Federal Trade Commission

Will the Affordable Care Act Stand?
Assessing the Constitutional and Competitive Concerns Raised by Healthcare Reform

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before the

Houston Bar Association

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Next week the Supreme Court will hear argument on the constitutionality of President Obama's health care reform legislation. Although most of the attention has focused on the so-called individual mandate, the Court will address a total of four issues over three days of oral argument. Today I will describe the background to this litigation, summarize the issues before the Court, and offer some predictions on the outcome of the litigation.

In addition, I will describe some concerns I have about the Medicare Shared Savings Program, another aspect of the health care reform legislation. This program, in my view, has the potential to increase market power of Medicare providers, with little offsetting benefit to

[*] The views stated here are my own and do not necessarily reflect the views of the Commission or other Commissioners. **I am grateful to my attorney advisor, Darren Tucker, for his invaluable assistance in preparing this paper.**

consumers. The net result of this program may be *higher* costs and *lower* quality health care for Medicare enrollees – precisely the opposite of its goal.

I. Constitutionality of the Affordable Care Act

The Patient Protection and Affordable Care Act (the "Act"), a.k.a. ObamaCare, was signed into law almost two years ago to the day, on March 23, 2010.[1] The Act creates obligations on individuals, employers, insurers, and others that are designed to expand both the demand and supply of health insurance to achieve Congress's goal of "near-universal" health insurance coverage.[2]

I am no fan of ObamaCare. But, in fairness, I have to stress that many years before ObamaCare was enacted there was great concern—that I shared—about the run-up in healthcare costs in the United States. In fact, in the late 1990s and early 2000s, I represented Safeway and a number of supermarket chains, as well as their union (I believe it was called the United Foodworkers union), whose interests were united in combatting non-union Walmart. We huddled in Washington and Palm Beach on a number of occasions about how to reform the health care system so that union employers would not see their health care costs soar. We ultimately concluded that it couldn't be dome for two reasons: first, every society had to ration healthcare or society would go bankrupt (though every country rationed differently, in the U.S. through means testing); and second, whether rationing could be done legally, there wasn't the political will necessary to do it (looking at Oregon, for example). All that may have changed, however, when the Democrats captured the White House and both Houses of Congress in the 2008 elections.

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[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). This Act was amended a few days later by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2] *Id.* § 1501(a)(2)(D).

The Supreme Court will decide the constitutionality of two aspects of ObamaCare.[3] The first is the individual mandate. Starting in 2014, the Act requires most U.S. citizens and legal residents to have "minimum essential" health insurance coverage or pay a penalty that is included with the individual's tax return. After a brief ramp-up period, this penalty, which is called a "Shared Responsibility Payment," will be $695 per person or 2.5% of household income, whichever is greater.[4]

The other provision before the Supreme Court is the expansion of Medicaid. The Act significantly expands the Medicaid program starting in 2014 by, among other things, mandating coverage of certain population groups not previously required, such as low-income, childless adults.[5] The federal government will cover 100% of the added cost of this expanded coverage for the years 2014 through 2016. After that, the federal share will gradually drop to 90%, leaving the states to pick up the remaining 10%. States must either accept these new enrollees, or withdraw from the Medicaid program entirely and forego all federal Medicaid funding.[6]

More than two dozen lawsuits have challenged the Act's constitutionality. The case that, from the beginning, has garnered the most attention was filed by 26 states and is led by the

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[3] The Act will also create Health Benefit Exchanges through which individuals and small businesses can purchase coverage; subsidies for low income persons who purchase insurance through the exchanges; and new requirements for health plans and insurers, including guaranteed issue and partial community rating.

[4] The initial penalty on individuals who do not secure insurance will be $95 or up to 1% of income, whichever is greater. By 2016, this will rise to $695 or 2.5% of income, whichever is greater; families have a limit of $2,085 or 2.5 percent of household income, whichever is greater. There are limited exemptions to the fine in cases of financial hardship or religious beliefs. After 2016, the penalty is increased based on cost-of-living adjustments.

[5] Low-income adults, including those without children, will be eligible, as long as their incomes do not exceed 133% of the federal poverty level.

[6] HHS has some discretion as to whether to terminate a state that fails to meet the new requirements.

Florida Attorney General.[7] In that case, the Eleventh Circuit, in a two-to-one decision, held that the individual mandate exceeds Congress's powers under the Commerce Clause.[8] The decision was not a total victory for the States, however. The court held that the remainder of the Affordable Care Act was valid, including the Medicaid expansion.

In contrast, Sixth Circuit and D.C. Circuit upheld the individual mandate.[9] Both of those decisions were also by a margin of two to one.

In a final twist, the Fourth Circuit twice rejected challenges to the Affordable Care Act, but did so on procedural grounds, rather than on the merits. In the first case, the court held that the State of Virginia lacked standing.[10] In the second, the court held that a suit was barred until any penalties for violating the individual mandate were assessed.[11]

One thing that stands out about these circuit court decisions is that political persuasion was not a very accurate predictor of the results. For example, one of the judges in the Eleventh Circuit majority that struck down the individual mandate was appointed by a Democratic President.[12] Likewise, in both the DC Circuit and Sixth Circuit decisions, a well-known conservative judge voted to uphold the constitutionality of the individual mandate.[13]

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[7] The case was initially filed by Florida and 12 other states; they have since been joined by 13 additional states, the National Federation of Independent Business, and several individuals.

[8] *Florida v. HHS*, 648 F.3d 1235 (11th Cir. 2011).

[9] *Seven-Sky v. Holder*, 661 F.3d 1 (D.C. Cir. 2011); *Thomas More Law Ctr. v. Obama*, 651 F.3d 529 (6th Cir. 2011).

[10] *Virginia* ex rel. *Cuccinelli v. Sebelius*, 656 F.3d 253 (4th Cir. 2011).

[11] *Liberty Univ., Inc. v. Geithner*, -- F.3d -- (4th Cir. 2011).

[12] Frank M. Jull was appointed by President Clinton in 1997.

[13] In the Sixth Circuit case, Jeffrey Sutton, who was appointed by President George W. Bush in 2003, was in the majority. In the D.C. Circuit case, Senior Judge Lawrence Silberman was in the majority, explaining that "the right to be free from federal regulation is not absolute and yields to the imperative that Congress be free to forge national solutions to national problems no matter how local—or seemingly passive—their individual origins." *Seven-Sky*, 661 F.3d at 20.

Given the rather stark split among the circuits on the individual mandate, it was no surprise that the Supreme Court agreed to take the case. It was, however, somewhat of a surprise that the Court also decided to hear the Medicaid issue, given that no lower court had viewed this aspect of health care reform to be constitutionally invalid.

The Court has set aside six hours of time for oral argument, which is the most time the Court has set aside for a case since the 1966 *Miranda* case. Typically, the Court will allot just one hour of argument for a case.

The case is also unusual in another respect: the prominent role of amici. The Court has appointed private attorneys to present two positions that neither party is advocating. As you might expect, an unusually large number of "friend of the court" briefs have also been submitted.

There have been calls for two Justices to recuse themselves for perceived conflicts of interest. Congressional Democrats and some interest groups have said that Clarence Thomas should recuse himself because of his wife's work with conservative groups opposed to the Affordable Care Act. At the same time, some Republicans have argued that Elena Kagan should not be involved because of concerns that she may have discussed litigation involving health care reform when she was Solicitor General. Whether a justice should be recused is a matter left to the individual justice, and no justice has indicated he or she will not participate in the case. The full Court is therefore expected to hear the case.

As a result of the high interest in the case, C-SPAN sent a letter to the Court requesting permission to televise the proceedings. The Court has never allowed cameras in the courtroom, notwithstanding occasional Congressional pressure to do so. Instead, the Court's current practice is to offer audio recordings of oral argument at the end of each week. The Court has provided

same-day audio in a handful of recent cases, such as *Bush v. Gore*, and that's what the Court is going to do here.

The Court will likely release its opinion in late June, at the end of its term. By that point, the Republican primaries will be over or nearly so, and both parties will be gearing up for their national conventions.[14]

A. The Anti-Injunction Act

The first issue that the Court will address is whether the Anti-Injunction Act prevents challenges to the Affordable Care Act at this time. The Anti-Injunction Act, which dates to 1867, bars pre-enforcement challenges to tax laws. In other words, a person cannot challenge the constitutionality of a tax until they (1) pay the tax, (2) demand a refund from the IRS, and (3) are denied that refund.

The Obama administration initially took the position that the Anti-Injunction Act barred challenges to the individual mandate because the penalty for noncompliance was a tax that would not be imposed until the 2014 tax year. Under this view, only after taxpayers filed their tax returns in early 2015 and were denied relief from the IRS could they file suit. The Fourth Circuit accepted this argument and held that the penalty for not complying with the individual mandate *was* a tax, which meant that a challenge to the individual mandate was premature.[15]

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[14] The last Republican primaries occur on June 5 and 26, 2012. Three of the current individuals seeking the Presidency – President Obama, Mitt Romney, and Newt Gingrich – have supported individual mandates in some form.

[15] In the D.C. Circuit case, Judge Kavanaugh also reached this conclusion. *Seven-Sky v. Holder*, 661 F.3d 1, 54 (D.C. Cir. 2011) (Kavanaugh, J.) ("I would adhere to the text of the Anti-Injunction Act and leave these momentous constitutional issues for another day — a day that may never come."). Judge Kavanaugh did not address the merits of the individual mandate. The Eleventh Circuit did not address the Anti-Inunction Act issue because neither party advanced the issue.

Since then, the administration has changed its position on this issue, and now contends that the penalty is *not* a tax for purposes of the Anti-Injunction Act.[16] Since the parties now agree that the Anti-Injunction Act does not bar a challenge, the Court appointed a prominent appellate advocate as amicus curiae to argue that the Anti-Injunction Act precludes the challenge.[17]

Amicus argues that this suit falls within the scope of the Anti-Injunction Act for two reasons. *First*, Congress enacted specific statutory language providing that the individual mandate penalty shall be "assessed and collected in the same manner" as taxes.[18]

Second, when Congress enacted the Anti-Injunction Act, the ordinary meaning of "tax" was much broader than the common meaning today and included almost every collection going to the public treasury. This is significant because, as you know, Justice Scalia at least subscribes to the "original intent" school of jurisprudence. Consistent with that broader meaning, amicus argues that the Supreme Court has construed the Anti-Injunction Act broadly, including any "exaction [that] is made under color of their offices by revenue officers charged with the general authority to assess and collect the revenue."[19] Thus, according to amicus, the penalty is a "tax" because "it is codified in the [ta]x Code, calculated as part of the taxpayer's federal income tax

[16] U.S. Supp. Br. at 2, *Liberty Univ., Inc. v. Geithner*, -- F.3d -- (4th Cir. Sept. 8, 2011) (No. 10-2347) (the Administration has "concluded that the [Act] does not foreclose the exercise of jurisdiction in these cases").

[17] The amicus is Robert Long from Covington & Burling in Washington DC.

[18] 26 U.S.C. § 5000A(g)(1) (referring to *Id.* § 6671(a)).

[19] Brief for Court-Appointed Amicus Curiae Supporting Vacatur (Anti-Injunction Act) at 37, HHS v. Florida, No. 11-398 (U.S. Jan. 2012) (quoting *Phillips v. Comm'r of Internal Revenue*, 283 U.S. 589, 596 (1931)).

liability, assessed and collected by the IRS, and paid into the federal government's general revenues."[20]

In addition, amicus argues that the Court *must* address the Anti-Injunction Act issue because it is a jurisdictional statute. Because jurisdiction involves a court's power to hear a case, the Supreme Court has an obligation to determine whether subject-matter jurisdiction exists, even in the absence of either party raising the issue.

The States argue that the Anti-Injunction Act is inapplicable for several reasons. Under their view, the Anti-Injunction Act is not jurisdictional and is not pressed by any party to this case. Thus, the Court need not even address whether the Anti-Injunction Act is applicable. Furthermore, even if the Court concludes that the Anti-Injunction Act *is* jurisdictional, the States contend that it does not bar the States' challenge to the mandate for three reasons.

First, the States argue that the Anti-Injunction Act does not apply to states, but rather only to individuals. The statute uses the generic term "person" and contains no clear indicia to overcome the "longstanding interpretive presumption that 'person' does not include the sovereign."[21]

Second, the States assert that their challenge is to the mandate, not the penalty that enforces it. They argue that these are distinct provisions because numerous individuals subject to the mandate are exempt from the penalty. Thus, the Anti-Injunction Act has no bearing on their challenge, regardless of whether the penalty is a tax.

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[20] *Id*. at 12.

[21] Brief for State Respondents on the Anti-Injunction Act at 37, HHS v. Florida, No. 11-398 (U.S. Feb. 6, 2012) (quoting *Vt. Agency of Natural Res. v. United States ex. rel. Stevens*, 529 U.S. 765, 780 (2000)).

Finally, the states assert that the penalty is not a tax. Congress considered and rejected proposals to impose a tax on the insured, and instead imposed a stand-alone regulatory command to obtain insurance, with a "penalty" provision to enforce it.[22]

The Administration's position is in between that of the States and that of amicus. The Administration agrees with the States that the penalty is not a tax. According to the Administration, a true "tax" carries with it a number of procedural and substantive implications under the Internal Revenue Code. The penalties under the Affordable Care Act do not match up, for the most part, with the standard rules applicable to taxes under the Internal Revenue Code.

On the other key issues involving the Anti-Injunction Act, however, the Administration sides with amicus. The Administration agrees with amicus that the Anti-Inunction Act is jurisdictional in nature and that the Supreme Court has an obligation to determine whether it applies in this case.

In addition, the Administration disputes the States' argument that their challenge is limited to the individual mandate, rather than the penalty. According to the Administration's brief, "the two provisions are inextricably intertwined; the only consequence of failing to maintain minimum coverage is payment of a penalty."[23]

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[22] A brief filed by the state chambers of commerce argues that a delay ruling on the individual mandate would create significant hardship on U.S. businesses, including payment of "approximately 536 billion dollars in revenue over the next seven years through various taxes and penalties." Brief of State Chambers of Commerce and Related Organizations as Amici Curiae in Support of the Respondents on the Anti-Injunction Act at 20-21, HHS v. Florida, No. 11-398 (Feb. 13, 2012).

[23] Brief for Petitioners (Anti-Injunction Act) at 7, HHS v. Florida, No. 11-398 (U.S. Feb. 2012).

Finally, the Administration takes issue with the States' claim that states are not subject to the Anti-Injunction Act. According to the Administration, "states, like individuals, are 'persons' subject to the prohibitions of the [Anti-Injunction Act]."[24]

As I previously mentioned, the Fourth Circuit found that the Anti-Inunction Act barred a challenge to the individual mandate, while the Eleventh Circuit found that it did not. Most observers think that it's unlikely that the Court will find the Shared Responsibility Payment to be a tax for purposes of the Anti-Injunction Act. Many were therefore surprised that last month the Court increased the amount of oral argument time allotted for this issue on March 26 from 60 to 90 minutes. This is significant because the extra time may signal that the Court is interested in "kicking the can down the road," which it could do simply by determining that ObamaCare imposes a "tax" within the meaning of the Anti-Injunction Act and that the Anti-Injunction Act is jurisdictional.

B. The Individual Mandate

The second issue that the Court will address is the constitutionality of the individual mandate. The Court has set aside 2 hours of argument on March 27 for this subject. The Solicitor General will have 60 minutes to argue that the minimum coverage provision is constitutional. The States and the National Federation of Independent Businesses (a private plaintiff) will each have 30 minutes to argue that the provision is unconstitutional.

The fundamental question here is whether Congress has the power under the Commerce Clause (or its taxing power) to require individuals to purchase health insurance. Since the New Deal era, the Court has steadily expanded Congress's power under the Commerce Clause.

[24] *Id.*

However, in 1995, the Court handed down the *Lopez* decision,[25] which held that a federal criminal statute prohibiting the possession of a firearm near a school was beyond Congress's commerce power. The Court explained that the "possession of a gun in a local school zone is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce."[26] Then, five years later in the *Morrison* case,[27] the Court concluded that a statute providing for a federal cause of action for the victims of gender-motivated violence was also beyond Congress's commerce power. The Court explained that "[g]ender-motivated crimes of violence are not, in any sense of the phrase, economic activity."[28] Thus, the Court in recent years has tried to identify limits to Congress's powers under the Commerce Clause and has been willing to strike down federal statutes regulating non-economic conduct. This is significant because Justice Scalia held in *Gonzales v. Raich*[29] that growing marijuana was sufficiently close to "commerce" to justify a federal ban and because Justice Scalia's acolyte, Judge Sutton, relied heavily on that decision in upholding the individual mandate in the Sixth Circuit.

Against this backdrop, the Administration argues that the individual mandate is a permissible exercise of the commerce power for four reasons.[30]

First, the Administration argues that the individual mandate is an essential part of the health care reform and that the Affordable Care Act, when considered as a whole, is within the

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[25] *United States v. Lopez*, 514 U.S. 549 (1995).

[26] *Id.* at 567.

[27] *United States v. Morrison*, 529 U.S. 598 (2000).

[28] *Id*. at 613.

[29] 545 U.S. 1 (2005).

[30] Brief for Petitioners (Minimum Coverage Provision) at 21-52, HHS v. Florida, No. 11-398 (U.S. Jan. 2012).

commerce power. The Administration points out that in the modern era of Commerce Clause jurisprudence, the Court has never invalidated a federal provision that was "part of a comprehensive scheme of national economic regulation."[31] The Administration asserts – and the States do not dispute – that the minimum coverage provision is an integral part of the Affordable Care Act's regulation of the individual insurance market.

Second, the Administration argues that the individual mandate, standing alone, regulates economic conduct with a substantial effect on interstate commerce. Congress expressly found that the individual mandate regulates the way in which individuals finance their participation in the health care market. The mandate creates an incentive for individuals to finance their purchases of health care by means of insurance, rather than at the time services are provided. In other words, the individual mandate regulates the timing and manner of paying for health care services.

The Administration takes issue with the claim that the effect of the individual mandate is limited to the insurance market. According to the Administration, the Court must defer "to Congress's judgment about how to define the market it is regulating,"[32] and here, Congress has defined the relevant market as health care services. Furthermore, the Administration argues that health insurance and health care services are "inherently integrated" and that one should not be artificially isolated from the other.[33]

Third, the Administration asserts that the individual mandate is "fully consistent with *Lopez* and *Morrison* and the allocation of authority between the federal and state

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[31] *Id.* at 26-27.

[32] *Id.* at 41.

[33] *Id*. at 41-42.

governments."[34] In those cases, the Court emphasized the noneconomic nature of the regulated conduct in finding it outside Congress's commerce power. By contrast, health care and the financing of health care are "quintessentially economic."[35] In addition, neither *Lopez* nor *Morrison* involved a comprehensive scheme of regulation. Finally, the Administration asserts that upholding the individual mandate would not usurp the states' general police power because, as the States' concede, Congress could have obtained similar results through more coercive, yet Constitutional means.[36]

Fourth, the Administration disputes the States' argument that the Commerce Clause cannot extend to the regulation of inactivity. The Commerce Clause states that Congress shall have the power "To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[37] The administration asserts that the term "regulate" can mean to require action. In addition, the Administration argues that the States are incorrect in describing the individual mandate as a regulation of inactivity. As I've already mentioned, the Administration argues that the mandate regulates how individuals finance their purchases of health care services, something that is undoubtedly economic activity.

The Administration argues that Congress's taxing power provides an independent ground to uphold the individual mandate. The individual mandate is "fully integrated into the tax system, will raise substantial revenue, and triggers only tax consequences for non-compliance."[38]

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[34] *Id.* at 45.

[35] *Id.* at 46.

[36] For example, Congress could have prohibited individuals without insurance from obtaining health care.

[37] U.S. Const. art I, § 8, cl. 3.

[38] *Id.* at 52.

That tax liability will be based, in part, on the taxpayer's household income, and individuals who are not required to file income tax returns for a particular year are not subject to the penalty.

The fact that the penalty is intended to adjust behavior has no bearing on whether it is a tax, according to the Administration. The Court has said that a tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed."[39] The fact that Congress used the world "penalty," rather than "tax" to refer to the payment is also immaterial.

In their briefs, the States argue that the "individual mandate is an unprecedented law that rests on an extraordinary and unbounded assertion of federal power."[40] They claim that the individual mandate is not a valid exercise of Congress's commerce power or its tax power.[41]

With respect to the Commerce Clause, the States assert that "the Constitution grants Congress the power to *regulate* commerce, not the power to compel individuals to enter into commerce."[42] The framers intended for Congress to have the power to regulate existing commerce but not the power to bring commerce into existence. The power to force individuals to engage in commercial transactions against their will was the kind of police power that was reserved for the states. If Congress can not only regulate individuals once they decide to enter into commerce but can also compel them to enter commerce in the first place, then there is

[39] *Id.* at 55 (quoting *United States v. Sanchez*, 340 U.S. 42, 44 (1950)).

[40] Brief for State Respondents on the Minimum Coverage Provision at 10, HHS v. Florida, No. 11-398 (U.S. Feb. 6, 2012).

[41] The States also take issue with the Administration's invocation of the "Necessary and Proper Clause." The States argue that this provision does not give Congress any "great substantive and independent power" that may be "used for its own sake." *Id.* at 34 (quoting *McCulloch v. Maryland*, 17 U.S. 316, 411 (1819)). Rather, it only gives Congress the authority to employ "means by which other objects are accomplished." *Id.* Thus, because the individual mandate is not a law that executes Congress's valid commerce power, the Necessary and Proper Clause has no bearing.

[42] *Id*. at 11 (emphasis in original).

nothing left of the principle announced in *Marbury v. Madison* that Congress's powers are "defined, and limited."[43]

The States acknowledge that the Supreme Court's conception of "commerce" has expanded substantially since the New Deal era, but that the meaning of "regulate" has not undergone a similar expansion. At no time has the Court interpreted the term "regulate" to include bringing the subject into existence. "When the Constitution does grant Congress the power to bring something into existence, it does so in language that is unmistakably clear."[44] Furthermore, if the meaning of "regulate" were as broad as the Administration claims, many of the other Article I enumerated powers would be redundant.

The States also note that the individual mandate is the first ever law of its kind and point to studies performed by the non-partisan Congressional Budget Office and Congressional Research Service, both of which advised Congress that the constitutionality of the individual mandate was questionable.

The States also take issue with the Administration's argument that the individual mandate regulates the financing of the purchase of health care services. The States point out that the mandate forces individuals to *purchase* insurance but does not require the *use* of that insurance. In other words, insurance is distinct from the service to be insured. Furthermore, the mandate was, for the most part, directed at healthy individuals in the hopes that they would *not* use the insurance to obtain health care but would instead subsidize the costs of less-healthy individuals.

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[43] *Id.* at 11 (quoting *Marbury v. Madison*, 5 U.S. 137, 176 (1803)).

[44] *Id*. at 20. For example, Congress has the power to "establish Post offices" and to "constitute Tribunals inferior to the Supreme Court." U.S. Const, art. I, § 8, cl. 7, 9.

The States respond to the Administration's comprehensive-regulatory-scheme argument by pointing to a number of cases where the Court struck down unconstitutional laws even though they were integral components of otherwise permissible regulatory schemes.

With respect to Congress's taxing power, the States reiterate that they are not challenging the penalty, but rather the mandate. Furthermore, the States assert that Congress made a deliberate decision not to enact a tax and repeatedly referred to the mandate's enforcement mechanism as a "penalty." More importantly, the payment operates as a penalty because it is imposed only for an improper act. In contrast, a tax provides for the general support of the Treasury. Penalties do not become taxes "simply because they are housed in the tax code and collected by the Internal Revenue Service."[45]

The States conclude by observing that if the individual mandate is upheld, there is no principled reason why Congress cannot compel individuals to engage in a wide range of commercial activities. This has sometimes been called the "Broccoli issue" on the theory that the government could require the daily purchase of Broccoli to reduce health care costs related to obesity. Likewise, the government could mandate the purchase of a Chevy to aid the government's automotive bailout.

C. Severability of the Individual Mandate

The third issue that the Court will address is whether the individual mandate is severable if it is found to be unconstitutional, or instead whether other parts of the Act would also have to fail. The Eleventh Circuit held that the individual mandate was completely severable and left the remainder of the Act standing. In contrast, the district court struck down the entire statute

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[45] *Id*. at 60.

because the individual mandate was so closely tied to everything else in the Affordable Care Act.[46]

The Supreme Court will hear 90 minutes of argument on this issue on March 28. The States will have 30 minutes to argue that the entire law must be invalidated. The Solicitor General will have 30 minutes to argue that only the guaranteed issue and community rating provisions in the Act are inseverable from the minimum coverage provision. Court-appointed amicus will argue that the minimum coverage provision is completely severable from the rest of the Act.[47]

The States argue that severability is a remedial inquiry that turns on legislative intent. According to the States, the question is *not* whether the remainder of the Act, or some portion of it, could function effectively without the individual mandate. Rather, the proper inquiry is whether Congress would have enacted the Affordable Care Act without an individual mandate.

The States concede that divining legislative intent is often difficult, but argue that here, Congress made express legislative findings as to the essential role of the individual mandate to the Affordable Care Act.[48] In addition, the States argue that the Act would never have passed Congress without the promise of insuring the uninsured. The States point to statements from the leadership of Congress to the effect that even minor changes to the Act would have doomed its passage. Finally, the States assert that "[w]ithout the demand mandated by the individual mandate, Congress would not have enacted the various supply-side provisions."[49]

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[46] *Florida v. HHS*, 780 F. Supp. 2d 1256, 1299-1305 (N.D. Fl. 2011).

[47] The court-appointed amicus is H. Bartow Farr from Farr & Taranto in Washington DC.

[48] *See, e.g.*, Affordable Care Act § 1501(a)(2)(H)-(J).

[49] Brief for State Petitioners on Severability at 42, National Federation Indep. Businesses v. Sebelius, Nos. 11-393, 11-400 (U.S. Jan 6, 2012). The States also point out that if the Court holds the Medicaid expansion to be unconstitutional, there is an even stronger argument for

The Administration argues that the States lack standing to challenge any provisions of the Act that do not apply to them, citing to *Printz v. United States*.[50] Under that view, only the severability of the Medicaid expansion could properly be decided by the Court because the States are subject to that provision. The remaining provisions of the Affordable Care Act only affect third parties, such as insurance companies.

If the Court does address the severability issue, the Administration asserts that only the guaranteed issue and community rating provisions of the Act are inseverable from the individual mandate and must therefore be struck down. These provisions require insurers to offer the same premium to all applicants of the same age and location without regard to most pre-existing conditions (other than tobacco use).

According to the Administration, the "Court has repeatedly held that, 'when confronting a constitutional flaw in a statute,' a court must 'try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact.'"[51] The Administration argues that most of the other provisions in the Affordable Care Act can operate effectively without the individual mandate and will further Congress's goal of expanding affordable coverage. In contrast, the guaranteed issue and minimum coverage provision depend on the individual mandate; without the mandate, "healthy individuals would defer obtaining insurance until they

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invalidating the entire Act. Without the individual mandate or Medicaid expansion, the Act would do almost nothing to increase insurance coverage. *Id*. at 50-51.

[50] 521 U.S. 898 (1997).

[51] Brief for Respondents (Severability) at 27, Nat'l Fed. Indep. Business v. Sebelius, Nos. 11-393, 11-400 (U.S. Jan. 2012) (quoting *Free Enter. Find v. Public Co. Accounting Oversight Bd*., 130 S. Ct. 3138, 3161 (2010)).

needed health care,"[52] resulting in higher premiums and fewer insured lives—the opposite of Congress's intentions.

Court-appointed amicus argues in support of the judgment of the Eleventh Circuit that the individual mandate is severable from the remainder of the Affordable Care Act.[53] Amicus claims that the Court generally "refrain[s] from invalidating more of [a] statute than is necessary."[54] The only exceptions are where the remaining provisions of the statute are not fully operative as a law, or it is evident that Congress would not have enacted the remaining provisions.

Given the States' and the Administration's agreement that the guaranteed issue and community rating provisions are not severable, amicus directs most of its attention to those provisions. Amicus argues that these requirements were the core reforms to the insurance market in the Act and that they were designed to make health insurance affordable to millions with preexisting conditions.

Finally, amicus argues that the dire results predicted by the States and the Administration of invalidating only the individual mandate are overblown. Amicus points to a Congressional Budget Office analysis suggesting that a number of other provisions in the Act will discourage the uninsured from waiting until they are sick before purchasing insurance – what economists call adverse selection.

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[52] *Id.* at 12-13.

[53] Brief for Court-Appointed Amicus Curiae Supporting Complete Severability (Severability), National Federation of Indep. Businesses v. Sebelius, Nos. 11-393, 11400 (U.S. Feb. 17, 2012).

[54] *Id*. at 2 (quoting *United States v. Booker*, 543 U.S. 220, 258 (2005)).

D. Medicaid Expansion

The final issue that the Court will address is whether the Affordable Care Act's expansion of the Medicaid program is constitutional. This argument has not been successful in any of the lower courts. The Court will hear one hour of argument on this issue on March 28, with each side having 30 minutes.

The States' challenge to the expanded Medicaid coverage rests on what is known as the coercion theory, a doctrine the Court has addressed only a handful of times. The Supreme Court has held "that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which 'pressure turns into compulsion.'"[55] In the *South Dakota v. Dole* case, the State of South Dakota challenged Congress's decision to withhold five percent of federal highways funds until states increased their drinking age to 21. The Court rejected the challenge because Congress had only offered "relatively mild encouragement to the states."[56] In other words, Congressional *pressure* to raise the drinking age had not yet crossed the line to *compulsion*.

In the current case before the Court, the States argue that the Affordable Care Act exceeds Congress's spending power by crossing the line into coercion. They argue that Congress itself recognized that the Medicaid expansion was not voluntary. Congress provided no means other than Medicaid through which the neediest individuals could obtain insurance and comply with the individual mandate. (These individuals were specifically barred from heath care exchanges.) The lack of a contingency plan for states that opt-out of Medicaid stands in contrast

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[55] *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)).

[56] *Id*.

with several other aspects of the Act, where Congress provided a "Plan B" if any states declined to participate.

In addition, the States argue that refusal to go along with the Medicaid expansion would threaten states with the loss of "every penny of federal funding under the single largest grant-in-aid program in existence—literally billions of dollars each year."[57] For prior expansions of Medicaid, Congress had offered additional funds to states that agreed to accept additional obligations. Here, however, Congress threatened to withhold *all* funds from states that refuse to implement the Medicaid expansion.

The Administration argues that the Affordable Care Act's expansion of the Medicaid program is a constitutional exercise of Congress's Article I authority. According to the Administration, Congress has broad authority to attach conditions to federal spending.

From the outset, Congress specifically reserved the right "to alter, amend, or repeal any provision" of the Medicaid Act,[58] and Congress has on several occasions required states to accept an expansion as a condition of continued participation in the overall Medicaid program. The Administration also points out that the Affordable Care Act will result in a very small increase in costs to the states due to the federal government covering between 90 to 100 percent of the expansion. There is no dispute that the states are free, as a matter of law, to withdraw from the Medicaid program and turn down its funding.

The Administration says that the States' argument that Congress itself passed the Act on the understanding the states could not leave Medicaid is factually wrong. If a state withdrew

[57] Brief of State Petitioners on Medicaid at 23, Florida v. HHS, No. 11-400 (U.S. Jan. 10, 2012).

[58] 42 U.S.C. § 1304.

from Medicaid, individuals that could not afford insurance would be exempt from the individual mandate penalty.

II. Accountable Care Organizations

I'd now like to turn to another aspect of ObamaCare: the Medicare Shared Savings Program. This part of the Affordable Care Act promotes the formation and operation of Accountable Care Organizations (''ACOs'') to serve Medicare fee-for-service beneficiaries. Under this provision, ''groups of providers . . . meeting the criteria specified by the [Department of Health and Human Services] may work together to manage and coordinate care for Medicare . . . beneficiaries through an [ACO].''[59] An ACO can share in a portion of any savings it creates if it also meets certain quality performance standards published by the Centers for Medicare and Medicaid Services (''CMS''). The Act requires that ACOs that wish to participate in the Shared Savings Program enter into an agreement with CMS for at least three years and agree to accept at least 5,000 beneficiaries assigned by CMS.

ACOs may be formed from a variety of entities, including networks of individual practices, partnerships, hospitals, and other health care professionals. Some ACOs are expected to be newly-formed joint ventures among previously independent, competing entities. It is expected that most health care providers that form ACOs for Medicare beneficiaries will also seek to use the ACO structure for their commercially-insured patients.

The final regulations provide for two "tracks" for ACOs: the "one-sided" track and the "two-sided" track.[60] Under the one-sided track, an ACO receives up to 50% of any savings but

[59] Affordable Care Act § 3022 (to be codified as 42 U.S.C. § 1395jjj).

[60] Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, 42 C.F.R. § 425 (2011), 76 Fed. Reg. 67,802 (Nov. 2, 2011), *available at* http://www.ofr.gov/OFRUpload/OFRData/2011-27461_PI.pdf [hereinafter Final CMS

is not subject to sharing in losses. Under the two-sided track, an ACO receives up to 60% of any savings but must absorb a portion of expenses that exceed a certain benchmark. An ACO participating in the two-sided track can reduce its liability for losses by hitting certain health care quality benchmarks. An ACO can have only one agreement period under the one-sided model; after that, it must agree to shared losses as well as shared savings. CMS has estimated that 1 to 5 million Medicare beneficiaries will be aligned with 50 to 270 ACOs during the first four years of the Shared Savings Program.

The antitrust agencies recognize that the formation of ACOs raises a number of antitrust concerns, in particular that ACOs run the risk of price fixing if they engage in joint price negotiations, and that they may be able to exercise market power, particularly in rural markets.[61] To address these antitrust concerns, the FTC and DOJ issued a joint enforcement Policy Statement specific to ACOs last year.[62] The Policy Statement describes the standards under which the antitrust agencies will review ACOs that participate in both the Medicare and commercial markets.[63]

The Policy Statement provides that the antitrust agencies will evaluate an ACO under the rule of reason if, in the commercial market, the ACO uses the same governance and leadership

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Regulations]. The proposed regulations are at 76 Fed. Reg. 19,528 (Apr. 7, 2011), *available at* http://www.ftc.gov/opp/aco/cms-proposedrule.pdf.

[61] There is also a risk that ACOs could facilitate collusion by participants when operating outside the venture.

[62] Fed. Trade Comm'n & Antitrust Div. of U.S. Dep't of Justice, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, -- Fed. Reg. -- (2011) [hereinafter Final Policy Statement].

[63] The final Policy Statement was preceded by a draft Policy Statement that was released for public comment in the Spring. 76 Fed. Reg. 21,894 (Apr. 19, 2011) [hereinafter Draft Policy Statement]. Differences between the draft and final policy statements are described in my comments to the ABA Fall Forum. *See* J. Thomas Rosch, Accountable Care Organizations: What Exactly Are We Getting?, Remarks before the ABA Section of Antitrust Law Fall Forum (Nov. 17, 2011), *available at* http://www.ftc.gov/speeches/rosch/111117fallforumspeech.pdf.

structure and the same clinical and administrative processes as it uses to qualify for and participate in the Shared Savings Program. This rule of reason treatment will apply to the ACO for the duration of its participation in the Shared Savings Program.

With that background in mind, I would like to share with you two concerns I have as an enforcer about the Shared Savings Program. The first is that the Program is unlikely to result in any overall health care cost savings. The second is that the government may not be able to accurately monitor the quality of health care services by participating providers, which may lead to providers reducing the quality of their services in order to qualify for the shared savings rebates.

A. ACO Cost Savings

On its face, the Shared Savings Program sounds promising: using financial incentives to reduce costs and improve the quality of care. Who could be against that? Nevertheless, I am skeptical that ACOs will actually lead to any net health care cost savings. The available evidence suggests that the cost savings to Medicare will be very small to nonexistent, and there is a substantial risk that any reduction in Medicare expenditures will simply be shifted to payors in the commercial sector.

The Congressional Budget Office projected that Medicare would save $5.3 billion over ten years from the formation of ACOs.[64] Over the same period, total Medicare spending is projected to be over $7 trillion.[65] Thus, the cost savings from ACOs, assuming that these

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[64] Congressional Budget Office, Budget Options Volume I: Health Care at 72-74 (Dec. 2008), *available at* http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf. In a more recent analysis, CMS estimated $470 million in Medicare savings in the first four years of the program. *See* Final CMS Regulations, *supra* note 60, at Table 8.

[65] 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds at Table III.A1 (2011), *available at* https://www.cms.gov/reportstrustfunds/downloads/tr2011.pdf.

organizations are actually effective in improving quality and containing costs, represent less than one tenth of one percent of expected Medicare expenditures over the next decade. In other words, even under the most optimistic scenario, the savings to Medicare from the ACO program are no more than a rounding error.

Yet even the CBO's modest cost savings projections are likely overstated. CMS has been running what is known as the Physician Group Practice (PGP) Demonstration for the last several years.[66] The PGP Demonstration created incentives for physician groups to coordinate care delivered to Medicare patients, rewarded them for improving the quality and cost of services, and created a framework for collaboration with other providers – in other words, they've done a trial run of the ACO program. The results were nothing to crow about. While all participating physician groups improved the quality of their services based on certain benchmarks, the cost savings were, in CMS's own words, "minimal."[67] Even after five years of the project, a majority of the participating practice groups did not achieve any cost savings.[68] In addition, the practice groups that did hit cost savings targets had, again according to CMS, "exhibited favorable cost trends prior to the Demonstration – trends that might have continued had the Demonstration not

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[66] Secretary of Health and Human Services, Report to Congress: Physician Group Practice Demonstration Evaluation Report (2009) [hereinafter PGP Report]; Centers for Medicare & Medicaid Services, PGP Demonstration Fact Sheet (July 2011); Centers for Medicare & Medicaid Services PGP Demonstration Summary Results (undated). All of these materials are at https://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?itemid=CMS1198992.

[67] PGP Report, *supra* note 66, at 9; *see also id.* at 9 ("Ignoring performance payment offsets, Actual Expenditures were $120 per person or 1.2 percent less than Target Expenditures per beneficiary for the combined 10 PGPs in PY2."); *see also id.* at 17 ("The effect of the Demonstration on promoting expenditure savings is less certain.").

[68] PGP Demonstration Summary Results, *supra* note 66.

occurred."[69] In other words, CMS acknowledged that the reduction in Medicare expenditures at these practice groups might have occurred even absent the financial incentives of the project.[70]

There is also a substantial risk that any reduction in costs due to the Shared Savings Program will simply be borne by commercial payors. The commercial sector already subsidizes providers accepting Medicare and Medicaid payments for certain services. The ACO program may exacerbate this trend by causing providers to shift more of their costs to commercially insured patients in order to qualify for the Medicare cost-reduction bonuses. This cost shifting may be facilitated by the enhanced market power of some ACOs in the commercial market. One recent study showed that this is precisely what happened in California as independent practice associations flourished there.[71] In short, even if ACO participants demonstrate that they are lowering costs to Medicare, that will say nothing about the net changes in health care costs for the country as a whole.

B. ACO Service Quality

Another problem with the Shared Savings Program is the way in which the quality of care of participating ACOs is measured. CMS's regulations link the amount of shared savings an ACO can receive (and in certain instances shared losses it may be accountable for) to its performance on 33 quality measures.[72]

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[69] PGP Report, *supra* note 66, at 14.

[70] ACOs in the Shared Savings Program will have smaller financial incentives to reduce costs than providers in the PGP Demonstration had. PGP Demonstration participants could receive a rebate of up to 80% of the cost savings, while ACOs will only receive up to 50% for participation in the one-sided model or 60% in the two-sided model.

[71] Robert A. Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout in California Foreshadows Challenges to Health Reform*, 29 Health Affairs 699 (2010).

[72] Final CMS Regulations, *supra* note 60, at 67,802.

Accurate quality measurements are critical for several reasons. First, by accurately measuring an ACO's quality, CMS can ensure that cost savings are the result of improved provider coordination and adherence to best practices, rather than through a reduction of needed services. Recall that the Shared Savings Program rewards ACOs that achieve cost savings. Thus, both ACOs and their participating physicians have an incentive to undertreat their patients to earn the shared savings rebates. CMS intends to use the quality metrics to ensure that ACOs will not scrimp on needed services in order to qualify for the shared savings rebates.

In addition, the quality of care provided by a particular ACO may be relevant to an antitrust inquiry of that ACO. If an ACO can demonstrate that it has scored well on the CMS quality metrics (and has lowered costs), it may have a defense to an antitrust challenge to the formation of the ACO or its contracting practices in the commercial market.

Finally and most importantly, lives are at stake. If the Shared Savings Program leads to inferior health outcomes, Congress and CMS need to know so that they can consider adjustments to the Program.

There are several reasons to question whether CMS's 33 quality metrics will, in fact, provide an accurate reflection of the quality of care provided by ACOs participating in the Shared Savings Program.[73]

The first problem is that the quality metrics do not account for differences in patient populations served by different ACOs. An ACO formed in a poor, rural area is going to have a very different patient population from one formed, for example, in Hunters Creek Village. These two groups are likely to have rather different socioeconomic levels, education, English fluency,

[73] This discussion is drawn in part from Gregory J. Pelnar & Gretchen M. Weiss, *Rule of Reason Analysis for Accountable Care Organizations*, Antitrust Source, Dec. 2011, at 6-10, http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/dec11_pelnar_12_21f.authcheckdam.pdf.

medical conditions, physical fitness, and health literacy. These differences are likely to have a significant effect on patient compliance, patient attitudes toward their caregivers, and the extent of care required – some of the very factors on which ACOs will be evaluated.

I am far from alone in recognizing this problem. In response to CMS's initial proposed rules, "many commenters," according to CMS, suggested including a risk-adjustment mechanism to account for the differences in beneficiary characteristics.[74] Commenters were also concerned that ACOs would be penalized for factors outside of the ACO's control, such as a patient's willingness to vaccinate. In response, CMS agreed to include risk adjustment for *some* of the quality measures but generally only with respect to age and gender. CMS also determined not to include any risk adjustment to account for the many other differences among ACO populations or the personal preferences of beneficiaries. Thus, ACOs that serve healthy or compliant populations – particularly those in more affluent, more educated areas – are likely to achieve higher quality scores.[75]

This problem is compounded by the incentive of ACOs to enroll healthy patients and avoid at risk populations, who are less likely to be healthy and compliant. CMS itself has acknowledged this concern and asserted that it "intend[s] to monitor the quality of care furnished by ACOs in an effort to identify patterns of avoiding at-risk beneficiaries."[76] To what extent CMS will be able to do this is unclear, given the myriad ways ACOs could attempt to jettison at risk patients and enroll healthy ones. For example, ACOs could attract more desirable patients

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[74] Final CMS Regulations, *supra* note 60, at 67,873.

[75] The same is true for individual physicians or physician groups within an ACO. Those that serve more at risk patients are more likely to obtain lower quality scores and thus be at greater risk of discipline or expulsion from the ACO.

[76] Final CMS Regulations, *supra* note 60, at 67,871.

through targeted marketing campaigns or through recruiting physicians that have healthy or compliant patients.

The second problem with CMS's 33 quality metrics is that they suffer from a number of inherent limitations. Seven of the quality metrics are based on patient surveys. It's no secret that designing an accurate survey is not easy, and CMS has acknowledged that "survey mode and methodology can affect results."[77] For example, patients with limited English skills are unlikely to complete written surveys. Furthermore, survey results are influenced by a variety of subjective factors, including patients' attitudes toward their own health. Imagine a physician that repeatedly urges a patient to get stop smoking, but the patient refuses. Despite following recommended guidelines, the doctor may receive low survey scores because of the patient's displeasure with the doctor's repeated counseling. In addition, studies have shown that socioeconomic status is correlated with an individual's views about his health.[78] Thus, this is yet another reason to expect more favorable results from ACOs serving more educated, affluent areas.

Another inherent limitation with some of the quality metrics is that they measure processes or outcomes that are beyond the ACO's control. A patient may refuse to have a colonoscopy, for example, despite the best efforts of his physician. In this case, the physician would be penalized on one of the process metrics. Likewise, outcome metrics do not account for patient-specific health issues, individual patient compliance, or care provided by providers

[77] *Id*. at 67,875

[78] *See, e.g*., Jane Wardle & A. Steptoe, *Socioeconomic Differences in Attitudes and Beliefs About Healthy Lifestyles*, 57 J. Epidemiol Community Health 440 (2003) ("Socioeconomic differences in healthy lifestyles are associated with differences in attitudes to health . . . ."); Paula M. Lantz, et al., *Socioeconomic Factors, Health Behaviors, and Mortality*, 279 JAMA 1703, 1708 (1998) ("health behaviors are related to both income and education").

outside the ACO. As a result, the quality metrics may overstate – or understate – the true quality of care provided by an ACO.

A third problem with the CMS quality metrics is that they are not universally accepted. Physicians participating in ACOs that follow different, but equally valid, clinical practice guidelines will either be penalized or have to abandon their preferred guidelines.

The final problem with CMS's quality metrics is that ACOs may be able to develop strategies to perform well on the quality metrics but provide sub-standard care in other respects. In other words, there is a risk of "teaching to the test."[79] For example, ACOs will be rated on their screening for weight, tobacco use, depression, colorectal cancer, breast cancer, and blood pressure, but are not rated on other NQF-endorsed screenings,[80] such as cervical cancer, osteoporosis, drug use, body mass index, and sexually-transmitted diseases. CMS's regulations appear to be based on the assumption that good performance on the CMS quality measures is likely to be closely related to the ACO's performance on other untested quality measures. I, for one, am skeptical. Call me a cynic, but it would not surprise me if ACOs have a higher rate of screening for the CMS-endorsed conditions than for other, equally-important screenings. In short, an ACO's performance on CMS's quality measures may tell us little about non-reported quality measures and, thus, the overall quality of care provided by the ACO.

III. Conclusion

This summer, the Supreme Court will decide the fate of the President's most significant legislative achievement. Most Supreme Court experts predict that the four liberal justices will

[79] Pelnar & Weiss, *supra* note 73, at 9-10.

[80] CMS's quality performance standards are largely derived from the National Quality Forum's (NQF) standards. In January 2009, NQF entered into a contract with HHS to help establish a portfolio of quality and efficiency measures for use in reporting on and improving healthcare quality.

uphold the individual mandate and that Justice Thomas will vote to strike it down, but avoid predictions regarding the remaining four conservative justices. However, notwithstanding Justice Kennedy, Scalia, and Thomas's majority opinions in the *Lopez* and *Morrison* cases, which arguably recognized a more significant limitation on the commerce power than is urged by the States here, I *don't* think it's safe to say that those three justices, particularly Justice Scalia, will vote to strike down the individual mandate, at least not now. However, if those three do vote to strike down the individual mandate, that leaves the decision to Justices Roberts and Alito, the two newest conservative members of the Court.

If the Court does strike down the individual mandate, I expect that it will also strike down the guaranteed issue and community rating requirements, but not any other aspect of the Act. The States and the Administration agree that these provisions are untenable without the individual mandate. The Court is unlikely to go any further, in light of the Court's well-established principle that statutory invalidation should be as narrow as possible.

While the Court is likely to uphold the Medicaid expansion, it will be interesting to see the number and vigor of any dissenting opinions on this issue, which could symbolize renewed interest from some justices in the largely moribund coercion doctrine.

Whatever one thinks about the health care reform legislation from 2010, it's hard not to be skeptical about the prospects of the Medicare Shared Savings Program. CMS' own pilot program was far from a success, and there is a significant risk that any actual cost savings from the program will be offset by higher costs to payors in the commercial market. Against the very meager prospects for cost savings, there is a very real risk that some ACOs will be formed with an eye toward creating or exercising market power. These concerns are exacerbated by the very

real risk that providers will have the incentive and ability to reduce the quantity and quality of needed services to Medicare beneficiaries without detection from CMS.

That brings me to my fundamental objection to ObamaCare, namely that it imposes more government regulation and control over a marketplace that is functioning poorly in large part due to existing over-regulation. Assuming it is upheld, the Act may lead to greater coverage but with the tradeoffs of higher costs to consumers, employers, and the government, and forcing some consumers to purchase a product they don't want. The better approach, in my view, would have been to eliminate, to the extent possible under our federalist system, the barriers at the state and federal level to a truly competitive health care marketplace—and here I am talking about the barriers posed by the McCarran-Ferguson exemptions to the antitrust laws. This would have lowered costs to consumers, improved health care quality, increased innovation, and increased coverage—all at little to no cost to the federal government or consumers.