The Patient Protection And Affordable Care Act Of 2010: Constitutional?

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ABSTRACT

After decades of debates and policy discussions, in early 2010, the Obama Administration, with the Democrat party controlling both the House and the Senate, passed a National Health Insurance Act. The Patient Protection and Affordability Act was immediately challenged in court. One district court in Florida declared it unconstitutional. Two other district courts and an appellate court declared it constitutional. This paper looks at the Act and those issues.

Keywords: National, Health; Insurance; Patient Protection; Affordability; Act; Health Care; Policy; Process; Debate; Congress; President; Obama; Obamacare; Supreme Court; Judicial System

INTRODUCTION

After decades of debate and policy discussion, the USA passed a National Health Insurance law. On March 23rd, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act. The Act proposes to expand health care coverage to an additional 31 million uninsured Americans at a cost of $848 billion over a ten year period (Pear & Herszenhorn, 2009).

PASSAGE OF THE ACT

Health care, and payment for health care services, has occupied a unique place in American commerce. Payment for health care services and costs has evolved from a "fee for service" model (when the patient received health care services, the patient immediately paid the service provider directly) to a third party reimbursement model, where an entity other than the patient pays the provider of services, typically through a negotiated contract with the patient's employer and at time later than the service was provided. Today in the USA, "managed care" occurs at all levels of health care, not just at the level of reimbursement. And with the advent of managed care, where costs of goods and services in the health care system are analyzed and controlled, patients receiving health care complain about the "insurance companies" policies regarding reimbursement.

In response to numerous consumer and constituent complaints, the state and federal legislative and administrative branches have instituted a number of laws, rules and regulations regarding the delivery of health care services. State departments of insurance regulate individual health care contracts within each state. Federal agencies regulate Medicare (health insurance and reimbursement for those over 65) and Medicaid (health insurance and reimbursement for the economically disadvantaged). The costs of both Medicare and Medicaid have exploded in the federal budget. In 2011 Medicare is projected to account for 12.5% ($450,664 billion) of the total expenditures. Medicaid is projected to cost the federal government $245118 million, with a like amount for the states. But complaints continue about third party conduct in health care, including allegations of interference in the delivery of care. As a result, the US Congress took up the debate.

Congressional members argued that many aspects of the current health care system needed to be addressed in order to control national medical costs. After his victory in the 2008 USA Presidential election, President Barack Obama outlined his public policy to a joint session of Congress on September 9th, 2009, and introduced the basic policy for the current Act. He stated:

We must also address the crushing cost of healthcare. This is a cost that now causes a bankruptcy in America every thirty seconds. By the end of the year, it could cause 1.5 million Americans to lose their homes. In the last eight years, premiums have grown four times faster than wages. And in each of these years, one million more Americans have lost their health insurance. I am not the first president to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way.

CHANGES TO THE AMERICAN HEALTH CARE SYSTEM UNDER PPACA

PPACA will attempt to correct the current health care concerns seen as facing the USA. One of the stated goals is to limit the rate differential between high risk and low risk beneficiaries while providing coverage for all Americans. Some of these health care changes under PPACA have already been implemented, however, many provisions are not set to take effect until the start of 2014.

A few regulations under PPACA went into effect in September of 2010. Health care insurers must cover dependants under the age of 26 years under their guardian's insurance policy (Rowen, 2011). Also third party payors must permit beneficiaries access to preventative care and exams without a co-payment charge. (Rowen, 2011). The Act aims to diagnosis medial issues, such as cancer and disease, before they become a life threatening condition to the patient. This will also theoretically reduce the burden on individuals seeking preventative care but who are unable to afford it. Medical insurers are also restricted in their ability to deny coverage to children under the age of 19 for pre-existing medical conditions (Rowen, 2011). Before the regulations outlined in PPACA, insurance providers were able to deny coverage due to the known medical conditions on an individual case by case basis.

Even though some provisions for insurers have already become enacted, a majority of the regulations under PPACA will not be enforced until the start of 2014. The largest and most controversial issue in PPACA is the requirement that all Americans obtain medical insurance. According to the regulations, all individuals under the age of retirement must be insured by an employer, purchase individual insurance coverage or be eligible for Medicaid coverage under their states requirements (Rowen, 2011). If an individual fails to obtain medical insurance, each can be assessed tax penalties starting in 2014. Under the current PPACA regulations, uninsured individuals will face a $95 fine each year for being uninsured with rates steadily increasing in the following years (Rowen, 2011).

Another regulation under PPACA includes placing a cap on the insurance premium ratio that insures use to determine insurance premiums. The exception to the law will include any lower premiums offered for participation in wellness programs. The ratios examine the difference in price between the most expensive premium charged to a coverage group meeting a certain criteria versus the lowest premium offered to a coverage group of the same criteria. Regulations under PPACA limit the ratio of premiums for age and tobacco users. Starting in 2014, a cap involving of a 3 to 1 ratio difference between the lowest and highest priced age groups will be put into effect (Rowen, 2011). Insurers will also be limited to a 1.5 to 1 difference ratio in premiums between tobacco users and non-tobacco users (Rowen, 2011). These ratios will limit the variation in coverage costs for insurance premiums.

While many of these requirements are aimed at existing health providers, state governments will also see changes in the way they administer health care to their citizens. The first example of this is the creation of state ran insurance exchanges. By 2014, all states must establish a web based insurance exchange to facilitate the purchase of individual and small group coverage (Rowen, 2011). States are not required but encouraged to offer additional large group coverage on the insurance exchange. These insurance policies offered on the exchange must cover the essential health benefits specified in PPACA. The essential health benefits include coverage of ambulatory services; emergency services; hospitalization; maternity and newborn care; mental health; laboratory services; preventative screening; as well as oral and vision care (Rowen, 2011). PPACA will require states to offer four levels of coverage based on the percentage of coverage under the plan. These coverage categories to choose from include Bronze, Silver, Gold and Platinum and they cover 60, 70, 80 and 90 percent of the projected cost respectively (Rowen, 2011). Individuals seeking insurance on these exchanges will have the ability to choose their coverage amounts with the bronze level being the minimum insurance coverage offered.

States will also see a change in the Medicaid requirements that must be met in order to receive the federal matching program. Under the requirements set forth in PPACA, states will have to increase the Medicaid allotment to all individuals and families earning less than 133 percent of the federal poverty level by 2014 (Hatch & Upton, 2011 According to the Department of Health and Human Services the federal poverty level for a family of four in 2011 is $22,350 (Hatch & Upton, 2011.). In result of the new regulation, states will be forced to cover families that make less than $29,725 if they choose to stay enrolled in Medicaid. By increasing the percentage of the federal poverty level covered under Medicaid, the Congressional Budget Office expects that 32 million addition citizens will become eligible for Medicaid by 2019 (Hatch & Upton, 2011). Many states have started to examine their budgets in anticipation for the Medicaid changes and are left wondering how they will afford the increase in coverage. The section to follow describes how Ohio is preparing for the new increase in Medicaid participants and the concerns they have about the new regulations.

PROS & CONS OF PPACA

Almost everyone agrees that rising health care costs are an issue that needs to be addressed in the near future and there are many opinions on how the issue should be addressed. PPACA was the first health care bill that called for a complete overhaul of the current health care system. Many individuals and organizations have published opinions in regards to PPACA both positive in negative.

Passage of the PPACA has extended coverage to many more Americans. Some of the positive attributes with the passage of PPACA can even been seen today. Under new regulations, anyone under the age of 26 can be carried on their parental guardian's insurance policy (Coburn, 2010). Full-time student status or marital status will no longer be a determinant in offering medical coverage under PPACA. The PPACA will also limit insurance companies from denying coverage to individuals with pre-existing medical conditions (Coburn, 2010). Another added benefit is insurance benefices will have greater access to preventative screenings without a co-payment (Coburn, 2010). Such screenings will include routine checkups, well child care, well adult care, immunizations and cancer screenings (Coburn, 2010).

Another added benefit with the passage of the PPACA is the ease of securing health insurance in the state insurance exchange programs. States under the PPACA regulations must establish a web based portal by 2014 in which individuals can purchase different ranges in medical coverage (Rowen, 2011). These exchanges are expected to become low cost distribution channel for insurance providers and will be able to reach anyone with an internet connection (Rowen, 2011). Also by purchasing a program through the states insurance exchange, participants will know they will be covered for ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health as well as vision and dental (Rowen, 2011). These exchanges may prove to be a one shop stop for all an individual's medical insurance needs.

Some still argue that the PPACA has gone the about the issue of correcting our current health care crisis the wrong way. The National Federation of Independent Businesses (NFIB) published their concerns in regards to PPACA in the document *PPACA: Endless Problems for Small Business* (NFIB: The Voice of Small Business, 2011). They predict that 80 percent of small business will be forced to drop their current health insurance plans within the three years following PPACA's 2014 effective date (NFIB, 2011). They cite that the added expense of providing coverage for employees will lead small businesses with no other choice than to have employees purchase their own insurance on state ran insurance markets. The NFIB also agrees that PPACA creates powerful financial incentives for businesses to shrink their employee head count. Employers will find it adventitious to outsource operations to foreign countries where they will not be mandated to pay for employee health care. They are also against new provisions in PPACA that limit the ability of employees to use flexible spending and health savings accounts to purchase over-the-counter medications without a prescription (NFIB, 2011). Their concern is that without these plans coving over-the-counter medicines, costs for the employees and their employers will increase (NFIB, 2011). The NFIB also brings to light the need for business to devote considerable resources to monitoring and navigating newly written regulations and requirements associated with PPACA (NFIB, 2011). This will increase their overall cost of operations and businesses will be forced to pass these expenses onto the consumers of their products.

CONSTITUTIONALITY

The Judicial system of the Federal Government plays a significant role in the modification of public policy. The Judicial system has the role in determining how laws are interpreted and enforced within the United States. This type of policy making exists because perfection cannot be achieved in the other phases of policy making (Longest, 2010). A handful of court cases were filed shortly after the Act was passed, most notably *State of Florida v. The Department of Health and Human Services.* In that case, U.S. District Court Judge Roger Vinson of the Northern District of Florida declared the provision of the law requiring all Americans to purchase health insurance otherwise face a fine unconstitutional (Pear & Herszenhorn, 2009).

State of Florida v. United States Department of Health and Human Services was filed on March 23, 2010, only hours after PPACA was signed into law by President Obama. This suit was filed in the Florida Northern District Court by the Attorney General of Florida, Bill McCollum. Attorney General McCollum's case challenged the constitutionality of the PPACA. Originally Bill McCollum represented twelve other states which included South Carolina, Nebraska, Texas, Utah, Louisiana, Alabama, Michigan, Colorado, Pennsylvania, Washington, Idaho and South Dakota. (Smith, 2011). Attorney General McCollum filed the suit against the Department of Health and Human Services. After McCollum's term as Attorney General concluded, newly elected Attorney General Pamela Bondi continued to progress with the case. On January 19th, 2011, Attorney General Bondi filed a motion adding six new states, Maine, Wisconsin, Ohio, Kansas, Iowa and Wyoming to the suit (Smith, 2011). This brought the total number of states being represented in the lawsuit to 26 states. Aside from the states that were being represented, two private citizens and the National Federation of Independent Business (NFIB) were also being represented. The defendants named in the case were the United States Department of Health and Human Services and the Department of Treasury and the Department of Labor.

Senior United States District Judge Roger Vinson presided over the court proceedings deciding the constitutionality of PPACA. The plaintiffs in this case were seeking a summary judgment by Judge Vinson and an injunction placed on the enforcement of the act scheduled to start in 2014. There were a total of two counts that court examined in regards to this case. The first challenge was over the mandate that all Americans beginning in 2014 will be required to purchase federally approved health insurance or face a monetary penalty. This requirement was set forth in section 1501 of PPACA. The defendants argued that Congress has the power to mandate the purchase of insurance by all Americans under provisions in the Commerce Clause. The second challenge in the case deals with the provision that altered and amended the Medicaid program. This amendment required states to offer Medicaid to individuals under the age of 65 with income under 133 percent of the federal poverty level. Today the Department of Health and Human Services has set the federal poverty level for a family of four at $22,350 (Hatch & Upton, 2011). New regulations under PPACA will require states to offer Medicaid to citizens making less than $29,725. The plaintiffs argue that the increase in Medicare requirements for the states violates the Spending Clause set forth to regulate government spending.

After hearing both sides and analyzing the matter of facts presented in both arguments, Judge Roger rendered his decision of the case on January 31, 2011.

Judge Vinson addressed the issue regarding the increase to Medicaid first in his decision of the court case. Under PPACA, states must offer Medicaid to individuals that make less than 133 percent of the federal poverty level starting in 2014. The plaintiffs in the case argue that since Medicaid is the largest grant-in-aid program, they have no other choice but to participate in the government program. Judge Vinson makes note in his decision that the, "…plaintiffs appear to have relied solely on the coercion and commandeering theory." The plaintiff also makes the argument that Congress is in violation of their spending power set forth in the spending clause. Judge Vinson is quick to list the four restrictions of the Spending Clause. The restrictions to the Spending Clause are the federal spending must be for the general welfare, the conditions must be clearly stated, the conditions must bear a relationship to the purpose of the program and the conditions imposed may not require states to engage in activities that would themselves be unconstitutional. Judge Vinson determined that the provisions under PPACA meet requirements set forth in the Spending Clause. He also mentions in his decision that the Medicaid program under the Medicaid Act has always remained voluntary. States have the ability to opt out of receiving the government matching grant at any time and stop the funding of Medicaid in their states. The states of Nevada and South Dakota

have taken this into account and have weighed the option of suspending their Medicaid programs due to budget concerns. Judge Vinson also cites some previous court cases that have established the case that Medicaid is a voluntary program. He uses the example of the case of Florida Association of Rehab Facilities v. Florida Department of Health and Rehab Services to show that "No state is obligated to participate in the Medicaid Program." Judge Vinson determines that states have a choice to participate in the Medicaid program and granted judgment in favor of the defendants on the Medicaid issue.

The second issue that Judge Vinson heard arguments on was in regards to the individual mandate that all Americans must purchase health insurance under PPACA. The plaintiffs in the case claim that the mandate exceeds Congress' power under the Commerce Clause. Judge Vinson outlines the Supreme Court's interpretation of the Commerce Clause before discussing the details of the case. He concludes that there are three broad categories of activity that Congress may regulate under the commerce power. Congress has the ability to regulate the use of the channels of interstate commerce. Congress may also regulate and protect the instrumentalities of interstate commerce or person or things in interstate commerce even though the threat may come from intrastate activities. Judge Vinson also states that Congress commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce. Judge Vinson is the fourth Judge in the United States have taken up the issue of Congress over reaching the Commerce Clause.

Judge Vinson concluded that for Congress to inactivate use of the Commerce Clause, an "activity" by an individual must present that has a substantial relation to interstate commerce. Judge Vinson concludes that by implementing a mandate to purchase health insurance, the government is trying to empower use of the Commerce Clause to mandate inactivity. Therefore, the mandate was deemed unconstitutional. However, if an individual become sick or injured, uninsured while seeking medical treatment, unable to pay for medical care or unwilling to make payment arrangements directly with the health care provider, Congress could enact their right to use the Commerce Clause. As long as these stipulations have not been met, Congress cannot regulate inactivity and therefore cannot impose a mandate to purchase health insurance. Based on the inactivity of individuals who do not have health care, Judge Vinson ruled that Congress' attempt to use the Commerce Clause to issue a federal mandate of health insurance is unconstitutional.

Judge Vinson was left with the decision to determine if PPACA could stand as a law on its own without the individual mandate. After examining the 450 separate provisions of PPACA, Judge Vinson came to the conclusion that many of the provisions were dependent on the individual mandate. Due to this, he found that the remaining provisions of the PPACA were inextricably bound together in purpose and must stand or fall as a single unit. For this reason, Judge Vinson awarded the plaintiffs in the case declaratory relief from the PPACA. Judge Vinson closes his decision with the remarks that "…my conclusion in the case is based on an application of the Commerce Clause law as it exists pursuant to the Supreme Court's current interpretation and definition. Only the Supreme Court can expand on that." The Supreme Court is currently examining the case to decide if they will issue a ruling on the legality of PPACA.

On June 29, 2011, in a different case, the 6th Circuit Court of Appeals ruled that the Act was constitutional. *Thomas More Law Center v. Obama*, 6th Cir. Case No. 10-2388. In affirming a U.S. District Court decision out of Michigan, and quoting the Commerce Clause, the court determined that the Act was Constitutional (Contrary to Judge Vinson's decision), stating:

The minimum coverage provision, like all congressional enactments, is entitled to a "presumption of constitutionality," and will be invalidated only upon a "plain showing that Congress has exceeded its constitutional bounds." United States v. Morrison, 529 U.S. 598, 607 (2000). The presumption that the minimum coverage provision is valid is "not a mere polite gesture. It is a deference due to deliberate judgment by constitutional majorities of the two Houses of Congress that an Act is within their delegated power . . . ." United States v. Five Gambling Devices, 346 U.S. 441, 449 (1953).

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Virtually everyone will need health care services at some point, including, in the aggregate, those without health insurance. Even dramatic attempts to protect one's health and minimize the need for health care will not always be successful, and the health care market is characterized by unpredictable and unavoidable needs for care.

The ubiquity and unpredictability of the need for medical care is born out by the statistics. More than eighty percent of adults nationwide visited a doctor or other health care professional one or more times in 2009. Centers for Disease Control and Prevention National Center for Health Statistics, Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2009, table 35 (2010). Additionally, individuals receive health care services regardless of whether they can afford the treatment. The obligation to provide treatment regardless of ability to pay is imposed by the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd, state laws, and many institutions' charitable missions. The unavoidable need for health care coupled with the obligation to provide treatment make it virtually certain that all individuals will require and receive health care at some point. Thus, although there is no firm, constitutional bar that prohibits Congress from placing regulations on what could be described as inactivity, even if there were it would not impact this case due to the unique aspects of health care that make all individuals active in this market.

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Congress had a rational basis for concluding that, in the aggregate, the practice of self-insuring for the cost of health care substantially affects interstate commerce. Furthermore, Congress had a rational basis for concluding that the minimum coverage provision is essential to the Affordable Care Act's larger reforms to the national markets in health care delivery and health insurance. Finally, the provision regulates active participation in the health care market, and in any case, the Constitution imposes no categorical bar on regulating inactivity. Thus, the minimum coverage provision is a valid exercise of Congress's authority under the Commerce Clause, and the decision of the district court is AFFIRMED.

On August 12, 2011, the 11th Circuit Court of Appeals, based in Atlanta, Georgia, affirmed part and reversed part of Judge Vinson's decision in *State of Florida v. United States Department of Health and Human Services.* Because there is now a conflict in the Circuit Courts of Appeal (as well as two other pending appellate cases in the 4th and D.C. Circuits, this will certainly be heard by the Supreme Court of the United States, probably in the 2012-2013 term which ends in June 2013.

CONCLUSION

In the litigation with Judge Vinson and the 6th Circuit Court of Appeals, arguments were advanced claiming the PPACA of being in violation of several rights, specifically the 9th Amendment and 10th Amendments to the U.S. Constitution. In contrast, those supporting the law claimed that the individual mandate was constitutional under the commerce clause because interstate commerce would be affected. As different courts have ruled differently, ultimately the final decision will be addressed in some manner by the Supreme Court of the United States.

The Act sets up a classic conflict of Constitutional law: the 9th and 10th Amendments versus Article I, Section 8 (commerce clause) and the necessary and proper clause. No matter which way the law is decided, however, American healthcare and its system of reimbursement will never be viewed the same again.

AUTHOR INFORMATION

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