

## CHAPTER 2

# THE AFFORDABLE CARE ACT

**T**he Patient Protection and Affordable Care Act was signed into law on March 23, 2010. The title has been abbreviated to the Affordable Care Act (ACA) or, more informally, “Obamacare.” The contours of healthcare’s future will clearly be shaped by the ACA, and this chapter provides a foundation for understanding the theories that underlie the law. Because the ACA contains more than 400 complex sections, a straightforward reading of it is of limited use to understand its full impact. However, awareness of the theories that shaped the ACA can be useful in understanding how the law is designed to work and anticipating the future environment of the US healthcare system.

This book is organized around the three fundamental theories of the ACA. Through these theoretical viewpoints a more complete understanding of the framework for the policy changes that were eventually included in the law can be obtained:

1. *Systems.* How does each element in the system interact with and affect the other elements to achieve the desired outcomes (patient health)?
2. *Funds flow and incentives.* How can revenue and payment systems be designed to create change in behaviors to achieve desired outcomes (increased quality and patient satisfaction with lowered cost)?
3. *Markets.* How can markets be made to operate effectively to allow the “invisible hand” of capitalism to achieve the desired outcomes (provider market share and profit)?

### THE GROUNDWORK IS LAID

The debate on health reform in 2009 and 2010 might lead one to conclude that the final product is simply a random collection of ideas from various interest groups, academics, and politicians. However, the ACA is the result of many years of health policy research, demonstration projects, pilots,

and many of the best practices being used by leading healthcare organizations throughout the country.

Senator Max Baucus (chair of the Senate Finance Committee) released a comprehensive report on November 12, 2008, just eight days after the presidential election. “Call to Action: Health Reform 2009” (Baucus 2008) includes many of the features and architecture of the final law. This report was well researched and included more than 290 footnotes from scholarly research publications. It reports the results of many federally funded pilot projects and demonstrations. It outlined the key elements needed for reforming the US health system:

- ◆ Increased access to affordable healthcare
- ◆ Improved value by reforming the healthcare delivery system
- ◆ Financing changes for a more efficient system

Although the legislation passed along party lines, it includes many policies that have been recommended over the years by Republicans and Democrats alike. In addition, many of the policies were advanced by nonpartisan academics and career federal staff. Although generalization is always dangerous, the source of specific policies can be grouped as shown in Exhibit 2.1.

## THE THREE THEORIES

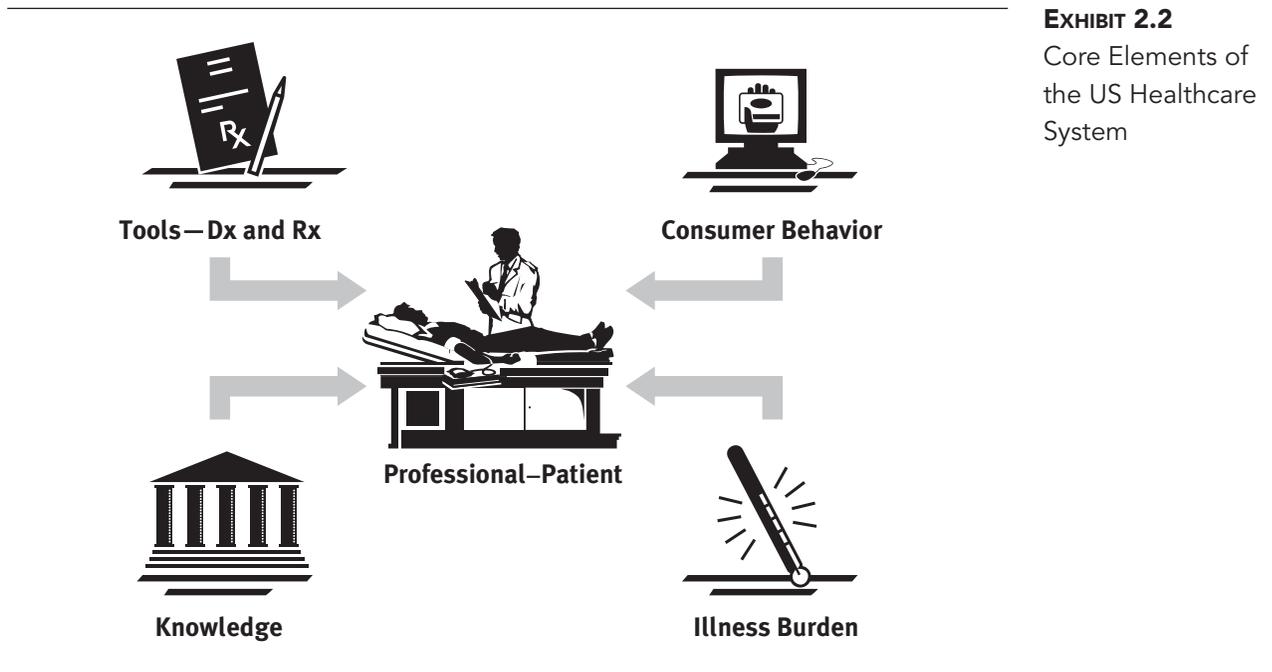
### SYSTEMS VIEW

A useful systems view of US healthcare starts with the patient–provider relationship. This is the system that is the most visible to patients and providers. The provider is frequently a physician but includes healthcare professionals such as nurses, pharmacists, chiropractors, and others.

Both the provider and the patient are influenced by other systems, and Exhibit 2.2 illustrates this relationship.

**EXHIBIT 2.1**  
Source of Theories  
Contained in the  
ACA

Source	Theory
Academics, nonpartisan think tanks, and career federal officials	Systems
Liberals	Funds flow and incentives
Conservatives	Markets



The providers deliver the service based on the diagnostic and therapeutic tools available. The patients receive the service in the context of their own behaviors (e.g., smoking, weight control) and the burden of illness they may bear as a result of genetic makeup, their living and working environments, and other factors beyond their control.

This model can be expanded outward by examining the details of each element (Exhibit 2.3).

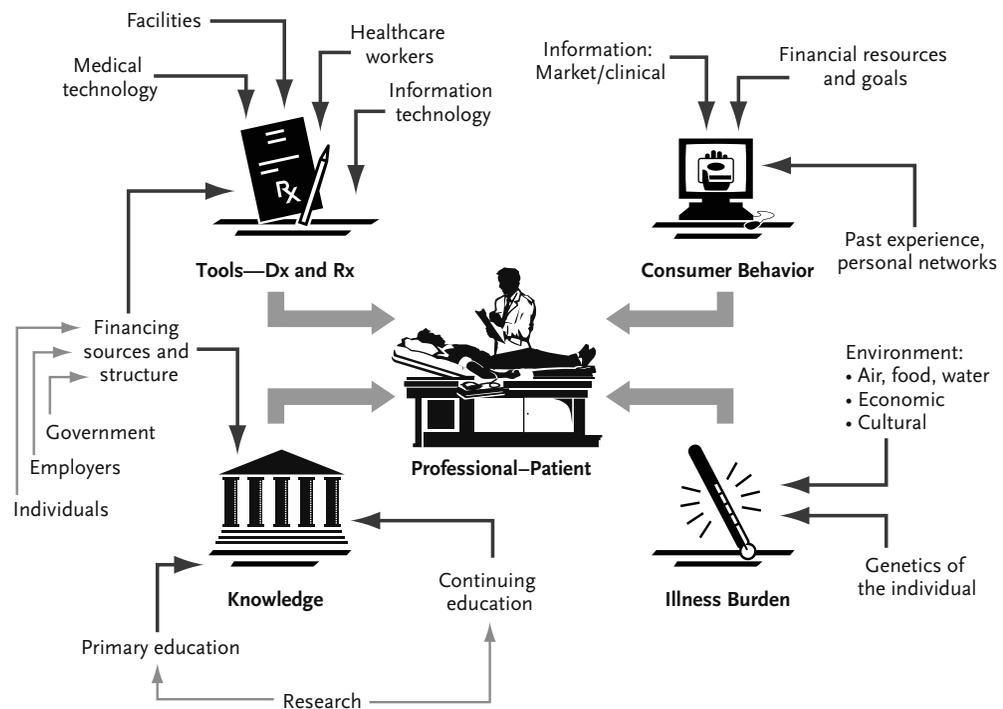
This expanded model has many interlocking elements. For example, the provider has an array of tools that are used for diagnosis and treatment: medical technology, facilities (e.g., hospitals, clinics), healthcare professionals, and, most recently, advanced healthcare information technology. The use of these tools is affected by financing structures (see the incentives and funds flow model in the next section).

Knowledge is another key to the effective functioning of the system. The system starts with basic research, the research is translated into practice, and then this knowledge is conveyed to practitioners through formal and informal education.

Consumers' behavior is affected by the information they gather (much of it now from the Internet), the financial constraints and incentives of their health insurance, and the information they acquire from their family, friends, and coworkers.

The final aspect of the systems view of healthcare is the underlying environmental factors that influence an individual's health, such as genetic makeup.

**EXHIBIT 2.3**  
Second-Level  
Model of the US  
Healthcare System

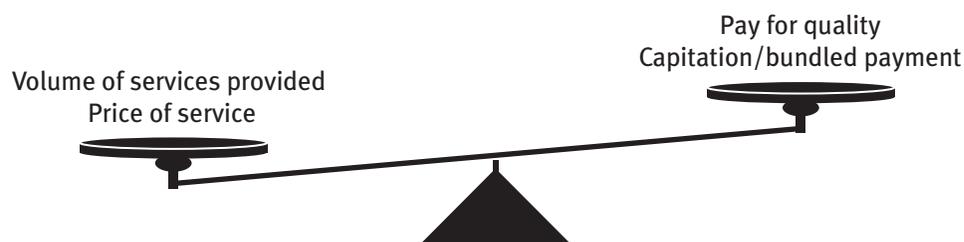


The authors of the ACA sought to improve the US healthcare system by improving almost all of the elements in the system. For example, the need for improvements in the workforce—particularly in primary care—was included in Title V: “Health Care Workforce.” Healthy communities affect the disease burden on individuals, and this is addressed in the ACA in §4201, “Community Transformation Grants.” The need for ongoing and comprehensive research on the effectiveness of various treatments is addressed in §6301–6302, “Patient Centered Outcomes Research.”

Crosson and Tollen (2010) demonstrated that large integrated systems can deliver high-quality care cost effectively. These systems effectively manage, align, and optimize most of the elements shown in Exhibit 2.3. The designers of the ACA included many elements to encourage the growth of integrated systems.

### FUNDS FLOW AND INCENTIVES VIEW

“It’s not about the money—it’s about the money.” This quote from a leading health plan CEO provides a concise summary of the confusing financial signals currently inherent in the US healthcare system.



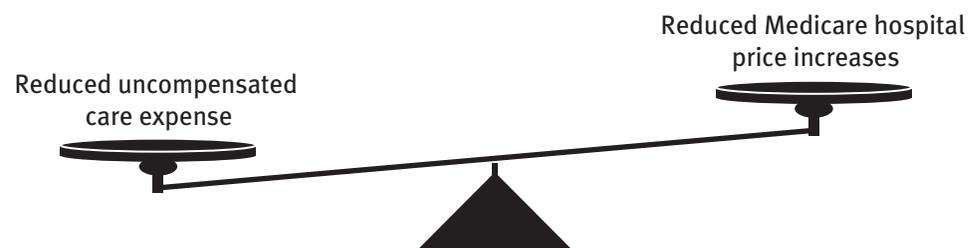
**EXHIBIT 2.4**  
Balancing Payment  
Incentives in the  
ACA

For example, most of the hospitals in the United States are religious and charitable institutions and maintain a nonprofit legal status, yet many of these institutions compete as aggressively as any global public for-profit company. Physicians uniformly attempt to provide optimal care but are also sometimes influenced by fee schedules and financial incentives to provide services that may be of limited value.

The designers of the ACA understood this historic conflict between organizations' desire to provide quality services and their desire to maximize revenue and profit. Exhibit 2.4 demonstrates the incentives dilemma as providers need to balance the existing fee-for-service system—which rewards volume and price—with the new elements of the ACA that reward quality and efficiency. Perhaps the greatest question of reform is whether the new incentives in the ACA are strong enough to tip this scale.

Another funds flow element of the ACA that will have a significant effect on providers is the balance between a significant reduction in uncompensated care and a reduction of Medicare base rate payment increases. Exhibit 2.5 provides an illustration of this redirected funds flow.

Funding policies and incentives in the ACA are designed to move care for an individual to its lowest cost site. Exhibit 2.6 shows a generic mapping of this movement. For example, individuals who live in healthy communities, live healthy lifestyles, and get regular preventive services are less likely to need the more expensive professional services of doctors and hospitals. Even when clinical services are required, the ACA provides



**EXHIBIT 2.5**  
Balancing the  
Newly Insured  
with Reductions  
in the Increase  
in Medicare  
Payments

**EXHIBIT 2.6**

Incentives in the  
ACA Encourage  
Lowest-Cost Site of  
Care



incentives for the use of the lowest cost and most effective service (e.g., home health as opposed to inpatient care).

Policymakers who believe in government-administered pricing and incentives can point to past successes. Medicare has had a relatively positive record of using administered pricing to meet policy gains. For example, the prospective payment system using diagnosis-related groups (DRGs) that was implemented in 1983 succeeded in reducing hospital length of stay significantly more than was predicted at the time of enactment. The Congressional Budget Office estimated that the DRG system would save Medicare \$10 billion from 1983 to 1986. Actual savings were \$21 billion (Gabel 2010).

Incentives are the carrot in the toolbox of the policymaker. Regulation is the stick. Unfortunately, regulation tends to freeze systems in place and provides limited mechanisms for innovation or needed system change. Therefore, the authors of the ACA chose incentives as their primary policy tool, but if the incentives fail, new regulations will appear. The Independent Payment Advisory Board (§3403) has been established as the vehicle for this correction to the system.

The aggregate funding for the ACA is a complex set of revenues, transferred funding, and payments made into newly created federal programs. The main sources of funding for the ACA include: reduced inflationary pay for Medicare providers, reductions in Part D payments (Medicare Advantage), taxes on health insurance plans, taxes on medical devices, and many other miscellaneous taxes, such as a 10 percent tax on indoor tanning services. This new funding goes toward the subsidies for individual buyers of health insurance, the federal portion of Medicaid (and the Children's Health Insurance Program) and its enhanced share, and many other programs that are detailed in the remainder of this book.

The impact of the ACA on the federal budget and federal deficit are always a source of intense partisan debate. The Congressional Budget Office (CBO) issues an annual report on the economy, and its April 2014 report indicated that "the ACA's coverage provisions will result in lower net costs to the federal government: The agencies currently project a net cost of \$36 billion for 2014, \$5 billion less than the previous projection for the year;

and \$1,383 billion for the 2015–2024 period, \$104 billion less than the previous projections” (CBO 2014).

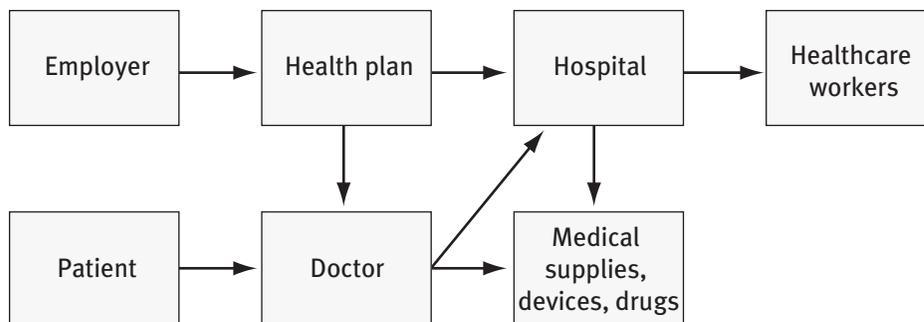
A continuing question on the funds associated with the ACA is whether this new system is truly affordable. Therefore the question of affordability will be asked from a variety of perspectives. Is the new system affordable for:

- ◆ The federal government?
- ◆ A specific state government?
- ◆ Employers?
- ◆ Individuals?
- ◆ Health plans?
- ◆ Healthcare providers?
- ◆ Suppliers to the healthcare industry?

The answers to these questions will shape future changes to the ACA.

### MARKETS VIEW

The healthcare system can also be conceptualized as a series of buyers and sellers of products. In this classic view of market-based capitalism, the sellers will be rewarded if their products provide high value at low prices. Although many have argued that markets do not work well in healthcare, the authors of the ACA attempted to maintain this important aspect of the system. A markets viewpoint of traditional employment-based health insurance and private healthcare delivery is illustrated in Exhibit 2.7.



**EXHIBIT 2.7**  
Market Perspective  
on Employment-  
Based Healthcare  
System

In this model the initial buyer in the system is the employer, who purchases health insurance on behalf of employees from a health plan. The employees in turn choose their providers from those available in the health plan's network.

The market is becoming more sophisticated because of the increase in high-deductible insurance plans, and because patients are beginning to pick providers based on cost and perceived quality (Robinson and Ginsburg 2009).

In the markets model, doctors (and other providers) are also buyers, as they choose the resources they need to treat the patient. Resources include everything from medical supplies to which hospital to use for a particular patient. Hospitals also purchase from other markets for their workforce and supplies. Because health plans pay for most of these items, buying and selling in this market is complex. The general economic theory of market capitalism predicts that the interactions of all of these markets should produce the greatest value at the lowest cost. The characteristics of perfect market competition are (Henderson 2002):

- ◆ many buyers and sellers,
- ◆ a standardized product,
- ◆ mobile resources, and
- ◆ buyers with access to complete and comprehensive information.

To reinforce this concept of market competition, the ACA has many competitive features, the most prominent of which are the health insurance exchanges (§1311–1313). Instead of direct regulation of health insurance rates (as is done in some European countries) the designers of the ACA expect that competition between health plans will contain costs and increase value. The law contains numerous sections in Title I: “Quality, Affordable Health Care for All Americans” that are designed to ensure a fair competitive playing field for health plans and affordability for individuals and small employers.

For health plans to be price competitive they must buy carefully from their suppliers (e.g., doctors, hospitals, pharmaceutical companies). This careful purchasing will encourage providers to improve their operations to deliver the highest value possible. The characteristics of perfect competition and the elements of the new health exchanges are compared in Exhibit 2.8.

A unique aspect of the US health system is the health savings account (HSA), which provides a direct financial incentive for consumers to purchase carefully in the healthcare market. Although many observers expected that HSAs would be eliminated in the ACA, they were preserved with only minor modifications (§9004). More than 10 million Americans use HSAs, and their use is predicted to increase (Fronstin 2010).

Perfect Competition	Affordable Care Act—Health Exchanges	<b>EXHIBIT 2.8</b> Perfect Market Competition and the ACA
Many buyers and sellers	A large number of health plans are available in the exchanges in most states. Thirty million or more individuals and small firms will buy their insurance in this market.	
A standardized product	The exchanges have four different standardized benefit levels and a standardized benefit set.	
Mobile resources	Health plans will be able to compete across state lines. Some healthcare organizations will become national players for both the direct provision of care (e.g., Mayo Clinic, Cleveland Clinic) and health insurance (e.g., United Health Care, Wellpoint).	
Buyers with complete and comprehensive information	Healthcare.gov provides links to comprehensive data on both costs and quality. These resources will expand greatly in the future.	

Other competitive bidding opportunities exist for durable medical equipment suppliers (§6407) and healthcare systems that wish to participate in the national pilot project for bundled inpatient care payments (§3023).

Relying entirely on market forces to constrain costs in the US health system has not proved effective. However, market competition is an underlying philosophy and important part of the law. If market forces fail to restrain healthcare inflation after the full enactment of the ACA, the next round of legislative action will include much stronger direct federal regulation of all of the financial aspects of the system.

## LEGAL CHALLENGES TO THE ACA

Twenty-six states challenged the ACA's constitutionality, and in June 2012 the US Supreme Court held that the individual mandate is valid under Congress's power to tax. It also held that the mandate for states to expand Medicaid was optional. **Reading 2A** at the end of this chapter provides a detailed analysis of the legal issues surrounding the ACA.

## HOW TO USE THIS BOOK

The ACA was originally more than 2,400 pages long, and it is accompanied by the final reconciliation bill, which is 200 pages long. Although numerous summaries are available, considering the specific legislative language is useful. This can be accomplished by opening the bill (available in a link on this book's companion website at [ache.org/books/reform](http://ache.org/books/reform)). This book contains many references to specific sections of the ACA as it was enacted by Congress. They are preceded by the section symbol (*signum sectionis*) §. The congressional act has been codified as Public Law 111-148 and is integrated into the Code of Federal Regulations—predominately in Titles 42 and 45. This book will use the original congressional sectional notation.

The congressional research summary is here: [bit.ly/Reform2\\_2](http://bit.ly/Reform2_2).

The full text of the ACA and the Supreme Court decision is here: [bit.ly/Reform2\\_3](http://bit.ly/Reform2_3).

## SUMMARY

The ACA contains policies that will initiate the largest change in the US healthcare system since the enactment of Medicare and Medicaid. To develop successful strategies in this new environment, healthcare leaders should understand the three theories that underlie these policies.

The first theory is based on a systems perspective. This theory advances the concept that because all elements of the healthcare system are connected, strategic changes to individual elements can have widespread effects. The second theory is based on funds flow and incentives. Many Medicare programs have succeeded with administered pricing, which includes incentives to change provider behavior. Because of this history, these types of tools are also part of the ACA. The funding sources and uses for the ACA will remain controversial as healthcare stakeholders evaluate their impact. Finally, US capitalism and a markets view of the healthcare industry is also a part of the ACA—most prominently on display in the health insurance exchanges.

## APPLICATIONS: DISCUSSION AND RESEARCH

1. What other national policies outside of healthcare are based on
  - a. Systems theory?
  - b. Funds flow?
  - c. Markets?

(Consider these federal systems and do library or Internet research: the military, federal highways, securities regulations, the US Food and Drug Administration, the US Department of Education [e.g., No Child Left Behind], the Commerce Department, the Environmental Protection Agency.)

2. Which theory is the most powerful in moving a healthcare organization's strategy? Why? (Interview healthcare executives and ask them which theory is more important to their strategy development.)
3. Where do states fit into the implementation of the ACA? (Access the National Conference of State Legislatures and search on ACA: [bit.ly/Reform2\\_4](http://bit.ly/Reform2_4).)

## REFERENCES

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## CHAPTER 2

# ADDITIONAL READING

### READING 2A

#### LEGAL ISSUES IN HEALTH INSURANCE AND HEALTH REFORM (EXCERPT)

Dean M. Harris

From *Contemporary Issues in Healthcare Law and Ethics*, 4th ed. (2014),  
Chapter 15, 380–401. Chicago: Health Administration Press.

#### **THE 2010 FEDERAL AFFORDABLE CARE ACT**

##### **ENACTMENT OF THE 2010 FEDERAL LAW**

In Congress, serious disagreements arose about several issues. Some members of Congress wanted to create a public health insurance plan similar to Medicare as an option for the general public, but others were strongly opposed to that idea. In addition, members of Congress disagreed about the cost of health reform and how we should pay for it. Conflicts also occurred about using government funds to help people buy health insurance that would cover abortion. In many ways, the legislation that was finally enacted represented a compromise among conflicting views.

The legislation was enacted in two parts. First, Congress enacted HR 3590 as the Patient Protection and Affordable Care Act (PPACA),<sup>1</sup> which was signed by President Obama on March 23, 2010. A few days later, Congress resolved some outstanding issues by enacting HR 4872 as the Health Care and Education Reconciliation Act of 2010,<sup>2</sup> which the president signed on March 30, 2010. For convenience, the two parts of that legislation are often referred to collectively as the Affordable Care Act or the ACA.

Some critics have argued that the ACA is an example of excessive government intervention in the healthcare system. However, it is important to recognize what the ACA does *not* do. The ACA does not establish a Canadian-style single-payer system or a United Kingdom-style national health system. The ACA continues the system in which millions of people obtain coverage through their place of employment. It continues to allow the sale of private health insurance policies in a competitive market, and it does not establish a public option for all residents of the country.

Before enactment of the ACA, the U.S. system of healthcare financing was fragmented, with different sources of coverage for different groups of people, such as participants in Medicare, Medicaid, employer-based health plans, and private health insurance plans. After enactment of the ACA,

healthcare financing remains fragmented, with different sources of coverage for different groups of people. As one commentator has noted, “[U]nlike Medicare or Social Security, the ACA is not a single program. Rather, it is a collection of mandates, public insurance expansions, subsidies, and regulations that affect different groups of Americans in different ways and at different times.”<sup>3</sup> Therefore, analyzing the ways in which the ACA affects these different groups of people is useful.

*Medicare:* The ACA made some improvements in coverage for beneficiaries. For example, the ACA provided for the reduction and eventual elimination of the “doughnut hole,” which was the gap in coverage under Medicare prescription drug plans after the beneficiary exhausts the standard amount of coverage and before she qualifies for catastrophic coverage. In addition, the ACA includes many initiatives to reduce costs, improve efficiency, and increase the quality of care for Medicare beneficiaries. As one example, the ACA promotes the development of accountable care organizations (ACOs) under the Shared Savings Program, in which groups of healthcare providers deliver quality care to Medicare patients in a coordinated manner and share the cost savings resulting from those efforts. In addition, the ACA makes some adjustments to Medicare payment on the basis of quality by reducing the level of payment to hospitals that have a high rate of hospital-acquired conditions and an excessive rate of readmissions.

The ACA also provides for an Independent Payment Advisory Board (IPAB) to be established in 2014 to review excessive Medicare spending and submit legislative proposals for cutting spending. Some critics of the IPAB have argued that it would evaluate decisions about treatment options as a sort of “death panel.” However, the ACA explicitly limits the power of the IPAB by providing that its proposals “shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums . . . increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.”<sup>4</sup>

*Medicaid:* The ACA expands the Medicaid program by providing coverage for many poor adults under age 65 who have no dependent children and who had been unable to qualify for Medicare or Medicaid. However, as discussed in Chapter 8, the U.S. Supreme Court held in 2012 that the federal government cannot withdraw existing Medicaid funds from states that decline to participate in the ACA’s expansion of Medicaid.<sup>5</sup> Thus, expansion of Medicaid is optional for the states. As of this writing, some state governments have decided to expand their Medicaid programs, while others have refused to participate in the expansion.

*Employer-based coverage:* Under the ACA, employers may continue to provide health insurance benefits for their employees. The ACA does not explicitly require employers to provide health insurance for their employees. However, employers that have at least 50 employees must pay penalties if any of their employees obtain subsidized insurance through an exchange, as discussed later. That requirement was delayed until 2015.<sup>6</sup>

The ACA also imposes requirements in regard to coverage and benefits in health insurance plans, including the health insurance plans that employers provide for their

employees. One of the most controversial requirements is the mandate for most employers to provide insurance coverage for contraceptives, as one type of preventive service, with no copayment or deductible. This requirement does not apply to employees of churches, but it does apply to employees of some church-affiliated organizations, such as universities and hospitals. This requirement also applies to private, for-profit businesses that are owned by religious individuals. At the time of this writing, legal challenges to this mandate were pending in federal courts, and courts have disagreed among themselves about the legal issues.

*Individual coverage:* The ACA establishes new exchanges where individuals may purchase health insurance regardless of their current health status. For some individuals, government subsidies are available on the basis of income. Under the ACA, each state may choose to operate its own exchange, partner with the federal government in operating the exchange, or let the federal government operate it alone. Many states have refused to establish an exchange, and, therefore, the federal government will operate the exchange in those states.

Some opponents of the ACA argue that, under the statutory language, federal subsidies may not be provided for coverage purchased through a federally operated exchange. However, the IRS, which is responsible for implementing the health insurance premium tax credits under the ACA, takes the position that subsidies are indeed available.<sup>7</sup> As of this writing, the issue is subject to litigation in federal courts.<sup>8</sup> Because this is an issue of statutory interpretation rather than constitutional law, most courts would be likely to give deference to the interpretation of the IRS as the agency responsible for implementing the statute.

The ACA also increases the regulation of health insurance companies and prohibits specific practices that have an adverse effect on consumers. For example, health insurance companies may not “rescind” (cancel) a health insurance policy because a person becomes sick. Health insurance companies may not refuse to cover people who have preexisting medical conditions or charge higher rates to people who are sick or have preexisting medical conditions.

Finally, the ACA provides that most individuals will be required to pay a penalty if they do not have health insurance. The individual mandate to have insurance—and the penalty for failure to do so—provided the basis for legal challenges to the ACA and a ruling by the Supreme Court in 2012 on the law’s constitutionality.

## **LEGAL CHALLENGES AND THE SUPREME COURT’S DECISION**

Together with some private parties, state officials from 26 states challenged the federal government’s authority to adopt the ACA, including the individual mandate to obtain health insurance and the penalty for failing to have insurance. On June 28, 2012, the U.S.

Supreme Court held in *National Federation of Independent Business v. Sebelius* that the individual mandate to buy health insurance is not a valid regulation of interstate commerce, but the penalty for failure to do so is valid under Congress' power to tax.<sup>9</sup>

The individual mandate from Congress to buy health insurance is *not* analogous to requiring owners of automobiles to buy insurance because automobile insurance mandates are state laws. State governments have police power to protect the public.<sup>10</sup> Thus, state governments clearly have the power to require their residents to buy health insurance, as the state of Massachusetts has done. In contrast, a dispute arose over whether Congress has the power to require individuals to buy health insurance under its constitutional power to regulate interstate commerce.

Parties challenging the ACA argued that refusing to buy health insurance is merely “inactivity,” and, therefore, cannot be regulated as conduct affecting interstate commerce. Supporters of the ACA argued that refusing to buy insurance is really an “activity” of imposing one’s inevitable healthcare costs on other people, and, therefore, can be regulated as conduct affecting interstate commerce. Parties challenging the ACA responded that, if the federal government could require people to buy health insurance, Congress could also require people to buy broccoli or other healthy foods.<sup>11</sup>

The Supreme Court agreed with those challenging the ACA that Congress may not regulate inactivity under its constitutional power to regulate interstate commerce. However, the court also held that Congress may use its constitutional taxing power to impose taxes on those individuals who remain inactive by refusing to buy health insurance.

The debate over health reform and the constitutionality of the ACA was often viewed in partisan terms as a dispute between Democrats and Republicans or between liberals and conservatives. Yet the deciding vote at the Supreme Court to uphold most of the ACA was provided by Chief Justice John Roberts, who is widely regarded as a conservative. The reason for this apparent anomaly is that conservative jurisprudence includes a profound respect for decisions that were made by the legislative branch of government.

In making predictions about the outcome of that litigation, some people had emphasized the tendency of conservative justices to limit federal authority vis-à-vis the authority of the states. That is accurate, but it is not the only principle of conservative legal analysis. Another important conservative principle is to defer to decisions of the people’s elected representatives in Congress.

From a political perspective, many people had viewed the litigation over constitutionality of the ACA as a judgment on the work of President Barack Obama and his administration. From a constitutional perspective, however, the ACA was not simply the work of President Obama and his appointees, even though he signed the law and provided the leadership for its enactment. Rather, the ACA was an act of the United States Congress. That was the basis on which the Supreme Court reviewed the law, and that was the basis for the deference which was given to the law by the majority of justices.

The Supreme Court reasoned that the individual mandate was not a valid exercise of Congress' power to regulate interstate commerce because the law attempted to regulate inactivity rather than activity. If Congress could require inactive individuals to enter commerce and buy insurance, what else could Congress require individuals to buy?

When one party to litigation argues for a particular interpretation of a law, the other party often tries to point out the harmful consequences that would occur if that argument were to be taken to its logical extreme. Then, the party arguing in favor of that interpretation bears the burden of demonstrating how its proposed rule could be limited in a reasonable and practical manner.

In the dispute over the individual mandate, parties challenging the law argued that, if the federal government could make people buy health insurance, that principle would also allow the federal government to make people buy broccoli. Supporters of the ACA were not able to articulate a logical and practical limit to their interpretation of the Constitution's Commerce Clause. Instead, supporters were forced to insist that health insurance is simply unique, but the Supreme Court was not persuaded by that argument. The inability to identify and articulate a limit was a major reason for holding that the individual mandate was not a valid regulation of interstate commerce.

Nevertheless, the court reasoned that the penalty for failure to buy health insurance was a valid exercise of Congress' constitutional power to impose taxes. In that part of its opinion, the court relied on longstanding conservative principles, such as providing significant deference to acts of Congress.

Moreover, when a statute enacted by Congress can be interpreted in two different ways, courts should interpret the statute in the way that makes it constitutional. In this case, the federal government argued that the penalty provision in the ACA could be interpreted as a tax, in which case it would be constitutional. Although the ACA could be interpreted in other ways, the court concluded that the financial penalty could reasonably be described as a tax. That was sufficient to uphold the constitutionality of the penalty under conservative legal principles.

Significantly, the Supreme Court did *not* hold that Congress lacked the power to require individuals to participate in a health insurance system. The court merely held that Congress could not rely on its power to regulate interstate commerce as the basis for requiring individuals to buy insurance. As one possible alternative, Congress could use its taxing power to establish a new tax-supported health insurance system for the entire country or expand the existing, tax-supported Medicare program to cover all residents of the United States. In 1937, the Supreme Court held that, because Congress has the power to tax and spend, it may require individuals to contribute to the federal Social Security system.<sup>12</sup> On the same basis, Congress would have the power to establish a government health insurance system for all residents of the country and could require all individuals to pay taxes in support of that system.

As another possible alternative, Congress could use its conditional spending power to provide federal funding to those states that are willing to impose an individual mandate

or adopt other reforms that would expand health insurance coverage in a particular state. Congress has the power to impose conditions on the use of specific federal funds, but it may not impose conditions that relate to the use of other federal funds. In another part of its opinion, the Supreme Court explained that “[n]othing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use.”<sup>13</sup> In fact, beginning in 2017, the ACA will provide an option for states to implement their own systems to expand insurance coverage and receive federal funds for state systems that meet ACA requirements.

## NOTES

1. Pub. L. No. 111-148 (2010).
2. Pub. L. No. 111-152 (2010).
3. J. Oberlander (2010). “Beyond Repeal—The Future of Health Care Reform.” *New England Journal of Medicine* 363 (24): 2277–79.
4. Pub. L. No. 111-148, § 3403 (c)(2)(A)(ii), 10320(b) (changing the name of the board).
5. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012).
6. U.S. Department of the Treasury, “Continuing to Implement the ACA in a Careful, Thoughtful Manner” (July 2, 2013). [www.treasury.gov/connect/blog/pages/continuing-to-implement-the-aca-in-a-careful-thoughtful-manner.aspx](http://www.treasury.gov/connect/blog/pages/continuing-to-implement-the-aca-in-a-careful-thoughtful-manner.aspx).
7. 77 Fed. Reg. 30377 (May 23, 2012) (final regulations), at 30378.
8. See, e.g., *Halbig v. Sebelius*, 2014 U.S. Dist. LEXIS 4853 (D.D.C. 2014).
9. 132 S. Ct. 2566 (2012).
10. *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905).
11. See, e.g., W. K. Mariner, G. J. Annas, and L. H. Glantz, “Can Congress Make You Buy Broccoli? And Why That’s a Hard Question,” *New England Journal of Medicine* (2011), 364 (3): 201–203.
12. *Helvering v. Davis*, 301 U.S. 619 (1937) (upholding mandatory Social Security contributions under the taxing power).
13. 132 S. Ct. at 2607.