HEALTH CARE REFORM AND THE CONSTITUTION
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The Patient Protection and Affordable Care Act of 2010 -- Obamacare -- is the most significant federal reform of the U.S. healthcare system since 1965 when we adopted Medicare and Medicaid. Health care financing is deeply politically divisive. In June 2012, Supreme Court upheld large portions of the law in what may be the most important High Court decision of our lives. I will criticize the decision. But the alternative -- the Court thwarting monumentally important social legislation – would have been infinitely worse. Three cheers for Democracy! Two cheers for John Roberts! Maybe even a cheer for the rule of law.

Congress adopted the Act to increase the number of Americans with health insurance. It passed by the narrowest of margins, with votes along strict party lines. Opposition to Obamacare is a central aim of the Republican Party. Disagreement about health care reform was a major factor in the 2010 midterm elections and in the 2012 Presidential race. The 2010 elections gave Republicans control of the House which has repeatedly voted to repeal the Act. If the 2012 elections were referenda on the Act, Obamacare won. Last week, the South Carolina house voted to make it a crime to take any action to implement the Act.

I will first provide a short history of health care financing in the United States. I will then sketch the major provisions of the Act and the politics that produced it. I will briefly describe and critique the Supreme Court’s decision.

That is a lot. But my main focus will be on the states. Each state must answer two big questions. First, should the state create and run a Health Care Exchange or allow the Federal Government to perform this critical role? Second, should the state accept the Act’s offer to extend Medicaid to more poor citizens at 100% federal costs for the first four years and 90% federal cost thereafter.

Hawaii has legitimately been regarded as the health care state, since it adopted the Pre-Paid Health Care Act in 1973. Hazel Bah will detail the interrelationships between Hawaii’s Pre-Paid Health Care Act and Obamacare.
Until Massachusetts adopted its health care reform act, Hawaii had more citizens covered by health insurance than any other state. At the same time, Hawaii is low on national lists in terms of health insurance coverage for poor children and Medicaid more generally.

The past is prologue. As Paul Star observed thirty years ago in his classic book, The Social Transformation of American Medicine, the set of decisions society faces at any moment is shaped by the choices made in the past, even though circumstances have changed. The U.S. chooses to be more “path dependent” than most developed cultures, particularly in relation to health care. Thus, it is essential to understand our past.

Until the mid 20th Century, babies were born and people died at home. But, as medicine had more to offer, doctors consolidated professional authority and hospitals proliferated. Prior to the 1940s, people paid for care out of pocket. Some doctors and hospitals provided charity care to people unable to pay. The Depression had a devastating impact on medical providers. The then newly organized hospitals and doctors created Blue Cross/Blue Shield. In Hawaii, that is HMSA. Until the 1970s, the Blues were provider governed, non-profit organizations, authorized in every state, exempt from state taxation and insurance regulation, in exchange for a commitment to serve the community. The commitment to community service meant that the Blues would accept anyone who sought insurance (open-enrollment), and would charge everyone the same rate, whatever their health risks (community rating). On the one hand, the Blues were self serving, monopolistic, provider-controlled institutions. On the other hand, they recognized that health insurance is a social good that should be accessible to all and that depends on pooling risks. They achieved huge market power and the descendents of the Blues still dominate the health insurance market in many states, including Hawaii. The creation of the Blues was the first big step in the construction of our path. It was and is state based.

Our next big step was driven by the federal government, big business and labor, and eventually by commercial insurers. During the Second World War, the federal government imposed wage and price controls, but exempted health benefits. The IRS allowed employers to treat contributions to health insurance as a business expense. Employers recruited workers in tight labor markets by offering health benefits. Commercial insurers entered the insurance market. Unlike the Blues, these profit-making companies had no commitment to open enrollment or community rating. They denied coverage and charged higher premiums to high risk people, and excluded coverage for a wide range of beneficial medical care,
including childbirth, preventive care, and treatment for HIV. To compete, the Blues abandoned their commitment to open enrollment and community rating. Private commercial insurers came to dominate most markets. Hawaii, where the market is dominated by the non-profit HMSA and Kaiser, is unusual in this regard.

Seniors were most adversely affected by the emergence of commercial insurance. Age easily identifies a group at high risk. But, seniors are politically potent. In 1964 seniors mobilized around health care and elected a Democratic President, Senate, and House. In 1965 Congress adopted Medicare and Medicaid. Modeled on private insurance, Medicare provides catastrophic insurance for the elderly and later the disabled.

In 1965, Congress also adopted Medicaid. Built on the model of cooperative federalism, it offered states federal matching funds if they created a program, meeting federal standards, to finance the costs of medical care for poor people who were aged, blind, disabled, children deprived of the support of a parent, and the caretakers of those kids. Because those eligible for Medicaid are, by definition, very poor, the services covered by Medicaid are comprehensive and patient cost-sharing is limited. Over the years, Congress has expanded the services covered and the groups eligible. Many states have sought federal matching to help provide essential care. Medicaid is now the largest single source of health insurance in the United States. Most Democratic, liberal states have embraced and expanded Medicaid. Medicaid in Hawaii has been more limited.

When Obama was elected, private health insurers, Medicaid and Medicare financed 85% of the medical costs of U.S. citizens. In promoting the Act President Obama promised, “if you like the health care and health insurance you now have, you will keep it.” That tradition of incrementalism, accommodation, path dependence is the American way. We build on what we have, even if it was created accidentally and is disorganized and dysfunctional. Bill Clinton, with a far stronger economy and a more robust political mandate, was not able to enact similarly incrementalist health financing reform.

The core political premise of Obamacare is to preserve everything that is politically popular, while addressing the critical problems raised by people who are uninsured. Since the 1970s, a broad coalition of Democrats, led by the late Senator Kennedy, sought comprehensive health insurance coverage. They enlisted the support of the major affected groups, including the medical profession, hospitals, the insurance industry, the business community, organized labor, the Catholic Church, and many advocacy organizations, such as Families USA and the AARP.
They met for years and the approach on which they settled was Romneycare, which had been adopted in Massachusetts in 2006, and now Obamacare.

The central problem was that approximately 50 million people were uninsured. Most could not afford to buy insurance and others were denied insurance or charged prohibitive rates because they were high risk. The uninsured do seek and obtain medical care. Over 60% of people without insurance visit a doctor's office or emergency room in a given year. Unlike every other product or service, the inability to pay for medical service does not mean that an individual will be refused care. Federal law, as well as professional obligations and embedded social norms, require hospitals and physicians to provide care when it is most needed, regardless of the patient's ability to pay.

Providing care to the uninsured imposes heavy burdens on health care providers. In 2008, hospitals and doctors received no compensation for $43 billion worth of the care they provide. Providers pass the cost of uncompensated care to those who do pay. On average, this cost-shifting increases family insurance premiums by over $1,000 a year. Further, those without insurance do not receive treatment for conditions- like hypertension and diabetes-that can be successfully and affordably treated if diagnosed early on.

Justice Ruth Bader Ginsburg describes the Act’s central provisions.

To ensure access to affordable insurance, Congress devised a three-part solution. First, Congress imposed a "guaranteed issue" requirement, which bars insurers from denying coverage to any person on account of that person's medical condition or history. Second, Congress required insurers to use "community rating" to price their insurance policies. Community rating, in effect, bars insurance companies from charging higher premiums to those with preexisting conditions.

But these two provisions, Congress comprehended, could not work effectively unless individuals were given a powerful incentive to obtain insurance. “Imposition of community-rated premiums and guaranteed issue on a market of competing private health insurers will inexorably drive that market into extinction, unless these two features are coupled with . . . a mandate on individuals to be insured.”

To assure that individuals had access to timely, transparent, accurate information about available health plans, Congress provided for the creation of a health insurance Exchange in each state. A state can choose whether to organize
an Exchange itself, with federal financial support, or to allow the federal government to do the job.

In addition, Congress sought to assure that low income people could afford to buy the required health insurance. The Act provides tax credits for low income working people and offers states the opportunity to expand Medicaid for people with very low income, initially at 100% federal expense and, after four years, at 90% federal expense.

The Act was immediately challenged in over two dozen federal law suits. The most rhetorically powerful challenge was that the individual mandate interfered with individual liberty. Healthy young invincibles, or really rich people who can pay for health care out of pocket, should not be forced to buy health insurance! In reality, not rhetoric, these people are few and far between, and even they get hit by trucks. Neither liberals nor conservatives defend a constitutional claim of individual liberty to refuse to buy health insurance.

Rather, the constitutional challenges focused on the claim that Congress lacks power to require citizens to buy health insurance. Like the Congress, the Court was sharply divided. Four liberals affirmed Congressional power under both the Commerce and spending power. Four conservatives denied Congressional authority to impose the mandate. Chief Justice Roberts provided the swing vote, holding that the mandate could not be justified as a regulation of commerce, but was authorized by the federal taxing power.

During the New Deal, a central conflict between the Roosevelt Administration and the conservative Supreme Court was whether the constitution gives Congress authority to adopt laws that have a substantial impact on interstate commerce. With the famous “switch in time that saved the nine” the Court returned to the Founders view that the commerce clause gives Congress broad authority to address national economic problems.

Chief Justice Roberts largely affirmed the post-New Deal standards defining the power of Congress under the Commerce Clause. However, he found that the power to “regulate Commerce” does not include the power to create it. “Congress has never attempted to rely on the Commerce power to compel individuals not engaged in commerce to purchase an unwanted product”

Justice Ginsburg, writing for the four liberals, would have affirmed that the Commerce Clause authorizes Congress to require people to purchase health insurance. Ginsberg found that the market for health services is unique. It is not simply that everyone eventually needs medical care, but rather that doctors and
hospitals are required to provide essential care, as a matter of law and social and professional norms. By contrast, if an individual “wants a car or has a craving for broccoli, she will be obligated to pay at the counter before receiving the vehicle or nourishment. She will get no free ride or food, at the expense of another consumer forced to pay an inflated price.” “In requiring individuals to obtain insurance, Congress is therefore not mandating the purchase of a discrete, unwanted product. Rather, Congress is merely defining the terms on which individuals pay for an interstate good they inevitably consume: Persons subject to the mandate must now pay for medical care in advance (instead of at point of service) and through insurance (instead of out of pocket).”

By contrast, for the conservatives, including Roberts, the fact that the uninsured present a real problem, with a substantial impact on interstate commerce, is irrelevant. The Constitution “enumerates not federally soluble problems, but federally available powers.” The Constitution gives Congress “no whatever-it-takes-to-solve-a-national-problem power.”

Chief Justice Roberts then pivots. Having joined the conservatives in holding that the constitutional power to regulate interstate commerce does not authorize Congress to require individuals to buy health insurance, he then finds that Congress can impose the insurance mandate as a form of taxation. The four liberal Justices joined him in that majority, and the four conservatives dissented.

Roberts explained that the Act provides that “if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes.” It is not a legal command to buy insurance. Rather, it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income.

The Act calls the payment a “penalty,” but Roberts found that the label was not determinative. It is enforced by the IRS and paid to them. There are no criminal or other sanctions for failure to comply. The payment is capped at the level of a health insurance premium. The failure to have coverage is not unlawful, merely taxable. Taxes often encourage behavior, such as home ownership, or discourage behavior, such as smoking. The conservative dissenters protest that the Court should take Congress at its word in calling the payment a “penalty.”

What is the likely impact of the Court’s decision upholding the individual mandate? Most important, Obamacare moves forward. Already, people have realized important benefits. Thousands of people have received checks from their insurance companies that spent more than 15% of premiums on administrative costs, rather than on medical care. Tens of thousands of people under age 26 are
able to remain on their parents’ health insurance plans, albeit at a significant cost. The ideas that insurers should not be allowed to deny coverage for pre-existing conditions or charge prohibitive rates to people most likely to need health care are politically popular. Republicans are scrambling to figure out how to keep this aspect of health care reform, even while condemning the mandate.

In terms of Constitutional doctrine, Chief Justice Roberts’ finding that the Commerce Clause does not allow the Congress to affirmatively require action of an individual is probably not of much practical importance. Congress has never before sought to invoke the Commerce power to require action of people who are just “living and breathing.” That fact was used to argue that Congress lacked the power to do so. Because Congress so rarely seeks to regulate inaction, the Roberts commerce clause opinion will likely not have much practical impact.

A second aspect of the Court’s ruling was more surprising and may have broader practical implications. A critical element of Obamacare is expansion of Medicaid to cover all poor citizens under the age of 65. States decide whether to participate in Medicaid. By 1982, all states did so. Medicaid pays between 50% and 83% of the costs of Medicaid services, depending on the wealth of the state. Federal standards define the basic structure of Medicaid. Federal rules require that state Medicaid programs process applications with reasonable promptness and give people notice and the opportunity for a hearing when an application is denied. Federal rules define a broad benefit package and prohibit most patient cost sharing. States retain broad discretion to set income eligibility standards and levels of provider payment.

States have used this discretion to create 50 diverse Medicaid programs. Many states respond to compelling human need, the needs of health care providers, and the offer of federal financial help to take full advantage of Medicaid. In 2008, 40% of federal Medicaid dollars supported optional services that states decided to provide, even though federal law did not require them to do so. In other states, only a small portion of the eligible population and services are covered.

The ACA adds a new category of poor people eligible for Medicaid: people between the ages of 18 and 65 who are not caretakers of dependent children or disabled. The federal government pays 100% of the cost of the newly eligible people through 2018 and 90% after 2020. Because Medicaid expansion is so important to the success of Obamacare, Congress wanted all states to participate. It offered carrots that Justice Kagan called “boatloads of money,” and a stick saying that if a state refuses to expand Medicaid, it risked termination of its entire Medicaid program.
Federal grants to states, conditioned on compliance with federal standards, are common. “Cooperative federalism” allows Congress to assure that federal funds are used to further complex, federally defined goals. At the same time, it respects that states know local conditions and values better than Congress. Because states are free to accept or reject federal funds and the conditions that come with them, the Court has never found that a condition on federal funding violates state sovereignty. None of the many lower federal courts that considered the challenges to the Act accepted the constitutional challenge to Medicaid expansion.

Justice Roberts recognized that Congress can impose conditions on federal grants offered to states. But he characterized the Medicaid expansion as a “new program.” Medicaid “is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.” Medicaid expansion is “a shift in kind, not merely degree.” If a state refuses to accept the “new” Medicaid, the Act authorizes the federal government to “penalize” them by terminating funding for the “old” Medicaid. This is a “gun to the head” of the states. Roberts does not tell us the difference between financial inducements and conditions, which are constitutionally permissible, and a penalty, or gun to the head, which is not.

What are the practical constitutional implications of this decision? Because conditional federal grants to states are so common, many speculate that the decision invites challenges to many federal programs. Important anti-discrimination laws are cast in the form of conditions on federal funding. Title Nine prohibits sex discrimination in federally funded education. Title Six prohibits race discrimination in federally funded programs. The Clean Air Act, the Elementary and Secondary Education Act of 1965 and the Individuals with Disabilities Education Act of 2004 all condition money on state performance of certain activities. Using the Roberts Medicaid decision, states now challenge the constitutionality of federal conditions they dislike.

The Court’s Medicaid decision, limiting the power of Congress to impose conditions on federal spending, may be a one-off, with few broader applications. It is very fact specific. Medicaid is uniquely large, constituting an average of more than 21% of most state budgets. It was challenged by 26 states.

Under the Act and the Supreme Court decision, states confronted two critical choices in relation to health reform: whether and how to adopt Exchanges and whether to accept the offer to expand Medicaid at federal expense.
The Exchanges lie at the heart of health reform. Modeled on the highly effective Massachusetts Connector, they create a virtual, transparent, regulated market place. They will provide a website where individuals can put in their ZIP code and get a list of available, approved, health plans. Approved plans will not be allowed to refuse to insure any individual, impose lifetime or annual limits, or rescind coverage. Premiums may vary only on the basis of age, family status, location, or tobacco use. People will be able to learn whether particular doctors and hospital participate in the plan. Individuals can also provide information to the Exchange and learn whether they are qualified for tax subsidies or Medicaid. They can offer a seamless web as people move from eligibility for Medicaid, tax subsidies, or employment based coverage. The Act offers substantial federal subsidies to states to establish exchanges, but anticipates that the exchanges will eventually be financially self-sufficient. They will be open for business in a few months. We live in exciting times!!

The Act gives states a choice whether to create a health care exchange or to allow the federal government to do the job for them. Enlisting states to administer the Exchanges follows the long U.S. tradition of regulating insurance at the state rather than federal level. It respects history, local values, diversity and expertise.

The politics of the state choice are complex. A traditional federalism story might say that more conservative states would prefer state control. Liberal states might prefer a federal Exchange offering both national expertise and economies of scale. Liberal states might also welcome being more removed from parochial local influence.

Events did not fit this classic federalism trope. 18 states, including Hawaii, are setting up Exchanges. All but two are headed by Democratic Governors. On the other hand, 26 states have declared that they will not create an Exchange. All are headed by Republican governors.

Why would a state reject an offer of federal support to create a state Exchange? The story is complex and different in every state. In many states, traditional conservative interests, -- the Chamber of Commerce, health care providers and dominant insurers -- sought to retain local control of health care financing. But even more conservative Tea Party Republicans, embracing ideological purity and a hope to repeal the Act, abandoned traditional commitment to local control to double down on their opposition to Obamacare.

The federal government faces challenges in creating Exchanges for a large number of states. Historically, the federal government has always counted on states, or private insurers, to administer health financing. On the other hand, the
federal government runs Social Security and Medicare eligibility with admirable efficiency that compares favorably with any state or private insurance program.

States confront even bigger choices regarding Medicaid. Congress understood that, to achieve universal coverage of citizens, it was necessary to expand Medicaid to include those who cannot realistically buy insurance or qualify for tax subsidies. For almost half a century, Medicaid has picked up the pieces that the market has dropped. Medicaid expansion is an essential piece in the mosaic of universal coverage. Congress sought to make the states an offer too sweet to refuse. The Supreme Court held that Congress cannot terminate federal matching funds for “old” Medicaid services if a state refuses the “new” expansion. But the expansion offer is still very sweet.

As of today, the federal Department of Health and Human Services and the Kaiser Family Foundation report that 28 states are expanding Medicaid, 20 states oppose expansion and three are still weighing options.

It is difficult to understand why a state would refuse 100 percent federal funding for health care for people previously excluded from Medicaid. A growing body of detailed analysis demonstrates that Medicaid expansion is a financial benefit to states. Particularly if we consider the needs of a state’s citizens, health care providers and economy, the “boatload of money” that the Act offers states to expand Medicaid, is huge fiscal gravy to the states.

Nonetheless, state Medicaid costs are likely to grow, even in states that reject Medicaid expansion, or make it difficult for people to enroll. In 2008, nationally only 62 percent of the people eligible for Medicaid had actually enrolled. The individual mandate and the Exchanges, will encourage people who are eligible for Medicaid to sign up. The exact impact is not precisely knowable. But, this will happen in every state, whether or not the state expands Medicaid eligibility.

Failure to expand Medicaid eligibility will be devastating to hospitals. The Act calls for a 75 percent reduction in the Disproportionate Share Hospital payments made to hospitals that serve a high volume of uninsured patients. $35 billion of the costs of the Act is funded through reductions in these payments. Hospitals confront these reductions, whether or not their state expands Medicaid eligibility. Federal law requires that hospitals provide emergency care, whether or not people are insured.

Hawaii is always listed as one of the states that embraces Medicaid expansion. This is not surprising. But, it underscores the complexity of the issues.
In 2011, just after adoption of the Affordable Care Act, many states negotiated with the federal government to obtain enhanced federal reimbursement for their early embrace of broader Medicaid coverage. By contrast, in 2011, Hawaii instituted massive cuts in Quest and Quest Expansion. I look forward to learning the details of Hawaii’s plans to make it a Medicaid expansion state.

The choice whether to expand Medicaid may not be yes or no. Last month Arkansas offered a controversial proposal for Medicaid expansion. Initially Arkansas was solidly on the list of states refusing Medicaid expansion. Hospitals protested, and the state came up with an alternative. Arkansas has asked the federal government to approve a Medicaid expansion that takes the form of using federal dollars for “premium support” to enable low income people to buy private health insurance policies in the Exchange. HHS Secretary Sebelius has indicated that this alternative might be acceptable, if the state assures that the poor people newly eligible for Medicaid in the form of federally subsidized private insurance are also provided a “wrap around” policy that protects against onerous cost-sharing and assures benefits, particularly for the disabled, that are traditionally covered by Medicaid, but not by private insurance.

The Arkansas alternative, and the federal response that it might be acceptable, have sparked interest in other states that previously rejected Medicaid expansion, including Tennessee, Florida and Nebraska. The primary attraction of the Arkansas “premium support” alternative is that it might allow the states to capture federal dollars for providers who care for poor people, without expanding government controlled Medicaid. Premium support for private insurance is not likely to save money or deliver better care. It is a political compromise that allows Red states to capture federal funds to finance care for the poor, albeit in an inefficient way.

The community of people concerned about access to health care for the poor and disabled, of which I have long been a part, have mixed views of the Arkansas model. Some reject it on grounds that it is irrational from a fiscal and care perspective and fear that it poses a longer term threat to Medicaid, the work horse of the health financing system. Others think that it is the best that can be achieved in the current political climate. Again, we live in exciting times!

Access to health insurance is not the same thing as access to care. Neither Medicaid nor the Affordable Care Act assures access to care. Medicaid does a bit more, particularly in relation to children. But the Medicaid access requirements are rarely enforced. Provider reimbursement, particularly for physicians, is a critical issue, which the Affordable Care Act largely avoids.