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Virginia Federal Court Strikes Down Individual Mandate: What's Next for the Health Reform Law?



BY WEBB MILLSAPS AND J. PETER RICH

Since the passage of the Patient Protection and Affordable Care Act (PPACA) in March, the health care sector has been in hyper-drive, as the nation's health insurance companies and other health plans, employers, hospitals and other health care providers, and federal and state health regulators have responded

Webb Millsaps is an associate in McDermott Will & Emery LLP's Miami office, where his practice focuses on health care transactions and health care regulatory and reimbursement matters. J. Peter Rich is a partner in McDermott Will & Emery's Los Angeles office. He co-chairs the firm's Insurance/Payers Affinity Group.

swiftly to comply with the sweeping new federal health care requirements.

While there have been legal challenges to the constitutionality of the PPACA, the first two federal courts (one in Michigan and another in Virginia) upheld the constitutionality of the new law. On Dec. 13, Judge Henry E. Hudson of the U.S. District Court for the Eastern District of Virginia held that the individual mandate (IM), perhaps the key provision of the PPACA, is unconstitutional, suddenly bringing the future of the PPACA into doubt—particularly since it is anticipated that a Florida federal district court will shortly reach the same conclusion.

In the short run, however, the Virginia decision alone will have no direct impact on the implementation of the PPACA. The Virginia decision holds that *only* the IM portions of the PPACA are unconstitutional. Judge Hudson's opinion severed the IM provisions from the rest of the PPACA and expressly concluded that Congress would have enacted the remainder of the PPACA even without the IM. Therefore, the decision did not affect any of the other provisions of the PPACA. The IM provisions, which require that individuals purchase insurance or pay a modest penalty, are not even scheduled to take effect until 2014. The Justice Department is appealing the Virginia decision and it is clear that the Supreme Court will ultimately decide whether the IM—and, perhaps the PPACA as a whole, is constitutional. Some observers have noted that severability language typically found in many statutes is not incorporated in the PPACA and that this could be a factor in whether other federal courts and ultimately the Supreme Court scrutinize the IM alone or all of the PPACA.

Since the IM does not become effective until 2014, the Supreme Court could wait for additional federal court decisions on the issue, including appellate decisions by federal circuit courts before hearing the case. Alternatively, some Republicans have called on the White House to fast-track an appeal to the Supreme Court.

While the Obama administration itself has commented in the past that the IM is the linchpin of the PPACA, there are many important provisions in the law that have nothing to do with the IM, and which could remain just as viable with or without the IM, such as the many provisions of the PPACA relating to Medicare and Medicaid. The PPACA contains provisions that create new payment models that are designed to drive better quality and more cost-efficient care delivery for Medicare and Medicaid beneficiaries. The Medicare Shared Savings Program under the PPACA, for example, presents opportunities for providers looking to leverage clinical integration to deliver better care at a lower cost, through new “Accountable Care Organizations.” The IM issue is largely irrelevant to the future of the Medicare Shared Savings Program, which only applies to care for Medicare beneficiaries.

From the perspective of health care providers, the Virginia decision has no significant, immediate impact. In the longer run, however, if the IM mandate is struck down by the Supreme Court, there would be a significant adverse impact on providers, particularly hospitals required to provide emergency services under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and their emergency physicians and on-call providers who were anticipating that the IM would significantly reduce the amount of uncompensated care they must provide. Regardless, the IM issue is obviously beyond the control of health care providers, and providers will need to stay the course, continuing to find ways to reduce costs while maintaining and even improving the quality of care.

Of course, the PPACA was not enacted merely to improve Medicare, Medicaid or other existing programs. Rather, the PPACA also aims to substantially reform the private market for group and individual health insurance.

The IM is intended to drive consumer behavior by compelling more uninsured people to purchase health insurance. Accordingly, the IM is believed to be essential to achieve the cost-reduction objectives for private market reform, by spreading the health insurance risk to a much larger population of insureds and thus counter-balancing the higher cost of health insurance under the PPACA, resulting from PPACA provisions prohibiting pre-existing condition exclusions and minimum mandated benefits for private insurance. Without the IM, people—and particularly the younger, healthier population—will be able to wait until they are sick before purchasing health insurance, thereby undermining the risk-spreading that is central to insurance. Insurance companies have taken the position that in the absence of the IM, the other private market mandates in the PPACA will only drive up the cost of private health insurance. For these reasons, Judge Hudson’s opinion calls the IM the “pivotal enforcement mechanism of the health care scheme adopted by Congress in the PPACA.”

A Threshold Question About the Individual Mandate

Ironically, many commentators have questioned whether the IM will achieve its intended purpose even if it does withstand judicial scrutiny. Setting aside the constitutionality question, the IM is regarded by many as fundamentally flawed. The flaws have gone relatively unexamined for many reasons, including the PPACA’s enormous 2,700-page scope and the fact that, by design, the IM provisions do not kick in until 2014.

So, while no one knows when or how the Supreme Court will eventually rule, it may not matter whether the IM is constitutional or not. If the IM does not function effectively, the contemplated reformation of the private health insurance markets will almost certainly fail. Such a failure would force legislators to either abandon market reform or to reconceive and relaunch an alternative to the IM.

Framing the Issue: What Problem Is the Individual Mandate Supposed to Solve?

The IM applies only to the uninsured and is intended to compel them to buy health insurance. In particular, the IM is supposed to compel younger, healthier people to buy health insurance or be subject to a potential financial penalty. Beneficiaries of Medicare, Medicaid or other government programs are not affected by the IM.

Individual and small group health insurance markets function differently than large group health insurance markets. In the large group health market, insurance plans do not have to recruit members in order to assure that the risk pool includes a cross-section of lower, medium, and higher risk members. Moreover, these pools are typically populated on the basis of some objective affiliation unrelated to health status (e.g. an employer, union trust fund, or association). Participation of lower risk individuals is often assured because an employer pays a large subsidy to encourage employees to join the plan.

Consumers who purchase insurance as individuals and through small groups are more dynamic in the way that they enter and exit risk pools. Especially in the case of individuals, no one is subsidizing the insurance purchase. In most cases, there is not even the tax subsidy that is applicable with group insurance purchased through payroll deductions. For these and other reasons, a problem for the individual and small group health markets is attracting lower risk individuals to join in the pooling of funds, in order to make such health insurance affordable.

Historically, individuals at the lowest risk (i.e. younger, healthier individuals) have proven much less eager to purchase health insurance. People who perceive they are at low risk feel comfortable retaining that risk and using their money for other purposes.

In addition, the health system maintains a built-in safety net for the uninsured. EMTALA requires hospitals and providers to treat patients even if they do not have insurance. If a relatively healthy person thinks that he is not likely to be sick or hurt in the first place, he or she may further rationalize there is little risk in not purchasing health insurance. Even the potential, catastrophic financial consequences may be rationalized—ultimately, medical bills can be dealt with through bankruptcy laws.

Simply put, the IM is supposed to force young, healthy people into risk pools in the individual and

small group health insurance markets before they become sick or injured.

Individual Mandate: A Weak Enforcement Mechanism?

The IM is supposed to be the cornerstone of individual reform because it will compel individuals to purchase insurance. In the relevant Section entitled “Requirement to Maintain Minimum Essential Coverage,” the PPACA boldly declares that each applicable individual “shall for each month beginning after 2013 ensure that the individual, and any dependant of the individual, is covered under minimum essential coverage for such month.” A big bark, but where is the bite?

Many experts regard the penalties as simply too small to compel individuals to buy health insurance. In 2014, a person who refuses to comply with the IM would have to pay a whopping \$75 penalty—for the year. Ouch. Granted, the penalty provisions of the IM are phased-in for 2014 and 2015. Yet, even at the maximum in 2016, the IM penalty for an individual caps out at maximum of \$750. After 2016, the penalty increases according to a cost-of-living adjustment formula, rounded down to the nearest \$50 increment. What if a family of five refuses to purchase health insurance? Interestingly, the penalty is capped at a maximum of three people per household, which would be \$2,250 in 2016.

Therefore, the choice is between paying the fine (say \$2,250 for the family of five) and the cost of purchasing health insurance. A family of five almost certainly will not be able to purchase health insurance for \$2,250 a year. Indeed, the annual deductible for affordable health insurance is likely to be greater than \$2,250. Therefore, a family may rationally choose to pay the fine. Furthermore, as discussed below, the PPACA is going to make health insurance more expensive because the law mandates that insurance policies have substantial mandatory benefits.

The “Problem” of Guaranteed Issue Insurance

It is difficult to see how the IM will compel younger, healthier people to buy insurance when there are many provisions in health care reform that will work in the opposite direction. The PPACA provides “Guaranteed Availability of Coverage” and prohibits insurers from imposing limitations on pre-existing conditions.

Since an individual can purchase health insurance after a diagnosis, what is the incentive to do so ahead of time? True, there are some scenarios where a person could get hurt and be in a coma before they had the opportunity to buy insurance. But remember, the type of people that the IM is supposed to compel to buy insurance are the younger, healthier people pre-disposed to rationalize that they do not need insurance because their risk is so low. The guaranteed issue provision in the PPACA may well persuade people to take precisely the opposite action intended by the IM. Many will find that the federal government mandate that insurance companies must provide guaranteed issue health insurance with no pre-existing condition limitations to be a

compelling reason to **never** purchase health insurance until it is needed to pay for an illness. The result is adverse selection on steroids.

PPACA Provisions at Cross-Purposes with the Individual Mandate

Aside from the guaranteed issue provision, the PPACA contains a number of provisions that will work to compel younger, healthier people *not* to purchase insurance. The PPACA increases the benefits that are included in an insurance policy (e.g. no lifetime limits; no annual limits). This will make insurance more expensive. Try calling your auto insurance agent and saying that you want to increase your coverage so that it is unlimited. Think the premium might go up? Imagine if there was a mandate that you had to buy auto insurance, but that the policy you were forced to buy was an extravagant “unlimited” policy with a higher price tag. If you are surprised that some people have no problem driving uninsured now, just wait until the **only** policy offered is a more expensive option.

On top of that, the PPACA provisions setting maximum premium ratios will tend to drive younger people completely out of the insurance market. The PPACA mandates that younger adults must pay artificially higher insurance rates than might otherwise be the case based on their risk profile in order to keep rates artificially low for older adults. The rates in an insurance plan cannot vary by more than a 3 to 1 ratio from the oldest to the youngest members of the group. This ratio is mandated even if, statistically, the oldest members are, say, seven times the risk of the younger members. The approach may be perceived as fairer to older members who have to purchase a plan. It will not matter whether the plan seems fair, however, if younger people decide the plan is too expensive and do not buy in at all. Again, the result is that only older, and less healthy people are attracted to the plan, which drives premiums up and further deters younger, healthier participants from joining.

The Driving Force Fueling PPACA’s Reforms

The driver of health care reform is that the current system of health care delivery and financing is widely regarded as unsustainable. Annual spending on health care in the United States is upwards of \$2.4 trillion or about 17 percent of GDP. Americans like their health care, but think it is overly expensive. Fortunately, a concerted effort is under way by a substantial number of providers who are actively embracing payment reform initiatives and demonstration projects under the PPACA, such as the Shared Savings Program. If these programs show that the cost curve can be bent for Medicare and Medicaid, the principles learned could be applied to help truly reform private insurance markets.

Of course, the 800-pound gorilla is the \$2.4 trillion in spending that continues to grow at a rate of approximately 7 percent per year. If the Supreme Court ruled tomorrow that the IM was constitutionally sound, the IM does not appear to be sufficient to compel people to buy health insurance—especially, health insurance that is going to be even more expensive under the new requirements in the PPACA.