheld one of the Act’s central and most controversial provisions – a requirement that all Americans obtain “minimum essential” health coverage2 -- by recasting it as an exercise of the federal government’s taxing power. The only provision of the PPACA to fall was a requirement that states participate in a substantial expansion of Medicaid to continue to receive any Medicaid funding. *NFIB* will not be the judiciary’s last words on health care reform, however. PPACA litigation continues apace and could well increase in the years to come as federal agencies seek to implement this complex and contentious law. Having survived a frontal assault, the PPACA will continue to be the subject of legal attacks.

This chapter provides a brief overview of how continuing litigation in federal court will affect the implementation – and perhaps even the ultimate viability – of Congress’s latest and most ambitious health care reform effort. First, this chapter surveys those factors that will

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* Johan Verheij Memorial Professor of Law and Director of the Center for Business Law and Regulation, Case Western Reserve University School of Law. This paper is based on a presentation at the Conference on the Future of Health Care Reform in the U.S., University of Chicago Law School, October 12, 2012.


2 26 U.S.C. §5000A. The Act exempts some groups from this requirement, including prisoners, undocumented aliens, and those with valid religious objections. *Id.* at §5000A(d).
contribute to a surge of litigation as the PPACA is implemented in the coming years – a surge that has already begun.

One of the larger and more significant PPACA implementation challenges will be the establishment and operation of health insurance exchanges in all fifty states. As the next part explains, this implementation will be complicated by the PPACA’s statutory language and consequent legal challenges to administrative fixes. The PPACA’s authors hoped exchanges would play a key role in expanding access to affordable health insurance. Yet political miscalculation, drafting compromises, state resistance and litigation could hinder the exchanges’ viability as a means to expand insurance coverage.

Litigation and conflict are inevitable for any policy reform that touches questions of reproductive healthcare and the sanctity of life, and the PPACA is no exception. The chapter next details the legal challenges to regulations adopted under the PPACA requiring group insurance plans to include coverage for all forms of contraception. This litigation is emblematic of the ideological and value-driven litigation that is likely to persist as federal agencies make policy choices about what sorts of health care services can or must be covered, under what conditions, and at whose expense.

Challenges to PPACA provisions adopted to control health care costs could open another front in the legal battle over health care reform. Congress created a new federal agency – the Independent Payment Advisory Board – to constrain the growth of Medicare spending. To ensure the IPAB’s effectiveness, the PPACA insulates it from outside political pressure and entrenches its policy recommendations in unusual ways. These provisions, intended to strengthen the IPAB’s ability to constrain costs could also be the source of legal vulnerabilities
as the IPAB’s unique structure and authority raise constitutional questions that may need to be resolved by federal courts.

Even the individual mandate could be the source of additional litigation. NFIB upheld the imposition of a tax penalty on individuals who fail to obtain qualifying health insurance coverage. Yet as the next part explains, it may also have constrained the federal government’s ability to use this penalty as a means of combatting adverse selection in health insurance markets and exposed future reforms to the threat of further legal challenge. The bottom line throughout is that PPACA litigation is not over; it has scarcely begun.

A Perfect Storm for Litigation

NFIB presented the Court with a facial challenge to key provisions and the statute as a whole. Few other such facial challenges to the PPACA remain.\(^3\) The vast bulk of PPACA litigation going forward will concern the Act’s application and implementation. Many key provisions do not take effect until 2014, and many implementation details have yet to be worked out. The Congressional Research Service projects that federal agencies will be adopting new regulations to implement the PPACA for years, if not decades, to come.\(^4\) With each new regulation and exercise of discretion by federal agencies will come another opportunity for litigation. Various interest groups will challenge agency actions under the PPACA as well as

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\(^3\) At the time of this writing, there are lawsuits pending in federal court challenging the constitutionality of the PPACA under the origination clause and due process clause. Neither challenge is likely to succeed.

\(^4\) CURTIS W. COPELAND, CONG. RESEARCH SERV., R41180, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010) (“it seems likely that there will be a great deal of regulatory activity relating to the many provisions in PPACA for years, or even decades to come.”), available at: http://www.ncsl.org/documents/health/Regulations.pdf.
agency compliance with the Administrative Procedure Act. Additional constitutional challenges are also likely.5

Legal challenges against the implementation of large regulatory statutes are inevitable. Two decades after the 1990 Clean Air Act Amendments were adopted legal challenges to implementing regulations continue to be heard in federal court.6 The PPACA is likely to spur even greater amounts of litigation. Health care represents nearly one-seventh of the domestic economy. Any effort to reform this sector necessarily creates winners and losers. With so much money on the table, litigation is inevitable as various interest groups seek to protect their gains, recapture losses or seek out new rents within the PPACA’s health care regime.

The economic incentives for additional litigation are substantial, but economic interests will not be the only driver of PPACA litigation. Even after the NFIB decision the law remains unpopular with a substantial portion of the public and many Republican politicians are still clamoring for repeal. Ideological objections and partisan opposition to the law fuel litigation beyond that which might be economically justified. Republican state attorneys general along with conservative and libertarian public interest groups continue to seek opportunities to hamper full implementation of “ObamaCare.” NFIB did little to quell the broader political debate over the PPACA.

Health care reform is inherently more controversial and divisive than many other sorts of large-scale administrative reform efforts. Health care reform inevitably tranches on matters of

5 For example, physician-owned hospitals have challenged differential reimbursement rules under the Equal Protection Clause and the State of Maine sought to bring suit alleging that the “maintenance of effort” requirement limiting state ability to modify pre-existing state Medicaid rules, exceeds the scope of the federal spending power.

6 In 2011 and 2012 alone the U.S. circuit courts of appeal decided over two dozen cases concerning the implementation of the Clean Air Act.
deep ethical and personal concern for many Americans.\footnote{See B. Jessie Hill, What Is the Meaning of Health? Constitutional Implications of Defining ‘Medical Necessity’ and ‘Essential Health Benefits' Under the Affordable Care Act, 38 AMER. J. L. & MED. 445, 336 (2012) (noting “the intensely fraught nature of any attempt to define the essence of ‘health,’ ‘healthcare,’ or ‘medical necessity.’“).} Government decisions to pay for or subsidize some forms of health care and restrict others necessarily implicate contested questions of medical ethics and broader normative debates within society about nature of life, the importance of individual autonomy, and the role of government in promoting public health and particular visions of individual freedom. This is most apparent in the context of reproductive healthcare and end-of-life decisions, but permeates much of health care policy. Even seemingly technical questions about the comparative cost-effectiveness of various procedures necessarily implicates these broader ethical debates. As a consequence, health care reforms stir the passions and ignite ideological opposition in a way that policy initiatives in many other areas do not – and much of this passion will be channeled into the courts. An increasing array of public interest legal groups across the political spectrum stand ready to file legal challenges on behalf of various political, moral and religious causes.

The PPACA’s scope and complexity also make it particularly vulnerable to legal challenge. Such vulnerabilities were compounded by the unusual circumstances surrounding its passage, and the need to resort to the budget reconciliation process – as opposed to a House-Senate conference – to iron out legislative language. The law was rushed to the President’s desk without benefit of the usual review and revision processes that can smooth a statute’s rough edges. Many members also voted on the bill without being fully aware of all that it contained.

Two different reform bills initially emerged from the legislature. After each House of Congress passed its reform proposal along party lines, House and Senate negotiators met to negotiate a conference bill. It was not to be, however. Republican Scott Brown won a special
election in Massachusetts to replace Edward Kennedy in the Senate, thus depriving Democrats of a filibuster-proof majority. This forced health care reform proponents to abandon their efforts to craft a conference bill. Enacting the PPACA required taking a less-traveled path.

Lacking a sixty-vote margin in the Senate, reform proponents’ options were limited. The only way to get a bill to the President’s desk was for the House to pass the bill that had already passed the Senate – the PPACA – and then amend it as much as would be allowed under the budget reconciliation process. Reconciliation only requires a majority vote to pass the Senate, but may be used only for budget-related measures. This limited the range of amendments that could be offered and constrained last-minute efforts to “fix” the legislation. As reform advocates noted at the time, this presented a difficult choice: Enact a flawed bill with many imperfections or risk enacting no bill at all. In this case passing a flawed bill meant enacting a PPACA that would be less effective at expanding health insurance coverage or controlling health care costs than its proponents had hoped. Yet that was the choice reform proponents ultimately embraced even though, as one health law expert noted later, it meant enacting a law that no one had intended to become law. As a consequence, the PPACA would prove difficult to implement and particularly vulnerable to legal challenge.

Insurance Exchanges and the Consequence of Omission

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9 See Timothy Jost, Tax Credits in Federally Facilitated Exchanges Are Consistent with the Affordable Care Act’s Language and History, HEALTH AFFAIRS BLOG, July 18, 2012 (noting “the Senate Bill was not supposed to be the final law.”).
One of the central features of the PPACA is the creation of state-based health insurance exchanges, government-managed marketplaces in which consumers can shop for health insurance plans. Exchanges are a key element of the PPACA’s efforts to increase health insurance coverage. These marketplaces are intended to empower consumers to compare competing health plans by providing standardized comparative information about competing health insurance plans. At the same time, exchanges facilitate government regulation of insurance markets. Exchanges also play a role in the provision of tax credits and subsidies for insurance coverage and enforcement of the requirement that all but the smallest employers provide health insurance for their employees.

The creation of health insurance exchanges in every state is one of the greatest challenges of PPACA implementation. Section 1311 of the Act calls upon each state to create an “American Health Benefit Exchange” (“Exchange”). Section 1311’s requirement that states create exchanges is not enforceable, however, as the federal government may not commandeer state governments to implement a federal regulatory scheme. Rather, the federal government must give states a choice whether to cooperate. The federal government may offer various

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10 Some describe exchanges as the “centerpiece” of the PPACA reforms. See, e.g., Sandy Praeger, A View from the Insurance Commissioner on Health Care Reform, 20 KANSAS J. L. & PUB. POL.’y 186, 189 (2011) (“The centerpiece of the reform is the new health insurance exchanges that will operate in every state.”); see also Robert Pear, Health Care Overhaul Depends on States’ Insurance Exchanges, N.Y. TIMES, Oct. 23, 2010.


12 See Printz v. United States, 521 U.S. 898, 925 (1997) (“the Federal Government may not compel the states to implement, by legislation or executive action, federal regulatory programs.”); New York v. United States, 505 U.S. 144, 162 (1992) (“the Constitution has never been understood to confer upon Congress the ability to require States to govern according to Congress’s instructions”).
inducements for state cooperation, such as financial support or regulatory consequences, but states must be left with a meaningful choice.\textsuperscript{13}

Despite the obligatory language of Section 1311, the PPACA gives states a choice of whether to take responsibility for (and bear the cost of) operating an Exchange. States that agree to set up an exchange are eligible for start up funds from the federal government and, as the PPACA is written, low-income residents of such states are eligible for tax credits and cost-sharing subsidies to aid in the purchase of insurance. Should a state refuse to create its own exchange, Section 1321 provides that the federal government to create an Exchange in the state’s stead.\textsuperscript{14} In this respect, the PPACA embodies the sort of “cooperative federalism” common in many federal programs, from environmental regulation to Medicaid.\textsuperscript{15}

As written, the PPACA provides generous tax credits and subsidies to low and middle income individuals and families for the purchase of qualifying health insurance plans in state-run exchanges. Specifically, the Act offers refundable “premium assistance” tax credits to households with incomes between 100 and 400 percent of the federal poverty level (FPL).\textsuperscript{16} These tax credits are refundable, which means that if the credit is larger than a taxpayer’s tax obligations, the taxpayer is eligible for a refund. The Act further offers “cost-sharing” subsidies to help low-income individuals and families obtain more than the minimum level of coverage at

\textsuperscript{13} See \textit{NFIB}, 132 S.Ct. at 2602 (“Congress may use its spending power to create incentives for States to act in accordance with federal polices. But when ‘pressure turns into compulsion,’ the legislation runs contrary to our system of federalism.” (citation omitted)).

\textsuperscript{14} See 42 U.S.C. §18041(c)(I).

\textsuperscript{15} \textit{New York}, 505 U.S. at 167 (“where Congress has the authority to regulate private activity under the Commerce Clause, we have recognized Congress’ power to offer States the choice of regulating that activity according to federal standards or having state law pre-empted by federal regulation . . . This arrangement . . . has been termed “a program of cooperative federalism.””)

\textsuperscript{16} See 26 U.S.C. § 36B.
no additional cost. The plain text of the law limits these credits and subsidies to those who obtain health insurance through a state-run exchange, however.\textsuperscript{17}

Section 1401 of the PPACA creates a new section of the Internal Revenue Code – Section 36B – authorizing refundable premium assistance tax credits to aid in the purchase of health insurance in exchanges.\textsuperscript{18} Specifically, Section 1401 authorizes tax credits for each month in a given year in which a taxpayer has obtained qualifying health insurance. As defined by Section 1401, a “coverage month” is any month in which the taxpayer is “covered by a qualified health plan . . . that was enrolled in through an Exchange established by the State under section 1311.” The amount of the tax credit is also calculated with reference to a qualifying health insurance plan “enrolled in through an Exchange established by the State under [Section] 1311 of the Patient Protection and Affordable Care Act.” Section 1311 further defines an “Exchange” as “a government agency or nonprofit entity that is established by a State.” The cost-sharing subsidies provided under Section 1402 are similarly limited as this section expressly provides that cost-sharing reductions are only allowed for “coverage months” for which Section 1401’s tax credits are allowed.

Section 1321 requires the Department of Health and Human Services to “establish and operate” an Exchange in any state that does not choose to establish one of its own.\textsuperscript{19} A federal exchange is intended to perform the same functions as a state exchange. While a federal exchange may operate like a state exchange, nothing in the PPACA authorizes the provision of tax credits or cost-sharing subsidies in federal exchanges. To the contrary, the relevant

\textsuperscript{17} For a more extensive discussion of this issue and the implications for PPACA implementation, see Jonathan H. Adler & Michael Cannon, Taxation without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA, __ HEALTH MATRIX: JOURNAL OF LAW-Medicine __ (2013).

\textsuperscript{18} See 26 U.S.C. § 36B.

\textsuperscript{19} See 42 U.S.C. §18041(c)(1).
provisions of Section 1401 only provide for tax credits for the purchase of health insurance “established by a state under section 1311.” Nothing else in the PPACA provides that exchanges established by the federal government under Section 1321 can be treated as exchanges “established by a state” under Section 1311. Indeed, the PPACA expressly defines Section 1311 exchanges as those “established by a State” and defines “State” as “each of the 50 states and the District of Columbia.”

The textual limitation of tax credits to state-established exchanges has implications beyond the affordability of health insurance. Under Section 1513 of the PPACA employers with more than 50 full-time employees are required to offer “minimum essential coverage” to their employees.20 Failure to offer such insurance can subject employers to a $2,000 fine for every full-time employee beyond the first 30 employees.21 Significantly, this penalty is triggered when an employee becomes eligible for tax credits or cost-sharing subsidies by obtaining a qualifying health insurance plan through a state-run exchange. In effect, the penalty is designed to help offset the federal government’s cost of providing tax credits and cost-sharing subsidies and prevent employers from dropping employee health insurance coverage due to the availability of subsidized insurance in exchanges. Yet if tax credits are unavailable in a given state, due to the lack of a state-run exchange, employers in that state will not face penalties for failing to offer qualifying health insurance.

20 26 U.S.C. §4980H.

21 The PPACA provides, in the alternative, that if an employer provides “minimum value” insurance coverage that is not “affordable,” the employer is fined $3,000 per employee that receives tax credits or cost-sharing subsidies or $2,000 per employee after the first 30 employees, whichever is less.
When the PPACA was enacted, it was generally assumed that most if not all states would willingly create exchanges.\(^{22}\) As President Obama explained shortly after signing the landmark legislation into law, “by 2014, each state will set up what we’re calling a health insurance exchange.”\(^{23}\) Allowing states to create their own exchanges, in lieu of a federal exchange or a federally sponsored “public option” for insurance coverage, was intended to ameliorate concerns about a federal “takeover” of health care.\(^{24}\) It would also enable exchanges to take advantage of state experience with health insurance regulation.\(^{25}\) Few expected that many (if any) states would refuse.

States have turned out to be far less cooperative than anticipated. The PPACA provides that the Secretary of Health and Human Services was to determine by January 1, 2013 whether or not states would have a qualifying Exchange up and running by 2014.\(^{26}\) Accordingly, HHS initially set a November 16, 2012 deadline for states to declare their intentions. Yet by that date only seventeen states had indicated they would establish Exchanges under the law.\(^{27}\) Even given

\(^{22}\) Robert Pear, *U.S. Officials Brace for Huge Task of Operating Health Exchanges*, NY TIMES, Aug. 5, 2012 (“When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange”).


\(^{26}\) Section 1321.

more time, few additional states agreed to step forward.\textsuperscript{28} Despite the Administration’s best efforts to encourage state cooperation, including an offer to create “partnership” exchanges with state governments,\textsuperscript{29} as of this writing over thirty states have refused or otherwise failed to establish their own Exchanges as called for by the Act. Among the reasons offered by non-cooperating states are expected operating costs, uncertainty about the legal and technical requirements HHS will impose, and skepticism that state officials would really be in control of state Exchange operations. “State authority to run a health insurance exchange is illusory,” Pennsylvania Governor Tom Corbett explained, warning that cooperating states “would end up shouldering all of the costs by 2015, but have no authority to govern the program.”\textsuperscript{30} In some states, political opposition to the PPACA also remains substantial, precluding state officials from cooperating with the Act’s implementation.\textsuperscript{31}

Faced with the prospect that widespread state refusal to establish Exchanges under the PPACA would make tax credits and cost-sharing subsidies unavailable in much of the country, the Internal Revenue Service sought to fix the problem by reinterpreting (some would say disregarding) the relevant statutory language. In May 2012, the IRS adopted regulations concerning the availability of health insurance premium tax credits under the PPACA.\textsuperscript{32} Under the IRS rule, taxpayers would be eligible for tax credits (and, as a consequence, cost-sharing subsidies) upon purchase of a qualifying health insurance plan without regard to whether the plan


\textsuperscript{29} Interestingly enough, nothing in the PPACA would appear to authorize the creation of a “partnership” exchange.


\textsuperscript{31} Some states also enacted legislation, passed ballot referenda, or adopted constitutional amendments that would appear to preclude those states from establishing their own exchanges.

was obtained through a state-based exchange under Section 1311 or a federal exchange under Section 1321. In response to concerns that such a rule would extend eligibility for tax credits beyond what was authorized by the PPACA, the IRS responded:

The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.\footnote{Id. at 30378.}

No other explanation was offered in the Federal Register. Although commentators had argued that the express language of the PPACA limits the availability of the premium tax credits to those who enroll in qualifying health insurance plans through an Exchange established by a state under section 1311, the IRS did not identify any statutory language or legislative history to the contrary when it finalized the rule.

Pressed by members of Congress to offer a more complete justification for its rule authorizing tax credits and cost-sharing subsidies outside of state-created exchanges, the Department of the Treasury offered a fuller explanation some months later, embracing arguments put forward by some health care reform advocates.\footnote{See, e.g., Jost, HEALTH AFFAIRS BLOG; \textit{but see} Michael Cannon & Jonathan H. Adler, \textit{The Illegal IRS Rule to Expand Tax Credits Under the PPACA: A Response to Timothy Jost}, HEALTH AFFAIRS BLOG (Aug. 1, 2012).} Specifically, the Treasury Department suggested that the language of Section 1321 could be interpreted to make a federally established
exchange “the equivalent of a state exchange in all functional respects,” including an Exchange for purposes of determining eligibility for tax credits. The basis for this interpretation is that Section 1321 provides that if the HHS Secretary determines that a state will not have a required Exchange – that is, the Exchange required by Section 1311 – operational by January 1, 2014, the Secretary is required to “establish and operate such Exchange within the State.” “Such exchange,” according to Treasury, is a Section 1311 Exchange and should be treated as such for the purposes of authorizing tax credits and cost-sharing subsidies. Further, as an Exchange established by the federal government under Section 1321 would be subject to the same requirements as an Exchange established by a state under Section 1311, there would be no reason to limit tax credits to the purchase of qualifying health insurance plans in state-run Exchanges.

This would be a plausible interpretation of the relevant statutory text were it not for repeated references to the state role in establishing those Exchanges through which tax credits may be offered. As noted above, Section 1311 expressly requires that an authorized Exchange must be “established by a State.” Section 1304(d) also expressly defines “state” as “each of the 50 States and the District of Columbia.” Yet even if one were to set this language aside, as the Treasury Department suggests, and conclude that a Section 1321 Exchange is the equivalent of a Section 1311 Exchange, this is not enough to establish that tax credits are available to offset the costs of qualifying health insurance plans in either type of Exchange.

The eligibility requirements for the tax credits are not found in either Section 1311 or Section 1321, but in Section 1401. This section repeatedly defines qualifying health insurance

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36 See id. (citing 42 U.S.C. §18041(c)(1)).
plans eligible for tax credits as those purchased “through an Exchange established by the State under section 1311.” So even if one reads Section 1321 to provide that an Exchange established by the federal government is, for all intents and purposes, a Section 1311 Exchange, a federal Exchange is still not an Exchange “established by the State” as required by Section 1401.

The repeated reference to the state role in creating the relevant exchanges is significant.37 Not all references to exchanges in the PPACA reference the state role as Section 1401 does. Section 1421, for example, provides tax credits to small businesses that make nonelective contributions to employee plans offered through an Exchange. Yet whereas Section 1401 repeatedly references Exchanges “established by a State,” Section 1421 only references “Exchanges.” Under the Treasury Department’s interpretation, the additional language in Section 1401 is reduced to surplusage.38

Despite months of prodding, neither the Department of the Treasury nor the Department of Health and Human Services has been able to identify any legislative history that expresses legislative intent to provide tax credits and cost-sharing subsidies in federal exchanges. The only legislative history identified by the federal government in support of its interpretation is the addition of information-reporting requirements when the PPACA was amended during the Reconciliation process by the Health Care and Education Reconciliation Act of 2010 (HCERA). These requirements, which expressly apply to Exchanges established under both Section 1311

38 As a general rule, courts are not to treat any statutory provisions as mere surplusage. See, e.g., Duncan v. Walker, 533 U.S. 167, 174 (2001) (“We are . . . ‘reluctan[t] to treat statutory terms as surplusage’ in any setting” (citation omitted)); Jones v. U.S., 529 U.S. 848, 857 (2000) (“Judges should hesitate . . . to treat statutory terms in any setting as surplusage” (citation and internal quotation omitted)); see also Russello v. United States, 464 U.S. 16, 23 (1983) (“Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.”); NFIB, 132 S.Ct. at ___ (same).
and Section 1321, include information relevant to the administration of the tax credits, such as information relating to taxpayer eligibility and the receipt of advance payments. According to the Treasury Department, the addition of this language “strongly suggests that all taxpayers who enroll in qualified health plans, either through the federally-facilitated exchange or a state exchange, should qualify for the premium tax credit.”

The problem with this interpretation is that there is still no language in the PPACA that can be plausibly interpreted as authorizing the granting of tax credits and premium assistance in federal exchanges. That Congress chose to adopt a single set of information-reporting requirements to both state and federal exchanges does not suggest, let alone establish, that such exchanges are equivalent in all respects, particularly in the absence of any other language that would establish such equivalence. Given the various functions exchanges are required to perform, including determining Medicaid eligibility and monitoring insurance company compliance with applicable regulations, there were ample reasons to enact only one set of reporting requirements applicable to both state and federal exchanges. Further, if the reference to “such Exchange” in Section 1321 truly made federal exchanges established under Section 1321 the full equivalent of state exchanges established under Section 1311, there would have been no need to reference both sections in the HCERA’s reporting requirement.

Had Congress sought to make federal exchanges created under Section 1321 identical to state exchanges established under Section 1311, it could have done so. Indeed, when Congress amended the PPACA with the HCERA it adopted such equivalence language with regard to territorial exchanges – expressly providing that Exchanges established by territories would be

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treated as the equivalent as Exchanges established by states and that tax credits would be available in such Exchanges as well. Had Congress meant to ensure that tax credits could be available in federal exchanges, one would have expected it either to adopt similar language to this effect or to remove the “established by a State” language in Section 1401. It did neither, despite making numerous changes to that section through the HCERA.

Some commentators have suggested that the failure to authorize tax credits and cost-sharing subsidies in federal exchanges must have been a “drafting error” as “[t]here is no coherent policy reason why Congress would have refused premium tax credits to the citizens of states that ended up with a federal exchange.” After all, to prevent the issuance of tax credits and cost-sharing subsidies in states that refuse to create their own exchanges is to risk compromising the PPACA’s central goal of expanding health care coverage. Yet there are plenty of reasons why some in Congress may have believed a conditional offer of tax credits made sense, even if in hindsight it looks somewhat foolish or even absurd.

The most plausible reason for conditioning the availability of tax credits and cost-sharing subsidies on state cooperation would be to provide an additional impetus for states to create exchanges of their own accord. The authors of the Senate bill in particular wanted states to create exchanges. Yet, as noted above, Congress cannot simply tell states what to do. If the federal government wants states to cooperate, particularly at their own expense, the federal government needs to provide some inducement. Financial support of related programs is the most obvious, and commonly used, incentive (see, e.g., Medicaid), but there is only so much

money to go around. The PPACA authorized startup funding to help states get exchanges off the
ground, but left states responsible for funding their continued operation. Section 1321 also
committed HHS to creating federal exchanges as a fallback if states were late to come around,
but the threat of federal action of this sort is not the most powerful incentive for states to act.

Another way to encourage state participation, identified as the Senate’s health reform
legislation was first taking shape, would be to condition the availability of tax credits or other
subsidies on state cooperation. As one prominent health law scholar proposed in 2009, Congress
could encourage states to create their own insurance exchanges “by offering tax subsidies for
insurance only in states that complied with federal requirements.”41 While less common than
threatening to withhold funds (as was done with Medicaid) this approach was not unprecedented.
Other draft health care reform bills introduced in the Senate contained similar provisions
explicitly designed to encourage state cooperation. Moreover, on multiple occasions Congress
has offered or withheld tax benefits based upon state cooperation with or resistance to federal
policies.42

Threatening to deprive needy individuals of greater access to health insurance because of
state refusal to cooperate may seem like an “absurd” tactic for Congress to use, but it is hardly
unprecedented. It can actually be found in other parts of the PPACA, as with the Medicaid
expansion. As originally enacted, the PPACA provided that if a state were to refuse to
participate in the Medicaid expansion, it would forfeit all federal funding for the expansion as

41 Jost, Health Insurance Exchanges, at 7.
42 The Supreme Court has also upheld the constitutionality of imposing differential tax burdens as a consequence of
state cooperation with or resistance to federal policy priorities. As the Supreme Court noted in NFIB, the Court had
previously upheld federal legislation “predicating tax abatement on a State’s adoption of a particular type of
unemployment policy” in Steward Machine Co. v. Davis, 301 U.S. 548 (1937). See NFIB, 132 S.Ct. at ___. See also
Act Amendments that authorized surcharges on importation of low-level radioactive waste from noncompliant
states).
well as all federal support for the pre-existing Medicaid program. In other words, Congress threatened to withhold federal support for medical care for some of the most vulnerable populations in a state were that state to refuse to implement the federally preferred policy. The result of such a sanction would have been to greatly reduce access to health care in an uncooperative state, thereby compromising efforts to maintain (let alone expand) health insurance coverage under the PPACA. Yet there is no question this is what Congress intended (even if, as a majority of the Supreme Court ultimately concluded, such a threat was unconstitutional on other grounds).

Congress decided to pursue the PPACA’s goal of expanding coverage by enlisting states in the cause, and it sought to encourage state participation with incentives, including a threat to withhold funding for benefits to needy populations. Congress did not think any state would refuse the Medicaid expansion, just as few considered that states might not be willing to create their own exchanges. Whether due to the use of conditional tax subsidies or not, most commentators simply assumed that states would willingly create their own insurance exchanges, particularly when the most likely alternative would be a federal exchange – ominously characterized by some as a “federal takeover” of the health care system.43

As it happened, some members of Congress were concerned that states might fail to implement exchanges or otherwise cooperate with federal health care reform. For this reason, some members of the House of Representatives urged the House-Senate conference committee to reject the state-based exchanges contained in the Senate PPACA in favor of a federally run

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43 The Senate Democratic Policy Committee, for example, responded to claims that health care reform would result in a federal “takeover” with a “fact check” claiming that “All the health insurance exchanges . . . are run by states.” See Senate Democratic Policy Committee, Fact Check: Responding to Opponents of Health Insurance Reform, Sept. 21, 2009, available at: http://dpc.senate.gov/reform/reform-factcheck-092109.pdf.
model that had been included in the House bill. Had Republican Scott Brown not been elected to
the Senate, thereby depriving Senate Democrats of a filibuster-proof majority, the conference
negotiators may well have followed this advice. In the end, however, Massachusetts voters took
this option off the table. The only way to enact comprehensive health care reform was to stick
with the Senate bill – and this meant sticking with state-based exchanges and a conditional offer
of tax credits and cost-sharing subsidies.

The fate of tax credits and cost-sharing subsidies in states without state-run exchanges
will ultimately be decided in federal court. In September 2012, the state of Oklahoma filed suit
challenging the IRS rule on both substantive statutory and procedural grounds. The suit alleges
the IRS rule conflicts with the plain language of the PPACA and that the IRS failed to comply
with the Administrative Procedure Act when promulgating the rule. Oklahoma’s suit was
subsequently joined by private employers seeking to free themselves of the employer mandate
and, as of this writing, it appears that additional challenges to the IRS rule are likely.

The federal government may be able to delay legal challenges to the IRS rule, relying
upon the Anti-Injunction Act or citing ripeness concerns, but it will not be easy to forestall these
claims indefinitely. As a general rule, taxpayers lack standing to challenge the misuse of federal
funds or preferential tax treatment given to others. Were tax credits and premium assistance the
only consequence of the IRS rule, there would be no viable litigation. Yet because the
availability of tax credits and cost-sharing subsidies triggers the imposition of penalties to
enforce the employer mandate, employers in applicable states should have standing to sue
provided they are threatened by these penalties.

Some individuals in states with federal exchanges may be able to challenge the IRS rule
as well, alleging injury due to the effect the authorization of tax credits and cost-sharing would
have on whether given individuals are required to pay the tax penalty for failing to maintain qualifying health insurance under the minimum coverage provision. Some individuals could have standing because the IRS rule deprives them of an exemption from the individual mandate penalty for which they would otherwise qualify. This “affordability” exemption is based upon the out-of-pocket cost an individual would have to pay for qualifying health insurance in relation to that individual’s income. Specifically, if an individual’s “required contribution” exceeds 8 percent of household income, that individual is exempt from the penalty. By providing tax credits in federal exchanges, the IRS rule reduces the out-of-pocket cost of purchasing a qualifying health insurance plan for some individuals from above 8 percent of household income (where the taxpayer would be exempt from the penalty) to below 8 percent, thereby exposing some individuals who do not wish to purchase health insurance to the tax penalty. Therefore, an individual who lives in a state that will not establish an Exchange by 2014 and that would otherwise qualify for the affordability exemption in the absence of tax credits would have standing to challenge the rule, provided that they earn between 100 and 400 percent of the federal poverty level, do not receive health insurance from their employer, and would be exposed to the tax penalty due to the availability of tax credits under the IRS rule. Several million Americans satisfy these criteria. Many taxpayers will also suffer injury because the IRS rule will deprive them of the ability to purchase a low-cost “catastrophic” plan, which the law makes available to those over age 30 who qualify for the affordability exemption. Given continued opposition to the implementation of “ObamaCare,” it seems quite likely that at least a few of these taxpayers will sue.

The creation of health insurance exchanges is one of the central features of the PPACA. Yet given the way the statute is written, and the manner in which many states have responded, it
could be difficult for these exchanges to operate in the way that many had hoped. No less significant, the operation of health insurance exchanges, and the availability of tax credits and cost-sharing subsidies in states that refuse to cooperate with the PPACA, is a question that will be ultimately decided by the federal courts.

Conflict Over the Contraception Mandate

Challenges to the IRS rule purporting to authorize tax credits and cost sharing subsidies in federal exchanges may be among the most consequential for the ultimate operation of the PPACA, but they may not be the legal challenges that evoke the most popular concern. People care deeply about their health care. And some people care even more deeply about health care policy when it touches upon questions of sexual morality and reproductive health. Thus of all the decisions implementing the PPACA HHS has made thus far, none have been as controversial as the decision that employer health insurance plans must cover all forms of federally approved contraception, including sterilization and medications that can act as abortifacients. None have been more litigated either. As of 2013, more than fifty separate lawsuits had been filed challenging the so-called contraception mandate.  

Under Section 1001 of the PPACA, non-grandfathered group health plans are required to cover certain preventative health care services, and in particular preventative health care services for women, without any co-payments or other cost-sharing by the insured. As implemented by HHS, this requirement was interpreted to apply to all contraception methods that have been

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45 See 42 U.S.C. §300gg-13(a)
approved by the Food and Drug Administration.\footnote{See Health Resources and Services Administration, \textit{Women’s Preventative Services: Required Health Plan Coverage Guidelines} (Aug. 1, 2011).} Somewhat controversially, such approved contraception methods include sterilization and some forms of contraception than can prevent the implantation of a fertilized egg or otherwise act as an abortifacient (such as intrauterine devices and the so-called “morning after” pill). Such forms of contraception are opposed by some religious groups. The official doctrine of the Catholic Church, for example, prohibits the use of all such forms of contraception. Many Evangelical churches also oppose the use of abortifacients or contraceptive methods that they believe will terminate unborn human life. Failure to comply with the requirement subjects religious employers to substantial liability, however. Specifically, non-exempt employers are subject to a fine of $100 per employee, per day they fail to provide the required coverage.\footnote{26 U.S.C. §4980D(b).}

In response to religious objections, HHS created a narrow exemption for religious institutions. As promulgated by the Department, churches and other religious entities would be exempt should they meet the following four criteria:

1) The organization’s purpose is the inculcation of religious values;
2) The organization primarily employs individuals who subscribe to the religious tenets of the organization;
3) The organization primarily serves individuals who subscribe to the religious tenets of the organization; and
This exemption did not quiet the controversy over the contraception mandate, however. Under these criteria, many religious institutions, including religiously affiliated schools, universities, hospitals, and social service organizations, would be required to provide insurance that covers contraception methods that are contrary to their religious beliefs. As the head of Catholic Charities USA quipped, “the ministry of Jesus Christ himself” would not qualify under HHS’s criteria.⁴⁹ Some private, for-profit corporations owned by religious individuals objected as well.

HHS tried again to placate religious objections by announcing a one-year enforcement safe harbor and promising to adopt yet another accommodation for religious institutions.⁵⁰ One proposed accommodation suggested by HHS was to relieve religiously affiliated nonprofit employers from the obligation to provide insurance that covers all FDA-approved contraception methods and, instead, place the obligation to provide contraception coverage directly on insurers. So, for example, if a Catholic hospital objected to contraception coverage, it would no longer have to pay for insurance coverage that covered such contraception. The insurer with which the hospital contracted, however, would be required to provide contraception at no charge to either the employer or the insured. Even assuming that HHS has the legal authority under the PPACA to impose such a requirement, it would not solve the problem because many religiously affiliated employers self-insure.⁵¹ In such cases, the employer and the insurer are one and the same, so the suggested accommodation would not, in fact, ameliorate the religious employers’ concerns.

HHS faces two additional problems in that a) this accommodation would not purport to do anything for privately owned, for-profit employers with owners who object to providing such

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contraception coverage on religious grounds, and b) should HHS back off its initial commitment to ensuring that group insurance plans cover contraception, it would face a new set of objections from reproductive health advocates.

Facing the prospect of having to pay for or otherwise provide health insurance coverage to which they object on religious grounds, numerous religious institutions and employers filed suit against the contraception mandate on both constitutional and statutory grounds. Specifically, they alleged that the contraception mandate violates the Religious Freedom Restoration Act (RFRA) and, more ambitiously, the religion clauses of the First Amendment.

The strongest legal argument against the contraception mandate is statutory, not constitutional. Under current doctrine, the First Amendment does not pose much of an obstacle to a general law of neutral application, even if it requires some individuals to engage in actions prohibited by, or refrain from actions compelled by, their religious faith.\(^{52}\) RFRA, however, presents a larger hurdle for the federal government. Under RFRA, the federal government may not adopt a policy that imposes a substantial burden on a person’s religious faith unless that policy represents the least restrictive means of achieving a compelling governmental interest.\(^{53}\) As the Supreme Court has recognized, this means that policies that are fully constitutional under the First Amendment are nonetheless barred under federal law. Moreover, by its express terms, RFRA applies to subsequently enacted legislation, so it governs the implementation of the PPACA.

In defense of the contraception mandate, the federal government has argued that requiring group insurance plans to cover FDA-approved contraception methods does not


\(^{53}\) See 42 U.S.C. §2000bb et seq.
represent a substantial burden on the practice of anyone’s religion because the connection between the religious employer and the use of the contraception methods to which they object is sufficiently attenuated. Setting aside those religious employers that self-insure, the employer is not required to pay for or arrange for contraception because such contraception is only obtained and used as a result of independent choices made by the insured, the insured’s doctor, and the insurance company. Religious employers counter that their objection is to the requirement that they cover such contraception, not that it may be later purchased or used. Lurking in the background of this debate is the question of whether the government (and the courts) must defer to a religious institution’s own conception of what does or does not impose a substantial burden on religious practice.

Assuming that the contraception mandate does impose a substantial burden on religious exercise, defenders of the mandate contend it is nonetheless permissible because requiring coverage of FDA-approved contraception advances the compelling state interest in advancing gender equality and protecting women’s health.54 These government interests may well qualify as compelling under current doctrine. The government has also challenged the ability of private, for-profit employers to avail themselves of RFRA’s protections at all.

The biggest problem for the federal government’s position is RFRA’s requirement that any burden on religious practice be narrowly tailored and no more restrictive than necessary to advance its asserted interest.55 Those challenging the contraception mandate note that many group health plans – those grandfathered under the law or those offered by smaller employers -- are not subject to the mandate. A consequence of this exception is that even with the mandate,

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millions of individuals will have health insurance that does not cover contraception. Further, opponents argue that the federal government has other ways of expanding access to contraception that would be more effective and impose less of a burden on religious employers.

As noted above, at the time of this writing several dozen cases challenging the contraception mandate are already pending in federal court. Supreme Court resolution of this question is inevitable. By late 2012 lower federal courts had already divided on whether private, for-profit religious employers could obtain injunctions against the mandate before it became effective in 2013.56 In the meantime, HHS proposed additional measures to address the concerns of religious institutions, specifically by expanding the range of exempt non-profit religious institutions and formally proposing to accommodate the objections of other religious institutions, such as universities and hospitals, by requiring their insurance companies to provide for separate policies covering contraception. HHS proposes to offset the costs of such plans by reducing the fees for participating in health insurance exchanges and would address the concerns of self-insuring employers by placing the responsibility for arranging coverage on plan administrators. As before, the HHS proposal makes no effort to address the concerns of for-profit employers who have religious objections to providing contraception coverage to their employees, leaving this question to be decided in court.

The heated legal battle over the contraception mandate may also foreshadow legal fights yet to come over the scope of health insurance coverage, the obligations of employers, and access to controversial health care technologies and services. Four decades after *Roe v. Wade* the nation remains fiercely divided on the question of abortion, and many have deep moral

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convictions as to the appropriateness or even acceptability of modern reproductive technologies and approaches to end-of-life questions. Insofar as the PPACA places the federal government in the position of deciding what sorts of treatments or care can or must be covered by various insurance plans, partisans of these battles will rush to court. Even where little money is at stake, the preferences of those involved in such debates are sufficiently intense to make additional litigation a certainty.

**Constitutional Constraints on Controlling Costs**

Much of the PPACA seeks to expand health insurance coverage. The other major goal of health care reform was to tamp down on rising health care costs. Medical inflation has exceeded overall inflation for most of the past few decades and the cost of Medicare, in particular, has become a major budgetary concern, deemed “unsustainable” by the General Accounting Office.\(^{57}\)

The PPACA’s primary cost-control measure is the Independent Accounting Oversight Board (IPAB), a new independent agency tasked to “reduce the per capita rate of growth in Medicare expenditures.”\(^{58}\) The Board consists of fifteen members appointed by the President and subject to Senate confirmation. Because Congress has shown itself incapable of enacting (or even allowing) limits on Medicare’s growth, the PPACA shift this responsibility to the IPAB.\(^{59}\)

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\(^{58}\) 42 U.S.C. § 1395kkk(b).

Barring an unprecedented slowdown in health inflation, the IPAB must intervene and litigation is likely to follow.60

In any year in which Medicare spending is anticipated to grow by more than one percent above GDP, the IPAB is required to develop cost-reduction proposals that will bring Medicare growth rates back into line.61 The primary means for achieving this goal is proposing measures to constrain outpatient reimbursement rates.62 Not all such measures are on the table, however.

Under the PPACA, the IPAB is prohibited from proposing any measure to raise revenues, increase premiums or cost-sharing, limit benefits, or “ration health care,”63 yet the law does not define what would constitute prohibited rationing and, as noted below, provides no basis for enforcing such limitations.64 Although the IPAB’s authority is limited to Medicare, supporters hope that its reform proposals will reverberate throughout the health care sector.65

Whatever the IPAB puts forth is fast-tracked into law. Under the PPACA, the IPAB’s proposals are automatically introduced into Congress and, if Congress fails to act, take effect. Specifically, the HHS Secretary is required to implement the IPAB’s proposals unless Congress promptly enacts an alternative. Should Congress disapprove of the IPAB’s proposals, the

60 Some recent reports suggest that health care cost increases could slow enough that the IPAB will not be required to adopt cost-control measures, at least in the immediate future. See, e.g., Sarah Kliff, The $2.7 Trillion Question: Are Health-Care Costs Really Slowing? WASH. POST “WONKBLOG,” Jan. 7, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/01/07/the-2-7-trillion-question-are-health-care-costs-really-dropping/.

61 Should the IPAB fail to act, for whatever reason, this responsibility falls to the HHS Secretary.


64 As Professor Jost notes, this means the IPAB could adopt measures that arguably contravene the statutory limitations. See Jost, Real Constitutional Problem, at 505.

65 See, e.g., Aaron, at 2379; Marciarile & Delong, at 79; Timothy Stoltzfus Jost, The Independent Payment Advisory Board, 363 N. ENGL. J. MED. 103, 105 (2010).
PPACA provides that Congress must enact alternative measures by August of the same year that will generate equivalent cost savings.

There is nothing at all unusual about delegating an executive or independent agency the authority to adopt policy measures with the force of law. Yet such authority is typically subject to various procedural requirements, such as those provided under the Administrative Procedure Act for notice-and-comment rulemaking, and is subject to judicial review. Neither is the case with the IPAB. The PPACA imposes no meaningful administrative procedures on the Board and expressly precludes judicial review of IPAB actions and subsequent HHS implementation.\footnote{See 42 U.S.C. § 1395kkk(e)(5).} The result is the lack of any meaningful checks should the IPAB exceed the scope of its delegated authority.\footnote{As one commentator notes:

What is happening here is truly remarkable. Congress is delegating to HHS authority to waive the provisions of existing law, freeing it from judicial oversight and, in the case of the IPAB, even limiting Congress’s own authority to override the decisions of an executive agency.”

Jost, Real Constitutional Problem, at 503.}

Where Congress disapproves of specific agency action, regular legislation satisfying the constitutional requirements of bicameralism and presentment is sufficient to undo the agency’s work. Again, the IPAB is different, as the PPACA requires a three-fifths vote in the Senate to waive the requirement that cost-control measures be adopted each year Medicare cost increases exceed the stated target. The PPACA also purports to hamstring Congress’s ability to revise the law to alter or eliminate the IPAB. Specifically, the PPACA provides that a Joint Resolution to repeal the IPAB provisions can only be introduced in January 2017, is subject to special rules
governing floor consideration and debate, and can only be enacted by a three-fifths supermajority in both houses.\(^68\)

Although such provisions are designed to entrench the IPAB against subsequent political majorities, it is not clear these limitations are enforceable. Article I, section 5 of the Constitution provides that “Each House may determine the Rules of its Proceedings.” As traditionally understood, this provision prevents one Congress from entrenching procedural rules governing the consideration of legislation and preventing a subsequent Congress from determining its own rules. Should a future Congress exercise its prerogative to consider legislation modifying or eliminating the IPAB, litigation may well ensue by groups seeking to enforce the law’s limitations.

The first lawsuit against the IPAB was filed in 2010 alleging, among other things, that Congress delegated excessive authority to the IPAB without providing a sufficiently constraining “intelligible principle” to guide the Board’s efforts. Unsurprisingly, this claim was dismissed.\(^69\) It is particularly difficult to challenge an agency’s authority before it has taken any action. Once the IPAB swings into gear, however, additional litigation is likely, particularly once it puts forward specific proposals constraining provider reimbursements or otherwise compromising the economic interests of various providers. Once such suits are filed, courts will have to confront the lack of administrative procedures governing the IPAB’s activities and the PPACA’s limitations on judicial review. Whether the IPAB will survive such challenges is an open

\(^68\) In litigation challenging the constitutionality of the IPAB, the Obama Administration attested that these provisions merely provide for “one way for Congress to repeal the Board” and that “Nothing prevents Congress from repealing the Board via ordinary legislation.” See Coons v. Geithner, Motion to Dismiss, CV-10-1714-PHX-GMS (D. Ariz. May 31, 2011).

question. Even supporters of the PPACA recognize the IPAB, as enacted by Congress, represents “a troubling challenge to our constitutional order.”

Relitigating the Individual Mandate

Litigation over implementation of various portions of the PPACA will continue for some time. Even the individual mandate could end up back in court. Although NFIB upheld the constitutionality of imposing a financial penalty on individuals who fail to purchase and maintain qualifying health insurance, this may not be the last time a federal court has to consider the constitutionality of financial assessments imposed for failing to acquire health insurance. Chief Justice Roberts upheld the assessment in the PPACA as a permissible exercise of the federal taxing power. Yet his decision did not immunize the assessment from all future challenge. “Even if the taxing power enables Congress to impose a tax on not obtaining health insurance,” he explained, “any tax must still comply with other requirements in the Constitution.” Some commentators see this language as an invitation for future challenges to the tax penalty portion of the mandate, perhaps under the Constitution’s “uniformity clause.” Others think the Court’s resolution left open the question of whether such a tax could violate liberty interests, equal protection, or the due process clause. Such challenges are speculative, but they could be litigated nonetheless.

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70 Jost, Real Constitutional Problem, at 506.

71 See NFIB, 132 S.Ct. at __ (opinion of Roberts, C.J.).

Litigation is more likely to result should Congress or HHS revisit the operation of the individual mandate to prevent adverse selection and further upward pressure on health insurance premiums. Chief Justice Roberts reinterpretation of the PPACA’s requirement that individuals obtain health insurance or pay a tax may have saved the Act’s constitutionality, but it also constrained the minimum coverage requirement’s effectiveness at preventing adverse selection and consequent increases in health premiums. The point of the mandate was to counteract the potential effect of imposing community rating and guaranteed issue requirements on health insurance providers. Under the PPACA, insurers may not deny coverage or charge higher premiums to individuals for health insurance based upon their health status or any preexisting medical conditions. Such a requirement makes insurance more affordable for high-risk individuals while increasing premiums for low-risk individuals. A potential result of such a requirement is a vicious cycle of adverse selection if some low-risk individuals react to increased premiums by dropping their insurance, causing further premium increases, which could in turn cause more low-risk individuals to drop coverage, and so on.73

The mandate was intended to prevent adverse selection by requiring all individuals to obtain and maintain qualifying health insurance. Such a mandate can only be effective, however, if the penalty for noncompliance is large enough to discourage low-risk individuals from dropping their coverage. That is not the case with the penalty adopted in the PPACA. For many Americans, the penalty for failing to purchase health insurance will be substantially below the cost of purchasing a federally approved health insurance policy, and many of these people are

likely to forego obtaining insurance as a result.\textsuperscript{74} After the \textit{NFIB} decision, the Congressional Budget Office estimated that approximately six million Americans (of an estimated 30 million who would remain uninsured) will be required to pay the penalty in 2016.\textsuperscript{75}

The most obvious way to address this concern, and prevent adverse selection, would be to increase the penalty to amount until it was comparable with the out-of-pocket cost of a qualifying health insurance plan. At this point low-risk individuals would have little incentive to forego health insurance. The problem here is that were Congress to increase the penalty substantially, it might no longer qualify as a tax. The relatively small amount uninsured individuals would be required to pay the government as a consequence of being uninsured was one of the primary factors that led Chief Justice Roberts to include the payment constituted a tax.\textsuperscript{76} A payment that equaled or exceeded the cost of obtaining insurance, on the other hand, could resemble the sort of “‘prohibitory’ financial punishment” that would exceed the scope of the taxing power.\textsuperscript{77} While it is permissible to use a tax to “influence behavior,” Chief Justice Roberts explained, for an assessment to be a “tax,” and not an unconstitutional penalty or mandate, it must leave an individual with a meaningful choice and not become “so punitive” that it begins to resemble a punishment or a mandate.\textsuperscript{78}

Chief Justice Roberts’s opinion would seem to prohibit Congress from increasing the size of the tax penalty by any sizable degree, virtually assuring that the minimum coverage

\textsuperscript{74} See Thomas A. Lambert, \textit{How the Supreme Court Doomed the ACA to Failure}, REGULATION, Winter 2012-13.

\textsuperscript{75} \textsc{Congressional Budget Office, Payments of Penalties for Being Uninsured Under the Affordable Care Act}(Sept. 19, 2012), available at: \texttt{http://www.cbo.gov/publication/43628}.

\textsuperscript{76} See \textit{NFIB}, 132 S.Ct. at __ (opinion of Roberts, C.J.).

\textsuperscript{77} \textit{Id.} (quoting Bailey v. Drexel Furniture, 259 U.S. 20, 37 (1922)).

\textsuperscript{78} See \textit{NFIB}, 132 S.Ct. at __ (opinion of Roberts, C.J.).
requirement will not fulfill its intended purpose. It also ensures that any increase in the mandate tax would be met with a fresh legal challenge. Absent the ability to increase the assessment on those without health insurance, Congress or the Administration may seek out other ways of discouraging adverse selection. According to some reports, health insurers are encouraging HHS to implement additional measures, such as late-enrollment fees or other requirements, so as to discourage adverse selection, particularly as the mandate is first phased in. Should the Department seek to implement any such measures, however, legal challenges to its regulatory authority are equally likely.

Conclusion

Some expected and many hoped that the Supreme Court’s resolution of the NFIB litigation would have put an end to the legal challenges to the PPACA. Yet it was never to be this way. The PPACA is too expansive and significant a statute, affecting too many economic interests and implicating too many political, moral and ideological divisions within the country for the litigators to stay their hand. As the federal government implements the law in the years to come, its choices will be scrutinized and challenged at every turn. As a consequence, the ultimate shape of health care reform will still be decided in federal court.

79 See Thomas A. Lambert, How the Supreme Court Doomed the ACA to Failure, REGULATION, Winter 2012-13.