



People wait in line overnight in front of the Supreme Court for tickets on the eve of oral arguments on President Obama's health care legislation, in Washington, D.C., March 25, 2012.

(AP Photo/J. David Ake)

Health Care and the High Court: An Overview

Looking at the Law Editor's Note:

In late March, the Supreme Court heard arguments pertaining to the Patient Protection and Affordable Care Act (ACA). The arguments emerged from three separate cases: U.S. Department of Health and Human Services et al. v. State of Florida et al.; National Federation of Independent Business et al. v. Kathleen Sebelius, Secretary of U.S. Department of Health and Human Services et al.; and State of Florida et al. v. U.S. Department of Health and Human Services et al. The three cases presented four issues to the Court, which are outlined here. This overview is adapted from articles appearing in the special edition "Health Care and the High Court" issue of PREVIEW of United States Supreme Court Cases, presented by the American Bar Association Division for Public Education. For more information on the health care cases, you may download the special issue of PREVIEW at www.supremecourtpreview.org.

The Health Care Challenges

Bradley W. Joondeph

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA). Whatever its merits as a matter of policy, it was a historic legislative achievement. No prior administration had successfully pushed national health reform through Congress, despite several attempts. Understandably, the mood at the act's signing ceremony was festive. But not all Americans were thrilled. Within minutes, 12 state gov-

ernments filed two separate lawsuits in Virginia and Florida claiming that the act was unconstitutional, and within weeks private parties filed roughly 20 similar challenges elsewhere. Thus began the steady, collective march of ACA litigation, played out in federal courts across the country—a journey that everyone expected would ultimately end at the Supreme Court.

And so it has. The oral arguments took place March 26, 27, and 28, and the Court’s subsequent decision will likely mark the culmination of this two-year drama. (*Likely*, only because it is possible the justices will conclude that they lack jurisdiction over some of the questions presented, pushing a final resolution further into the future.)

How did we get here? In the beginning, the lawsuits raised a vast array of constitutional issues—such as whether the ACA violates the constitutional right to privacy, interferes with the free exercise of religion, or violates the Thirteenth Amendment’s prohibition on slavery. As the cases have inched forward, though, most of those claims fell by the wayside, as they generally lacked merit. What remained last month were four issues.

They included the two substantive questions on which the Court granted certiorari, or agreed to hear the cases. The first, and most noted, is whether the ACA’s minimum coverage provision (also called the “individual mandate”)—which requires almost every person legally residing in the United States to acquire minimally adequate health insurance by January 1, 2014—exceeds Congress’s enumerated powers. The second revolves around the ACA’s expansion of the Medicaid program, particularly its requirement that participating states expand eligibility to all legal residents under age 65 earning up to 138 percent of the federal poverty level. The challengers claim this expansion effectively “commandeers” the states by forcing them to implement a federal legislative program.

The Court has also asked for argument on two procedural questions: (1) whether

the Anti-Injunction Act (AIA), which generally bars federal courts from hearing any suit that seeks to prescribe the collection of a federal tax, precludes the Court from reaching the merits; and (2) whether, if the minimum coverage provision is unconstitutional, any of the ACA’s hundreds of other provisions are also unenforceable because they cannot be severed from the individual mandate.

BRADLEY W. JOONDEPH is a professor of law at Santa Clara University.

Issue 1: Anti-Injunction Act Issue

Bryan Camp and Jordan Barry

Several provisions of the ACA were codified in the Internal Revenue Code, including the individual mandate. This provision requires individuals to have health insurance beginning in 2014. Individuals who fail to do so must report that failure on their tax returns and must pay an amount labeled a “penalty” along with their federal income and other taxes. Congress specified how the Internal Revenue Service (IRS) must assess and collect this penalty.

The Anti-Injunction Act, enacted in 1867, says that “no suit for the purpose of restraining the assessment or collection of any tax may be maintained in any court by any person.” If the Anti-Injunction Act bars this lawsuit, the Supreme Court will not be able to decide whether the Patient Protection and Affordable Care Act (ACA) is constitutional and the lower court opinions will be vacated.

To decide a case, a federal court must have the power to judge matters of that type. This concept is known as “subject matter jurisdiction.” Generally, federal courts only have subject matter jurisdiction when a federal law gives it to them. And what Congress gives, it can also take away, by changing the law. The question in this case is whether the Anti-Injunction Act, which prohibits “any person” from suing the federal government “for the

purpose of restraining the assessment or collection of any tax,” strips federal courts of their power to decide this case at this time. This law is commonly called “the Anti-Injunction Act” because it prevents federal courts from hearing cases where taxpayers are seeking court orders, such as injunctions, to prevent the government from assessing or collecting federal taxes. So before the Supreme Court can address whether the ACA is a constitutional exercise of congressional power, it must first decide that the Anti-Injunction Act either (1) does not take away subject matter jurisdiction from the federal courts or (2) does not apply to this case. If the Anti-Injunction Act is jurisdictional and does apply, courts likely will not be able to decide whether the ACA is constitutional until at least 2015, after Congress has an opportunity to reform the law.

BRYAN CAMP is a professor of law at Texas Tech School of the Law, and **JORDAN BARRY** is an associate professor of law at the University of San Diego School of Law. Professors Camp and Barry prepared one of the *Amici* briefs in the case *United States Department of Health and Human Services et al. v. State of Florida et al.*

Issue 2: Minimum Coverage Provision, or “Individual Mandate” Issue

Elliott B. Pollack

A key component of the ACA is the individual mandate, or minimum coverage provision, requiring that all Americans, with limited exceptions, maintain a base level of health care coverage. Those who fail to do so are liable for a penalty assessed by the IRS. This challenge asks the Supreme Court to determine whether Congress has the power, under the Constitution’s Commerce Clause, to issue such a mandate and, further, if Congress has the right to assess a penalty and/or a tax against those who refuse or fail to meet the mandate.

The ACA mandates that all Americans, with certain limited exceptions, maintain

“minimal essential health care coverage” beginning in 2014. Certain individuals whose religious beliefs preclude doing so, illegal aliens, and prisoners are exempted. The ACA obligates insurance companies to file informational returns to identify the names of their insured and the dates of coverage. The IRS is tasked to notify taxpayers who are not enrolled about accessing coverage through the health benefit exchange operating in their state. Under the ACA, the penalty for not maintaining “minimal essential health care coverage” begins at \$95 in 2014 and rises to \$695 annually, per person, in 2016.

The Commerce Clause of the U.S. Constitution states that Congress shall have power “To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.” Another clause in the Constitution gives Congress the authority to make all Laws “which shall be necessary and proper for carrying into Execution” the powers it is granted by the Constitution. So, does Congress have the authority to require us to buy health insurance?

In as much as the Supreme Court granted certiorari from the opinion of the Eleventh Circuit U.S. Court of Appeals on August 12, 2011, overturning the ACA entirely, the discussion here will begin with that ruling.

The Eleventh Circuit agreed with the contention of the 26 state respondents and the individual plaintiffs who brought the pending litigation that the health insurance mandate effectively requires “individuals to *enter* into commerce so that the federal government may regulate them. . . .” An individual who chooses not to purchase insurance is not within commerce; their decision “is marked by the *absence of a commercial transaction.*”

A prong of the Eleventh Circuit’s opinion was its respect for the states’ long-established and powerful role in regulating insurance and the provision of health care—notwithstanding that Congress also has legislated extensively and powerfully in those arenas. Noting that insurance is more traditionally linked to the states as compared to the federal government’s

activities, the court’s Commerce Clause analysis was that “the individual mandate exceeds constitutional boundaries.”

The United States maintained before the court of appeals that the individual mandate was a necessary adjunct to a “broader regulation of the insurance health care market” and therefore appropriately relied on the Commerce Clause.

The U.S. Department of Health and Human Services (HHS) also stressed the active, even if sometimes unintentional, extensive involvement of the federal government in health care and in insurance markets. Medicare and Medicaid, the Children’s Health Insurance Program, tax deductions given to employers for paying their employees’ health insurance premiums, the nontaxable status afforded to employees for the value of their health insurance premiums, and the regulation of employer-sponsored health coverage through the Employee Income Security Act, among others, demonstrate how thoroughly the government has already planted itself within the field of health insurance.

Further, HHS pointed out that our current way of paying for health care on a national level has serious financial costs. According to HHS, 50 million people who lacked health insurance in 2009 consumed health care resources far above their ability to pay for services; 2008 data cited by HHS indicate that uninsured Americans pay for only 37 percent of their health care costs. As a result, the need for health care providers to capture these uninsured costs by inflating the charges to insured consumers, the so-called “cost shift,” increases health care insurance premiums for the balance of Americans; according to HHS, this cost shift certainly has an impact on commerce among the states.

Twenty-six states led by Florida characterized the individual mandate as a “threat to liberty.” The states argued that through the ACA, Congress is asserting “the power to compel individuals to engage in commerce in order more effectively to regulate commerce.” This is the first

time in the history of the country, they maintained, that Congress has asserted such an “unbounded power;” rejecting it will not imperil any other legislation or a sound health care policy.

Moreover, the states asserted that while individuals must obtain health care insurance by virtue of ACA, they are not required to use that insurance when obtaining health care. According to the states, this gap further demonstrates the weakness of the constitutional arguments asserted by the United States. The states contend that use would more closely relate to actions taken in commerce and therefore be more likely to survive scrutiny.

Is the ACA, particularly the “individual mandate” provision, a proper exercise of congressional power to reform our staggering health care system consistent with Congress’s powers under the Commerce and Tax and Spending Clauses? Or is it a constitutionally improper effort “to compel the uninsured into engaging in economic activity that is harmful for them but beneficial to third parties,” as the private respondents’ brief asserts?

ELLIOTT B. POLLACK is a member of Pullman & Comley, LLC, in Hartford, Connecticut, and adjunct faculty at University of Connecticut Law School.

Issue 3: Severability Issue

Erwin Chemerinsky

If the minimum coverage provision—the individual mandate—is declared unconstitutional, is it severable from the rest of the ACA or does the entire act need to be declared unconstitutional?

The ACA is a large statute that does many different things. For example, one aspect of the act is to provide tax credits for small businesses to increase the subsidy for employee health coverage, while at the same time imposing a tax liability on large employers that do not provide adequate coverage to full-time employees. Another part of the act increases Medicaid coverage—the constitutional-

ity of which is one of the separate issues before the Court—seeking to add as many as 10 million individuals to the Medicaid rolls in the next decade.

The act also regulates many aspects of the market for health insurance. For example, the act provides that insurers cannot rescind coverage absent fraud or intentional misrepresentation on the part of a policyholder. Insurers no longer may impose lifetime dollar limits on essential benefits and there are restrictions on the ability of insurers to impose annual dollar limits on coverage. Insurers are generally required to provide family coverage that includes adult children until age 26. Also, the act bars insurers from denying coverage to individuals because of preexisting medical conditions.

The act also has a number of other provisions, which are not directly related to insurance but relate to the health care system. For example, the act requires chain restaurants to disclose nutritional information about standard menu items, establishes a National Prevention, Health Promotion, and Public Health Council, amends an aspect of the False Claims Act, and reauthorizes the Indian Health Care Improvement Act.

Except for the increased burden on the states with regard to Medicaid funding, none of these provisions are being challenged as unconstitutional. The provision being challenged is the “minimum coverage provision.” If the Court were to declare this unconstitutional, there is then the question of whether the entire Act should be struck down or whether the minimum coverage provision is severable.

Thus, there were two very different visions of the ACA presented to the Supreme Court. The petitioners contend that the entire act was a hard fought compromise in Congress and that the individual mandate was the key without which the act would not have been adopted. The United States, by contrast, says that the act contains a myriad of provisions, some having nothing to do with the individual mandate, and that these likely would have been adopted.

In assessing severability, the Supreme Court has declared that it “must retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress’s basic objectives in enacting the statute.”

ERWIN CHEMERINSKY is dean and Distinguished Professor of Law at the University of California, Irvine School of Law.

Issue 4: Medicaid Expansion Issue

Steven Schwinn

Medicaid, established in 1965, is a cooperative federal-state program that funds medical care for needy individuals. Under the program, the federal government provides funds to participating states, and participating states agree to provide their own additional funds and abide by certain federal standards. While participation is optional, every state participates.

The ACA sets a new standard by expanding Medicaid eligibility to individuals with incomes up to 138 percent of the federal poverty level. While participating states must accede to this expansion, the federal government will pay for 100 percent of Medicaid costs associated with the expansion through 2016; the federal share then gradually decreases to 90 percent in 2020.

America’s Health Care Journey

1870s	The Grange (officially the Patrons of Husbandry) helps organize access to health care for member farmers in the Plains States.	1940s/50s	Truman’s efforts toward a national health program are opposed as socialist.
1912	Theodore Roosevelt first proposes national health insurance.	1965	Johnson enacts legislation that introduces Medicare, covering both hospital and general medical insurance for the poor and elderly.
1915	Progressive politicians propose bill to provide subsidized health coverage for the poor.	1970s/ 80s	Concern over inflation and spiraling costs doom several competing health care reform efforts in Congress.
1930s	Blue Cross and Blue Shield expands the field of employer-backed health coverage.	1993	Clinton’s Health Security Act meets with limited, conditional support in Congress.
1940s	Franklin Roosevelt continues to support national health reform throughout his terms.	2010	National health reform legislation is signed by Obama, mandating that all individuals have health insurance beginning in 2014.

Congress has authority to spend funds to promote the general welfare. It also has authority to set conditions on those funds, even when the conditions apply to states. Thus, federal spending programs work like a contract with participating states: the federal government agrees to give money to the states in exchange for their agreement to comply with the attached conditions. If a state declines or fails to comply with the conditions, it sacrifices the federal funds.

While Congress can use these authorities to *encourage* states to adopt its conditions, Congress cannot use these authorities to *compel* states. A group of 24 states, a state's attorney general, and a governor sued the U.S. Department of Health and Human Services to halt implementation of the Medicaid expansion. The states argued that the expansion exceeded Congress's power to set conditions on

the receipt of federal funds—that the expansion was unduly coercive.

The states framed their arguments around that ill-defined point at which “pressure turns into compulsion.” The states argue that the massive amounts of federal money in the Medicaid program and the structure of the ACA make the Medicaid expansion compulsory on the states; while the government argues that the Medicaid program, as it has in the past, merely pressures states to accede to its many conditions, including the ACA's expansion.

Most immediately, this case will affect needy individuals' access to medical care. Outside of that most central aspect, the case is also important because it tests the limits of one of Congress's most significant and wide-ranging authorities, the power to spend money. Congress's power to spend money—along with its

ancillary power to set conditions on that money—is enormous. This power allows Congress to operate vast programs and to effect sweeping policies in all areas of life, without respect to the bounds on other congressional authorities in the Constitution (such as the Commerce Clause). This power also allows Congress to operate any manner of cooperative federal-state programs, achieving joint policy aims through the combined and coordinated efforts of the federal and state governments. Many of these programs, such as Medicaid, have enjoyed a long history and have become embedded in our system of federalism. 🌐

STEVEN D. SCHWINN is an associate professor of law at The John Marshall Law School and coeditor of the *Constitutional Law Prof Blog*.



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