

50 VETOES



HOW STATES CAN STOP THE
OBAMA HEALTH CARE LAW

MICHAEL F. CANNON

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Executive Summary

Despite surviving a number of threats, President Obama's health care law remains harmful, unstable, and unpopular. It also remains vulnerable to repeal, largely because Congress and the Supreme Court have granted each state the power to veto major provisions of the law before they take effect in 2014.

The Patient Protection and Affordable Care Act (PPACA) itself empowers states to block the employer mandate, to exempt many of their low- and middle-income taxpayers from the individual mandate, and to reduce federal deficit spending, simply by not establishing a health insurance "exchange." Supporters of the law do not care for this feature, yet they adopted it because they had no choice. The bill would not have become law without it.

To date, 34 states, accounting for roughly two-thirds of the U.S. population, have refused to create Exchanges. Under the statute, this shields employers in those states from a \$2,000 per worker tax that will apply in states that are creating Exchanges (e.g., California, Colorado, New York). Those 34 states have exempted at least 8 million residents from taxes as high as \$2,085 on families of four earning as little as \$24,000. They have also reduced federal deficits by hundreds of billions of dollars.

The Obama administration is nevertheless attempting to tax those employers and individuals, contrary to the plain language of the PPACA and congressional intent, and to deny millions of Americans the opportunity to purchase low-cost, high-deductible coverage. Employers, consumers, and even state officials in those 34 states

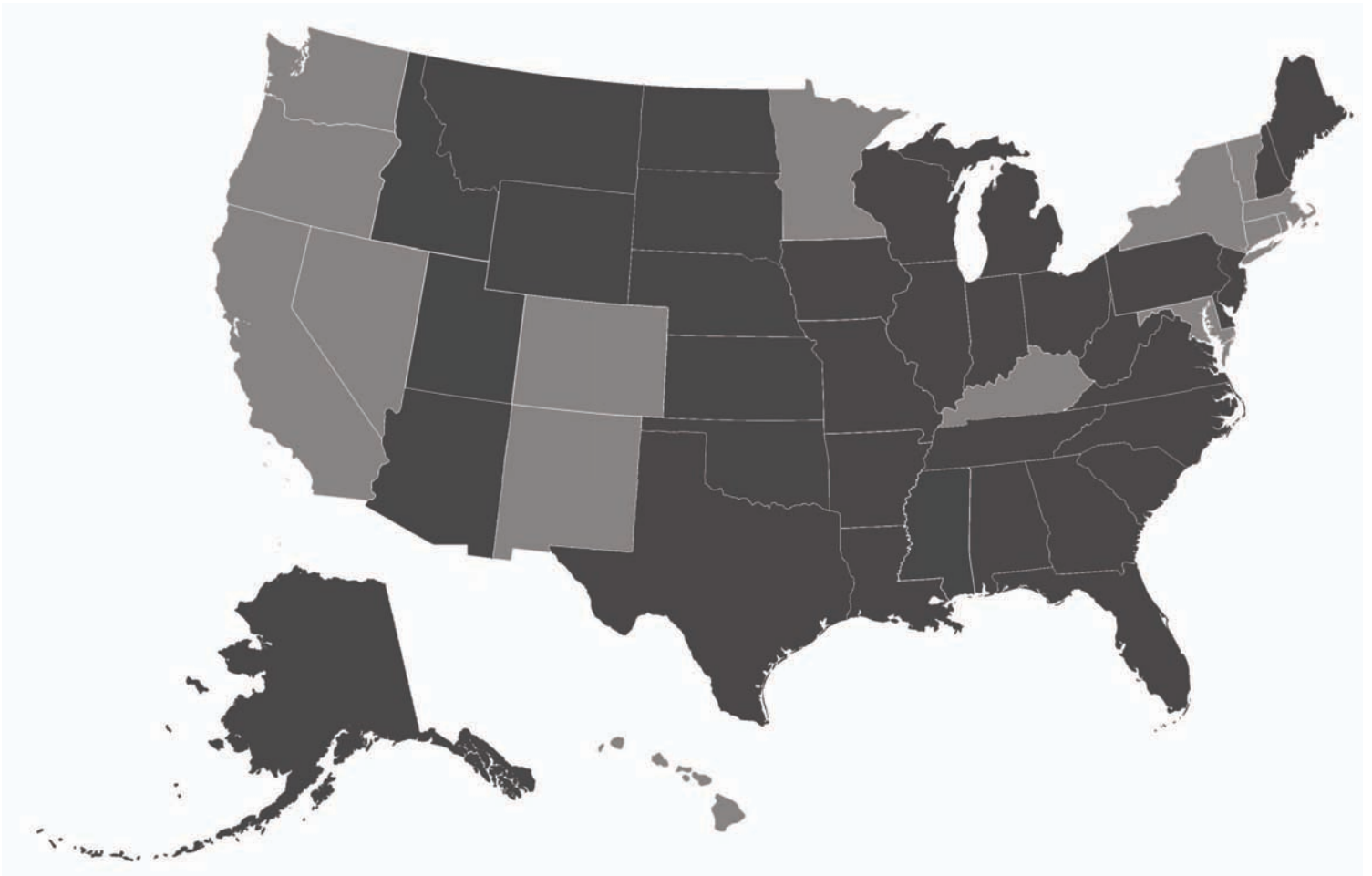
can challenge those illegal taxes in court, as Oklahoma has done. States can also block those illegal taxes—and even stop the federal government from operating an Exchange—by approving a strengthened version of the Health Care Freedom Act.

The PPACA's Medicaid expansion, which would cost individual states up to \$53 billion over its first 10 years, is now optional for states, thanks to the Supreme Court's ruling in *NFIB v. Sebelius*. Some 16 states have announced they will not expand their programs, while half of the states remain undecided. Yet the Obama administration is trying to coerce states into implementing parts of the expansion that the Court rendered optional. States can replicate Maine's lawsuit challenging this arbitrary attempt to limit the Court's ruling.

Collectively, states can shield all employers and at least 12 million taxpayers from the law's new taxes, and still reduce federal deficits by \$1.7 trillion, simply by refusing to establish Exchanges or expand Medicaid.

Congress and President Obama have already repealed the third new entitlement program the PPACA created—the Community Living Assistance Services and Supports Act, or CLASS Act—as well as funding for the "co-op" plans meant to serve as an alternative to a "public option." A critical mass of states exercising their vetoes over Exchanges and the Medicaid expansion can force Congress to reconsider, and hopefully repeal, the rest of this counterproductive law. Real health care reform is impossible until that happens.

The 34 States That Have Vetoed Major Provisions of the Patient Protection and Affordable Care Act



Source: Kaiser Family Foundation, "State Decisions for Creating Health Insurance Exchanges," *State Health Facts*, February 15, 2013, <http://statehealthfacts.kff.org/comparemtable.jsp?ind=962&cat=17>; Kaiser Family Foundation, "State Activity around Expanding Medicaid under the Affordable Care Act," *State Health Facts*, February 26, 2013, <http://www.statehealthfacts.org/comparereport.jsp?rep=158&cat=4>.

Introduction

The Patient Protection and Affordable Care Act of 2010 (PPACA) depresses economic activity, eliminates jobs, increases health care costs, makes access to care less secure, increases the burden of government, and traps people in poverty. Repealing the PPACA is essential to making health care better, more affordable, and more secure.

In just its first six years, the PPACA will reduce economic output by as much as \$750 billion¹ and eliminate an estimated 800,000 jobs.² Some of those job losses will be the result of the law's "employer mandate," which fines employers up to \$2,000 per worker if they fail to offer "minimum value" and "affordable" health benefits.³ The rest will result from the disincentives to work the Act creates, such as implicit marginal tax rates that exceed 100 percent for many low-income households.⁴

The "individual mandate" requires nearly all Americans to purchase a government-designed health plan or pay a penalty. That mandate has already increased the cost of health insurance for millions of Americans,⁵ has forced many to choose between violating their religious principles and paying a fine,⁶ and will increase premiums for millions more Americans when it takes full effect in 2014. Neutral observers and even supporters of the law project that in 2014, some consumers and employers will see their health insurance premiums rise by more than 100 percent.⁷

The PPACA will make access less secure in numerous ways. Its "community rating" price controls will destroy innovations that make health insurance better and more secure.⁸ These price controls have already caused the markets for child-only health insurance to collapse in 17 states and caused insurers to flee the child-only market in an additional 18 states.⁹ When implemented elsewhere, these price controls have perversely forced health insurance companies to compete with each other to avoid and mistreat the sick.¹⁰ Millions of Americans will

suffer those consequences if these price controls take full effect in 2014. When informed that these price controls will reduce the quality of care their families receive, consumers overwhelmingly oppose these supposedly popular provisions.¹¹ The law's minimum "medical loss ratio" requirement has already forced at least one health insurance carrier, Principal Financial Group, to exit the market, forcing nearly one million Americans out of their existing coverage.¹² The Act's Medicaid expansion will crowd out private health insurance and leave many Americans with less secure access to care.

The Act will further reduce access to care by reducing incomes. From 2013 through 2022, it imposes \$1.2 trillion in new taxes¹³ and commits taxpayers to pay for an estimated \$1.6 trillion in new federal spending through 2023.¹⁴ Roughly half of that amount consists of subsidies to private health insurance companies that will flow through new government agencies called health insurance "Exchanges." The balance comes from a potential 50 percent increase in the number of nonelderly Medicaid enrollees.¹⁵

Despite those new taxes, the PPACA spends money the federal government simply does not have. The federal debt stands at \$12 trillion in 2013, or 76 percent of gross domestic product. In 2013, the federal treasury will run a projected \$845 billion deficit.¹⁶ Under current law, annual deficits will cause the federal debt to grow to \$20 trillion by 2023. According to the Congressional Budget Office (CBO):

Along such a path, federal debt held by the public will equal a greater percentage of GDP than in any year between 1951 and 2012 and will be far above the average of 39 percent over the 1973–2012 period. Moreover, it will be on an upward trend by the end of the decade. Debt that is high by historical standards and heading higher will have significant consequences for the budget and the economy. . . . The nation's net interest costs will

Repealing the PPACA is essential to making health care better, more affordable, and more secure.

States have the power to reduce federal deficits by \$1.7 trillion by refusing to implement Exchanges and the Medicaid expansion.

be very high . . . [and] will require the government to raise taxes, reduce benefits and services, or undertake some combination of those two actions. National saving will be held down . . . which in turn will decrease income in the United States. . . . The likelihood of a fiscal crisis will be higher. . . . Those consequences would be exacerbated if federal debt exceeded the amounts projected in CBO's baseline, as it would if certain deficit-reducing policies that are scheduled to take effect were instead reversed without being replaced by other policies with similar budgetary effects.¹⁷

Since Congress tends to reverse deficit-reducing policies before they take effect, the CBO also projects that current *policies* will cause the federal debt to grow to \$29 trillion by 2023, or 114 percent of GDP.¹⁸

The PPACA's new spending is a large contributor to that growth. State-funded Exchanges and the Medicaid expansion will add roughly \$1.7 trillion to federal deficits by 2023.¹⁹

Congress and President Obama have already repealed one of the PPACA's three new entitlement programs: the Community Living Assistance Services and Supports Act, or CLASS Act.²⁰ (They have also repealed federal funding for any new Consumer Operated and Oriented Plans,²¹ which Congress enacted as an alternative to a public option.²²) States can push Congress closer to repealing the remaining two.

The Role of States in Implementing the PPACA

In a February 2011 opinion piece in the *Washington Post*, Secretary of Health and Human Services (HHS) Kathleen Sebelius wrote that the PPACA "puts states in the driver's seat" and "gives states incredible freedom to tailor reforms to their needs."²³ Strictly speaking, this is not true. The federal govern-

ment wields full control over those aspects of the PPACA that states choose to implement. States have considerable power, however, to block major portions of the law by choosing not to implement them.

The PPACA relies on states to implement two of its central provisions: health insurance Exchanges and a vast expansion of Medicaid. Exchanges are not markets, but rather new government agencies through which the PPACA will channel a projected \$1 trillion in taxpayer subsidies to private health insurance companies.²⁴ The Medicaid expansion likewise threatens to spend \$1 trillion, with private insurers again taking a large slice.²⁵

States are under no obligation to implement either an Exchange or the Medicaid expansion. Secretary Sebelius writes that under the statute, creating an Exchange is an "option" for states.²⁶ The Supreme Court's ruling in *NFIB v. Sebelius*, which invalidated Congress's attempt to require states to implement the Medicaid expansion, freed states to reject it.²⁷

Both provisions are a bad deal for taxpayers and states. Implementing either raises the prospect of state-level tax increases. Implementing both would commit the federal government to spend \$1.6 trillion it simply does not have.

Collectively, states have the power to block that spending and to reduce federal deficits by \$1.7 trillion by refusing to implement Exchanges and the Medicaid expansion.

So far, 34 states, accounting for roughly two-thirds of the U.S. population, have refused to establish an Exchange, while 16 have refused to implement the Medicaid expansion. Those states have reduced federal deficits by hundreds of billions of dollars.

In the process, by refusing to create Exchanges or expand Medicaid, states can block many of the PPACA's worst provisions and push Congress to reconsider the entire law. As discussed below, states that decline to implement these provisions will protect their residents from the Act's employer mandate and in many cases its individual mandate.

Why States Should Reject Exchanges

In early 2012 Secretary Sebelius predicted that 15 to 30 states might decline to create Exchanges.²⁸ That estimate proved too low, as an astounding 34 states have so far refused.²⁹ Many states that initially pursued an Exchange did a complete about-face. Oklahoma, Kansas, and Wisconsin each returned to the federal government tens of millions of dollars in Exchange-related grants.³⁰ After an Exchange bill died in the New Hampshire Senate, a bill to prohibit the state from establishing an Exchange cleared the legislature and was signed by Democratic governor John Lynch.³¹ After initial steps toward establishing a PPACA-compliant Exchange, Utah and Mississippi have rejected the idea.³²

Many factors are driving state officials to reject Exchanges. First, the PPACA does not mandate that states create Exchanges. Second, in many states, creating a PPACA-compliant Exchange would violate state law. Third, Exchanges could require states to raise taxes. Fourth, there is no rush. The deadlines for establishing an Exchange are no more real than the “deadlines” for implementing REAL ID, which overwhelmingly have been ignored. Fifth, states can always switch to a state-funded Exchange if they decide they don’t like a federal Exchange. Sixth, state officials are increasingly coming to see that they do not face a choice between a state controlled Exchange and a federally controlled one, because even state-funded Exchanges will be controlled by Washington. Seventh, it is questionable whether the federal government will be able to create any Exchanges at all. The choice states actually face is therefore between a state-funded, federally controlled Exchange and perhaps no Exchange at all. Eighth, states are leery of committing to an Exchange when the federal government has yet to provide crucial information that states need to make an informed decision. Ninth, creating an Exchange sets state officials up to take the blame when the PPACA increases insurance premiums and denies care to the sick.

Tenth, refusing to create an Exchange blocks federal subsidies for controversial abortifacients. Eleventh, small businesses could still receive health insurance tax credits through a federal Exchange. Twelfth, Jonathan Gruber, one the PPACA’s leading advocates, has acknowledged there is no reason for a state to establish its own Exchange for 2014. Thirteenth, the PPACA is still unpopular even after nearly four years.

Finally, rejecting an Exchange blocks major provisions of the law. Those provisions include the tax penalties imposed by the employer and individual mandates and hundreds of billions of dollars in deficit spending. Rejecting an Exchange therefore improves a state’s prospects for job creation and protects the religious freedom and conscience rights of millions of employers and individuals whom the Obama administration would force to purchase items that violate their moral convictions.

Exchanges Are Not Mandatory

The PPACA does not—because the federal government cannot—mandate that states create Exchanges. The Supreme Court has held that the federal government cannot “commandeer” states in that manner.³³ Secretary Sebelius acknowledges the PPACA “gives states the option” of creating an Exchange.³⁴

PPACA Exchanges Violate States’ “Health Care Freedom Acts”

A key role of state-funded Exchanges is to assist federal officials in the enforcement of the PPACA’s individual and employer mandates. State-funded Exchanges must report to the IRS when residents drop their coverage, which can result in penalties under the individual mandate.³⁵ They must notify employers when one of their employees receives a tax credit.³⁶ That very notification triggers penalties against the employer.³⁷ They must collect all the information the federal government needs to determine eligibility for tax credits and deliver it to the federal government—a crucial component of enforce-

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ing both the individual and employer mandates.³⁸ The secretary can require state-funded Exchanges to verify that information for the federal government,³⁹ and state-funded Exchanges must resolve any inconsistencies between the information provided by applicants and official records.⁴⁰ If a state-funded Exchange can't resolve an inconsistency within a certain time period, it has to notify residents that they will be penalized under the individual mandate.⁴¹ State-funded Exchanges must maintain an appeals process for individuals and employers who believe they were wrongly penalized.⁴²

Thirteen states have passed statutes or constitutional amendments—often called Health Care Freedom Acts—that prohibit state officials or agents of the state from assisting in the enforcement of penalties against employers or individuals for failure to purchase health insurance. Alabama,⁴³ Arizona,⁴⁴ Georgia,⁴⁵ Idaho,⁴⁶ Indiana,⁴⁷ Kansas,⁴⁸ Louisiana,⁴⁹ Missouri,⁵⁰ Montana,⁵¹ Tennessee,⁵² and Virginia⁵³ adopted the Health Care Freedom Act via statute. Alabama,⁵⁴ Arizona,⁵⁵ Ohio,⁵⁶ and Oklahoma⁵⁷ adopted it via constitutional amendment. Voters in each state approved those constitutional amendments—in Ohio and Oklahoma, by 2-to-1 margins.⁵⁸

If Idaho were to establish an Exchange, for example, its Health Care Freedom Act would require the attorney general to seek an injunction prohibiting Exchange officials from engaging in the above-mentioned activities.⁵⁹ If Arizona were to establish an Exchange, and its attorney general failed to seek injunctive relief, its constitutional amendment would empower the governor, the speaker of the House of Representatives, or the president of the Senate to “direct counsel to initiate a legal proceeding or appear on behalf of” the state or the legislature “to enforce” Arizona’s Health Care Freedom Act.⁶⁰

Exchanges Portend Higher State Taxes

Various estimates indicate Exchanges will cost states between \$10 million and \$100 million per year to operate (see Figure 1).⁶¹ Funding an Exchange in Oregon, for exam-

ple, will require a new premium tax of up to 5 percent.⁶²

Minnesota initially estimated its Exchange would cost \$30 million to \$40 million per year to operate in 2015. The state subsequently increased that projection to \$54 million in 2015 and \$64 million in 2016. That’s a 35–80 percent jump over initial projections and a growth rate of 19 percent per year.⁶³

“There Is No Deadline”

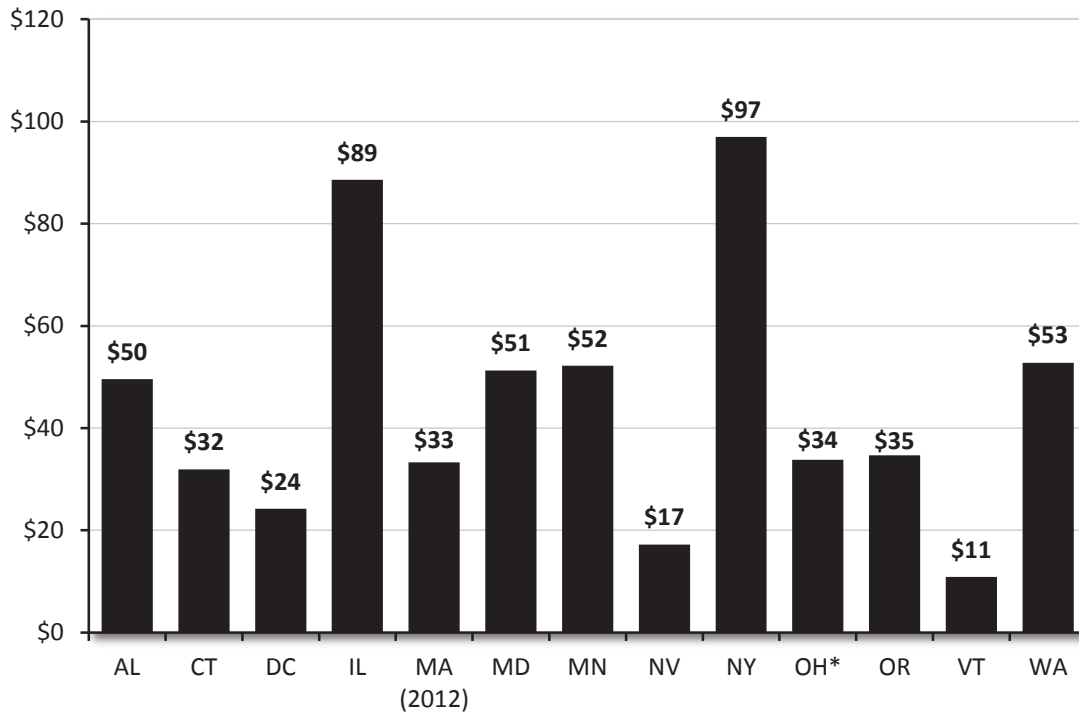
The Obama administration originally told states that want to establish an Exchange that they must submit their proposals to HHS by November 16, 2012.⁶⁴ The administration subsequently pushed that deadline back to December 14, 2012.

The Act requires HHS to certify states’ proposals by January 1, 2013.⁶⁵ Even some officials who are eager to implement the law correctly predicted that deadline was not realistic. The acting director of the District of Columbia’s Health Care Reform and Innovation Administration predicted, “No state is going to be able to be fully certified on January 1. . . . When they passed the [PPACA], they were highly optimistic about the timeline for states to implement exchanges.”⁶⁶ HHS has issued no final approvals and very few conditional approvals, and many of those missed the January 1 deadline.⁶⁷

Gary Cohen directs the federal agency responsible for approving state Exchanges. On January 14, 2013, Cohen finally admitted, “There is no deadline,” and that the Obama administration would approve Exchanges whenever states were ready.⁶⁸

The situation is similar to the REAL ID Act. That statute became law in 2005 and directed states to begin issuing national identification cards by March 2008. States rebelled. By 2009, 10 states had passed resolutions denouncing REAL ID and 15 states passed laws prohibiting its implementation.⁶⁹ The federal government began an ongoing cycle of issuing extensions, pushing back deadlines, setting deadlines aside, and issuing new deadlines. The last “deadline” for state compliance was January 15, 2013—

Figure 1
Estimated Exchange Operating Costs in Select States 2015 (\$ millions)



* May not include all costs.

Sources: Robert L. Carey, “Financial Sustainability of the Alabama Exchange,” November 2011, <http://www.insurance.alabama.gov/PDF/Consumers/Exchange%20Financial%20Sustainability%20BMA10T9.pdf>; Kevin Lurito et al., “Health Insurance Exchange Planning Report: State of Connecticut,” Mercer Consulting Health Care Exchange Report, January 19, 2012, http://www.ct.gov/hix/lib/hix/mercer_final_report_ct_hix1.2012.pdf; District of Columbia, “Health Benefit Exchange Design Review Narrative,” 2012, <http://www.statereform.org/sites/default/files/dcdesignreviewnarrative.pdf>; Wakely Consulting Group, “Illinois Exchange Strategic and Operational Needs Assessment,” September 2011, <http://www.ilga.gov/commission/cgfa2006/Upload/FINAL%20IL%20Exchange%20Needs%20Assessment%20091511.pdf>; Wakely Consulting Group, “Maryland Health Benefit Exchange: Financing the Exchange Vendor Report,” November 7, 2011, <http://dhmh.maryland.gov/exchange/pdf/FinalFinancingReportWakely.pdf>; Commonwealth Health Insurance Connector Authority, “FY 2011 & FY 2012 Administrative Operating Budget” (presentation to the board of directors, June 9, 2011), https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-6-9/4%2520-%2520FY11%2520FY12%2520Admin%2520Budget%2520BOD%25202011_06_09%2520v1%25209.pdf; Minnesota Office of Management and Budget, “8.1 Finance Preliminary Budget Estimates,” November 27, 2012, <http://mn.gov/hix/images/BC8-1-FIN-Budge%2520Estimates2011-2016.pdf>; New York Health Benefit Exchange, “New York State Health Benefit Exchange Five Year Budget—DRAFT,” October 26, 2012, http://healthbenefitexchange.ny.gov/sites/default/files/8-0_exchange_five_year_budget.pdf; Jeremy D. Palmer, Jill S. Herbold, and Paul F. Houchens, “Financing Options to Sustain Ohio’s Exchange,” Milliman Client Report, August 2011, <http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf>; Oregon Health Insurance Exchange Corporation, “Oregon Health Insurance Exchange Corporation Business Plan,” February 2012, http://www.leg.state.or.us/committees/exhib2web/2011interim/HHC/Meeting%20Materials/1-18-2012%20meeting%20materials/11-Exchange_King_ORHIX%20Business%20Plan1-18-2011.pdf; Silver State Health Insurance Exchange, “Finance and Stability Plan,” December 24, 2012; Burns and Associates, Inc., “Vermont Health Insurance Exchange Planning: Task 6.0: Analysis of Exchange Financial Functions,” August 30, 2011, <http://dvha.vermont.gov/administration/hbe-financial-functions-report-08-30-11.pdf>; Washington State Health Care Authority, “8.1: Model budget and revenue generation plan,” *Health Insurance Exchange Blueprint*, October 10, 2012, http://wahbexchange.org/wp-content/uploads/HBE_HHS_Guidance_121010_WA_Blueprint1.pdf.

The federal government will exercise total control over both federal and state-funded Exchanges.

almost five years after the initial deadline, and even that was recently vitiated in favor of state-by-state deadlines even further into the future.⁷⁰

Similarly, any supposed deadlines for establishing Exchanges are not real. States can take their time and make the right decision.

States Can Create Exchanges Later

State officials can always change their minds later. The original “deadlines” applied only to states that wanted to establish their own Exchange by October 2013. Federal regulations also provide that states may “elect[] to operate an Exchange after 2014.”⁷¹ Again, there is no rush, and there are no real deadlines.

Exchanges Do Not Preserve Local Control

Exchange proponents initially sold many state officials a line—recapitulated here by Michigan governor Rick Snyder (R)—that seems designed and tested to appeal to conservative Republicans: “It is vital that we move forward and implement our own health insurance exchange before Washington imposes one upon us.”⁷² Michigan’s House Democratic Floor Leader Kate Segal (Battle Creek) elaborates:

Governor Snyder and the Senate Republicans are ready to work with us to create a health care exchange so that we don’t have to rely on a “one size fits all” exchange designed by the federal government. . . . It is time for the House Republicans to allow us to move forward and design our own health care exchange that will best meet the needs of Michigan residents and businesses.⁷³

The Michigan House ultimately blocked Exchange legislation.⁷⁴

Though the PPACA directs the federal government to create an Exchange in states that do not, a state creating its own Exchange does not increase its control over its health care sector. The federal government

will exercise total control over both federal and state-funded Exchanges.⁷⁵

Three provisions of the PPACA give federal officials complete and total control over state-funded Exchanges. First, the Act empowers the secretary of HHS to impose on state-funded Exchanges “such . . . requirements as the Secretary determines appropriate.”⁷⁶ Second, the Act specifies that states “may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary.”⁷⁷ Third, the Act grants the secretary final authority to approve or reject a state-funded Exchange.⁷⁸ If a state-funded Exchange fails to satisfy the secretary, she may reject it and create a federal fallback Exchange.

The Act thus empowers the secretary to require state-funded Exchanges to operate exactly as she would operate a federal Exchange. One example is the Act’s “navigator” program, in which groups that help consumers select an insurance plan—a role traditionally performed by insurance agents and brokers—receive funding from Exchanges.⁷⁹ Some states have enacted laws requiring navigators to obtain a license.⁸⁰ Yet the secretary has prohibited states from requiring navigators to be licensed agents or brokers, or to carry insurance typically carried by agents and brokers.⁸¹ She has also prohibited navigators from receiving any compensation from health plans either inside or outside an Exchange.⁸² If the secretary later decides to prohibit insurance agents and brokers from serving as navigators, or likewise to require state-funded Exchanges to exclude certain health plans, state-funded Exchanges will have to obey. What the secretary declares bound in Washington shall be bound in the states; what she declares loosed in Washington shall be loosed in the states. As another example, in 2010 carriers began informing enrollees how much the Act was increasing their premiums. Sebelius responded with a threat: “Simply stated, we will not stand idly by as insurers blame their premium hikes and increased profits on the requirement that they provide consumers with basic protections.” Sebelius threatened

to bar those carriers from all Exchanges, not just federal Exchanges.⁸³ Never to pass on an Orwellian flourish, Congress gave the secretary these sweeping powers under a section of the law titled, “State Flexibility Relating to Exchanges.”⁸⁴

The experiences of Massachusetts and Utah are also illustrative. These states created Exchanges prior to the PPACA—and lost control of them the moment it became law. Utah’s governor had asked the secretary to certify that state’s Exchange as satisfying the PPACA’s requirements.⁸⁵ HHS offered its conditional approval⁸⁶ even though, as the *Washington Post* reports, “The federal government almost certainly won’t let the Utah exchange stand as is, given requirements for exchanges under the Affordable Care Act.”⁸⁷ Utah ultimately opted not to fund a PPACA-compliant Exchange.⁸⁸

The conservative Heritage Foundation initially took the position that states should set up “defensive” Exchanges to preserve a modicum of control over their Medicaid programs.⁸⁹ Like many state officials, Heritage scholars eventually concluded that states will enjoy no such autonomy. Heritage scholars now counsel states to refuse to establish Exchanges and to send all related grants back to Washington.⁹⁰

Federal Exchanges Doubtful

The *New York Times* reports that creating and operating federal Exchanges “will be a herculean task that federal officials never expected to perform” because “When Congress passed legislation to expand coverage two years ago, Mr. Obama and lawmakers assumed that every state would set up its own exchange.”⁹¹ *Politico* reports, “there are significant doubts that HHS will have the time and manpower to establish exchanges in all the states that will need it.”⁹²

For example, Oklahoma has opted not to establish an Exchange. According to one official, “We have not seen evidence of any steps to set up a federal exchange in Oklahoma.” Another Oklahoma official commented, “I assume the federal government is working

quickly to build an exchange here and in other states. But the only evidence we’ve seen is a couple of telephone calls seeking information about state insurance regulations.”⁹³ South Carolina’s secretary of HHS agreed: “This is a huge task. The feds have been conspicuously absent on the ground for somebody who needs to set up a huge system in less than a year. Everybody is massively behind on this.”⁹⁴

One obstacle to federal Exchanges is that, because Congress assumed states would be eager to comply, it authorized no funding for the creation of federal Exchanges.⁹⁵ The Obama administration has vowed to create federal Exchanges anyway,⁹⁶ but there are political obstacles. To create federal Exchanges, the Obama administration is necessarily taking funds away from a congressionally authorized purpose and diverting those funds to an unauthorized purpose. The administration moved the office responsible for creating federal Exchanges into the agency that administers Medicare and Medicaid. This suggests the administration may be siphoning funds away from those programs to create Exchanges.⁹⁷ That may explain why, according to the *New York Times*, “federal officials have disclosed little about their plans [and] are vague about the financing of the federal exchanges.”⁹⁸ Members of Congress have begun an investigation.⁹⁹ Oversight hearings should follow.

The administration faces similar challenges when it comes to operating costs of federal Exchanges, for which Congress has also authorized no funding. HHS has proposed to cover those costs with a 3.5 percent premium tax on health plans sold through federal Exchanges. Yet HHS has no power to impose such a tax. HHS implausibly claims that a paragraph of the Act that pertains to state-funded Exchanges, that appears in a section devoted entirely to state-funded Exchanges, and that bears the title, “No Federal Funds for Continued Operations,”¹⁰⁰ somehow authorizes a *federal* agency to impose a *federal* tax to fund “continued operations” of federal Exchanges.¹⁰¹ HHS alternatively

The Obama administration is necessarily taking funds away from a congressionally authorized purpose and diverting those funds to an unauthorized purpose.

Somewhat ironically, if states want to prevent a federal takeover of their health insurance markets, the best thing they can do is invite the federal government to create their Exchange.

claims that the Independent Offices Appropriation Act (IOAA)¹⁰² gives it the authority to impose “user fees” in federal Exchanges. The Supreme Court has held that under the IOAA federal agencies may impose fees on those who privately benefit from the agency’s activities, but those fees may not exceed the “value to the recipient.”¹⁰³ In the case of federal Exchanges, the value to the recipient, whether defined as insurance issuers or consumers, would be zero. As discussed below, the PPACA authorizes tax credits and subsidies only through state-established Exchanges. Industry experts have predicted that without those measures, “No one would go to those exchanges.”¹⁰⁴ Federal Exchanges would provide no value. HHS therefore has no authority to levy user fees or taxes under the IOAA either.

Somewhat ironically, if states want to cede their sovereignty to the federal government, the best thing they can do is fund an Exchange themselves. If they want to prevent a federal takeover of their health insurance markets, the best thing they can do is invite the federal government to create one.

Unanswered Questions

The federal government has failed to provide states with details they need to make a fully informed decision on Exchanges. Many state officials want to know how a federal Exchange would operate before deciding whether to create one themselves. The *New York Times* offers a revealing look into how the federal government has left states in the dark:

States have done their work in public, but planning for the federal exchanges has been done almost entirely behind closed doors.

“We have gotten little bits of information here and there about how the federal exchange might operate,” said Linda J. Sheppard, a senior official at the Kansas Insurance Department. “I was on a panel at Rockhurst University here, and I was asked, ‘Where is the

Web site for the federal exchange?’ I chuckled. There really isn’t any federal exchange Web site.”

Sabrina Corlette, a research professor at the Health Policy Institute of Georgetown University, said the federal exchanges were “much more opaque” than the state exchanges.

In New Hampshire, Thomas M. Harte, the president of Landmark Benefits, which arranges health insurance for 300 employers of all sizes, said: “Nobody has any idea what the federal exchange will look like. There has not been much communication between officials drafting plans for the federal exchange and the people who will use it: consumers, employers, brokers and insurers.” . . .

The 2010 health care law says that if a state runs its own exchange, it must “consult with stakeholders,” including consumers and small businesses. Subsequent rules go further, requiring states to consult health care providers, insurers, agents and brokers.

Kathleen Sebelius, the secretary of HHS, has repeatedly emphasized that “states have to meet a standard of transparency and accountability.” A state exchange must have “a clearly defined governing board,” and the board must hold regular public meetings. . . .

By contrast, federal officials have disclosed little about their plans, are vague about the financing of the federal exchanges and have refused even to divulge the “request for proposals” circulated to advertising agencies.¹⁰⁵

In July 2012 the Republican Governors Association requested that President Obama provide information on 17 issues relating to Exchanges that states will need before making an informed decision.¹⁰⁶ Despite additional correspondence and even a final rule on Exchanges, the Obama administration has yet to provide substantive responses to many questions posed by state officials.¹⁰⁷

State Officials Would Take the Blame

Creating an Exchange will put state officials in a position where they take the blame for rules they did not write and cannot change. In states that fund Exchanges, for example, consumers could receive information about the PPACA's premium increases—which for some will reach 100 percent or more—on state rather than federal letterhead.¹⁰⁸

Worse, state officials will take the blame when the PPACA denies care to the sick. The Act's "community rating" price controls force insurers to sell coverage to the sick far below cost, and to the healthy far above cost. In that environment, an insurer that provides the highest-quality care to the sick will attract all the sickest patients, and will quickly go bankrupt, as healthy people avoid that carrier's higher premiums. In this way, the Act's community-rating price controls literally punish health plans that provide the most attractive coverage to the sick. The Act thus forces health plans into a race to the bottom, where insurers compete to avoid, mistreat, and dump the most vulnerable patients.

States that run their own Exchanges are responsible for implementing regulations designed to prevent that race to the bottom. These include "network adequacy" requirements and marketing restrictions.¹⁰⁹ When those regulations inevitably fail, patients harmed by *federal* price controls will blame *state* officials. In venues ranging from public hearings to political attack ads, patients, their survivors, and political candidates will blame state officials for problems they did not create and cannot fix.

State officials who establish Exchanges, in addition to being unfair to themselves, will shield federal officials from accountability for their actions. The Supreme Court has written, "[W]here the Federal Government directs the States to regulate, it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision."¹¹⁰

Block Federal Subsidies for Abortifacients

The PPACA allows states to block federal subsidies for controversial forms of contraception by refusing to establish Exchanges.

Many Americans have deep religious or moral objections to abortion, including some forms of birth control that opponents believe induce abortions. The PPACA has several provisions designed to prevent health plans from using federal funds to subsidize surgical abortions. For example, the Act enables states to prohibit coverage for abortion services in health plans sold through both state-funded and federal Exchanges.¹¹¹ Other provisions attempt to prevent health plans from using Exchange subsidies to pay for abortion services.¹¹² These latter provisions are controversial. Supporters of the Act claim they effectively prevent health plans from directly or indirectly paying for abortions with taxpayer dollars.¹¹³ Abortion opponents disagree.¹¹⁴ They claim that fungible federal dollars are not and cannot be segregated effectively, and they object to taxpayer subsidies going to any health plan that includes abortion coverage.

In addition to that controversy, regulations implementing the PPACA require nearly all Americans to purchase coverage for all forms of contraception approved by the Food and Drug Administration. Abortion opponents maintain that certain forms of contraception can prevent the survival of a fertilized ovum, which they believe to be a human life, and are therefore abortifacients.¹¹⁵ The Act both mandates coverage of such forms of contraception, and subsidizes them through state-funded Exchanges.

As noted above, states can prevent plans sold through either a state-funded or a federal Exchange from covering abortion services. But if a state creates its own Exchange, the PPACA would still subsidize all forms of contraception through that Exchange. If a state declines to create an Exchange, on the other hand, it blocks federal subsidies for contraceptives, including abortifacients (see below).

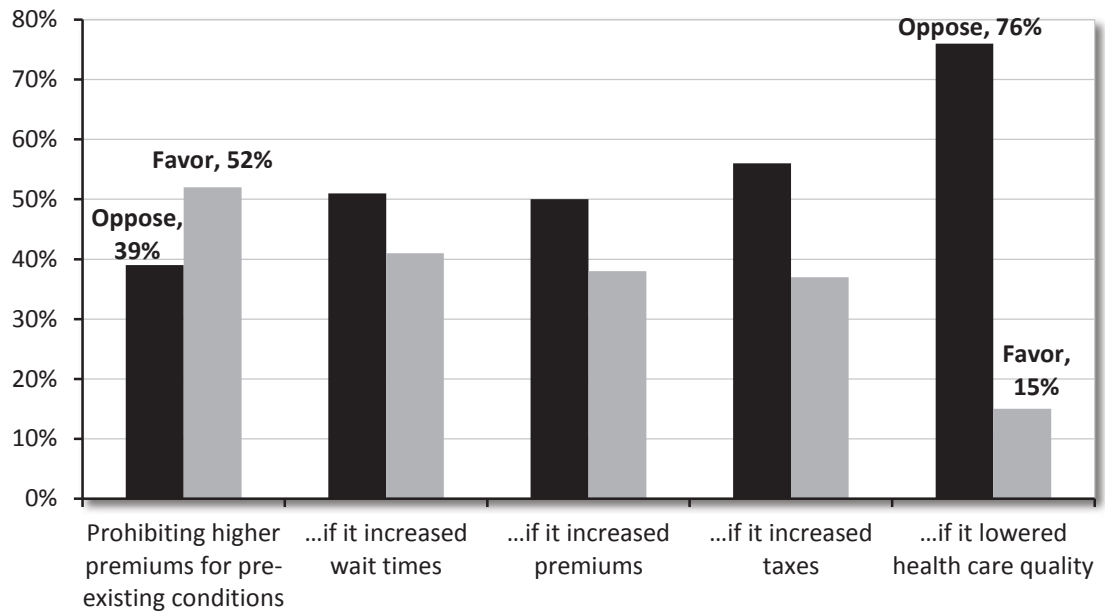
Small-Business Tax Credits

As discussed below, employers benefit

Creating an Exchange will put state officials in a position where they take the blame for rules they did not write and cannot change.

The public turned against the PPACA the moment supporters introduced the first draft in Congress in June 2009. The public has remained opposed to it since.

Figure 2
When Asked about Likely Costs, Americans Oppose ‘Popular’ Provisions by 5–1



Source: “Reason-Rupe Public Opinion Survey, March 2012 Topline Results,” <http://reason.com/assets/db/13327241811317.pdf>.

when states refuse to establish an Exchange, because that refusal exempts in-state employers from penalties under the PPACA’s employer mandate. Under Section 1421 of the PPACA, however, small businesses can still receive health insurance tax credits through a federal Exchange.¹¹⁶ States can therefore exempt employers from the employer mandate, and still enable small businesses to receive those tax credits, by refusing to establish an Exchange.

Gruber: No Reason to Create Exchanges for 2014

One of the leading architects and proponents of the PPACA is Massachusetts Institute of Technology health economist Jonathan Gruber. Testifying before the Florida legislature in January 2013, Gruber advised state officials not to create an Exchange themselves, at least for 2014.¹¹⁷

Still Not Popular

The public turned against the PPACA

the moment supporters introduced the first draft in Congress in June 2009. The public has remained opposed to it since.¹¹⁸ Independents favor full repeal by 56 percent to 42 percent.¹¹⁹ Intensity also favors opponents. Those with a very unfavorable view of the law outnumber those with a very favorable view by 31 percent to 20 percent.¹²⁰

As mentioned above, Americans strongly disapprove of even the Act’s supposedly most popular provisions—the “community-rating” price controls that ban discrimination against insurance purchasers with pre-existing conditions—when informed of both the costs and benefits (see Figure 2).¹²¹

When given a choice, voters in the November 2012 elections rejected the Act. Exit polling shows majorities or pluralities of voters nationwide (49 percent) as well as in Florida (49 percent), Ohio (52 percent), Iowa (53 percent), New Hampshire (50 percent), Colorado (55 percent), and even Illinois (49 percent) want ObamaCare repealed in whole or in part.¹²² Health Care Freedom Acts won

handily in Alabama (59 percent of the vote), Montana (67 percent), and Wyoming (77 percent).¹²³ Missouri voters re-elected Gov. Jay Nixon (D) with 55 percent of the vote, yet a ballot initiative that blocks him from implementing an Exchange won with 62 percent.¹²⁴

A January 2013 poll found that 52 percent of adults believe opponents “should continue trying to change or stop” the law, while only 40 percent want opponents to “stop trying to block the law’s implementation.”¹²⁵

Refusing to Create an Exchange . . .

Most important, refusing to establish an Exchange blocks many of the PPACA’s most harmful provisions. States can effectively block the law’s employer mandate, exempt millions of taxpayers from the individual mandate, and reduce future federal deficits by nearly \$700 billion, simply by refusing to create Exchanges.

Congressional Democrats had no choice but to grant states a veto over these provisions. In order for the PPACA to pass the Senate, its authors needed to secure the votes of moderates like Ben Nelson (D-NE) and Joseph Lieberman (I-CT), who preferred state-based Exchanges to a federal Exchange.¹²⁶ The law’s authors were also sensitive to charges that the law constituted a “federal takeover” of health care.¹²⁷

But the federal government cannot command states to establish Exchanges. Thus the authors needed a constitutionally permissible means of motivating states. In early 2009, before Senate Democrats had even drafted the bill that would become the PPACA, law professor Timothy Jost offered three suggestions:

Congress could [1] invite state participation in a federal program, and provide a federal fallback program to administer exchanges in states

that refused to establish complying exchanges. Alternatively it could exercise its Constitutional authority to spend money for the public welfare . . . either by [2] *offering tax subsidies for insurance only in states that complied with federal requirements* (as it has done with respect to tax subsidies for health savings accounts) or by [3] offering explicit payments to states that establish exchanges conforming to federal requirements.¹²⁸

Though the Act employs all three proposals, the italicized one is the most consequential. The PPACA authorizes “premium-assistance tax credits” for certain individuals. But the Act tightly restricts eligibility for tax credits to those enrolled in a health plan “through an Exchange established by the State.”¹²⁹ The statute contains no language authorizing tax credits through federal fallback Exchanges. The law’s lead author, Sen. Max Baucus (D-MT), acknowledged during congressional consideration that conditioning tax credits on each state creating its own Exchange was intentional and purposeful.¹³⁰

In early 2010 congressional Democrats and President Obama had hoped to jettison this feature in favor of the House’s approach to Exchanges. But then Massachusetts voters elected Republican Scott Brown to the Senate on his pledge to be the 41st senator in a GOP filibuster of any compromise between the House and Senate bills. At that moment, congressional Democrats’ only option was to have the House approve the Senate bill and present it to President Obama. Every single member of Congress who voted for the PPACA intentionally limited tax credits to state-funded Exchanges. If they hadn’t, the PPACA would not have become law.

To be sure, PPACA supporters do not care for this feature, because it gives states the power to block the Act’s “cost-sharing subsidies,” employer mandate, and individual mandate, all of which depend in whole or in part on the availability of premium-

The employer mandate reduces job creation and violates the religious freedom and conscience rights of employers.

When a state declines to create an Exchange there can be no penalties against that state's employers.

assistance tax credits.¹³¹ Yet they adopted it because they had no choice. The bill would not have become law without it.

All that states have to do to block all of these provisions, therefore, is refuse to create an Exchange.

. . . Blocks the Employer Mandate

Consider the employer mandate. This costly provision reduces job creation and violates the religious freedom and conscience rights of employers by forcing them to comply with the Obama administration's contraceptives mandate.

The employer mandate penalizes employers in two ways. If an employer with 50 or more employees (1) fails to offer health benefits with "minimum value" to all full-time employees and their dependents, *and* (2) one of those employees enrolls in a health plan "with respect to which an applicable premium tax credit . . . is allowed or paid with respect to the employee," then the PPACA fines the employer \$2,000 per worker, minus the first 30 workers.¹³² An employer with 50 workers would face a tax of \$40,000, while an employer with 100 workers would face a tax of \$140,000. Alternatively, if an applicable employer's health benefits provide "minimum value" but (1) do not meet the statutory criteria for "affordable," *and* (2) one or more employees becomes eligible for a tax credit, then the employer faces a tax of \$3,000 for every employee eligible for a credit.¹³³

The threat of those hefty taxes is already reducing workers' incomes, as employers cut workers' hours below the 30-hour per week threshold for full-time employees just to avoid those taxes.¹³⁴ The employer mandate will likewise prevent many small employers from expanding, because hiring a 50th employee subjects them to those taxes. Economic research finds that similar regulations "appear to have led firms to distort their firm-size decisions to avoid the more

regulated market" and that such regulation "might put [regulated] firms at a competitive disadvantage."¹³⁵

Adding to the burden, employers face considerable uncertainty about how to comply with the mandate. Economist Robert Graboyes explains:

What makes it very difficult for businesses is that the penalties involve so much that is outside of their control or even outside of their view. Let's say you're married with two children and you and your wife together earn \$100,000. Now your wife's income drops a bit, and you're below \$89,000. Your employer and your wife's employer will both be slammed with a fine.

I have jokingly referred to this as the "employee's spouse's uncle tax," because it is literally true that an employer could be fined because one of its employees has a spouse, who has an elderly uncle, who moves into their spare bedroom, thereby increasing family size.¹³⁶

Compliance will become more difficult over time as a result of "mandate creep." The Act requires self-insured employers to offer health benefits that provide "minimum value." The statute defines "minimum value" to mean *only* that "the plan's share of the total allowed costs of benefits provided under the plan" must be at least "60 percent of such costs."¹³⁷ Nevertheless, the federal government has indicated it may impose additional requirements that self-insured employers would have to meet to remain in compliance.¹³⁸ For example, the Obama administration's decision to force employers to provide "free" contraceptives to their employees is not mandated by the Act.¹³⁹

How States Can Protect Employers

Yet the PPACA only authorizes premium-assistance tax credits—the very tax credits that trigger penalties against employers—through Exchanges that are "established by

the state.”¹⁴⁰ When a state declines to create an Exchange, no tax credits are allowed. Without tax credits, there can be no penalties against that state’s employers.

The benefits to such states are substantial. Employers would not have to cut workers’ hours or shed workers to avoid those taxes. Indeed, they could hire more workers, because blocking the employer mandate reduces the cost of hiring. Smaller firms could expand beyond 50 employees without the mandate discouraging growth and hiring, or inhibiting their ability to compete with larger employers. Firms that do not offer health benefits could continue to do so without penalty. The uncertainty that employers face about whether they will be hit by these taxes would disappear. Self-insured employers would be freed from the federal government’s expanding definition of “minimum value,” and could offer a wider range of more affordable health benefits, including plans that have high deductibles or cost-sharing.

Given that states compete with each other for employers, state officials should be extremely wary about establishing an Exchange. A state that creates an Exchange may find its tax base shrinking as it loses employers to states that choose not to impose this optional and unnecessary tax on job creation. Conversely, a state that rejects an Exchange will have an advantage in competing for jobs with other states. For example, Hostess Brands Inc. shuttered four California bakeries when the company liquidated.¹⁴¹ Whoever purchases the Hostess brand will face an enormous incentive to relocate those bakeries to states like Arizona or Texas that have declined to create Exchanges. Even states that have already begun implementation would be wise to wait for the resolution of pending litigation (see below) before imposing a tax that would cause employers to flee the state.

Finally, refusing to create an Exchange gives sanctuary to employers who object to the Obama administration’s contraceptives mandate. Religious employers have filed

more than 40 lawsuits challenging that mandate, which carries much higher penalties than the employer mandate. Michigan’s Weingartz Supply Company, for example, whose owners are Catholic and employ 170 people, has won a temporary reprieve from the contraceptives mandate.¹⁴² If the company loses its lawsuit, failing to offer contraceptives coverage will cost the company \$280,000 per year in fines. Oklahoma-based Hobby Lobby Stores, Inc., will face fines of \$1.3 million *per day* for refusing to cooperate with the contraceptives mandate.¹⁴³ If these legal challenges fail, then states that refuse to establish an Exchange would enable employers to remain true to their consciences by ceasing to offer health benefits, if it comes to that, without facing penalties under the employer mandate.

... Exempts Millions from the Individual Mandate

Likewise, states can collectively exempt at least 12 million low- and middle-income individuals from the PPACA’s costly individual mandate.¹⁴⁴ This would free those individuals from that punitive tax and the PPACA’s burdensome health insurance regulations and would likewise protect freedom of conscience.

The Individual Mandate

Beginning in 2014, the Act’s individual mandate will require nearly all Americans to purchase a government-defined health insurance plan or pay a tax to the Internal Revenue Service.¹⁴⁵ According to projections by Milliman, Inc., in 2016:

- Families of four headed by a 35-year-old will be subject to a tax of up to \$10,168.
- If headed by a 55-year-old, families of four will be subject to taxes reaching \$18,085.
- Families of four earning as little as \$24,000 will be subject to a tax of

States can collectively exempt at least 12 million low- and middle-income individuals from the PPACA’s costly individual mandate.

Somewhat ironically, states can shield millions of their residents from the taxes imposed by the individual mandate by blocking the law's premium-assistance tax credits.

\$2,085—nearly 9 percent of their income.¹⁴⁶

The CBO has estimated six million Americans will pay those taxes in 2016.¹⁴⁷

The individual mandate burdens far more than 6 million people, however. The PPACA eliminates from both the individual market and fully insured employer plans (i.e., the “small-group” market) any health insurance policy that does not provide an expensive suite of “essential health benefits.” In 2010 the Obama administration estimated about half of employer-sponsored health plans would have to purchase additional coverage to comply with the Act’s mandates.¹⁴⁸ In the individual market, for example, the PPACA will increase premiums by an average of 30 percent.¹⁴⁹ As noted above, in both the individual and small-group markets, many consumers will see their premiums rise by more than 100 percent.¹⁵⁰ The individual mandate strips Americans of the ability to refuse that expensive coverage. It thereby imposes an implicit tax, in the form of higher premiums, on many if not most of the 200 million Americans who maintain coverage.¹⁵¹

Expanding the “Affordability” Exemption

Fortunately, the PPACA exempts taxpayers from the individual mandate if their out-of-pocket costs for health insurance exceed the statute’s definition of “affordable,” and states have the ability to expand the number of their residents who qualify for this “affordability” exemption.

Somewhat ironically, states can shield millions of their residents from the taxes imposed by the individual mandate by blocking the law’s premium-assistance tax credits. All that states need do is refuse to establish an Exchange. Here’s why:

- The PPACA exempts households from penalties under the individual mandate if their out-of-pocket costs for health insurance—i.e., their “required contribution”—exceeds roughly 8 percent of household income.¹⁵²

- This “required contribution” is equal to the least-expensive health plan available to a consumer through an Exchange, *minus* the amount of the premium-assistance tax credit for which she is eligible.¹⁵³
- For many taxpayers, the mere fact that a premium-assistance tax credit is available to them reduces their “required contribution” from above 8 percent of household income to below that threshold. It thereby strips them of the individual mandate’s affordability exemption. Perversely, the mere *availability* of this tax “credit” subjects them to a tax penalty, even if they do not claim the credit. In the convoluted world of the PPACA, becoming eligible for a tax credit increases one’s tax liability, while blocking tax credits reduces tax liabilities.

When states refuse to create Exchanges, however, they block those premium-assistance tax credits and preserve the affordability exemption for potentially millions of their residents.

Collectively, states can exempt at least 12 million Americans from this mandate’s tax (see Box 1). Table 1 provides state-by-state estimates. The 34 states that have so far refused to establish Exchanges have exempted at least 8 million taxpayers from the individual mandate’s penalty tax.

Refusing to create an Exchange also protects the religious freedom and conscience rights of individuals. Expanding access to the affordability exemption would free 12 million currently uninsured Americans, and millions of currently insured Americans, from the Obama administration’s contraceptives mandate. Like employers, those individuals could—again, if it came to that—decline to purchase health insurance rather than pay for contraceptives or abortifacients. This would not be as high-risk a proposition for individuals as one might think, since the Act allows individuals to wait until they are sick to buy insurance coverage again.

Box 1. How Many Residents Can States Exempt from the Individual Mandate?

In states that establish Exchanges, legal U.S. residents with incomes between 100 percent and 400 percent of the federal poverty level (FPL), and even some below the poverty level, who do not have an offer of coverage from an employer will qualify for premium-assistance tax credits. In 2016 those thresholds roughly correspond to \$12,000–\$47,000 for single adults and \$24,000–\$96,000 for families of four.¹⁵⁴

If such households fail to purchase “minimum essential coverage,” they will pay an individual-mandate penalty tax that rises with household size and with age. Single adults in that income range would pay levies approaching \$1,000. Families of four would pay \$2,085.

If premium-assistance tax credits are not available, however, nearly all of those individuals would qualify for the affordability exemption from the individual mandate, because their “required contributions” would exceed 8 percent of household income.¹⁵⁵

Since the PPACA does not authorize tax credits in states that do not establish Exchanges, states that decline to create Exchanges enable those individuals to qualify for that exemption.

A rough proxy for how many people states can exempt from the individual mandate is the number of currently uninsured legal U.S. residents who have incomes within the relevant ranges, who do not smoke, and who do not receive an offer of coverage from an employer. Of an estimated 47.9 million uninsured U.S. residents, more than half (24.9 million) have incomes between 100 percent and 400 percent FPL.¹⁵⁶ An estimated 73 percent of uninsured individuals in that income range do not have an offer of insurance coverage from an employer.¹⁵⁷ An estimated 17 percent of the uninsured are undocumented immigrants, who are otherwise exempt from penalties under the individual mandate.¹⁵⁸ Finally, we must make an allowance for smokers. The PPACA allows insurers to charge smokers up to 50 percent more than nonsmokers, yet those higher premiums do not increase the amount of the smokers’ premium-assistance tax credits. As a result, all smokers between 100 and 400 percent of the poverty level who choose not to purchase health insurance likely will find their “required contribution” exceeds 8 percent of household income, and will thus be exempt from penalties under the individual mandate. A state’s decision not to create an Exchange therefore will not affect these taxpayers. Since an estimated 19 percent of U.S. adults are smokers, we can further reduce the number of currently uninsured taxpayers whom states could exempt by that percentage.¹⁵⁹

Thus, states can collectively exempt at least an estimated 12 million currently uninsured taxpayers from the individual mandate’s penalty tax, simply by refusing to create Exchanges. This estimate is conservative. It does not include legal U.S. residents just below the poverty level, whom states can also exempt from the individual mandate’s penalty tax. Nor does it include millions of currently insured individuals who would also be free to decline the PPACA’s expensive mandated coverage without penalty.¹⁶⁰

The 34 states that have so far refused to establish Exchanges have exempted at least 8 million taxpayers from the individual mandate’s penalty tax.

... Frees Consumers to Purchase Low-Cost Coverage

Refusing to create an Exchange also frees

more of a state’s residents to purchase the low-cost “catastrophic plans” the law authorizes.

The PPACA makes certain high-deductible health plans available to everyone under

Table 1
Estimated Number of Currently Uninsured Low- and Middle-Income Residents
Each State Can Exempt from Individual Mandate

| State | Number of Residents | State | Number of Residents |
|----------------------|---------------------|----------------|---------------------|
| United States | 12,195,139 | Missouri | 208,010 |
| Alabama | 141,495 | Montana | 42,434 |
| Alaska | 35,631 | Nebraska | 65,976 |
| Arizona | 289,207 | Nevada | 144,187 |
| Arkansas | 129,162 | New Hampshire | 40,966 |
| California | 1,744,687 | New Jersey | 328,802 |
| Colorado | 175,169 | New Mexico | 94,363 |
| Connecticut | 82,078 | New York | 640,278 |
| Delaware | 25,695 | North Carolina | 400,994 |
| District of Columbia | 11,306 | North Dakota | 18,647 |
| Florida | 925,276 | Ohio | 386,751 |
| Georgia | 420,277 | Oklahoma | 167,876 |
| Hawaii | 20,899 | Oregon | 157,304 |
| Idaho | 77,820 | Pennsylvania | 357,679 |
| Illinois | 455,272 | Rhode Island | 29,023 |
| Indiana | 195,627 | South Carolina | 220,882 |
| Iowa | 89,566 | South Dakota | 25,695 |
| Kansas | 96,370 | Tennessee | 235,565 |
| Kentucky | 157,549 | Texas | 1,553,367 |
| Louisiana | 210,359 | Utah | 103,320 |
| Maine | 36,854 | Vermont | 12,187 |
| Maryland | 198,808 | Virginia | 287,102 |
| Massachusetts | 35,386 | Washington | 253,282 |
| Michigan | 288,130 | West Virginia | 61,620 |
| Minnesota | 130,630 | Wisconsin | 140,859 |
| Mississippi | 127,693 | Wyoming | 26,625 |

Source: Kaiser Family Foundation, “Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), States,” 2010–2011 and 2009–2010; author’s calculations; and Lisa Dubay and Allison Cook, “How Will the Uninsured Be Affected by Health Reform?” Kaiser Commission for Medicaid and the Uninsured Issue Paper no. 7971, August 2009, p. 7, <http://www.kff.org/healthreform/upload/7971.pdf>. National estimate uses 2011 data. State estimates use data for 2010 and 2011, except for Massachusetts, which uses 2009 and 2010 data. Figures for D.C. and Vermont do not include uninsured residents between 100 percent and 138 percent FPL.

age 30, as a means of encouraging young adults to obtain coverage. Those “catastrophic plans” most likely will have the lowest premiums of any health plan allowed under the law.¹⁶¹

The Act also opens those low-cost plans to adults age 30 and over who qualify for the affordability exemption from the individual mandate. States can therefore give more than 12 million taxpayers access to this low-cost coverage by blocking the premium-assistance tax credits. All a state need do is refuse to establish an Exchange. Again, blocking one of the PPACA’s tax “credits” leaves many individuals better off.

... and Reduces Federal Deficits

Refusing to create Exchanges also prevents the federal government from spending money it does not have. If all states refuse to establish Exchanges, federal deficits will shrink by nearly \$1.2 trillion.¹⁶² The 34 states that have refused to create Exchanges could by themselves reduce federal deficits by perhaps two-thirds of that amount.

The IRS’s Illegal Taxes

Contrary to the clear language of the statute and congressional intent, the IRS has issued a final rule that attempts to issue premium-assistance tax credits where the PPACA specifically precludes them: through Exchanges established by the federal government.¹⁶³ *Kaiser Health News* reports, “the claim that Congress denied to the federal exchanges the power to distribute tax credits and subsidies seems correct as a literal reading of the most relevant provisions.”¹⁶⁴ The nonpartisan Congressional Research Service notes:

a strictly textual analysis of the plain meaning of the provision would likely lead to the conclusion that the IRS’s

authority to issue the premium tax credits is limited only to situations in which the taxpayer is enrolled in a state-established exchange. Therefore, an IRS interpretation that extended tax credits to those enrolled in federally facilitated exchanges would be contrary to clear congressional intent . . . and likely be deemed invalid.¹⁶⁵

PPACA supporter Mickey Kaus writes that defenders of the IRS rule are “starting in a hole.”¹⁶⁶

This illegal rule is designed specifically to strip states of their ability to block the individual and employer mandates and related deficit spending.

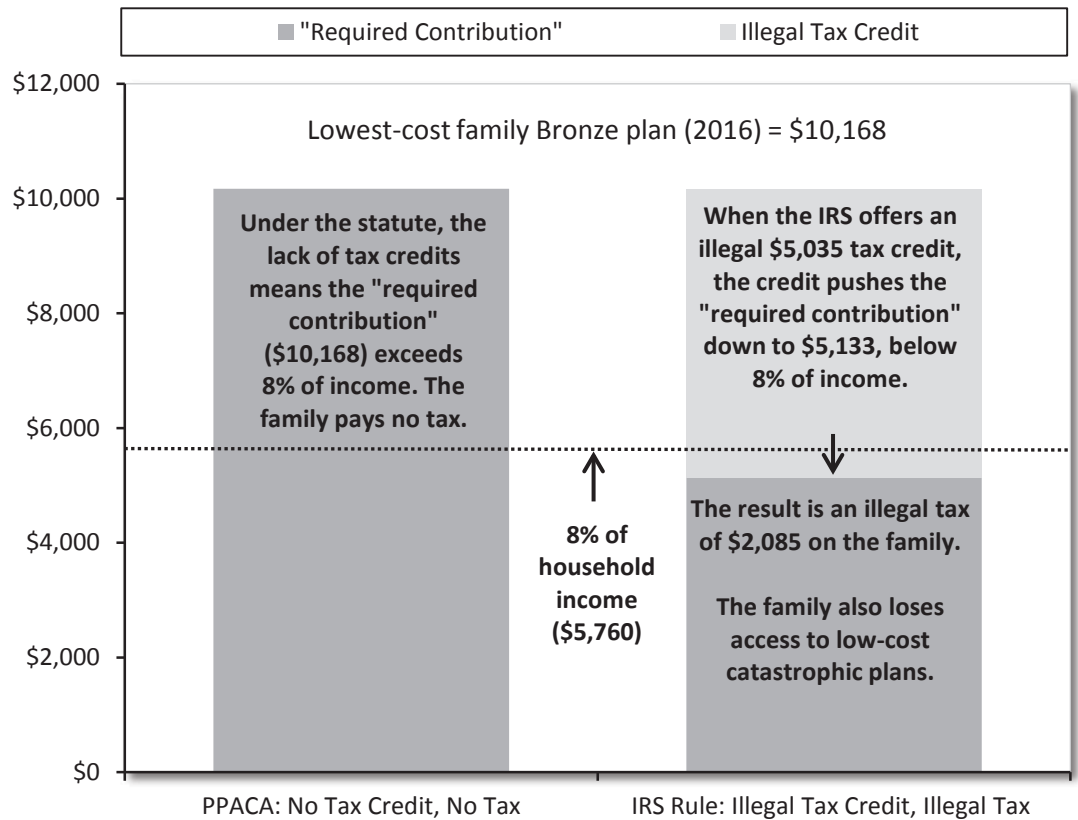
Unauthorized Taxes and Deficit Spending

Though nominally about tax credits, this IRS rule actually imposes a large and unauthorized tax hike on employers and individual taxpayers. By offering premium-assistance tax credits in states that do not establish Exchanges, the IRS rule would trigger taxes against individuals and employers whom Congress expressly exempted from those mandates. Firms with 200 employees would fall prey to an illegal tax of \$340,000. The IRS’s illegal tax credits would also strip the affordability exemption from those 8 million (or more) individual taxpayers. Families of four earning as little as \$24,000 per year will be subject to an illegal tax of \$2,085 in 2016.¹⁶⁷ Millions of Americans who by right would qualify to purchase low-cost catastrophic plans (by virtue of the affordability exemption) would have that right stripped from them (see Figure 3). Perhaps most troubling, this IRS rule imposes an illegal tax on certain legal immigrants living below the poverty level.

The IRS rule also spends federal dollars and increases federal deficits without congressional authorization. CBO projections suggest that if all states refused to establish Exchanges, this rule would commit taxpayers to pay for \$945 billion in unauthorized federal spending through 2023. At the same

This IRS rule imposes a large and unauthorized tax hike on employers and individual taxpayers.

Figure 3
How the IRS's Illegal Tax Credits Trigger Illegal Taxes on Individuals in the 34 States with Federal Exchanges



Sources: Congressional Budget Office, "Selected CBO Publications Related to Health Care Legislation, 2009–2010"; Milliman, "Measuring the Strength of the Individual Mandate," and author's calculations.
 Note: Graph shows projected premium of \$10,168 for a family of four with a 35-year-old head of household and without "minimum essential coverage," living in a state with a federal Exchange and earning 300 percent of federal poverty level in 2016 (\$72,000).

The IRS rule is thus likely to result in more than \$600 billion of unauthorized spending and more than \$100 billion in unauthorized taxes.

time, it could result in at most \$267 billion of unauthorized tax reduction, an amount that would be offset almost entirely by \$150 billion in unauthorized taxes on employers and tens of billions of dollars in unauthorized taxes on individuals.¹⁶⁸ The IRS rule will thus also increase the deficit by more than \$1 trillion, again without congressional authorization. Since every dollar of government spending must be paid for through taxes, this rule amounts to an implicit unauthorized tax increase that rivals the PPACA's original price tag.¹⁶⁹

Those figures are based on the admittedly unlikely scenario that all states refuse

to establish an Exchange. The actual cost of the regulation is likely to be somewhat lower—but perhaps not by much. The 34 states that have refused to establish Exchanges account for two-thirds of the U.S. population.¹⁷⁰ The IRS rule is thus likely to result in more than \$600 billion of unauthorized spending and more than \$100 billion in unauthorized taxes through 2023. Due to interactions between the Medicaid expansion and Exchange-related provisions, the cost of the rule increases with the number of states that refuse to expand Medicaid.

Regardless of how many states implement Exchanges, roughly 90 percent of the IRS

rule's net budgetary impact consists of new, unauthorized spending.¹⁷¹ Though supporters may try to portray the IRS rule as a tax break, an edict that imposes \$9 of unauthorized liabilities on taxpayers for \$2 of unauthorized tax reduction can hardly be called a tax cut.

States, Employers, and Taxpayers Can Stop these Illegal Taxes

Every governor, attorney general, and legislature in those 34 states can file suit to block the rule. Oklahoma attorney general Scott Pruitt has petitioned a federal court to do so because, "This unauthorized IRS rule has injured the State of Oklahoma in its capacity as a sovereign state, by depriving the State of an important sovereign choice that Congress gave the States the exclusive right to make, and it will injure the State of Oklahoma in its capacity as a 'Large Employer,' by requiring it to provide federally-approved health insurance to all full-time employees—or risk onerous penalties." Additional challenges increase the likelihood of success.¹⁷²

Since the rule imposes illegal taxes on both employers and individual taxpayers, those groups could challenge it in federal court. To establish standing employers must

- Reside in a state that will not create its own Exchange by 2014;
- Have more than 50 employees;
- Show either that they do not offer "minimum essential coverage" or that their health benefits do not meet the statutory definition of affordability;¹⁷³ and
- Show that one or more of their employees likely will become eligible for a tax credit as a result of the IRS rule.¹⁷⁴

Individuals would be injured by the rule, and thus could challenge it in court, if they

1. Do not smoke;
2. Are legal U.S. residents;
3. Reside in a state that will not create its own Exchange by 2014;

4. Have a household income above the income-tax-filing threshold;
5. Have a household income between 100 and 400 percent of the federal poverty level;
6. Do not have an offer of "minimum value" and "affordable" coverage from an employer or qualify for Medicaid; and
7. Are not covered by a health plan offering "minimum essential coverage."¹⁷⁵

Alternatively, individuals who meet criteria (1) through (6) could establish standing if they desire to purchase a low-cost "catastrophic plan" but are prevented from doing so because the IRS rule strips them of the affordability exemption.

Finally, single-adult, legal immigrants over age 30 with annual income above the income-tax-filing threshold and below the poverty level (roughly \$10,000 to \$12,000), and who are ineligible for Medicaid by virtue of their residency status will also be injured by the IRS rule. Plainly put, the IRS rule imposes an illegal tax of \$695 on legal immigrants below the poverty level. Though likely a small group, these legal immigrants could also establish standing to challenge the rule. (See checklist in Appendix A.)

The number of potential plaintiffs in each state is at least equal to the number of currently uninsured residents that the state can exempt from the individual mandate by refusing to establish an Exchange (see Table 1). Consistent with their share of the U.S. population, the 34 states that have so far declined to create an Exchange contain at least 8 million potential individual plaintiffs.

The federal Anti-Injunction Act generally bars legal challenges to a federal tax until that tax has been assessed.¹⁷⁶ It is possible that the AIA could impede an employer's ability to establish standing, though a plausible reading of the Supreme Court's holding in *NFIB v. Sebelius* suggests it would not.¹⁷⁷ At worst, the AIA could only delay an employer's ability to establish standing.

Individuals would not face the same obstacle. *NFIB* clearly holds that the AIA pres-

The 34 states that have so far declined to create an Exchange contain at least 8 million potential plaintiffs.

**State officials
can effectively
block the Obama
administration’s
illegal taxes, and
even prevent
the federal
government
from operating
Exchanges.**

ents no barrier to individuals who seek to establish standing to challenge the individual mandate. Since the injury that uninsured plaintiffs would suffer is the imposition of the individual mandate’s penalty tax, the AIA likewise would not impede uninsured individuals challenging the IRS rule. Finally, the AIA would present no barrier to individuals challenging the rule because it strips them of the affordability exemption and therefore denies them the opportunity to purchase a low-cost “catastrophic plan.”

If the Obama administration has any regard for the rule of law, it will rescind the IRS’s tax-credit rule. Until that happens, states should refuse to establish Exchanges if only to give themselves, their employers, and their residents standing to block the Obama administration’s illegal taxes in court.

A Legislative Strategy

State officials do not have to wait for the courts to act, however. States could also fight those illegal taxes with a strengthened Health Care Freedom Act—which could withstand an inevitable legal challenge claiming the PPACA preempts such a law.¹⁷⁸

Section 1301 of the PPACA provides Exchanges may only sell health insurance plans that are “offered by a health insurance issuer that is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title.”¹⁷⁹ The requirement applies equally to the federally chartered “multistate” plans the statute allows to participate in Exchanges nationwide.¹⁸⁰

States can therefore block the IRS’s illegal taxes, and effectively block federal Exchanges, by enacting a Health Care Freedom Act that partially suspends the license of any insurance carrier that accepts any remuneration that may result in an individual or an employer being penalized for failure to purchase health insurance. A strengthened Health Care Freedom Act would contain several provisions.

- First, it would declare that it is the public policy of the state that every person within the state is and shall be free to choose or decline any mode of securing health care services without penalty or threat of penalty.
- Second, it would provide that no public official, employee, or agent of the state or any of its political subdivisions, shall act to impose, collect, enforce, effectuate, or assist in the enforcement of, directly or indirectly, any penalty that violates this public policy.
- Third, it would find that Section 1412 of the Patient Protection and Affordable Care Act makes payments to insurance carriers that will result in penalties levied against many of the state’s employers and residents for failing to purchase health insurance, and in certain cases, those penalties would be levied against residents who refused to comply because purchasing the required health coverage would violate their religious beliefs.
- Fourth, it would find that federal law both reserves and grants to states certain powers over regulating health insurance, and does not require insurers to accept those penalty-triggering payments.
- Finally, it would provide that if any insurance carrier licensed by the state accepts any remuneration that has the effect, directly or indirectly, of triggering a penalty that violates the public policy stated in the Health Care Freedom Act, the state will partially suspend the insurer’s license immediately and until the insurer returns that remuneration to its source and represents that it will decline any such remuneration in the future. (See Appendix B for language that satisfies these criteria.)

With such a law, states could block the IRS from imposing illegal taxes on its employers and residents, and even prevent the federal government from operating an Exchange

within the state.

Carriers would know that the moment they accepted one of the IRS's illegal subsidies, state law would prohibit them from writing any new business in that state. Moreover, since they would no longer be licensed and in good standing with the state, they would no longer qualify under the PPACA as an issuer of "qualified health plans." The PPACA itself would then preclude them from writing new business or receiving subsidies through *any* Exchanges nationwide, for as long as the suspension remained in place. Without the (illegal) subsidies, consumers and carriers would have no reason to participate in a federal Exchange.

States could thus free their employers from the employer mandate even if the Obama administration attempts to impose its proposed illegal taxes. Employers face those tax penalties only if one of their employees enrolls in "a qualified health plan with respect to which an applicable premium tax credit . . . is allowed." Under a strengthened Health Care Freedom Act, employers could not be penalized because the health plan would cease to be a *qualified* health plan the moment the issuer accepted a penalty-triggering subsidy. As important, carriers simply will not offer those plans if it means they will be barred from writing new business in that state and through state and federal Exchanges nationwide.

Such a law would neither conflict nor interfere with federal law. On the contrary, it would work entirely within federal law.

A strengthened Health Care Freedom Act would merely create a situation similar to what happens when states refuse to certify plans to operate in Exchanges under the PPACA, or what senators envisioned under one of the PPACA's antecedent bills, or what existed after Congress created tax-free health savings accounts (HSAs). In each case, state laws would prevent private actors—whether insurance carriers, banks, or individuals—from obtaining a benefit created by federal law.¹⁸¹ In 2009 the Senate Health, Education, Labor, and Pensions (HELP) Commit-

tee approved a health care bill, many of whose features senators incorporated into the PPACA. The HELP bill would have conditioned subsidies to insurance carriers on whether states implemented that bill's employer mandate.¹⁸² When Congress created HSAs in 2003, many states had requirements in their health-insurance licensing statutes that prevented carriers from selling the type of health plan that consumers had to purchase in order to make tax-free contributions to their HSA. The PPACA itself grants states broad power to deny federal subsidies to any health plan the state determines is not "in the interests of qualified individuals and qualified employers."¹⁸³

The PPACA contains no express preemption of state powers to determine the conditions for licensure. Indeed, the requirement that issuers be "licensed and in good standing" is a nod to this traditional part of states' general police powers. Nor would a strengthened HCFA prevent the application of any part of the PPACA. Its effect would be to *apply* the provisions that the IRS rule ignores. Finally, the Supreme Court has held "the purpose of Congress is the ultimate touch-stone in every pre-emption case."¹⁸⁴ A strengthened HCFA *effectuates* Congress's purpose of allowing states that opt for federal Exchanges to avoid the PPACA's penalties on employers and many individual residents.

A strengthened Health Care Freedom Act would not interrupt anyone's coverage. Offending carriers could maintain, service, and renew existing business. States would merely prohibit carriers from writing any new business.

In all likelihood, states could stop the Obama administration's illegal taxes without ever having to suspend a single license.

State officials take an oath to defend the U.S. Constitution. A strengthened Health Care Freedom Act would enable them to fulfill their duty to protect the religious freedoms guaranteed by the First Amendment, and to prevent the president from usurping powers that the Constitution reserves to Congress.

States could thus free their employers from the employer mandate even if the Obama administration attempts to impose its proposed illegal taxes.

***NFIB v. Sebelius* frees states not to implement the Medicaid expansion. States should exercise that freedom.**

Reject the Medicaid Expansion . . .

Just as the PPACA gives states the power to block Exchanges and the associated taxes and deficit spending, the Supreme Court empowered states to block the Medicaid expansion.

As originally drafted, the PPACA's Medicaid expansion was mandatory. Congress made state implementation of the expansion a condition of federal Medicaid funds. Congress required states to expand their Medicaid rolls in numerous ways, resulting in a 50 percent increase in nonelderly enrollees.¹⁸⁵ The penalty for noncompliance was states would lose all federal Medicaid funds, which comprise 12 percent of state revenues.¹⁸⁶ Twenty-six states challenged that mandate as unconstitutional.

They won. A broad 7-2 majority of the Supreme Court found the Medicaid mandate to be unconstitutionally coercive. Chief Justice John Roberts described the Medicaid mandate as putting “a gun to the head” of states: “The threatened loss of over 10 percent of a State’s overall budget . . . is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”¹⁸⁷

Writing for the Court, Chief Justice Roberts ordered: “In light of the Court’s holding, the Secretary cannot . . . withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.”¹⁸⁸ *NFIB v. Sebelius* frees states not to implement the Medicaid expansion.

States should exercise that freedom. Even if states were facing deadlines and armed with all the regulatory guidance they need (neither of which is the case), states cannot afford to expand Medicaid. The expansion is not “free.” Rejecting it would reduce federal deficits and would reduce total government spending even more. Nor is Medicaid a form of economic development. Medicaid is rife with waste and fraud.¹⁸⁹ It increases the cost of private health care and insurance, crowds out private health insurance and long-term

care insurance, and discourages enrollees from climbing the economic ladder.¹⁹⁰ It offers inferior access to care. Finally, contrary to the claims of supporters, the Medicaid expansion is not necessary either to prevent discrimination against citizens, or to protect employers from the employer mandate.

Uncertainty

An important reason not to expand Medicaid is the considerable uncertainty surrounding the expansion. States cannot make an informed decision to implement the Medicaid expansion without regulatory guidance from HHS. Yet the *New York Times* reports that states lack basic information about how the expansion will work.¹⁹¹ The National Governors Association,¹⁹² the National Association of Medicaid Directors,¹⁹³ and the Republican Governors Association¹⁹⁴ have all submitted questions to HHS about how the Medicaid expansion would operate.

State officials are still waiting for answers to many of those questions. A recent survey of governors’ statements on the Medicaid expansion found, “three quarters of [uncommitted] governors said they needed more information on federal requirements, cost and enrollment projections, and policy alternatives.”¹⁹⁵

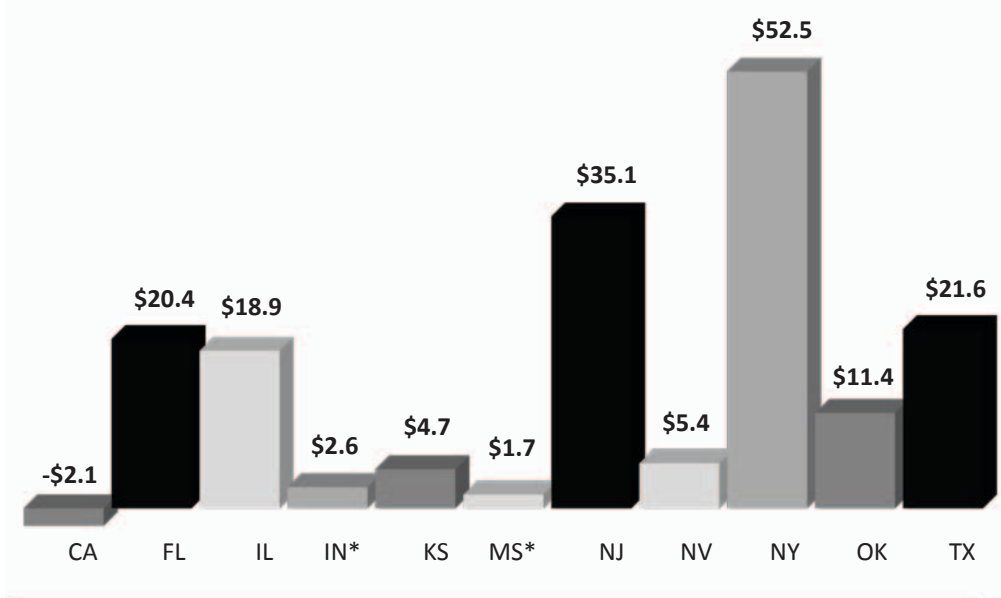
There’s No Rush

One thing that does seem certain is that states can take their time making a decision. Centers for Medicare and Medicaid Services administrator Marilyn Tavenner has written governors that “there is no deadline for a state to tell our department its plans on the Medicaid eligibility expansion.”¹⁹⁶

Medicaid Expansion Is Not Free

Even with regulatory certainty, states should find the cost of the expansion prohibitive. At no point will the federal government ever pick up 100 percent of the cost of the expansion. The federal government will fund 100 percent of *one* portion of the cost for *one* group of enrollees, and only for the next three years. Economist Jagadeesh Gokhale esti-

Figure 4
Ten-Year Cost of PPACA Medicaid Expansion in Select States (\$ billions)



* Only first seven years available (SFY 2014–2020).

Sources: Jagadeesh Gokhale, “The New Health Care Law’s Effect on State Medicaid Spending: A Study of the Five Most Populous States,” April 6, 2011, <http://www.cato.org/publications/white-paper/new-health-care-laws-effect-state-medicaid-spending-study-five-most-populous-states>; Jagadeesh Gokhale and Angela C. Erickson, “The Effect of Federal Health Care ‘Reform’ on Kansas General Fund Medicaid Expenditures,” Kansas Policy Institute, June 2011, <http://www.cato.org/articles/effect-federal-health-care-reform-kansas-general-fund-medicaid-expenditures>; Jagadeesh Gokhale, Angela C. Erickson, and Jason Sutton, “Projecting Oklahoma’s Medicaid Expenditure Growth under the PPACA,” Oklahoma Council of Public Affairs, May 18, 2011, <http://www.cato.org/articles/projecting-oklahomas-medicaid-expenditure-growth-under-ppaca>; Jagadeesh Gokhale, Angela C. Erickson, and Geoffrey Lawrence, “The Impact of ObamaCare on Nevada’s Medicaid Spending,” Nevada Policy Research Institute Analysis, May 5, 2011, <http://www.cato.org/articles/impact-obamacare-nevadas-medicaid-spending>; Jagadeesh Gokhale, “New Jersey’s Medicaid Spending Escalation Under the PPACA” (Presentation, Common Sense Institute, New Jersey, December 20, 2011); Michael Gargano, “Affordable Care Act (ACA)—Medicaid Financial Impact Analysis (Indiana),” September 18, 2012; John D. Meerschaert, “Financial Impact of the Patient Protection and Affordable Care Act, As Amended by H.R. 4782, The Reconciliation Act of 2010, On the Mississippi Medicaid Budget,” October 1, 2010.

mates the state share of the expansion would cost Florida, Illinois, and Texas roughly \$20 billion each in the first 10 years. The numbers for New Jersey and New York are \$35 billion and \$53 billion, respectively (see Figure 4).¹⁹⁷

Gokhale projects California, at least initially, would save money by implementing the Medicaid expansion. Yet President Obama has advocated shifting more of the cost of Medicaid to the states, including the cost of this expansion.¹⁹⁸ The Medicaid expansion is therefore an example of “predatory federalism,” where Washington uses a low introductory rate to encourage states to adopt a program, and then changes the

terms once states have taken the bait. In the end, even California will likely pay more.

This is money states don’t have. The National Conference of State Legislators reported that in 2012, states faced combined budget deficits of \$32 billion.¹⁹⁹

Lower Federal Deficits

Nor can the federal government, with its near-trillion-dollar deficits adding to a \$12 trillion national debt, afford the potential \$1 trillion the CBO projects the Medicaid expansion would cost the federal government if all states implemented it. State officials can reduce federal deficits by hundreds

The Medicaid expansion would cost Florida, Illinois, and Texas roughly \$20 billion each.

States that expand Medicaid are making another large contribution to organized criminals and other fraudsters.

of billions of dollars simply by not implementing the Medicaid expansion. According to CBO projections, as of July 2012 the states that had refused to expand Medicaid had saved federal taxpayers \$84 billion.²⁰⁰

Supporters argue that not implementing the expansion is unfair to a state's taxpayers, who would be forced to pay for the expansion in other states but would not enjoy any of the benefit. If Congress were financing the expansion with current tax revenues, that might be true. Since Congress is financing it with debt, however, supporters have it exactly backward: current taxpayers aren't paying for the expansion at all. The burden will instead fall on future generations. Thus it is *implementing* the expansion that would be unfair: it would force future generations to pay for benefits that would go exclusively to current generations.

Drawing Patients into Low-Quality Coverage

Expanding Medicaid will draw people out of private insurance into Medicaid, where access to care is inferior. A recent study projected "high rates of crowd-out for Medicaid expansions aimed at working adults (82%), suggesting that the Medicaid expansion provisions of PPACA will shift workers and their families from private to public insurance without reducing the number of uninsured very much."²⁰¹

Those new enrollees could have a much harder time obtaining medical care. Nationwide, nearly one-third of physicians refuse to accept new Medicaid patients.²⁰²

Medicaid's barriers to care can be fatal. In 2007, 12-year-old Deamonte Driver was suffering from a toothache, caused by an abscess. His mother struggled in vain to find a dentist who would accept the family's Medicaid coverage. According to the *Washington Post*, "By the time Deamonte's own aching tooth got any attention, the bacteria from the abscess had spread to his brain . . . After two operations and more than six weeks of hospital care, the Prince George's County [Maryland] boy died." "A routine, \$80 tooth

extraction might have saved him," the *Post* reported. "If Medicaid dentists weren't so hard to find."²⁰³

Finally, there is scant reliable evidence that Medicaid improves health outcomes at all, no reliable evidence that it reduces mortality, and absolutely no evidence that it is a cost-effective way of improving health.²⁰⁴

Not Economic Stimulus

Supporters claim that expanding Medicaid can improve a state's economy. In the *New England Journal of Medicine*, Harvard University economists Katherine Baicker and Amitabh Chandra explain why this is a fallacy:

[The] focus on health care jobs is misguided. . . . It is tempting to think that rising health care employment is a boon, but if the same outcomes can be achieved with lower employment and fewer resources, that leaves extra money to devote to other important public and private priorities such as education, infrastructure, food, shelter, and retirement savings. . . .

There is . . . mounting evidence that our health care system could deliver better care without spending more . . . which suggests that the increase in resources devoted to health care has not generated commensurate value. . . .

The bottom line is that employment in the health care sector should be neither a policy goal nor a metric of success. . . . Treating the health care system like a (wildly inefficient) jobs program conflicts directly with the goal of ensuring that all Americans have access to care at an affordable price.²⁰⁵

Rejecting the Medicaid expansion, on the other hand, restrains state taxes and spending, reduces federal taxes and spending, and reduces federal deficits.

Rife with Fraud

The amount of fraud in Medicaid is stunning even by government standards.²⁰⁶ In one example discovered by journalists rather than government auditors, a kinetic Brooklyn dentist billed taxpayers for nearly 1,000 procedures in a single day.²⁰⁷ The Government Accountability Office has for a decade deemed Medicaid to be at a “high-risk” for fraud.²⁰⁸ Official estimates suggest Medicaid loses tens of billions of dollars to fraud annually—but experts deride those estimates as “comfortingly low and quite misleading.”²⁰⁹

States that expand Medicaid are making another large contribution to organized criminals and other fraudsters.

The Discrimination and Employer-Protection Myths

Supporters erroneously claim that states must expand Medicaid to prevent discrimination against U.S. citizens and to protect employers of low-wage workers from punitive taxes. In fact, refusing to create an Exchange achieves both of those goals. Expanding Medicaid achieves neither.

In an odd quirk, the PPACA offers Exchange subsidies to certain legal immigrants below the poverty line, but offers Medicaid coverage to otherwise identical U.S. citizens. If a state implements an Exchange but does not implement the Medicaid expansion, then those legal immigrants could receive thousands of dollars in subsidies while their citizen counterparts receive nothing. Supporters argue states must implement the Medicaid expansion to avoid this inequity.²¹⁰ What causes that inequity, however, are the Exchange subsidies—not the decision to reject the Medicaid expansion. States can therefore block that inequity by refusing to establish an Exchange, which blocks the Exchange subsidies, and by fighting the Obama administration’s attempt to reintroduce those discriminatory subsidies into their states. Moreover, expanding Medicaid does not eliminate the inequity. Those legal immigrants would receive subsidies to purchase private health insurance, which offers

better access to care than the Medicaid coverage that citizens would receive.

Another quirk of the Act is that the employer mandate reduces or eliminates penalties for businesses if their workers are eligible for Medicaid. This feature has led some employers of low-wage workers to push their states to implement the Medicaid expansion, in the hope that this will reduce their exposure to those punitive taxes.²¹¹ Again, Medicaid expansion is the wrong solution to this valid concern. Refusing to establish an Exchange exempts *all* employers from the employer mandate, not just those with low-wage workers.

In both cases—whether state officials want to prevent discrimination against citizens, or to protect employers from the employer mandate’s punitive taxes—the solution is to refuse to establish an Exchange, and to fight the Obama administration’s efforts to reintroduce these harmful provisions that Congress empowered states to block.

... The Entire Medicaid Expansion

Despite the Supreme Court’s ruling in *NFIB*, the Obama administration is coercing states into implementing now-optional portions of the Medicaid expansion. States should feel free not to implement any of the PPACA’s previously mandatory Medicaid provisions.

The Court’s *NFIB* ruling rendered optional all of the Act’s mandatory Medicaid provisions. The Court adopted a two-part test to determine when the conditions Congress places on existing federal grants to states become coercive, and thus unconstitutional.²¹² It held that “the Medicaid expansion” satisfied both elements, and ruled, “In light of the Court’s holding, the Secretary cannot . . . withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.”²¹³

Crucially, the Court did not confine its ruling to individual provisions of “the Med-

Despite the Supreme Court’s ruling in *NFIB*, the Obama administration is coercing states into implementing now-optional portions of the Medicaid expansion.

The Obama administration is quite literally coercing states into implementing elements of the Medicaid expansion that the Court rendered optional.

icaid expansion” that satisfied each element of its test. It rendered the entire expansion optional. The Court did not explicitly delineate the boundaries of “the Medicaid expansion.” However, the Court explicitly noted that “the expansion” encompasses more than the single provision the Obama administration claims, and spoke of its remedy as applying to all of the new law’s Medicaid requirements.

At a minimum, *NFIB* renders specific Medicaid provisions optional if they are either part of “the Medicaid expansion” or otherwise satisfy *NFIB*’s two-part test. Such provisions include at least two other new mandatory populations (children up to 138 percent FPL and adults who are former foster children); the new “modified adjusted gross income” standard; the requirements that state Medicaid programs make eligibility determinations for Exchanges; the “maintenance of effort” requirements; and the marketing, education, and outreach requirements.

In a July 2012 letter to the nation’s governors, however, Secretary Sebelius arbitrarily attempted to limit the ruling’s impact to just one element of the law’s Medicaid expansion:

[B]eginning in 2014, the Affordable Care Act provides for the expansion of Medicaid eligibility to those adults under the age of 65 with incomes up to [138] percent of the federal poverty level who were not previously eligible for Medicaid. The Supreme Court held that, if a state chooses not to participate in *this* expansion of Medicaid eligibility for low-income adults, the state may not, as a consequence, lose federal funding for its existing Medicaid program. The Court’s decision did not affect other provisions of the law.²¹⁴

Those are Sebelius’ words, not the Court’s. Nonetheless, state officials heard the implied threat loud and clear: *Implement all other provisions expanding Medicaid, or you will lose 12 percent of your state’s revenues.*

A careful reading of *NFIB* shows the Court did not define “the expansion” as, or otherwise limit its remedy to, only those provisions pertaining to newly eligible adults. The Obama administration is quite literally coercing states into implementing elements of the Medicaid expansion that the Court rendered optional.

The Court’s *NFIB* Ruling

The Court adopted a two-part test for determining whether the conditions Congress places on an existing grant are coercive:

We have upheld Congress’s authority to condition the receipt of funds on the States’ complying with restrictions on the use of those funds . . . Conditions that do not here govern the use of the funds, however, cannot be justified on that basis. When, for example, such conditions take the form of threats to terminate other *significant independent* grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.²¹⁵

The first criterion is whether Congress places the condition on a “significant” federal grant. The second is whether the threatened grant is “independent” of the condition—that is, whether Congress conditions existing or “old” federal grants on states’ willingness to implement a new, independent program.

The Court found the threat of revoking all Medicaid funds unless a state implemented the Medicaid expansion satisfied the first prong. The Court measured “significance” in terms of the threatened grant’s impact on state budgets. It found that Congress put “a gun to the head” of states by threatening to revoke more than 10 percent of the average state’s annual revenues. The Court did not specify at what percentage of a state’s revenues encouragement becomes coercion, but wrote, “wherever that line may be, this statute is surely beyond it.”²¹⁶

The Court also found “the Medicaid expansion” satisfied the second prong:

Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with income below [138] percent of the poverty level. It 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.²¹⁷

A 7-2 majority of the Court therefore held: “Congress is not free . . . to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.”²¹⁸

The Court ruled that Sebelius may continue to withhold pre-PPACA Medicaid grants from states that fail to comply with conditions imposed by “the existing Medicaid program,” and she also remains at liberty “to withdraw funds provided under the Affordable Care Act if a State that has chosen to participate in the expansion fails to comply with the requirements of that Act.”²¹⁹ But the Court forbade Sebelius to withdraw old funds if a state fails to comply with the new requirements contained in the expansion.²²⁰

Scope of Ruling

The Court made no effort to limit “the Medicaid expansion” or its remedy to the newly eligible adults, as Sebelius suggests. In fact, the Court repeatedly affirmed that the expansion encompasses more than those provisions:

The Affordable Care Act expands the scope of the Medicaid program and increases the number of individuals the States must cover. For example, the Act requires state programs to provide Medicaid coverage to adults with incomes up to [138] percent of the federal poverty level . . .²²¹

Offering the mandatory income-eligibility threshold as an “example” of how the Act expands Medicaid indicates that “the expansion” encompasses additional Medicaid provisions. The Court’s ruling applies to them all. When the court wrote that the expansion transforms Medicaid “into a program to meet the health care needs of the *entire* non-elderly population with income below [138] percent of the poverty level,” it again affirmed that the expansion encompasses more than just newly eligible adults. Sebelius’s interpretation directly contradicts the Court’s ruling.

In the PPACA, Congress conditioned all the “old” Medicaid dollars not only on states opening their programs to the newly eligible adult population, but also on numerous other provisions that expand enrollment. The Act mandates a new method of measuring household income that expands enrollment by eliminating asset tests for certain categories of enrollees.²²² It mandates what was previously optional eligibility for former foster children up to the age of 26.²²³ It creates requirements whose express purpose is to expand enrollment in both Medicaid and the State Children’s Health Insurance Program (SCHIP). For instance, it requires states to “establish procedures for . . . enrolling” in Medicaid and SCHIP, individuals whom Exchanges identify as being eligible for those programs “without any further determination by the state.”²²⁴ It further mandates that each state’s Medicaid and SCHIP programs make enrollment determinations for a new and separate program—that is, an Exchange.²²⁵

Each of these provisions expands Medicaid independent of the newly eligible adult population, and each threatens states with the loss of all federal Medicaid funding if they fail to comply.²²⁶ Each is thus part of “the Medicaid expansion.” By attempting to write such provisions out of “the Medicaid expansion,” Sebelius is threatening to withhold from states more than 10 percent of their revenues—which the Court held to be coercion—unless states implement provisions of the law that the Court made optional.

Sebelius is threatening to withhold from states more than 10 percent of their revenues—which the Court held to be coercion—unless states implement provisions of the law that the Court made optional.

HHS is trying to coerce states into implementing what it acknowledges is part of a comprehensive national plan for universal health insurance coverage, even though *NFIB* expressly forbids it from doing so.

Some of these provisions, along with two “maintenance of effort” requirements on which Congress also conditioned all federal Medicaid grants, independently satisfy *NFIB*’s two-part coercion test.

Children up to 138 Percent FPL. Prior to the PPACA, the federal government required states to provide Medicaid coverage to children ages 6 to 18 up to 100 percent FPL.²²⁷ The Act makes coverage for such children mandatory up to 138 percent FPL.²²⁸ It finances that expansion under the “old” Medicaid matching formula, where states bear on average 43 percent of the cost.

This is another instance where Sebelius’s interpretation of *NFIB* directly contradicts the Court’s opinion. It would be difficult for “the Medicaid expansion” to cover “the entire nonelderly population with income below [138] percent of the poverty level”²²⁹ if, as Sebelius maintains, the Court did not consider the expansion to include children below 138 percent FPL.

There are 18 states whose Medicaid and SCHIP programs do not cover all children below 138 percent of poverty: Alabama, Arizona, California, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming.²³⁰ To use the Supreme Court’s language, Sebelius is putting a gun to the head of those states, coercing them into adopting this provision of the law.

Former Foster Children. Under the existing Medicaid program, states had the option of covering adults who were formerly foster children. The Act makes such coverage mandatory up to the age of 26.²³¹ This mandate is also part of the expansion.

MAGI. The Act mandates that states adopt a nationally uniform method of measuring income—“modified adjusted gross income,” or MAGI, as defined in the Internal Revenue Code—for determining eligibility for Medicaid and SCHIP. By design, this is the same method that the new health insurance Exchanges will use to determine eligibility for tax credits and subsidies. The

Act threatens states that fail to implement the MAGI income metric with the loss of all federal Medicaid funds.²³²

The MAGI standard is part of the broader Medicaid expansion. It opens Medicaid to many who would otherwise not be eligible, such as by eliminating asset tests. It applies to the “new adult group” but not to some traditional Medicaid-eligible groups (e.g., the blind, the disabled, those needing long-term care services, the elderly, the medically needy, and those receiving Supplemental Security Income).²³³ The primary purpose of the MAGI standard is to transform Medicaid into a more nationally uniform program and to integrate Medicaid into a new program—the Exchanges. The Obama administration even acknowledges that the MAGI standard is what the Court termed “an element of a comprehensive national plan to provide universal health insurance coverage.”²³⁴ The administration writes, the “overarching goal” of this nationally uniform definition of income is “[t]o create a seamless, coordinated system” with “a single streamlined application for all insurance affordability programs,” including Medicaid, the State Children’s Health Insurance Program, and the Exchanges.²³⁵ The Act conditions all Medicaid funding on states helping the federal government implement this element of what the Court called a “comprehensive national plan.” Under *NFIB*, HHS therefore has no authority to withhold all Medicaid grants from states that refuse to implement the MAGI standard.

Eligibility Determinations. If an Exchange identifies applicants as eligible for Medicaid, and the state fails to “establish procedures for . . . enrolling” them in Medicaid “without any further determination by the state,” then under the Act, the state loses all federal Medicaid funds.²³⁶ The same applies in reverse. If a state’s Medicaid program fails to establish procedures for screening applicants for eligibility for tax credits and subsidies through an Exchange, then the Act revokes all federal Medicaid funds to the state.²³⁷

The first mandate expands Medicaid by enrolling residents who would not other-

wise have applied. It is therefore part of “the Medicaid expansion.” The second mandate conditions all federal Medicaid funds on states making eligibility determinations for a new program—the Exchanges. It likewise puts a 12-percent-of-revenues “gun to the head” of states unless they “participate in [a] new program.” Yet HHS brazenly tells states:

State Medicaid and CHIP programs will need to coordinate with the Federally-facilitated Exchange, regardless of a state’s decision to proceed with expansion. States will need to be part of the seamless system for people to apply for all coverage programs; and will need to coordinate eligibility with the new insurance affordability programs.²³⁸

HHS is trying to coerce states into implementing what it acknowledges is part of a comprehensive national plan for universal health insurance coverage, even though *NFIB* expressly forbids it from doing so.

“*Maintenance of Effort.*” Prior to the PPACA, states had the option of modifying Medicaid eligibility criteria and the methods and procedures they used for determining eligibility. The Court found, for example, “States . . . enjoy[ed] considerable flexibility with respect to the coverage levels for parents of needy families.”²³⁹ This included the freedom to use these tools to reduce enrollment, which states would sometimes do when facing budget constraints.

The Act deprives states of that flexibility. It mandates that each state keep its “eligibility standards, methodologies, and procedures” exactly as they were when the Act became law on March 23, 2010.²⁴⁰ With respect to Medicaid eligibility for adults, this “maintenance of effort” mandate lifts only when states create their own health insurance Exchange. Even if a state establishes an Exchange, the maintenance-of-effort mandate remains in place with respect to Medicaid and SCHIP eligibility for children until October 1, 2019.²⁴¹ States that fail to com-

ply lose all federal Medicaid dollars.

HHS’s position is that these maintenance-of-effort mandates are not part of the Medicaid expansion. Yet the “adult” maintenance-of-effort mandates form an integral part of the Medicaid expansion. The purpose of this mandate is to contain the cost of the expansion to the federal government by preventing states from dropping their eligibility levels in order to have the federal government cover, under the expansion, a larger share of the cost of those existing enrollees. It is therefore rendered optional by *NFIB* by virtue of being part of “the Medicaid expansion.” At the same time, the maintenance-of-effort mandate for adults is a clear attempt to put the same “gun to the head” of states to force them to establish a new program: a health insurance Exchange. It is yet another effort “to penalize States that choose not to participate in [a] new program by taking away their existing Medicaid funding”—which “Congress is not free to do.”²⁴²

Scienter. Finally, both the majority opinion and Justice Ruth Bader Ginsburg’s dissent show that when discussing the remedy, the Court understood “the Medicaid expansion” to be all mandatory Medicaid provisions in the Act. The justices repeatedly draw clear distinctions between the existing Medicaid program and the expansion, with nothing in between.

The Court described the federal government’s projected Medicaid expenditures “[w]ithout the Affordable Care Act” as “the costs of pre-expansion Medicaid”—thus implicitly defining the “expansion” as *everything* that drives projected Medicaid spending above the pre-PPACA level.²⁴³ If the Court considered the expansion to consist of only the mandatory income-eligibility threshold, then “the costs of pre-expansion Medicaid” would have included the cost of other mandatory provisions of the Act.

When explaining its remedy, the Court drew a clear line between its application to “the existing Medicaid program” and the provisions of the PPACA:

The Court understood “the Medicaid expansion” to be all mandatory Medicaid provisions in the Act.

It is no exaggeration to say that by refusing to implement Exchanges and the Medicaid expansion, states can force Congress to reopen the PPACA.

Today's holding does not affect the continued application of §1396c to *the existing Medicaid program*. Nor does it affect the Secretary's ability to withdraw funds provided under the Affordable Care Act if a State that has chosen to participate in the expansion fails to comply with *the requirements of that Act*.²⁴⁴

Justice Ruth Bader Ginsburg, who joined the majority on the remedy, also suggested the remedy made all mandatory Medicaid provisions optional. Ginsburg wrote that the remedy "prohibits only the application of the secretary's authority to withhold Medicaid funds from States that decline to conform their Medicaid plans to *the ACA's requirements*."²⁴⁵

HHS's Fig Leaf. Sebelius' misinterpretation of *NFIB* rests on the fiction that the Court applied its remedy only to the more generous federal funding stream the Act provides for newly eligible adults. Yet the Court cites that new funding stream only to show that the expansion seeks to "transfor[m]" Medicaid from "a program to care for the neediest among us" into "an element of a comprehensive national plan to provide universal health insurance coverage." At no point does the Court use that funding stream to define the parameters of "the Medicaid expansion" or otherwise limit the scope of its remedy.

All of the above-discussed provisions put the same "gun to the head" of states as the mandatory income-eligibility threshold. All of them are part of "the Medicaid expansion," and many satisfy the Court's two-part coercion test on their own. In the wake of *NFIB*, all previously mandatory Medicaid provisions of the PPACA are now optional.

Maine's Legal Challenge

The Obama administration's overreach has come to a head in Maine. Facing a budget deficit last year, Maine officials eliminated Medicaid eligibility for parents and caretaker relatives with incomes above the

poverty level. When HHS refused to approve the cuts on the grounds they violate the "maintenance of effort" mandate,²⁴⁶ Maine's then-attorney general Bill Schneider (R) took HHS to court.²⁴⁷

After some bureaucratic wrangling that postponed the issue until after the election, on January 7, 2013, HHS gave Maine its final answer.²⁴⁸ The agency will do what the Supreme Court forbade it to do: withhold from Maine all federal Medicaid funds unless the state rescinds the cuts. It now falls to Maine governor Paul LePage (R)—and other states struggling to balance their budgets—to ask the courts to heed the Supreme Court's ruling.

It is worth reemphasizing that seven members of the Court found the Medicaid mandate unconstitutional. A challenge to Sebelius' attempt to coerce states into implementing these other portions of the Act would only need five to prevail.

"A Fatal Blow"? States Can Force Congress's Hand

It is no exaggeration to say that by refusing to implement Exchanges and the Medicaid expansion, states can force Congress to reopen the PPACA. The law requires state cooperation. *Kaiser Health News* describes Oklahoma's lawsuit as "[b]y far the broadest and potentially most damaging of the legal challenges" related to the law.²⁴⁹ Health policy journalist Sam Baker describes the states' ability to reject the Medicaid expansion as a "real weapon" that opponents can deploy against it.²⁵⁰ Timothy Jost writes that the Act's "entire structure" depends on the availability of tax credits in all states.²⁵¹ The trade publication *Business Insurance* cites industry experts:

If premium subsidies are not available in federally established exchanges, "No one would go to those exchanges. The whole structure created by the health care reform law starts to

fall apart,” said Gretchen Young, senior vice president–health policy at the ERISA Industry Committee in Washington.

“The health care reform law would become a meaningless law,” added Chantel Sheaks, a principal with Buck Consultants L.L.C. in Washington.²⁵²

Conservative health economist John Goodman writes that if states refuse to create Exchanges, it “could be a fatal blow to ObamaCare.”²⁵³ University of Missouri law professor Peter Lambert writes, “In addition to being too small, the subsidies for purchasing insurance may not be available in many states,” and thus “the out-of-pocket cost of insurance . . . would be tremendous.” Lambert concludes, “Given the act’s continued unpopularity, repeal is a genuine possibility.”²⁵⁴

Why would the PPACA’s authors give states the ability to deal the law a fatal blow? One reason is that they overestimated the appeal of their handiwork. PPACA supporters repeatedly and erroneously predicted that the more people learned about this law, the more they would like it.²⁵⁵ In the same way, they misjudged whether states would embrace it. They believed, as Secretary Sebelius testified to Congress, that states were “very eager” to create Exchanges.²⁵⁶ They thought they would be greeted as liberators, as it were. It never occurred to them that states would not cooperate.

Another reason is that they misjudged the limits of their own power. They believed they could impose any conditions they pleased on federal Medicaid funds, which the Supreme Court would dutifully uphold. Instead, seven Supreme Court justices—including two Democratic appointees—issued the PPACA’s authors a stern rebuke by declaring the Medicaid mandate unconstitutionally coercive.

But the most important reason is that its authors had no choice. The PPACA passed the Senate without a vote to spare.²⁵⁷ It would not have cleared the Senate at all without its emphasis on state-funded Ex-

changes, and making tax credits conditional on state compliance was the only way the Finance Committee—where the bill originated, but which does not have jurisdiction over health insurance—could even consider legislation directing states to establish Exchanges.²⁵⁸

Real Health Care Reforms

Americans’ access to health care is less secure than it should be precisely because of government interventions like the PPACA. Blocking and repealing this Act are therefore positive steps that will make health care more secure. For example, the CBO reports that repealing the Act would reduce premiums for many consumers by freeing them to purchase more affordable health plans.²⁵⁹ But state and federal officials should not stop there.

How States Can Improve Health Care

Good Samaritan Laws. Volunteer groups like Remote Area Medical engage doctors and other clinicians from around the country to treat indigent patients in rural and inner-city areas. States often prevent these clinicians from providing free medical care to the poor because, while they are licensed to practice medicine in their own states, they are not licensed to practice medicine where Remote Area Medical is holding its clinics.

Remote Area Medical has had to turn away patients or scrap clinics in California, Florida, and Georgia. “Before Georgia told us to stop,” says founder Stan Brock, “we used to go down to southern Georgia and work with the Lions Club there treating patients.” After a tornado devastated Joplin, Missouri, Remote Area Medical arrived with a mobile eyeglass lab, yet state officials prohibited the visiting optometrists from giving away free glasses.²⁶⁰

These stories belie the claim that government licensing of medical practitioners protects patients.²⁶¹ Instead, it blocks access to care for the most vulnerable patients.

Americans’ access to health care is less secure than it should be precisely because of government interventions like the PPACA.

Once Congress repeals the PPACA, it should let patients control the money that purchases their health insurance and medical care, then deregulate both.

States should adopt “Good Samaritan” laws, like those enacted in Tennessee, Illinois, and Connecticut.²⁶² Those states allow out-of-state-licensed clinicians to deliver free charitable care without obtaining a new license. To protect patients, visiting clinicians are and should be subject to the malpractice laws of the state in which they are practicing.

Find out Whether Medicaid Works. Most non-health care experts are surprised to learn how little reliable evidence there is that Medicaid has a positive impact on health, and how there is absolutely no evidence it is a cost-effective way to improve health.²⁶³

Rather than expand their Medicaid programs, states should apply for waivers to conduct experiments like the Oregon Health Insurance Experiment (OHIE).²⁶⁴ The OHIE randomly assigned patients to receive Medicaid or not, with the goal of producing reliable data to measure the impact of Medicaid on existing populations. Unfortunately, Oregon officials arbitrarily halted the experiment.

Other states should apply for waivers from the federal government to conduct similar studies with existing populations. There likely will be objections to randomly assigning slots to existing populations. This objection has it backward. Expanding Medicaid without knowing whether it helps would be unethical.

Let Patients Choose Their Med-Mal Reforms. The cost of medical malpractice liability insurance increases the price of health care services, pricing many low-income patients out of the market. Tort reformers have offered various medical malpractice liability reforms. But all of these reforms have costs and benefits. A given reform might reduce the price of medical services, but at the expense of preventing some injured patients from recovering the full cost of their injuries.²⁶⁵ When these complicated tradeoffs exist, the best approach is to let patients choose the tradeoff that works best for them.

State officials should allow patients and providers to adopt their own “med-mal” reforms via contract.²⁶⁶ Patients who want

caps on noneconomic damages, mandatory binding arbitration, medical courts, or a “loser pays” rule could have those measures, and any concomitant reduction in their medical bills. Patients who prefer to have an unlimited right to sue could write that into contracts with their medical providers, and pay whatever markup comes with that added protection.

The obstacle to such contracts is that judges have opted not to enforce them. That unfortunate trend denies access to care for low-income patients by denying them the choice of deciding whether accessing medical care now is more important than having an unlimited right to sue in the unlikely event they suffer an injury due to a provider’s negligence. In states that have already enacted caps on noneconomic damages or other med-mal reforms, freedom of contract would allow patients to obtain *greater* protections than those laws allow. State legislatures should direct courts to enforce such contracts.

There are other reforms that states should enact, such as allowing their residents to purchase insurance licensed by other states, which unfortunately will have zero impact so long as the PPACA remains on the books.

What Congress Should Do after Repealing the PPACA

As noted above, real health care reform is not possible so long as the PPACA remains law. Once Congress repeals that Act, it should take two basic steps to improve health care.²⁶⁷

First, it should let patients control the money that purchases their health insurance and medical care. That means reforming Medicare to look more like Social Security, where the federal government subsidizes seniors with cash and trusts them to spend the money wisely. A Social Security–like version of Medicare would give large “Medicare checks” to lower-income and sicker seniors, so they could afford a basic package of benefits and smaller checks to healthier and wealthier seniors. Congress should

also reform the tax treatment of employer-sponsored health benefits so that workers control the \$10,000 of their earnings that employers use to choose and purchase the workers' health insurance. When consumers control those dollars, they will reduce waste and fraud, demand cost-saving efficiencies that bring health care within the reach of vulnerable patients, and make health insurance and access to care more secure.²⁶⁸ While Medicare reform could improve health care even with the PPACA on the books, tax reform would not.

Second, Congress should deregulate health insurance and medical care so that innovators and entrepreneurs can develop quality-improving and cost-reducing innovations. Simply converting Medicare to a Social Security-like program would go a long way toward eliminating stifling regulations. Congress could also use its powers under the Constitution's commerce clause to free residents of each state to purchase health insurance licensed by any of the other 49 states. Unfortunately, this is another reform that would be meaningless so long as the PPACA survives.

Conclusion

The PPACA currently denies states the freedom to tailor health care reforms to their needs. States can regain that freedom by blocking major provisions of that law

and forcing Congress to reopen it.

Congress granted states the power to block the PPACA's employer mandate, individual mandate, and deficit spending by refusing to create Exchanges. *NFIB v. Sebelius* freed states to decline not just part of the Medicaid expansion, as the Obama administration claims, but all of it. State officials who wish to make health care better and more affordable, to expand job creation, and to limit state and federal taxes should politely decline to implement either provision. Approval of a strengthened Health Care Freedom Act can prevent even the federal government from operating PPACA Exchanges.

Blocking these provisions will not increase the cost of the PPACA. Rather, it will expose the law's costs, by preventing the federal government from shifting those costs to taxpayers. The resulting backlash will push Congress to reconsider the law—and could lead many to switch their votes and support repeal, just as two House Democrats did during the latest repeal vote.²⁶⁹

A critical mass of states could force Congress to repeal the law. To some, it is unimaginable that Congress and President Obama would do so—just as it was once unimaginable that 34 states would refuse to establish Exchanges, or that 16 states would refuse to expand Medicaid, or that congressional Republicans and President Obama would join together to repeal the CLASS Act. The PPACA is weaker, and the path to repeal is clearer, than it has ever been.

State officials who wish to make health care better and more affordable, to expand job creation, and to limit state and federal taxes should politely decline to implement either provision.

Appendix A: Individuals Injured by the IRS's Tax-Credit Rule

The Internal Revenue Service (IRS) has issued a final rule implementing the Patient Protection and Affordable Care Act's (PPACA's) premium-assistance tax credits.²⁷⁰ Contrary to the statute and congressional intent, the rule offers credits in states that opt not to establish an Exchange.²⁷¹ Due to an interaction between the credits and the individual mandate's "affordability exemption," the IRS rule will injure three types of individuals.

The affordability exemption shields certain taxpayers from penalties under the individual mandate and entitles them to purchase low-cost "catastrophic plans." Taxpayers qualify for the affordability exemption if the "required contribution" to their health insurance premiums exceeds roughly 8 percent of household income.²⁷² The required contribution equals the least-expensive health plan available to the taxpayer through an Exchange, *minus* the amount of any premium-assistance tax credit for which she is eligible.²⁷³

Mere eligibility for a tax credit therefore strips the affordability exemption away from many taxpayers by reducing the required contribution from above 8 percent of household income to below that threshold. The availability of tax credits therefore subjects those taxpayers to penalties and/or denies them the ability to purchase a catastrophic plan, even if they do not claim the credit.

The PPACA plainly restricts these credits to Exchanges "established by the State under section 1311." Yet the IRS rule attempts to issue tax credits in the 34 states that have opted not to establish an Exchange. As a result, the rule will strip the affordability exemption from at least 8 million individuals. Such individuals could establish standing to challenge the IRS's tax-credit rule.

There are three types of individuals injured by the IRS rule, and therefore three categories of potential plaintiffs.

- **"Uninsured" plaintiffs** do not want to purchase health insurance and qualify for the affordability exemption under the terms of the statute. The IRS rule strips them of that exemption, resulting in penalties plainly not authorized by Congress.
- **"Catastrophic plan" plaintiffs** qualify for the affordability exemption and desire to purchase a low-cost, catastrophic health plan. The rule strips them of the exemption and denies them the ability to purchase a type of health plan to which Congress entitled them.
- **"Poor immigrant" plaintiffs** are uninsured, single-adult, legal aliens with incomes below the poverty level but above the income-tax filing threshold (\$9,500–\$11,702 in 2011). The rule strips them of the exemption, resulting in unauthorized penalties.

Such individuals could likely establish standing to block the IRS rule. Table A-1 shows which criteria each type of potential plaintiff must meet.

Table A.1
Criteria for Plaintiffs Seeking to Challenge the Obama Administration’s Illegal Taxes

| Criteria | Type of Individual Plaintiff | | |
|---|------------------------------|---------------------|------------------|
| | “Uninsured” | “Catastrophic Plan” | “Poor Immigrant” |
| 1. Lawful U.S. resident. ^a | ✓ | ✓ | ✓ |
| 2. Resident of AL, AK, AZ, AR, DE, FL, GA, ID, IL, IN, IA, KS, LA, ME, MI, MS, MO, MT, NE, NH, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, UT, VA, WV, WI, or WY. ^b | ✓ | ✓ | ✓ |
| 3. Not eligible for Medicaid or other government program. ^c | ✓ | ✓ | ✓ |
| 4. No offer of “affordable”/“minimum value” health benefits from an employer. ^d | ✓ | ✓ | ✓ |
| 5. Not incarcerated, eligible for the religious conscience exemption, member of a health sharing ministry, member of an Indian tribe, or receiving a hardship exemption. ^e | ✓ | ✓ | ✓ |
| 6. Household income above the income-tax filing threshold in 2014. ^f | ✓ | ✓ | ✓ |
| 7. Nonsmoker. ^g | ✓ | ✓ | ✓ |
| 8. Household income between 100% and 400% FPL in 2014. ^h | ✓ | ✓ | |
| 9. Plan to be uninsured throughout 2014. ⁱ | ✓ | | ✓ |
| 10. Age 30+ and plan to purchase a low-cost “catastrophic plan” in 2014. ^j | | ✓ | |
| 11. Single adult with income below 100% FPL in 2014. ^k | | | ✓ |
| 12. Not eligible for Medicaid due to resident status. ^k | | | ✓ |

Sources:

^a I.R.C. § 5000A(d)(3).

^b This group includes states opting for “partnership” Exchanges. Residents of the remaining 16 states (plus D.C. and U.S. territories) would not have standing, since the IRS has authority to issue them tax credits. HHS has conditionally approved a state-run Exchange for Idaho, yet it remains to be seen whether the state will establish a compliant Exchange.

Continued next page.

Table A.1 Continued^c I.R.C. § 36B(c)(2)(B)(i).^d I.R.C. § 36B(c)(2)(B)(i).^e I.R.C. § 5000A(d) & (e).^f See Internal Revenue Service, “Filing Information,” *Tax Guide 2011: For Individuals*, December 21, 2011, http://www.irs.gov/publications/p17/ch01.html#en_US_2011_publink1000170407. In 2011, the filing threshold for singles (\$9,500) was lower than the FPL for singles, while the threshold for married couples filing jointly (\$19,000) was higher than the FPLs for many married couples. This feature tends to reduce the number of potential married plaintiffs but expand the number of potential unmarried plaintiffs.^g See Box 1, above.^h Only taxpayers between these income thresholds are eligible for tax credits. Those FPL thresholds translate into the following income ranges:

| | 2013 | 2016 |
|------------------------------|-------------------|-------------------|
| Single, childless adult | \$11,490–\$45,960 | \$11,800–\$47,200 |
| Single adult, one child | \$15,510–\$62,040 | |
| Single adult, two children | \$19,530–\$78,120 | |
| Married couple, no children | \$15,510–\$62,040 | |
| Married couple, one child | \$19,530–\$78,120 | |
| Married couple, two children | \$23,550–\$94,200 | \$24,000–\$96,000 |

Nearly all such taxpayers would qualify for the affordability exemption but for the availability of tax credits. For example, single 35-year-olds would suffer injury only if their income were between 100 and 360 percent FPL (\$11,800–\$42,480 in 2016). As noted above, however, the IRS rule would not subject single 35-year-olds from 365 to 400 percent FPL (\$43,070–\$47,200 in 2016) to penalties or deprive them of the right to purchase a “catastrophic plan,” because those individuals would already be subject to penalties and deprived of that right. Data available on request.

ⁱ Other methods of failing to satisfy the individual mandate’s “minimum essential coverage” requirement are possible but unlikely. Basically, the only way a taxpayer could obtain coverage that fails to meet the law’s definition of “minimum essential coverage” would be from a large, self-insured employer that chose to offer coverage with an unusually high deductible. In addition, taxpayers who are uninsured for less than three months are exempt from penalties. I.R.C. § 5000A(e)(4).^j 42 U.S.C. § 18022(e)(2).^k I.R.C. § 36B(c)(1)(B)(i). In regulations governing the “hardship” exemption from the individual mandate, HHS has proposed offering hardship exemptions to, among others, individuals “determined ineligible for Medicaid . . . solely as a result of a State not implementing” the Medicaid expansion. HHS has also proposed limiting those hardship exemptions “to such individuals who are also not eligible for advance payments of the premium tax credit.” If HHS ultimately extends hardship exemptions to such individuals who are eligible for premium-assistance tax credits, then citizens between 100 and 138 percent FPL would not be able to establish standing to challenge the IRS rule. Even though they would lose the “affordability” exemption, they would still be exempt from the individual mandate’s penalty tax, and able to purchase a catastrophic plan, by virtue of receiving a “hardship” exemption. Such citizens would suffer no injury from the IRS offering illegal premium-assistance tax credits. However, legal immigrants below 138 percent FPL who are eligible for tax credits could still establish standing. The reason such immigrants are eligible for tax credits is that they were already ineligible for Medicaid, for reasons other than their state’s refusal to implement the expansion. This dimension of HHS’s hardship-exemption proposal therefore would not apply to them, since their state’s refusal to expand Medicaid is not the sole reason they are ineligible. See HHS, “Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions,” Federal Register 78 (February 1, 2013): 7354, <http://www.gpo.gov/fdsys/pkg/FR-2013-02-01/pdf/2013-02139.pdf>.

Appendix B: A Strengthened “Health Care Freedom Act”²⁷⁴

SECTION 1.

SHORT TITLE. This chapter shall be known and may be cited as the “Health Care Freedom Act.”

(a) DEFINITIONS.

- (1) “Health care services” shall mean any service, treatment, or provision of product for the care of physical or mental disease, illness, injury, defect or condition, or to otherwise maintain or improve physical or mental health, subject to all laws and rules regulating health service providers and products within the state of [X].
- (2) “Mode of securing” shall mean to purchase directly or on credit or by trade, or to contract for third-party payment by insurance or other legal means authorized by the state of [X], or to apply for or accept employer- or government-sponsored health care benefits under such conditions as may legally be required as a condition of such benefits, or any combination of the same.
- (3) “Penalty” shall mean any civil or criminal fine, tax, salary or wage withholding, surcharge, fee or any other imposed consequence established by law or rule of a government or its subdivision or agency that is used to punish or discourage the exercise of rights protected under this chapter.

(b) STATEMENT OF PUBLIC POLICY.

- (1) The power to require or regulate a person’s choice in the mode of securing health care services, or to impose a penalty related thereto, is not found in the Constitution of the United States of America, and is therefore a power reserved to the people pursuant to the Ninth Amendment, and to the several states pursuant to the Tenth Amendment. The state of [X] hereby exercises its sovereign power to declare the public policy of the state of [X] regarding the right of all persons residing in the state of [X] in choosing the mode of securing health care services.
- (2) It is hereby declared that the public policy of the state of [X], consistent with our constitutionally recognized and inalienable rights of liberty, is that every person within the state of [X] is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty.
- (3) The policy stated herein shall not be applied to impair any right of contract related to the provision of health care services to any person or group.

(c) FINDINGS.

- (1) *The federal Patient Protection and Affordable Care Act preserves certain traditional state powers to regulate health insurance, and grants new powers to states, that permit the state of [X] to enforce the public policy set forth in this Health Care Freedom Act in a manner consistent with,*

and indeed expressly provided for by, federal law.

- (2) Sections 1311 and 1321 of the Patient Protection and Affordable Care Act grant the state of [X] the option of operating a health insurance “exchange,” or allowing the federal government to create one. Section 1412 authorizes payments to health insurance issuers that result directly or indirectly in penalties against [X] employers and residents, contrary to the public policy set forth in this Health Care Freedom Act. In certain cases, those penalties would be levied against [X] employers and residents who refused to purchase health insurance that violates their deeply held religious beliefs. Under the plain terms of Section 1401, the payments that result in penalties against [X] employers and residents become available only if [X] chooses to operate a health insurance “exchange.” Facilitating these payments and the enforcement of penalties against employers and individuals is a key function of a state-funded health insurance “exchange.” Section 1555 protects the right of health insurance issuers not to accept such payments.²⁷⁵
 - (3) A final rule issued by the U.S. Internal Revenue Service attempts to offer those payments, and therefore to penalize [X] employers and residents contrary to the public policy set forth in this Health Care Freedom Act, irrespective of whether the state of [X] elects to operate a health insurance “exchange.” As such, this rule would deny the state of [X] its power, granted by Congress, to enforce the public policy set forth in this Health Care Freedom Act by declining to operate a health insurance “exchange.” This rule denies the sovereignty of the state of [X], and is contrary to federal law and congressional intent.
 - (4) The Patient Protection and Affordable Care Act recognizes the states’ traditional powers to license and regulate health insurance carriers. Section 1311(e) permits states that operate health insurance “exchanges” to exclude certain health plans. Section 1301(a) reserves for all states, regardless of whether they operate a health insurance “exchange,” the power to exclude health insurance issuers from participation if such issuers are not “licensed and in good standing to offer health insurance coverage in [the] State.” Section 1321(d), titled “No Interference with State Regulatory Authority,” expressly provides that the Act preempts only those state laws that “that . . . prevent the application of the provisions of this title.” Section 1311(k) preempts only those state laws “that conflict with or prevent the application of regulations promulgated by the Secretary” of the U.S. Department of Health and Human Services.
 - (5) Subsection (d)(2) asserts only those state powers that Congress has expressly recognized or granted through the Patient Protection and Affordable Care Act. Enforcement of subsection (d)(2) therefore does not conflict with or prevent the application of any provisions of, or regulations promulgated under, the Patient Protection and Affordable Care Act.
 - (6) The federal government may, to the extent permitted by the U.S. Constitution, amend federal law at any time to preempt these powers that the Patient Protection and Affordable Care Act reserves and grants to the state of [X].
- (d) ENFORCEMENT.
- (1) No public official, employee, or agent of the state of [X] or any of its political subdivisions, nor any law or rule, shall act to impose, collect, enforce, or effectuate, directly or indirectly, any penalty in the state of [X] that violates the public policy set forth in this Act. It violates the public policy set forth in this Act for any such individuals, laws, or rules to implement or operate a health insurance “exchange” under the federal Patient Protection and

Affordable Care Act.

- (2) *If a health insurance issuer operating in the state of [X] accepts any remuneration that may result in the imposition of penalties contrary to the public policy set forth herein, such issuer's license to issue new business in the state of [X] shall be suspended immediately and until such time as the issuer represents it has returned that remuneration to its source and will decline any such future remuneration. Such suspensions shall not be construed as impairing the right of contract.*
- (3) The attorney general shall take such action as is provided in Section 2 in the defense or prosecution of rights protected under this act.

SECTION 2.

DUTIES OF ATTORNEY GENERAL. It is the duty of the attorney general to seek injunctive and any other appropriate relief as expeditiously as possible to preserve the rights and property of the residents of the state of [X], and to defend as necessary the state of [X], its officials, employees and agents in the event that any law or regulation violating the public policy set forth in this Act, is enacted by any government, subdivision, or agency thereof.

Notes

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101. Michael F. Cannon, “Does HHS Have the Authority to Tax Health Premiums in Federal Exchanges?” November 30, 2012, <http://www.cato.org/blog/does-hhs-have-authority-tax-health-premiums-federal-exchanges>. (“The proposed regulation correctly notes that Section 1311(d)(5)(A) only ‘contemplates’ state Exchanges charging assessments. It certainly doesn’t authorize states to make such assessments; states already have the authority to impose such levies. [They are states, after all.] Nor does it even direct states to levy user fees. It says, in essence, ‘You gotta fund this yourself. Here are a couple of methods. Knock yourselves out.’ Since Section 1311(d)(5)(A) doesn’t give states the authority to levy such taxes, it’s hard to see how that paragraph translates into ‘HHS has the authority, under this section of the statute, to collect and spend such user fees.’” Emphases omitted.)
102. 31 U.S.C. § 9701, <http://www.law.cornell.edu/uscode/text/31/9701>.
103. See General Accounting Office, *Principles of Federal Appropriations Law*, 3rd ed., vol. 3 (Washington: Government Printing Office, 2008), pp. 12–150, <http://www.gao.gov/assets/210/203470.pdf>.
104. Jerry Geisel, “Oklahoma Lawsuit Targets Premium Subsidy Provision of Health Care Reform Law,” *Business Insurance*, October 28, 2012, http://www.businessinsurance.com/article/20121028/NEWS03/310289979#full_story.
105. Pear, “U.S. Officials Brace for Huge Task of Operating Health Exchanges.”
106. Robert F. McDonnell, “Letter to President Obama on Medicaid and Exchanges,” July 10, 2012, <http://rgppc.com/medicaid-and-exchange-letter-2/>.
107. Marilyn Tavenner, “Letter to Virginia Gov. Robert McDonnell,” July 13, 2012, <http://www.naph.org/Links/ADV/Tavenner-Letter-to-McDonnell.aspx>; and Robert F. McDonnell, “Letter to President Obama Pressing HHS for Answers,” September 27, 2012, <http://rgppc.com/rga-letter-pressing-hhs-for-answers/>. U.S. Centers for Medicare and Medicaid Services, “Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid,” December 10, 2012, <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>. (“The proposed rules on essential health benefits and actuarial value and the market reforms, including rating, were published on November 20, 2012. Public comments are due by December 26, 2012. On November 20, 2012, we also issued a state Medicaid directors letter on how we will propose essential health benefits be implemented in Medicaid. HHS will analyze the comments, adjust any policies accordingly, and publish final rules early next year.”)
108. Jan Moller, “Louisiana to Opt Out of Health Insurance Exchanges in Federal Law,” *New Orleans Times-Picayune*, March 23, 2011, http://www.nola.com/politics/index.ssf/2011/03/louisiana_to_opt_out_of_health.html. (“‘Envision an exchange which, if we were to run it, has the governor’s name on top of the letterhead,’ Greenstein said. ‘We know we would see a number of letters that would go out to businesses and families throughout the state announcing the increase in premiums.’”)
109. Jost, “Implementing Health Reform.” (Explaining that state-run Exchanges “must ensure that [qualified health plan] service areas cover at least a county except under exceptional circumstances to discourage redlining. The final rule QHP standards require QHPs to meet network adequacy standards. Specifically, plans must maintain ‘a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay’ and include essential community providers. QHPs . . . cannot employ marketing practices or benefit designs that will discourage enrollment of individuals with significant health needs.”)
110. *New York v. United States*, 505 U. S. 144, 169 (1992).
111. 42 U.S.C. § 18023(a).
112. 42 U.S.C. § 18023(b).

113. See Robert Farley, “There will be no public funding for abortion in this legislation,” *Politifact*, March 23, 2010, <http://www.politifact.com/truth-o-meter/statements/2010/mar/23/bartstupak/stupak-says-there-no-federal-funding-abortion-sena/>.

114. *Ibid.*

115. Richard Doerflinger, “Life Issues Forum: Stop the New Attack on Conscience Rights,” [usccb.org](http://www.usccb.org), September 16, 2011, <http://www.usccb.org/about/pro-life-activities/life-issues-forum/life-issues-forum-11-09-19.cfm>.

116. I.R.C. § 45R(b).

117. Jonathan Gruber, “Before the Select Committee on Patient Protection and Affordable Care Act,” Florida Senate, video, January 22, 2013, at 42:40, http://www.flsenate.gov/Media/VideoPlayer.cfm?VideoPath=201301/sppaca_012213edit.mp4. (“I’m not sure the right path is for Florida to set up its own exchange at this point. It’s getting kind of late, especially for 2014. As Michael said, it will cost money . . . But remember, it would be cheaper in Florida if you did what I said and left the hard work to the federal government and did the fun work yourself. The hard work’s what costs money. All the software, customer support, that’s the expensive part. That’s where the money comes in. The fun part which is . . . helping to guide what your insurance market looks like, that’s cheap. You don’t even need new employees and can just do it in your existing insurance department. So the notion that the state can play no role without spending a ton of money is just wrong. The money is going to be spent on the hard stuff that the feds are willing to do for you. And quite frankly, for 2014, I’d probably let them do that for you and play the role of partnership.”)

118. “Obama Health Care Law: Favor/Oppose,” *Huffington Post*, August 22, 2012, <http://elections.huffingtonpost.com/pollster/us-health-bill>.

119. “CNN/ORC Poll for the week of June 28–July 1, 2012,” July 2, 2012, <http://i2.cdn.turner.com/cnn/2012/images/07/02/rel6a.pdf>.

120. Kaiser Family Foundation, “Kaiser Health Tracking Poll: July 2012,” July 2012, p. 1, <http://www.kff.org/kaiserpolls/upload/8339-T.pdf>.

121. Reason-Rupe Public Opinion Surveys.

122. Joe Von Kanel, “Exit polls: Obamacare Remains a Hot-button Issue,” CNN, November 7, 2012, <http://politicalticker.blogs.cnn.com/2012/11/07/exit-polls-obamacare-remains-a-hot-button-issue/>; Emily Schultheis, “Exit Polls 2012:

Split on Obamacare,” *Politico*, November 16, 2012, <http://www.politico.com/news/stories/1112/83427.html>.

123. “2012 Alabama Ballot Measures Results,” *Politico*, November 19, 2012, <http://www.politico.com/2012-election/results/ballot-measures/alabama/>; “2012 Montana Ballot Measures Results,” *Politico*, November 19, 2012, <http://www.politico.com/2012-election/results/ballot-measures/montana/>; “2012 Wyoming Ballot Measures Results,” *Politico*, November 19, 2012, <http://www.politico.com/2012-election/results/ballot-measures/wyoming/>.

124. “2012 Missouri Ballot Measures Results,” *Politico*, November 19, 2012, <http://www.politico.com/2012-election/results/ballot-measures/missouri/>.

125. Kaiser Family Foundation/Robert Wood Johnson Foundation/Harvard School of Public Health, *The Public’s Health Care Agenda for the 113th Congress*, January 2013, p. 7, <http://www.kff.org/kaiserpolls/upload/8405-T.pdf>.

126. Patrick O’Connor and Carrie Budoff Brown, “Nancy Pelosi’s Uphill Health Bill Battle,” *Politico*, January 9, 2010, <http://dyn.politico.com/printstory.cfm?uuid=11026320-18FE-70B2-A8DEC2E6CF44594F>.

127. See, for example, Senate Democratic Policy Committee, “Fact Check: Responding to Opponents of Health Insurance Reform,” September 21, 2009. (“There is no government takeover or control of health care in any [S]enate health insurance reform legislation. . . . All the health insurance exchanges, which will create choice and competition for Americans’ business in health care, are run by states.”)

128. Timothy S. Jost, “Health Insurance Exchanges: Legal Issues,” O’Neill Institute Papers no. 23, April 27, 2009, p. 7, http://scholarship.law.georgetown.edu/ois_papers/23/. Emphasis added.

129. See PPACA, Pub. L. 111-148, I.R.C. Sec. 36B(c)(2)(A)(i), 124 Stat. 119, 216 (2010). See also PPACA, Pub. L. 111-148, I.R.C. Sec. 36B(b)(2)(A), 124 Stat. 119, 213 (2010); PPACA, Pub. L. 111-148, I.R.C. Sec. 36B(b)(3)(B)(i), 124 Stat. 119, 214 (2010) and PPACA, Pub. L. 111-148, Sec. 1402(f)(2), 124 Stat. 119, 223 (2010).

130. Jonathan H. Adler and Michael F. Cannon, “Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA,” *Health Matrix: Journal of Law-Medicine* 23 (2013), <http://law.case.edu/journals/HealthMatrix/Documents/23HealthMatrix1.5.Article>.

Adler.pdf. See also Michael F. Cannon and Jonathan H. Adler, “The IRS Has Gone Rogue,” *National Review Online*, September 26, 2012, <http://www.nationalreview.com/articles/328523/irs-has-gone-rogue-michael-f-cannon>.

131. See Adler and Cannon.

132. I.R.C. § 4980H(a).

133. I.R.C. § 4980H(b).

134. See Julie Jargon, Louise Radnofsky, and Alexandra Berzon, “Health-Care Law Spurs a Shift to Part-Time Workers,” *Wall Street Journal*, November 4, 2012, <http://online.wsj.com/article/SB10001424052970204707104578094941709047834.html>; Sandra Pedicini, “Darden Tests Limiting Worker Hours as Health-Care Changes Loom,” *Orlando Sentinel*, October 7, 2012, http://articles.orlandosentinel.com/2012-10-07/business/os-darden-part-time-workers-20121007_1_darden-restaurants-health-insurance-olive-gardens; and Bill Sizemore, “Va. Workers’ Part-Time Hours Capped Due to Health Law,” *The Virginian-Pilot*, February 8, 2013, <http://hamptonroads.com/2013/02/state-workers-parttime-hours-capped-due-health-law>. (“The new policy will mean a pay cut for many part-timers, including adjunct college professors.”) In some cases, employers have backtracked under pressure from employees and customers. Megan Anderson, “Darden to Back Down on Some Health Care Reform Changes,” *Orlando Business Journal*, December 6, 2012, http://www.bizjournals.com/orlando/morning_call/2012/12/darden-to-back-down-on-some-health.html. Those examples merely demonstrate that consumers object to the law’s costs, which those employers will instead have to cover by reducing wages, eliminating jobs, or increasing prices.

135. Susan M. Gates and Kristin J. Leuschner, eds., *In the Name of Entrepreneurship? The Logic and Effects of Special Regulatory Treatment for Small Business* (Santa Monica, CA: Rand Corporation, 2007), pp. 79 and 243, <http://www.rand.org/pubs/monographs/MG663.html>.

136. “February Outlook: Business and Health Reform,” CoBank, 2012, <http://www.cobank.com/Newsroom-Financials/CoBank-News-Feed/February-Outlook.aspx>. Graboyes is senior fellow for health and economics at the National Federation of Independent Business Research Foundation, the research arm of a small-business lobbying group.

137. I.R.C. § 36B(c)(2)(C)(ii). In the language of the industry, to comply with the employer mandate, the only requirement imposed on self-insured plans is that they have an “actuarial value” of 60 percent.

138. Seth Perretta and Allison Ullman, “The Essentials: ACA Terminology Related to Essential Health Benefits, Minimum Essential Coverage and Minimum Value,” February 1, 2012, p. 4, http://www.americanbenefitscouncil.org/documents/hcr_ehb_summary-cm020112.pdf. (“Although the express statutory language appears to provide that employers are not subject to specific benefit mandates so long as the plan’s share of total allowed costs is at least 60%, it is our understanding that the agencies are considering the issuance of future rules that would impose a certain minimum value test on employer-sponsored plans [subject to a transition period]. Employer groups . . . are working hard to convey the message to regulators that they should not go beyond the express statutory language when issuing administrative guidance interpreting the term ‘minimum value.’”)

139. See, for example, Sarah Kliff, “Five Facts about the Health Law’s Contraceptive Mandate,” *Washington Post*, August 1, 2012, <http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/08/01/five-facts-about-the-health-laws-contraceptive-mandate/>. (“Contraceptives won’t cost patients, but that doesn’t make them free. Pharmaceutical companies are not handing contraceptives out to doctors’ offices without sending insurance companies a bill, too. Health plans ultimately end up paying the cost for any increased use of contraceptives. The Guttmacher Institute estimated in a 1998 paper that adding contraceptive coverage would cost \$21.40 per person per year in extra health insurance spending.”)

140. PPACA, Pub. L. 111-148, Sec. 1401, 124 Stat. 119, 213-220 (2010) (amended by the HCERA).

141. Lisa Liddane and Eric Carpenter, “Hostess Ends Production, Lays Off 18,000,” *Orange County Register*, November 16, 2012, <http://www.ocregister.com/articles/hostess-378041-anaheim-company.html>.

142. Terry Baynes, “Judge Backs Catholic Firm Over Contraception Mandate,” Reuters, November 1, 2012, <http://www.chicagotribune.com/news/sns-rt-us-usa-court-contraceptionbre8a1018-20121101,0,1450871.story>.

143. Eric Marrapodi, “Hobby Lobby Faces Millions in Fines for Bucking Obamacare,” CNN.com, December 27, 2012, <http://religion.blogs.cnn.com/2012/12/27/hobby-lobby-faces-millions-in-fines-for-bucking-obamacare/>.

144. I am indebted to investor and PPACA tracker Richard Urich for alerting me to the relationship between state-established Exchanges and the individual mandate’s affordability exemption.

145. In 2016 that penalty will equal \$695 or 2.5

percent of household income (in excess of the income-tax filing threshold), up to an upper limit of the least-expensive health insurance plan available to the household through an Exchange.

146. These upper-bound penalty estimates are conservative. The PPACA levies a penalty/tax on noncompliant taxpayers that can reach as high as “the national *average* premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges.” I.R.C. § 5000A(c)(1)(B). Emphasis added. These figures are taken from Milliman’s projections of the premiums for the *lowest-cost* bronze plan available for each age-household size category. See Paul R. Houchens, “Measuring the Strength of the Individual Mandate,” *Milliman Research Report*, March 2012, <http://publications.milliman.com/publications/health-published/pdfs/measuring-strength-individual-mandate.pdf>.

147. CBO, *Payments of Penalties for Being Uninsured under the Affordable Care Act*, September 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/Indiv_Mandate_Penalty_One-Col.pdf.

148. Robert Pear, “New Rules on Changes to Benefits,” *New York Times*, June 14, 2010, <http://www.nytimes.com/2010/06/14/health/policy/14health.html>.

149. Douglas W. Elmendorf, “Letter to Sen. Evan Bayh on Health Insurance Premiums under PPACA,” November 30, 2009, p. 9, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>.

150. Gruber et al.; Smith; Palmer, Herbold, and Houchens, p. 7.

151. Number of Americans with “private” insurance in 2016 comes from CBO, *Updated Estimates*, p. 12; and author’s calculations.

152. I.R.C. § 5000A(e)(1)(A). In 2015 and beyond, the PPACA indexes the affordability exemption threshold by pegging it to the cumulative gap between growth in health insurance premiums and incomes, beginning with the base year 2013. I.R.C. § 5000A(e)(1)(D). The calculations in this paper use Milliman’s projection of what that threshold will be in 2016—8.43 percent. See Houchens, p. 28. This is despite Milliman making that projection by employing an indexing provision taken from elsewhere in the PPACA. I.R.C. § 36B(b)(3)(A)(ii).

153. I.R.C. § 5000A(e)(1)(B).

154. CBO, *Selected CBO Publications Related to Health Care Legislation, 2009–2010*, December 2010, p. 73,

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12033/12-23-selectedhealthcarepublications.pdf>.

155. The IRS’s tax-credit rule may not injure certain single adults who are younger and near 400 percent of the federal poverty level. According to projections by Milliman, in 2016 the “required contribution” for a single 35-year-old falls and remains below the affordability exemption’s (indexed) 8-percent threshold starting at 365 percent of the poverty level (or \$43,070) in the absence of tax credits. Such individuals between 365 and 400 percent of poverty therefore would not qualify for the affordability exemption even in the absence of tax credits. The IRS rule cannot subject them to penalties under the individual mandate or deprive them of the ability to purchase a “catastrophic plan,” given that they would already be subject to those penalties and ineligible to purchase such plans. The IRS rule therefore would not injure single 35-year-olds between 365 and 400 percent of the poverty level (\$43,070–\$47,200 in 2016), nor younger adults over a broader range of income. However, this gap narrows and disappears with age, such that the IRS rule would injure all 55-year-olds between 100 and 400 percent of the poverty level (\$11,800–\$47,200 in 2016) and families of four at all ages between those poverty thresholds (\$24,000–\$96,000). Houchens, p. 28; and author’s calculations (available on request).

156. Kaiser Family Foundation, “Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2010–2011), U.S. (2011),” *State Health Facts*, 2012, <http://www.statehealthfacts.org/comparetable.jsp?typ=1&ind=136&cat=3&sub=40>.

157. Lisa Dubay and Allison Cook, “How Will the Uninsured Be Affected by Health Reform?” *Kaiser Commission for Medicaid and the Uninsured Issue Paper* no. 7971, August 2009, p. 7, <http://www.kff.org/healthreform/upload/7971.pdf>.

158. Jeffrey S. Passel and D’Vera Cohn, “A Portrait of Unauthorized Immigrants in the United States,” Pew Research Center Report, April 14, 2009, <http://www.pewhispanic.org/files/reports/107.pdf>.

159. Centers for Disease Control, “Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2011,” *Vital and Health Statistics: Series 10*, no. 256, December 2012, table 25, http://www.cdc.gov/nchs/data/series/sr_10/sr10_256.pdf.

160. An estimated 6.2 million Americans between 100 and 300 percent of the federal poverty level purchase health insurance in the individual market. Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis

of the March 2011 Current Population Survey,” Employee Benefit Research Institute Issue Brief no. 362, September 2011, Figure 18, p. 20, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2011_No362_Uninsured1.pdf. Some portion of this group may prefer not to purchase coverage rather than purchase “essential health benefits.”

161. 42 USC § 18022(e).

162. CBO, *Updated Estimates*, p. 12.

163. See Adler and Cannon.

164. Stuart Taylor, Jr., “Analysis: Health Exchanges and the Litigation Landscape,” *Kaiser Health News*, November 29, 2012, <http://www.kaiserhealthnews.org/Stories/2012/November/29/health-law--litigation-and-exchanges.aspx>.

165. Jennifer Staman and Todd Garvey, “Legal Analysis of Availability of Premium Tax Credits in State and Federally Created Exchanges Pursuant to the Affordable Care Act,” Congressional Research Service, July 23, 2012, p. 8, <http://www.ncsl.org/documents/health/LegAnalPTC.pdf>.

166. Mickey Kaus, Twitter Post, December 5, 2012, <http://twitter.com/kausmickey/status/276362427426287616>.

167. Not all uninsured single adults earning between 100 and 400 percent of the federal poverty level would be injured by the IRS rule. Projections from Milliman suggest that in 2016 the premium for the lowest-cost bronze plan (\$3,628) will fall below the affordability exemption threshold (8.43 percent of income) at roughly \$43,000 of income. Houchens. According to CBO projections, that will be equivalent to roughly 365 percent of the federal poverty level for single adults in 2016. CBO, *Selected CBO Publications*, p. 73. In that case, the IRS regulation would only injure 35 year old single adults between 100 and 365 percent of the federal poverty level. However, because the PPACA allows premiums to rise (somewhat) with age, the lowest-cost bronze plan premium rises for older singles until it eventually exceeds 8 percent of income even at 400 percent of the federal poverty level (\$47,200 in 2016).

168. CBO estimates show that only 22 percent of the budgetary impact of the credits/subsidies is tax reduction, while 78 percent comes from new spending. Elmendorf, “Letter to Rep. John Boehner,” Table 2, pp. 5–6; and author’s calculations. Thus new spending accounts for \$945 billion of the \$1.2 trillion budgetary impact of the credits/subsidies, while tax reduction accounts for just \$267 billion. CBO, *Effects of the Affordable Care Act on Health Insurance Coverage—February 2013 Baseline*, February 5, 2013, p. 2, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf, and author’s calculations.

www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf, and author’s calculations.

169. The CBO projected federal spending on the insurance coverage provisions to cost \$788 billion between 2010 and 2019. See Douglas W. Elmendorf, “Letter to Speaker Nancy Pelosi on the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872, the Reconciliation Act of 2010,” March 20, 2010, Table 4, p. 5, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf>.

170. Pear, “U.S. Officials Brace for Huge Task of Operating Health Exchanges.”

171. Offsetting the tax reduction with just the \$150 billion in employer-mandate penalties shows that at least 89 percent of the net budgetary impact of the IRS rule is due to new spending. This estimate is conservative, because the IRS rule imposes additional taxes under the individual mandate that further offset the \$267 billion of tax reduction. Those tax collections undoubtedly account for a substantial share of the \$52 billion CBO projects the individual mandate will raise through 2023, though ascertaining the effect of the IRS rule is difficult. CBO, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023*, February 2013, p. 63, <http://cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf>; and author’s calculations.

172. Response to Motion to Dismiss Amended Complaint, *Pruitt v. Sebelius*, No. CIV-11-30-RAW (E.D. Okla 2012). See also Amended Complaint for Declaratory and Injunctive Relief, *Pruitt v. Sebelius*, No. CIV-11-030-RAW (E.D. Okla 2012). Emphases omitted.

173. The PPACA deems an employer plan unaffordable if the “employee portion” of the premium for self-only coverage exceeds 9.5 percent of an employee’s household income. I.R.C. § 4980H(b).

174. I.R.C. § 4980H(a) and (b).

175. This group could include households that purchase a health insurance plan with a deductible so high that it causes the plan’s actuarial value to fall short of the required 60 percent.

176. I.R.C § 7421(a) (“no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed”).

177. Adler and Cannon.

178. I am indebted to Joe Coletti, analyst for program budgeting, Office of State Budget and Management, State of North Carolina, for alerting me to this joint-approval provision.
179. 42 U.S.C. § 18021(a)(1)(C).
180. Pear, “U.S. Set to Sponsor Health Insurance.” (“To be eligible to participate in the multi-state program, insurers must be licensed in every state.”)
181. See Timothy S. Jost and Mark A. Hall, “The Role of State Regulation in Consumer-Driven Health Care,” *American Journal of Law and Medicine* 31, no. 4 (2005): 403, <http://scholarlycommons.law.wlu.edu/cgi/viewcontent.cgi?article=1040&context=wlufac>.
182. U.S. Library of Congress: Thomas, *Bill Summary & Status, 111th Congress, S. 1697, All Information*, 2009, <http://thomas.loc.gov/cgi-bin/bdquery/z?d111:SN01679:@@L&summ2=m&>; Affordable Health Choices Act, S. 1697, 111th Cong. (2009), <http://www.gpo.gov/fdsys/pkg/BILLS-111s1679pcs/pdf/BILLS-111s1679pcs.pdf>.
183. 42 USC § 18031(e).
184. *Medtronic, Inc. v. Lohr*, 518 U. S. 470, 485 (1996) (internal quotation marks omitted).
185. CBO, *Updated Estimates*, p. 12.
186. Cindy Mann, Joan C. Alker, and David Barish, “Medicaid and State Budgets: Looking at the Facts,” May 2008, http://ccf.georgetown.edu/wp-content/uploads/2012/03/Medicaid_state-budgets-2008.pdf. (“It is often reported that states spend, on average, almost 22 percent of their state budgets on Medicaid, but this figure can be misleading because it considers federal as well as state funds. On average, federal funds account for 56.2 percent of all Medicaid spending.”)
187. *NFIB v. Sebelius*, 132 S. Ct. 2566, 2604 (2012).
188. *Ibid.* Emphasis added. Internal citations omitted.
189. Michael F. Cannon, “Entitlement Bandits,” *National Review*, July 4, 2011, <http://www.cato.org/publications/commentary/entitlement-bandits-how-ryan-plan-would-curb-medicare-medicaid-fraud>.
190. Michael F. Cannon, “Medicaid’s Unseen Costs,” Cato Institute Policy Analysis no. 548, August 18, 2005, <http://www.cato.org/publications/policy-analysis/medicaids-unseen-costs>. See also Michael F. Cannon, “Sinking SCHIP: A First Step toward Stopping the Growth of Government Health Programs,” Cato Institute Briefing Paper no. 99, September 27, 2007, <http://www.cato.org/publications/briefing-paper/sinking-schip-first-step-toward-stopping-growth-government-health-programs-0>.
191. Robert Pear, “Administration Advises States to Expand Medicaid or Risk Losing Federal Money,” *New York Times*, October 2, 2012, <http://www.nytimes.com/2012/10/02/us/us-advises-states-to-expand-medicaid-or-risk-losing-funds.html?>
192. Dan Crippen, “Letter to Secretary Kathleen Sebelius on the Supreme Court Decision,” July 2, 2012, <http://www.nga.org/cms/home/federal-relations/nga-letters/executive-committee-letters/col2-content/main-content-list/july-2-2012-letter---affordable.html>.
193. National Association of Medicaid Directors, “NAMD’s SCOTUS Questions,” July 3, 2012, http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_submitted_questions_120703.pdf.
194. Robert F. McDonnell, “Letter to President Barack Obama Pressing HHS for Answers,” September 27, 2012, <http://rgppc.com/medicaid-and-exchange-letter-2/>; Tavenner, “Letter to Virginia Gov. Robert McDonnell”; Republican Governors Association, “RGA Continues to Press HHS for Answers,” [rga.org](http://www.rga.org/homepage/rga-continues-to-press-hhs-for-answers/), July 24, 2012, <http://www.rga.org/homepage/rga-continues-to-press-hhs-for-answers/>.
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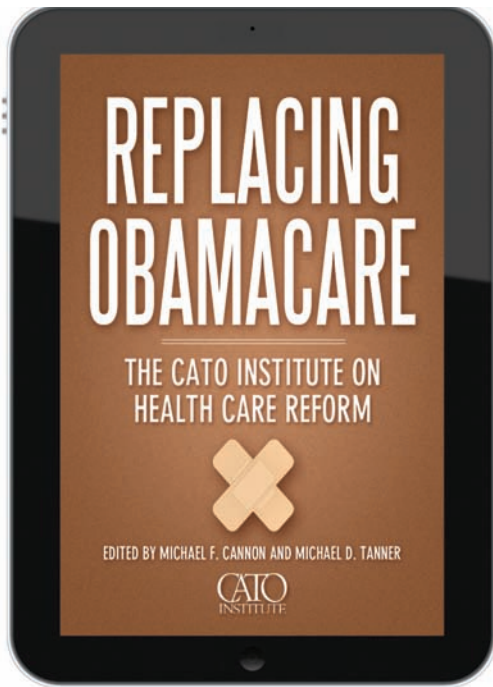
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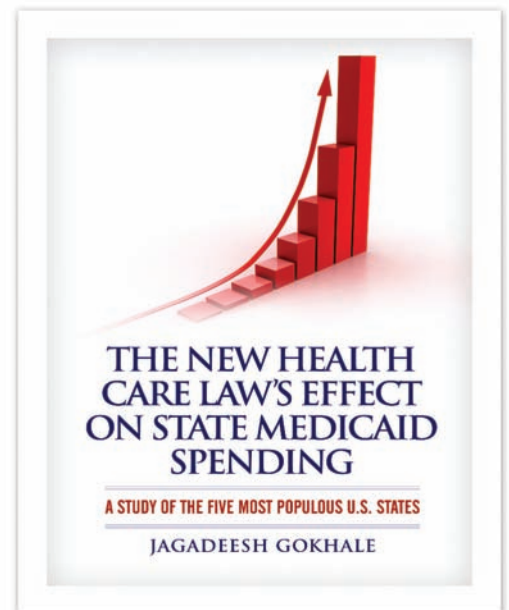
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