NATIONALIZING HEALTH CARE REFORM IN A FEDERALIST SYSTEM‡

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I. INTRODUCTION

When Professor Skocpol delivered her lecture at the Sandra Day O'Connor College of Law on January 21, 2010, the prospect for national health care reform was tenuous. Following months of contentious legislative and political wrangling, the houses of Congress were split on contrasting bills.¹ Seeking to overcome decades of notable failures to nationalize health care, Congress was poised to reconcile differences in its Houses’ bills, vote for passage, and obtain President Obama’s awaiting signature. The late-breaking dilemma, of course, was the election of Massachusetts’ Senator Scott Brown (R) to replace the late Senator Edward Kennedy (D).² Senator Kennedy, a longtime proponent of health care

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reform, assured Democrats sufficient votes to overcome a Republican filibuster, which constantly threatened progress. Senator Brown’s election suggestively shifted legislative power to control the floor of the Senate back to Republicans. The prospect for meaningful national health care reform legislation looked bleak.

As chronicled by Professor Skocpol and Ms. Williamson, President Obama remarkably led House and Senate Democrats through reconciliation toward passage of the Patient Protection and Affordable Care Act (PPACA) and its companion bill, the Health Care and Education Reconciliation Act of 2010. Where so many other national leaders since the 1930s (including FDR) failed to comprehensively reform health care services, President Obama succeeded—or did he? National health care reform is one of the most divisive political issues to be tackled by any Presidential administration in the last fifty years. Collateral damage is inevitable. Republicans and the Tea Party movement have promised severe repercussions at the polls, on the legislative floors of Congress and the states, and through the courts. The American public remains apprehensive about expanding governmental control over health care expenditures and services. Major health care providers and insurers are already bristling at initial reform efforts. Implementation of some portions of PPACA has already begun, including creation of temporary state high-risk insurance pools. However, multiple portions of the Act are scheduled to take effect far into the future, dampening the immediate impact of the legislation and

3. Id.
7. Skocpol & Williamson, supra note 4, at 1213–14.
11. PPACA, Pub. L. No. 111–148, § 1101(c), 124 Stat. 119 (2010) (according to PPACA the Secretary is responsible for creating a high risk insurance pool program ninety days after the enactment of PPACA).
allowing future administrations to derail its execution. Other objectives, including PPACA's prohibition of insurance discrimination based on an individual's pre-existing conditions, may be delayed. Professor Skocpol acknowledges these and other potential barriers to the full implementation of core principles of national health care reform.

However, significant, potential impediments to long-term success in reforming the crumbling national health care system may stem from our federalist system of government. The political and legal structure of the United States is unlike most other major industrial powers that centralized health services following World War II. Comprised of independent, sovereign states led in part by a federal government, the American foundation of federalism presents unique challenges for effectuating national reforms in the areas of health care and public health which have traditionally been left to the states. The Obama administration has admirably pushed hard for major changes to how health care is delivered and financed in the U.S. The question remains: how hard will states push back?

Critical legal and political challenges to national health care reform arose before and immediately after passage of PPACA. In Part II, we chronicle and explain multifarious legislative and policy arguments embedded in state legislative activity. Predominant among the bases for these legislative responses are core principles of federalism that disdain federal intrusions and expansion, reject federal efforts to commandeer state actors or dictate how states should legislate, and decry federal conditions over health care spending that place states in a "take or leave it" posture. Federalism overtones are also illustrated through judicial responses to national health care reform.
care reform as discussed in Part III. Leading up to and following enactment of national health care reforms, numerous state and local governments and private entities, have sued federal authorities to block implementation of current and forthcoming measures. Various bogus claims proposed in these suits do not dispel arguments of constitutional law grounded in violations of the structural principles of federalism. We lay out and explain these arguments, noting the potential pitfalls of national health care reform at the hands of active federal and state courts and legislatures.

In Part IV, we analyze how these state-based, federalism challenges may tentatively shape national health care reforms. Professor Skocpol and Ms. Williamson point out that the full merits and benefits of PPACA are years away. Among many factors that will affect the impact of national health services, constitutional impediments grounded in federalism may determine what and how services are provided. Americans have tolerated decades of inequities and inefficiencies in the allocation and quality of health care and public health services due, in part, to their adherence to principles of federalism. We seek to address whether states and their citizens are prepared to reconsider notions of federalism to advance population and individual health through national reforms.

II. STATE LEGISLATIVE AND POLICY RESPONSES TO NATIONAL HEALTH CARE REFORM

As federal legislators worked to pass PPACA on Capitol Hill, state legislators actively introduced and passed laws to reform their own state health care systems and, at times, impede implementation of federal reforms. Some states’ legislatures have taken steps toward implementation of PPACA by (1) specifically authorizing participation in PPACA’s new “high-risk health insurance pools,” (2) creating state executive agencies

20. See infra Part III.
21. Skocpol & Williamson, supra note 4, at 1231.
23. See PPACA, Pub. L. No. 111–148, § 1101(c), 124 Stat. 119 (2010). High-risk insurance pools provide health insurance coverage for individuals who are uninsurable because of their health status. Prior to the passage of PPACA, thirty-five states had established high-risk pools. PPACA established a federal insurance pool, intended to have lower premiums, copayments, and deductibles than its state counter parts. Under PPACA, states were given the option to participate in the high-risk pools through different methods. Nineteen states opted out of participating in the program, based on a concern that the federal government has not provided adequate funding for the pools. Igor Volsky, Updated: 19 States Opt Out of High Risk Insurance Pools, Will Allow Federal Gov to ‘Take Over’, THE WONK ROOM, May 3, 2010, available at http://wonkroom.thinkprogress.org/2010/05/03/report-hrp/.
and boards to facilitate national health care reform initiatives, or introducing state legislation directly to implement federal reforms. California legislators, for example, have introduced a series of bills to carry out various components of federal health reform. However, a number of states’ officials have expressed concern as to whether state agencies have the authority to implement portions of federal health care reform. Other state officials refuse to provide state agencies with the requisite authority to implement PPACA provisions.

While some states work proactively to address how to implement federal health care reform, a majority of states have fielded proposals and introduced legislation to amend state constitutions or adopt new laws to impede or interfere with implementation of portions of federal health care reform. A number of states are simultaneously proposing legislation to block federal reforms while introducing their own state health care reforms. As discussed below, underlying these and other legislative challenges are core federalism principles and arguments grounded in the Tenth Amendment and the Supremacy Clause of the U.S. Constitution.


26. Pear & Sack, supra note 24 (noting that state officials in “California, Florida, Hawaii, Michigan, Nebraska, Oklahoma, Virginia, and Wyoming” have expressed concern that they do not have the authority to implement provisions in PPACA).

27. Id. (discussing how Arizona Governor Jan Brewer has placed a moratorium on rule-making, with no plans to authorize state agencies to implement PPACA’s provisions).


29. Id.

30. States have enacted or introduced legislation challenging federal authority on a variety of issues other than health care reform. These include efforts to (1) preempt federal regulation of firearms made and used in the state, (2) create commissions to review the constitutionality of federal acts, and (3) prevent federal agents from arresting people without local government approval. Tenth Amendment Center, The 10th Amendment Nullification Movement, http://www.tenthamendmentcenter.com/the-10th-amendment-movement/ (last visited July 27, 2010). States have successfully derailed federal action in such areas as medical marijuana. The federal Department of Justice announced that, “it would no longer make medical marijuana a priority in the states where it was [sic] legal.” Kirk Johnson, States’ Rights Is Rallying Cry for Lawmakers, N.Y. TIMES, Mar. 17, 2010, at A1, available at http://www.nytimes.com/2010/03/17/us/17states.html. State opposition also forced the federal government to delay implementation of the REAL ID Act. Mimi Hall, States Get ‘Real ID’ Extensions, USA TODAY,
Proposals, including constitutional resolutions and statutory reforms, in forty states seek to derail or block components of federal health care reform. Table 1, State Legislative Proposals Opposing PPACA, below, delineates those states that have introduced or passed statutory amendments or constitutional resolutions to impede federal reforms. The primary focus of state constitution resolutions and statutory reforms has been to prohibit PPACA's individual and employer mandates that require individuals to purchase, or employers to provide, health insurance or face monetary fines. Additionally, Table 1 demonstrates that many states' proposals share common platforms adopted from, or similar to, proposed constitutional amendments in Arizona.

Conversely, the U.S. government may sue to block state laws that interfere with federal powers. Recently, the federal government filed suit to prevent the State of Arizona from implementing S.B. 1070, which requires state and local law enforcement agencies to enforce federal immigration laws. The federal government argues that the state law (1) is pre-empted by Congress' powers to "establish an uniform Rule of Naturalization," and (2) restricts Congress' interstate commerce powers. Complaint at 5, United States v. Arizona, 703 F. Supp. 2d 980 (D. Ariz. 2010) (No. 2:10-cv-01413-NVW).

2. Constitutional resolutions are generally introduced to a legislative body for approval, and then placed on a ballot for voter approval. In November 2010, Arizona H.C.R. 2014 will be the first constitutional resolution to seek approval from voters. Id.
Table 1. State Proposals Opposing PPACA

<table>
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<tr>
<th>State</th>
<th>Type of Proposal</th>
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<tr>
<td>Ala.</td>
<td>HB 42</td>
<td>Mont.</td>
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<tr>
<td>Alaska</td>
<td>HJR 35 *</td>
<td>Neb.</td>
<td>LR 289CA *</td>
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<tr>
<td>Ariz.</td>
<td>HCR 2014 +</td>
<td>Nev.</td>
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<tr>
<td>Ark.</td>
<td>ISP 2009-204 ‡</td>
<td>N.H.</td>
<td>CACR 30</td>
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<tr>
<td>Cal.</td>
<td>SCA 29</td>
<td>N.J.</td>
<td>ACR 109 ‡</td>
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<td>Colo.</td>
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<td>N.M.</td>
<td>SJR 1 <em>; HJR 5</em></td>
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<td>Conn.</td>
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<td>Fla.</td>
<td>HJR 37 + *;</td>
<td>N.D.</td>
<td>HCR 3010*</td>
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<td>SJR 72</td>
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<td>Ga.</td>
<td>SR 795 *</td>
<td>Ohio</td>
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<td>Haw.</td>
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<tr>
<td>Idaho</td>
<td>HB 391</td>
<td>Okla.</td>
<td>SJR 59 +</td>
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<td>Ill.</td>
<td>H 6842</td>
<td>Pa.</td>
<td>HB 2053 ‡</td>
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<td>Ind.</td>
<td>SJR 14 ‡</td>
<td>R.I.</td>
<td>S 2544 ‡</td>
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<td>Iowa</td>
<td>HJ 2007 ‡</td>
<td>S.C.</td>
<td>HJR 4181 ‡</td>
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<td>Kan.</td>
<td>HCR 5032 ‡</td>
<td>S.D.</td>
<td>HJR 1001 *</td>
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<td>Ky.</td>
<td>HB 307 ‡ *</td>
<td>Tenn.</td>
<td>HJR 0745 ‡</td>
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<td>La.</td>
<td>HB 94 ‡</td>
<td>Tex.</td>
<td>SB 2490 *</td>
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<td>Me.</td>
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<td>Utah</td>
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<td>Md.</td>
<td>HB 603 ‡</td>
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<td>Mich.</td>
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<td>Minn.</td>
<td>HF 171 ‡ *</td>
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<td>Miss.</td>
<td>HCR 17 ‡</td>
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<td>Mo.</td>
<td>HJR 48 ‡</td>
<td>Wyo.</td>
<td>SJR 3 ‡; SJ 1</td>
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+ Appearing on upcoming ballot to get voter approval or has passed legislative bodies;
* Adopts language similar to Arizona Proposition 101;
‡ Adopts language similar to Arizona H.C.R. 2014 Language

Arizona’s Proposition 101, introduced through a citizen petition in 2008, proposed a state constitutional amendment to promote individual

34. Cauchi, supra note 24.
35. See AZ. CONST. art. XXI, § 1 (In Arizona, a citizen-initiated measure to amend the constitution will be placed on the ballot for a general election if an initiative petition is signed by qualified electors equaling fifteen percent of the total number of votes cast for all candidates for governor in the most recent gubernatorial election. This is one of three ways the Arizona Constitution can be amended).
autonomy in health care decisions.\textsuperscript{36} Initially appearing on the ballot in November 2008, Proposition 101 sought to (1) secure an individual’s right to “make decisions about their health care” and (2) prohibit any law that “restricts a person’s freedom of choice of private health care systems or private plans of any type.”\textsuperscript{37} The measure was narrowly defeated that same year.\textsuperscript{38} In 2009, Arizona State Representative Nancy K. Barto\textsuperscript{39} introduced H.C.R. 2014 to amend Arizona’s constitution to include language similar to Proposition 101.\textsuperscript{40} The measure passed the necessary legislative bodies in June 2009.\textsuperscript{41} H.C.R. 2014 shares two primary goals with Proposition 101: (1) to protect an individual’s right to choose whether to participate in a health care system; and (2) to safeguard an individual’s or an entity’s right to pay directly for lawful medical services.\textsuperscript{42} However, the revised language of H.C.R. 2014\textsuperscript{43} more directly prohibits a law or rule that compels individuals or entities (i.e., employers) to participate in a health care


\textsuperscript{37} Ariz. Proposition 101, supra note 36.

\textsuperscript{38} ARIZONA SECRETARY OF STATE, STATE OF ARIZONA OFFICIAL CANVASS: 2008 GENERAL ELECTION (2010), available at www.azsos.gov/election/2008/General/CANvass2008GE.pdf (Yes: 1,048,512 (49.8%), No: 1,057,199 (50.2%)); see also CLINT BOLICK, THE HEALTH CARE FREEDOM ACT: QUESTIONS & ANSWERS, available at www.goldwaterinstitute.org/file/4372/download (“The measure qualified as a voter initiative on the 2008 ballot, and despite a well-financed opposition campaign, it was defeated by less than one-half of 1 percent of the vote.”).

\textsuperscript{39} Representative Nancy K. Barto (R) is the Chairman of the Health & Human Services Committee, House of Representatives. See Arizona State Legislature, http://azleg.gov/MembersPage.asp?Member_ID=3&Legislature=49&Session_ID=93 (last visited July 9, 2010).


\textsuperscript{41} H.C.R. 2014, 49th Leg., 1st Reg. Sess. (Ariz. 2009); see also BOLICK, supra note 38.


\textsuperscript{43} H.C.R. 2014, 49th Leg., 1st Reg. Sess. (Ariz. 2009). Similar views were shared by Chairman Barto: “[HCR] is better and includes definitions to address concerns that may occur with current government programs.” COMM. ON HEALTH & HUMAN SERVS. MINUTES, 1st Reg. Sess. (Ariz. 2009).
Additionally, it protects private insurers by allowing the sale or purchase of health insurance, in part to “defray some of the costs of health care.” H.C.R. 2014 also includes definitions and specifications as to the Resolution’s broader aspect.

Constitutional amendments prohibiting individual and employer mandates have more recently been proposed in thirty (30) states. Proposals in Florida, Missouri, and Oklahoma, featuring language modeled after Arizona’s Proposition 101, have passed their respective legislative bodies and await voter approval. Conversely, a Florida court found the state’s proposed amendment to be “manifestly misleading” and removed it from the November 2010 ballot. Virginia’s proposal would amend its state constitution to prohibit any law that requires individuals to purchase health insurance. While the substance of Virginia’s bill largely resembles Proposition 101, the bill couches its language in terms of individual

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44. H.C.R. 2014, 49th Leg., 1st Reg. Sess. (Ariz. 2009) (defining a “Health Care System” as “any public or private entity whose function or purpose is the management of processing of, enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants”).

45. S. COMM. ON HEALTHCARE & MEDICAL LIABILITY REFORM MINUTES, H.C.R. 2014 LANGUAGE BREAKDOWN, June 17, 49th Leg., 1st Reg. Sess. (Ariz. 2009). The Language Breakdown infers that the “cost of health care” refers to the costs to individuals for health care services. Id. Additionally, it notes that the Resolution does not prevent the “legislature and department of insurance from regulating insurance companies to protect Arizonans from fraud and abuse.” Id.

46. H. COMM. ON HEALTH & HUMAN SERVS. MINUTES, May 26, 49th Leg., 1st Reg. Sess. (Ariz. 2009) (“[The language] includes definitions to address concerns that may occur with current government programs for the indigent, mainly the Arizona Health Care Cost Containment System (AHCCCS).” The intent is not to “interfere with publicly funded programs, but rather to prevent the state or other government from forcing residents to be subject to the practice of medicine by government. It is not a fix for health care reform but it is a foundation upon which to build real and patient-centered health care reforms that will truly address the high cost of health care without sacrificing quality and availability of health care.”). Id.; see also H.C.R. 2014 LANGUAGE BREAKDOWN, supra note 45 (The Resolution’s limitations on what it affects protect: (1) Arizona Legislature’s authority to determine whether a health care service is legal; (2) worker compensation; (3) laws currently in effect; and (4) the terms and conditions of private insurers.).


48. Id.


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liberties.\textsuperscript{50} It seeks to protect a person’s: (1) “natural right and power” to contract; (2) “liberty” to determine whether to purchase private health insurance; and (3) right to pay for medical services “to preserve life or health.”\textsuperscript{51} Consistent with its proposed state constitutional amendment, Virginia’s legislature was the first state to pass statutory law with substantively similar language, as discussed below.

The California Senate’s proposed constitutional amendment differs from other states’ proposals. It does not seek to directly nullify federal health care provisions, but would require voter approval to implement a state or federal statute impacting health care.\textsuperscript{52} Voter approval would be required for any law that proposes: (1) health care reform provisions (including individual mandates); (2) requires health insurers and plans to guarantee plans or policies to all applicants or employers; or (3) creates government-operated plans to compete with private insurers or establishes a single-payer system.\textsuperscript{53}

Eighteen states have proposed or passed legislation to amend state statutory law to directly block the federal implementation of an individual or employer health insurance mandate.\textsuperscript{54} Like state constitution amendment proposals, a majority of these legislative bills are similar to or modeled after Arizona’s proposals.\textsuperscript{55} Prior to the passage of PPACA, Virginia passed legislation, modeled after Arizona Proposition 101, to prohibit a requirement that residents obtain health insurance or be liable for any fines, fees, or penalties for failing to obtain health insurance coverage.\textsuperscript{56} On August 3, 2010, Missouri’s constitutional proposition was approved by voters.\textsuperscript{57} Since enactment of PPACA, legislatures in Idaho, Georgia, and Utah have passed similar measures. Idaho’s new law assimilates Virginia’s, but further suggests that the U.S. Constitution does not empower government to “regulate a person’s choice in the mode of securing health

\begin{itemize}
  \item \textsuperscript{50} H.R.J. Res. 7, 2010 Gen. Sess. (Va. 2010) (“No law shall restrict a person’s natural right and power of contract to secure the blessings of liberty to choose private health care systems or private plans. No law shall interfere with the right of a person or entity to pay for lawful medical services to preserve life or health . . . .”).
  \item \textsuperscript{51} Id.
  \item \textsuperscript{52} S. Const. Amend. 29, 2009–2010 Sess. (Cal. 2010).
  \item \textsuperscript{53} Id.
  \item \textsuperscript{54} Cauchi, \textit{supra} note 24.
  \item \textsuperscript{55} Id.
\end{itemize}
care services or . . . impose a penalty."\(^{58}\) Georgia's legislature adopted language from Arizona's 2009 resolution.\(^{59}\) Specifically Georgia's legislation prohibits any law or rule from compelling individuals or employers to participate in any health care system and provides that individuals or employers may not be penalized for paying directly for health care services.\(^{60}\) Legislators in Utah passed a law to impede federal reforms by prohibiting its state agencies from implementing PPACA's provisions\(^{61}\) without first filing a report with the State Legislature.\(^{62}\) The legislation is consistent with the legislature's specific findings and the sentiments of some Utah legislators.\(^{63}\)

Several states have introduced legislation to directly request actions by or against the federal government.\(^{64}\) For example, Idaho's legislature has proposed a Twenty-eighth Amendment to the U.S. Constitution\(^{65}\) to make it unconstitutional for government to require individuals "to enroll in, participate in or secure health care insurance," or to penalize individuals for declining to do so.\(^{66}\) One day prior to President Obama's signing of PPACA, Utah Governor Gary R. Herbert signed a concurrent resolution urging Congress and the President to pass legislation that would grant states increased flexibility, without further restricting states' rights, regarding health care reform.\(^{67}\)

In addition to state legislation directly addressing federal health care reform, states have also sought to reform health care within their own jurisdictions. This includes state efforts to reform the health insurance

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58. H.B. 391, 60th Leg., 2d Reg. Sess. (Idaho 2010) (The Statement of Public Policy argues that this power is reserved to the states and to individuals under the 10th and 9th Amendments.).


60. Id.


62. Id. (stating that the report will include the specific federal statute or regulation requiring implementation of the federal reform provision, whether the reform provision has any waiver option, exactly what is required of the state, who in the state will be impacted, what the cost is to the state, and the consequences to the state for failure to comply).

63. See id. (The adopted legislation includes findings which claim federal reform would infringe on state and individual rights as well as Utah's prior and successful efforts to reform health care within its own state. Federal reform is characterized as "impos[ing] a uniform solution to a problem that requires different responses in different states.").

64. Several states have passed legislation requesting that their state file judicial actions against the federal government including Georgia, Illinois, Oklahoma, South Carolina, Tennessee, and Wyoming. Cauchi, supra note 24.


66. Id.

market, alter standards of eligibility for Medicaid, the State Children’s Health Insurance Program Act ("SCHIP"), and similar programs, and revise health insurance coverage. California, Colorado, Michigan, Minnesota, Missouri, and New Mexico have introduced health care reform plans or packages of varying breadth. Legislatures in California, Michigan, and Missouri seek to expand health care coverage either through a universal health system or by broadening eligibility criteria for Medicaid. Minnesota’s legislation would improve the public’s health by working toward decreasing the number of smokers and overweight residents. While states are working actively to improve health care within their states, federal reforms continue to be reviewed, assessed, and challenged.

III. JUDICIAL RESPONSES TO NATIONAL HEALTH CARE REFORM

Extensive state legislative activity aimed at quelling national health care reform and reinforcing states’ rights has been supplemented by direct judicial challenges from private actors and state governments. On June 3,
2010, Physician Hospitals of America and The Texas Spine & Joint Hospital (TSJH) filed a joint complaint in a Texas federal district court seeking to enjoin implementation of PPACA section 6001 which regulates Medicare servicing hospitals owned by physicians. The plaintiffs allege violations of due process, equal protection, and the Federal Takings Clause because the section "retroactively, illegitimately, and irrationally burdens its private property." In August 2010, the Arizona-based Goldwater Institute filed a legal challenge to PPACA on behalf of a Tempe business owner who disdains PPACA's employer mandate provisions. While private sector challenges like these may not survive judicial scrutiny, state-based judicial claims raise more intriguing issues.

As illustrated in Figure 1, States Filing Suit Contesting PPACA, below, twenty-one (21) state attorneys general are directly challenging the constitutionality of federal health care reforms in court. The Commonwealth of Virginia filed suit in the U.S. District Court for the Eastern District of Virginia, claiming that PPACA directly conflicts with its recently-enacted state health law, thus possibly providing sufficient standing and fulfilling ripeness requirements for the Commonwealth.

74. PPACA, Pub. L. No. 111–148, § 6001, 124 Stat. 119 (2010). The section only targets hospitals owned by physicians. Beginning next year, new physician owned hospitals will not receive Medicare certification if its physician-owners refer Medicare patients to that hospital. It also restricts physician ownership in Medicare certified hospitals. In addition, the law inhibits existing-Medicare certified physician-owned hospitals from expanding their facilities unless they meet certain qualifications. This section, plaintiffs contend, should be void for vagueness.

75. Id.; Health Care and Education Reconciliation Act, Pub. L. No. 111–152, 124 Stat. 1029 (2010). Prior to passage, TSJH was actively expanding its facilities. Construction ceased after enactment due to the limiting language in the section, which may be contradictory and unconstitutionally vague. PPACA § 6001(d)(3)(D) permits increased physician ownership of a Medicare certified hospital that meets requirements no later than eighteen months after enactment (September 23, 2011). However, certain requirements of (i)(1) state that all expansion or expanded physician ownership cease after March 23, 2010 if they want to qualify for expansion, instead of the eighteen months stated earlier in the act. PPACA, Pub. L. No. 111–148, § 6001(d)(3)(D), 124 Stat. 119 (2010).

76. Complaint for Declaratory and Injunctive Relief at 4, Physician Hosps. of Am. & Texas Spine & Joint Hosp., Ltd. v. Kathleen Sebelius, U.S. Dep’t of Health & Human Servs., No. 6:10-cv-00277-MHS (E.D. Tex. Jun. 3, 2010). The law clearly targets physicians. The complaint argues that the Physician Hospital Law singles out physicians by excluding them from ownership of a legal and necessary business without a rational basis or reasonable relation to any quality or medical care issues. The only reasonable relation, plaintiffs claim, is protection of the economic interests of the non-physician owned hospitals from competition. Id.


78. Standing requires a showing of actual injury and sufficient connection to the challenged law to support participation in the case. See BLACK’S LAW DICTIONARY 1536 (8th ed. 2004).
Missouri Lieutenant Governor Peter Kinder filed suit on July 7, 2010 claiming that PPACA violates the Missouri Constitution’s Hancock Amendment and infringes on individuals’ personal liberty interests. Most states, however, have joined a lawsuit filed by the State of Florida in the U.S. District Court for the Northern District of Florida, despite a potential lack of standing and ripeness which could result in its dismissal. As discussed below, these states allege that some PPACA provisions impinge on state sovereignty and overextend Congress’ power to regulate interstate commerce under the Commerce Clause. Florida’s lawsuit also claims that PPACA represents an improper exercise of Congress’ taxing power.

Figure 1: States Filing Suit Challenging PPACA

79. Ripeness is “[t]he circumstance existing when a case has reached, but has not passed, the point when the facts have developed sufficiently to permit an intelligent and useful decision to be made.” Id. at 1442.

80. Scott Lauck, Missouri Lt. Gov. Kinder Takes on Health Care Law in Federal Court, MISS. LAW. MEDIA, July 7, 2010, available at http://findarticles.com/p/articles/mi_7992/is_20100707/ai_n54425924/. The Hancock Amendment essentially prohibits the state legislature from raising taxes beyond a certain amount without placing the proposed increase on the ballot. Missouri argues that the expansion of Medicaid coverage will require an increase large enough to require a vote. Missouri’s suit also states claims similar to those advanced in Florida’s and Virginia’s cases.

Florida’s Attorney General Bill McCollum\textsuperscript{82} filed his lawsuit\textsuperscript{83} on March 23, 2010, alleging that the federal government overstepped its bounds by passing PPACA. Nineteen (19) other states have joined Florida’s suit to date.\textsuperscript{84} On May 14, 2010, the National Federation of Independent Business (NFIB) joined the suit as well.\textsuperscript{85} Other jurisdictions, however, have rejected Florida’s case. On June 23, 2010, Washington State Governor Christine Gregoire, along with Governors from Colorado, Michigan, and Pennsylvania, asked the federal court for permission to file an amicus brief in support of the U.S. Department of Justice’s (DOJ) motion to dismiss Florida’s lawsuit,\textsuperscript{86} even though Gregoire’s own Attorney General has joined the suit. The City of Seattle requested the Washington State Supreme Court withdraw the state from the lawsuit altogether.\textsuperscript{87} In Louisiana, the state Legislative Black Caucus promised to file a “friend of the court”\textsuperscript{88} brief on behalf of all Louisianans in opposition to Louisiana’s participation in the Florida case, after Louisiana Attorney General Buddy Caldwell refused to withdraw from the case.\textsuperscript{89} Some states are challenging the law while attempting to comply with it. In Texas, a joint party to Florida’s suit, state policymakers are working to implement PPACA even though the state

\textsuperscript{82.} McCollum for Governor, http://www.billmccollum.com (last visited Oct. 22, 2010). McCollum is a Republican currently running for Florida Governor, thus raising questions as to whether the filing of his suit is designed to strengthen his political profile among conservative voters in Florida.


\textsuperscript{88.} Friend of the court briefs are sometimes referred to as amicus briefs. An amicus brief is a brief, usually at the appellate level, prepared and filed by an amicus curiae with the court’s permission. See BLACK’S, supra note 78, at 1536.


\textsuperscript{88.} McCollum for Governor, http://www.billmccollum.com (last visited Oct. 22, 2010). McCollum is a Republican currently running for Florida Governor, thus raising questions as to whether the filing of his suit is designed to strengthen his political profile among conservative voters in Florida.

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Attorney General continues to debate its provisions in court. Other states may not have sufficient legal authority to fulfill PPACA’s provisions. Notwithstanding the controversy surrounding these cases, U.S. District Judge Roger Vinson intends to fast track Florida’s case and does not intend to accept any amicus briefs, even at later stages in the lawsuit.

Judge Henry E. Hudson of the U.S. District Court, Eastern Virginia, heard arguments on Virginia’s lawsuit on July 1, 2010. A month later, on August 2, 2010, he opined that Virginia’s “complaint did not fail to state a cause of action” thus allowing the case to proceed on the merits.

Over the past few decades, Congress’ power under the Commerce Clause has been gradually interpreted to include activities which “substantially affect” interstate commerce. The first count in Florida’s complaint attacks PPACA’s individual mandate provision as a violation of the Commerce Clause because it forces “all Americans to perform an affirmative act or incur a penalty simply on the bases that they exist and reside within any of the United States.” The same argument is proffered in Virginia’s suit, stating that there is “no tradition of using the commerce

93. Brunner, supra note 86.
97. Id.
98. United States v. Lopez, 514 U.S. 549, 559 (1995) (Congress may regulate: (1) the channels of interstate commerce (including roadways, waterways, and airways); (2) the instrumentalities of interstate commerce (including people, vehicles, machines, etc., which are employed or used in carrying out commerce); (3) things which move across state lines (any items or objects which themselves move in interstate commerce including electronic databases, machines, commodities and other things that are routinely transported across state lines); and (4) the activities which have a substantial effect on interstate commerce).
99. Id. at 558–59.
clause to require a citizen to purchase goods or services from another citizen.101 Congressional findings may contradict these assertions.102 In its filed response, DOJ relies on such findings to argue that “individuals who forgo health insurance coverage do not thereby forgo health care.”103 Virtually everyone, at some point, gets sick and requires health services. Some may forego care, but most uninsured will receive uncompensated health care services. In the aggregate, billions of dollars of uncompensated care are subsidized by public funds, thereby substantially affecting the interstate health care market.104 Without insurance, these people increase the financial risk to other households and medical providers.105 They also curtail the ability of the entire health care system to function properly because uninsured individuals can “game the system” by waiting to purchase insurance when they need it to cover the expenses of their illnesses.106 As DOJ notes, there are exceptions to PPACA’s individual mandate for people whose income falls below the tax filing limit or for whom insurance would cost more than eight percent (8%) of household income.107 Nevertheless, questions remain about Congress’ ability to require individuals to purchase any good or service based on its perceived impact on interstate commerce.108

Under PPACA, any individual who chooses not to purchase minimum health insurance coverage under the individual mandate will be assessed a monetary penalty.109 Florida’s Attorney General claims this penalty

101. Virginia Response to Opposition to Motion to Dismiss at 26, Virginia v. U.S. Dep’t of Health & Human Servs., No. 3:10-cv-00188-HEH (E.D. Va. June 7, 2010). The individual mandate may be distinguishable from Wickard v. Filburn, 317 U.S. 111 (1942). Filburn, a farmer, grew more wheat than allowed by the Agricultural Assessment Act of 1938 for his own use and not for re-sale. His violation was upheld against his challenge because the effect of his actions would be substantial enough to make the activity subject to Congressional regulation. Today, individuals who choose not to purchase insurance are not shirking the market, but rather choosing not to participate in it.

102. JENNIFER STAMAN ET AL., CONG. RES. SERV., REQUIRING INDIVIDUALS TO OBTAIN HEALTH INSURANCE: A CONSTITUTIONAL ANALYSIS 12 (2010).


104. Id. (The people who receive this uncompensated care are generally uninsured who are ill and receive treatment from traditional providers who then receive very little or nothing in compensation.).


106. Department of Justice Response to Florida, at 35.


109. PPACA § 1501(b).
"constitutes a capitation and a direct tax that is not apportioned among the States according to census data . . . and is unrelated to any taxable event or activity."\textsuperscript{110} As such, the penalty may be viewed as a coercive tool to get people to enroll either in the expanded Medicaid program or buy coverage from newly-created insurance exchanges.\textsuperscript{111} According to Florida’s and other states’ attorney generals, it may also be the first time a penalty has been used to mandate, not discourage, economic activity.\textsuperscript{112}

DOJ responds that measures enacted under the Commerce Clause are not subject to the apportionment requirement,\textsuperscript{113} nor is the penalty a direct tax if analyzed under Congress’ taxing authority because it is not a tax “imposed upon property solely by reason of its ownership. . . .”\textsuperscript{114} Moreover, notes DOJ, there is a taxable event; specifically, an individual’s monthly decision whether or not to obtain qualifying health insurance coverage.\textsuperscript{115} A tax predicated on a decision, as opposed to a tax on property, has always been understood to be indirect.\textsuperscript{116} And if the tax is indirect, it is not subject to the apportionment requirement.\textsuperscript{117} As discussed in Part IV, below, further investigation and clarification of Congress’ intent to act under its Commerce Clause or taxing powers are needed to resolve these arguments.

Since its inception in 1964, the Medicaid program has provided health care insurance and coverage for millions of disabled and impoverished citizens.\textsuperscript{118} It was established as a voluntary federal and state program for which states could choose whether or not to participate.\textsuperscript{119} While all states have created Medicaid programs, it took nearly twenty (20) years for them

\textsuperscript{110}. Amended Complaint at 25, State v. U.S. Dep’t of Health & Human Servs., No. 3:10-cv-91-RV/EMT (N.D. Fla. June 16, 2010); see also BLACK’S, supra note 78, at 1595–96 (Direct Tax: A tax that is imposed on property, as distinguished from a tax on a right or privilege; a direct tax is presumed to be borne by the person upon whom it is assessed, and not “passed on” to some other person. Ad valorem and property taxes are direct taxes. Poll Tax or Capitation: A fixed tax levied on each person within a jurisdiction).

\textsuperscript{111}. Amended Complaint, State v. U.S. Dep’t of Health & Human Servs.

\textsuperscript{112}. Id. at 10–11.


\textsuperscript{114}. Knowlton v. Moore, 178 U.S. 41, 81 (1900).

\textsuperscript{115}. Department of Justice Response to Florida, Florida v. U.S. Dep’t of Health & Human Servs., at 58.


\textsuperscript{117}. Department of Justice Response to Florida, Florida v. U.S. Dep’t of Health & Human Servs., at 57.


\textsuperscript{119}. Department of Justice Response to Florida, Florida v. U.S. Dep’t of Health & Human Servs., at 9.
The federal government pays a proportion (which varies among states) of all Medicaid expenses, but state governments are largely responsible for operating their own programs. PPACA’s provisions will expand Medicaid’s eligibility requirements to cover millions more Americans, which Florida complains changes the nature of the federal-state partnership. Expanding eligibility standards will bootstrap states with billions of dollars of expenditures at a time when states face extreme budget crises requiring cuts to existing Medicaid entitlements. Yet, Florida’s Attorney General argues states cannot simply withdraw from participation in the Medicaid program because it has become a customary and necessary part of their health care programs for residents. PPACA, it is contended, essentially converts Medicaid from a voluntary partnership to a top-down federal program, thus infringing states’ “sovereign interests” in violation of the Tenth Amendment. In response, the federal government notes the voluntary nature of the Medicaid program. To find in favor of Florida and other states, DOJ suggests, would create an untenable scheme where the “more popular a federal program becomes in the States, the less authority Congress has to change it.”

DOJ contends that expansion of Medicaid through PPACA does not present states with an unconstitutional offer they cannot refuse, but simply a hard choice.

The final count in Florida’s complaint is based on states’ traditional regulation and control over the health insurance market. It is alleged that PPACA’s requirement that states establish a health insurance exchange under the “threat of removing or significantly curtailing [the states’] long-held regulatory authority as to intrastate insurance” infringes state sovereignty in violation of the Ninth and Tenth Amendments. However, states are not required, according to DOJ, to create health insurance exchanges.


121. Centers for Medicare & Medicaid Services, supra note 118.


123. Id. at 18.

124. Id. at 15.

125. Id. at 22.


127. Id. at 15.

exchanges under PPACA.\textsuperscript{129} If states choose to do so, they must comply with guidelines promulgated by the U.S. Department of Health & Human Services (DHHS).\textsuperscript{130} Residents in states that choose not to set up an exchange are eligible to participate in the federal exchange established by DHHS.\textsuperscript{131}

Virginia’s lawsuit,\textsuperscript{132} filed on March 23, 2010 by Attorney General Ken Cuccinelli\textsuperscript{133} mirrors Florida’s attack on PPACA’s individual mandate. However, it also raises state sovereignty and conflict of laws issues related to Virginia’s own health care law\textsuperscript{134} passed just days before PPACA’s enactment. Virginia Attorney General Cuccinelli alleges that the direct conflict between Virginia’s own health care law and PPACA creates an actual controversy which establishes standing.\textsuperscript{135} DOJ filed a motion to dismiss Virginia’s case on May 24, 2010, claiming the Commonwealth manufactured standing by passing its health care law.\textsuperscript{136} DOJ also quipped

\begin{quote}

130. Id.

131. PPACA, Pub. L. No. 111–148, § 1321(c), 124 Stat. 119 (2010) ("If (A) a State is not an electing State under subsection (b); or (B) the Secretary determines, on or before January 1, 2013, that an electing State—(i) will not have any required Exchange operational by January 1, 2014; or (ii) has not taken the actions the Secretary determines necessary to implement—(I) the other requirements set forth in the standards under subsection (a); or (II) the requirements set forth in subtitles A and C and the amendments made by such subtitles; the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements."). Concerning costs, the federal government will reimburse states for all of benefits paid to newly eligible recipients from 2014 to 2016. Department of Justice Response to Florida, Florida v. U.S. Dep’t of Health & Human Servs., at 10. After 2019, these reimbursements level off at 90%. Id. at 11.


134. VA. CODE ANN. § 38.2-3430.1:1 (2010). During its 2010 Regular Session, the Virginia General Assembly passed this law which exempts Virginia residents from any federal or state requirement to purchase health insurance, or fines for failure to purchase such insurance. The provision was signed into law by Virginia Governor Bob McDonnell on March 10, 2010, thirteen days before President Obama signed PPACA.


136. Sebelius Response to Virginia at 1, Virginia v. Sebelius, No. 3:10-cv-00188-HEH (E.D. Va. Mar. 23, 2010). Allowing such an action would empower any state to import any dispute with the federal government into federal court simply by passing a conflicting law. Id. DOJ also points to precedent that suggests a state may not protect its citizens from the operation of federal statutes. Virginia’s challenge focuses on the individual mandate and alleges no actual or imminent injury to its own interests as a state. Since the challenged provision only applies to individuals, the state has not shown that it has suffered a direct or concrete injury or that it is in
that the issues raised are not yet ripe because PPACA’s individual mandate provisions are not yet in effect. 137 On June 18, 2010, the Washington, D.C. based group Doctors for America urged Virginia’s Attorney General to withdraw his case to avoid harming patients in Virginia’s underserved populations by delaying federal funding for health care services. 138 Senator Orrin Hatch (R-Utah) mentioned Virginia’s suit as part of a growing nationwide movement to repeal PPACA altogether, 139 although a Congressional vote to repeal PPACA’s individual mandate failed along mostly partisan lines. 140

IV. POTENTIAL IMPACTS OF STATE-BASED FEDERALISM CHALLENGES ON NATIONAL HEALTH CARE REFORM

In furtherance of their perceived roles and positions in the U.S. federalist system of government, states have advanced an array of arguments and impediments to Congress’ attempt to reform national health care insurance and services. Reflecting popular sentiment (in some jurisdictions) and traditional notions of state sovereignty, multiple states are poised to battle federal authorities over the scope and application of federal powers, funding, and policies to reform health care initiatives that impair state responsibilities and directly affect state residents. Limiting the impact of PPACA may be the overriding goal. Are states, however, positioned legally

137. Sebelius Response to Virginia, Virginia v. Sebelius, at 18. Since the mandate does not take effect until 2014, judicial review is not warranted because it rests upon “contingent future events . . . [that] may not occur at all.” Id. Virginia has countered that argument with a sworn affidavit by Virginia Health & Human Resources Secretary Bill Hazel. Hazel Aff. at ¶ 7, 13, No. ECF 3:10-cv-00188-HEH (June 7, 2010). Hazel’s filing details the effects the law has had on Virginia already. To date, the Commonwealth has been forced to elect whether to establish a state insurance exchange or forgo substantial sums by not doing so. Additionally, employees and officials have begun to alter their routines to prepare for the effects of the PPACA on Virginia’s Medicaid and insurance regulatory systems. Id.


to accomplish this objective in reclamation of their conception of states' rights and in defense of their residents' expectations? In this Part, we briefly lay out and discuss the merits of existing or prospective state-based arguments or options grounded in principles of federalism, including (1) states' legislative attempts to obviate PPACA’s individual and employer mandate requirements; (2) the limits of Congress’ commerce powers in support of these mandates; (3) Congress’ attempt to distinguish taxes and penalties in PPACA related to individual failures to obtain health insurance; (4) the ability of states to bypass federal control through PPACA’s Wyden Amendment; and (5) the scope of PPACA’s intrusions into state’s traditional public health roles and responsibilities.

A. Health Insurance Mandates: Will State Legislative Responses Succeed?

As described above, a majority of states have proposed, introduced, or adopted either constitutional or statutory amendments to block the federal implementation of individual and employer mandates within their borders. The impact of these proposals is limited due to the supremacy of federal law in the constitutional system. Under the Supremacy Clause of the U.S. Constitution, federal laws passed by Congress, pursuant to its delegated powers and consistent with structural principles of federalism, preempt conflicting or contrary state laws. State law is preempted where (1) it "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress;" or(2) "it is impossible to comply with both state and federal requirements." Multiple state officials have already questioned whether their proposals to block individual and employer mandates will be effective. The Arizona House of Representatives Committee on Rules has noted that H.C.R. 2014 must yield to any federal law. Similarly, Arkansas’ and Tennessee’s Attorney Generals have

141. See supra Part II.
142. U.S. CONST. art. 6, § 2.
144. Major, 278 F. Supp. 2d at 607 (noting four ways that a state law will be preempted by federal legislation including, “(1) Congress expressly defines the extent to which federal law preempts state law; (2) state law regulates conduct in a field that Congress intended the federal government to occupy exclusively; (3) it is impossible to comply with both state and federal requirements; or (4) the state law poses an obstacle to the accomplishment and execution of congressional purposes”).
opined that their states’ proposals will likely be preempted by PPACA. Conversely, Tennessee’s Attorney General suggested that other proposed bills prohibiting the state from requiring individuals to participate in a health care system or plan (as opposed to simply blocking federal mandates) are constitutionally valid because the prohibitions applied to the state, and thus could not be preempted by PPACA.

Ultimately, state actions to prohibit or limit enforcement of PPACA’s individual and employer mandates will likely be preempted under the Supremacy Clause for two primary reasons. First, aside from proposals that specifically apply to state actions, state laws seeking to block federal mandates will make it impossible for individuals to comply with PPACA and state law. Where federal and state laws directly conflict, federal law wins. Additionally, state proposals prohibiting individuals from being compelled to obtain health insurance directly contravene a stated objective of PPACA to increase the number of individuals with health insurance. Unless courts find that PPACA’s mandate provisions are an improper use of Congress’ Commerce powers or inviolate of principles of federalism (discussed below), state actions to derail individual and employer mandates may reflect popular sentiment, but lack legal support.

B. The Limits of Congress’ Interstate Commerce Powers

The Commerce Clause authorizes Congress to extensively regulate interstate commerce. Judicial interpretations have historically expanded the scope of Congress’ commerce powers, despite limited concerns about infringement of state sovereignty. While the U.S. Supreme Court has rarely struck down Congress’ authority to act in the interests of regulating interstate commerce, it has clarified that Congress’ commerce powers are

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147. Op. Att’y Gen. No. 10-47, 2010 WL 1524188 (Tenn. April, 2010) (While the Attorney General opined that the bills were constitutionally valid because they were not preempted, they were not valid per their attempt to restrict future actions by the Tennessee General Assembly).

148. Id.


151. Id.; see also United States v. Morrison, 529 U.S. 598 (2000); United States v. Lopez, 514 U.S. 549 (1995). These are recent cases where federal acts have been struck down on the basis they exceeded Commerce Clause powers.
not equivalent to states’ police powers. Against this backdrop, states’ arguments that PPACA’s individual mandate requirement unconstitutionally stretches Congress’ commerce powers are notable. Under PPACA, individuals may be penalized monetarily for their decisions not to purchase health insurance. Whether to enter into a private contract with a health insurance company or face monetary fines may be a choice states can impose on residents through states’ broad police powers, but there may be no identical examples of this type of Congressional coercion through the use of interstate commerce powers.

Still, PPACA’s link to regulating interstate commerce is seemingly clear. There is a near universal need of each American for health care insurance and health care services. Absent requirements for individuals to obtain health insurance, individuals may seek to purchase health insurance only when they are ill or in their later years when they are more likely to need it, pay out of pocket for routine health expenses in the interim, and rely on existing federal law that requires hospitals to provide emergency treatment regardless of one’s ability to pay (which remains intact after passage of PPACA). In the aggregate, individual decisions to forego health insurance affect interstate commerce by raising the cost of health insurance and care for all. The constitutionality of PPACA’s individual mandate may turn on whether courts find that an individual’s decision whether or not to purchase health insurance is a commercial activity that “substantially affects interstate commerce.” The novel question is whether Congress is empowered to regulate this and other forms of individual inactivity. If individuals can be required to obtain health insurance in furtherance of regulating interstate commerce, can they also be required to purchase other goods and services which may provide no immediate, direct benefit to the individual but further the common good?

152. Lopez, 514 U.S. at 549; Hodge, supra note 150.
153. See Gonzales v. Oregon, 546 U.S. 243, 270 (2006) (such a mandate and fine structures are conceptually part of the states’ police powers).
154. PPACA § 2704 (prohibiting insurance companies from denying coverage for pre-existing conditions). As a result, U.S. citizens can wait until they get sick before purchasing health insurance without fear of being denied coverage altogether.
157. PPACA § 1303(c) (“Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including [EMTALA].”).
159. Gonzales v. Raich, 545 U.S. 1, 24 (2005).
Answering this question may require courts to “define the outer boundaries’ of federal regulatory power.”

C. Federal Tax or Penalty: The End of Individual Mandates?

Federal taxes are typically levied to generate revenue and discourage or prohibit certain economic activities. Federal penalties, however, are imposed to regulate or punish behavior. As noted above, in passing PPACA Congress supported its individual mandate requirement by suggesting the purchase (or lack thereof) of health insurance substantially affects interstate commerce. To this end, the consequence of individual non-compliance with the mandate technically results in a penalty, not a tax. This conclusion is consistent with President Obama’s past assertions. Yet the Obama administration and DOJ are now seeking to re-characterize the penalty for failure to obtain health insurance as a tax. The “Technical Explanation” of PPACA’s revenue provisions, published by the non-partisan Congressional Joint Committee on Taxation, consistently refers to the penalty as a tax. In its response to Florida’s

160. Sack, supra note 94.
162. PPACA § 1501(a)(1).
163. id. § 10901 (excise tax on high cost employer-sponsored health coverage); id. § 10907 (excise tax on indoor tanning services). Whereas in sections of the same bill which discuss indoor tanning salons and “cadillac plans,” for example, the word “tax” is used consistently.
164. This Week: Interview With President Barack Obama, ABC NEWS, Sept. 20, 2009, available at http://abcnews.go.com/print?id=8618937 (President Obama stated the penalty was a fine and not a tax when questioned about raising taxes on middle class families).
167. The Joint Committee on Taxation, Congress of the United States: Overview, http://www.jct.gov/about-us/overview.html (last visited Nov. 7, 2010) (“The Joint Committee on Taxation is a [Congressional,] nonpartisan committee . . . originally established under the Revenue Act of 1926. The Joint Committee operates with an experienced professional staff of Ph.D economists, attorneys, and accountants, who assist [Congress members of both parties] on tax legislation.”).
168. Bailey v. Drexel Furniture Co., 259 U.S. 20, 38 (1922) (there comes a time in the extension of the penalizing feathers of the so-called tax when it loses its character as such and becomes a mere penalty with the characteristics of regulation and punishment).
DOJ indicated that the law “imposes a tax on the choice of a method to finance the future cost of one’s health care.”

Beyond the semantic debate over the meaning of taxes and penalties, attempts to justify the individual mandate under Congress’ taxing power are problematic. Without clear Congressional intent to raise revenue, courts may not consider the constitutionality of the individual mandate under Congress’ near limitless taxing power because Congress consistently used the word “penalty” in PPACA in reference to the individual mandate. This suggests Congress sought to generate revenues through PPACA. Demonstrating a revenue-based intent underlying PPACA’s individual mandate provision is difficult. If the provision results in complete compliance among citizens, it will generate no additional revenue (because the federal government will not collect any fines).

Furthermore, enforcement of this provision is tasked to the Internal Revenue Service, but PPACA specifies that no criminal penalties, liens, or levies can be imposed against individuals for their non-compliance, which is contrary to other tax enforcement schemes. A court’s refusal to consider the penalty a tax would require Congress to rely on its commerce powers to justify the individual mandate provisions of PPACA, which, as noted above, could be problematic.


171. Sonzinsky v. United States, 300 U.S. 506, 513–14 (1937) (the court will not look behind a Congressional failure to assert whether the provision was intended to be a tax).


173. PPACA §§ 1501(a)(1), 1501(b).


175. Id. § 5000a(g)(2)(A).

176. Id. § 9012 (violating Presidential Election Campaign Fund limits could result in a $5,000 fine or one year in jail).

Amidst arguments over PPACA’s mandates, the Act provides states with the ability to opt out of these requirements through what is known as the “Wyden Amendment.” A state can request a waiver of the individual mandate and other PPACA provisions from the Secretaries of DHHS and the Treasury Department if the state passes its own law to provide comprehensive health insurance for its residents which is as affordable as the federal plan and does not increase the federal deficit.

Some states’ independent health reform efforts cover similar issues addressed by PPACA, including: (1) expansion of or adjustments to eligibility Medicaid and similar programs; (2) regulation of the health insurance industry’s practices; or (3) the implementation of universal coverage via individual mandates or single-payer plans. States’ universal coverage programs may specifically qualify states for Wyden waivers. As of July 2009, three states (Maine, Massachusetts, and Vermont) had implemented plans to provide health insurance coverage to their residents. Several other states have similarly sought to provide residents

178. RON WYDEN, STATE WAIVERS: HOW A STATE COULD DO HEALTH REFORM ITS OWN WAY, http://wyden.senate.gov/download/?id=6073398f-c82c-42f4-8da5-e004a867e01a (last visited Nov. 7, 2010) (among other provisions including: employer penalty for not providing coverage; exact standards for a basic health insurance policy; health insurance exchange; and design for how federal subsidies would have to reduce premiums and copays).

179. PPACA, Pub. L. No. 111-148, § 1332, 124 Stat. 119 (2010). The Wyden Amendment is also referred to as the “Empowering States to be Innovative Amendment.” The amendment was taken almost verbatim from Senator Wyden’s “Healthy Americans Act.” Sam Stein, WYDEN, supra note 178 (state plans must cover at least as many people as the federal plan would).

180. Id. § 1332 (secretaries have 180 days to respond).

181. WYDEN, supra note 178 (state plans must cover at least as many people as the federal plan would).


184. S.B. 810, 2009–2010 Leg., Reg. Sess. (Cal. 2010) (introducing a single payer system as the sole health care service plan to be sold in the state).

185. KAISER COMM’N, supra note 182 (mandates were included in universal coverage plans in Maine, Massachusetts, and Vermont).
with universal health care coverage,\textsuperscript{186} with varying degrees of success due to political opposition and timing.\textsuperscript{187}

Although states’ efforts to provide universal coverage may meet Wyden Amendment requirements, there may be little incentive to quickly develop such programs. Relief for states from PPACA’s individual mandates and other provisions is not allowed until 2017, three years after the individual mandate takes effect.\textsuperscript{188} Forthcoming regulations from DHHS on the specific criteria to compare states’ plans against PPACA’s requirements leave states guessing as to exactly what they must do to receive a waiver. Whether states ultimately take the bait and legislate in promotion of the federal purposes underlying PPACA leads to federalism questions. Will states legislate in a manner consistent with Congress’ express objectives to escape direct federal control of their residents’ health care coverage? And if so, will state-based health insurance coverage assimilate Congress’ ideals pursuant to PPACA? If most states opt for waivers under the Wyden Amendment, even slight variations in their coverage may partly derail Congress’ goal of universal benefits and equal access.

\textit{E. Federal Intrusions into State Sovereignty to Protect the Public’s Health}

Core principles of federalism are consistently raised whenever federal actors attempt to enter the domain of public health traditionally reserved to the states.\textsuperscript{189} Though principally geared toward expanding access to

\textsuperscript{186} For Example, in 2009, Hawaii passed an act that created the Hawaii Health Authority to develop a comprehensive plan to provide universal coverage. H.B. 1504, 25th Leg., Reg. Sess. (Haw. 2009). Vermont passed similar legislation which established the goal of universal access to health care, S. 88, 2009–2010 Leg., Reg. Sess. (Vt. 2009), but failed to pass legislation establishing a single-payer system, H. 0491, 2009–2010 Leg., Reg. Sess. (Vt. 2009), or a comprehensive plan, H. 0510, 2009–2010 Leg., Reg. Sess. (Vt. 2009). Funding sources vary among states. While some states have proposed a tax increase (on tobacco products, health insurers, or through personal income taxes), others have considered reallocating existing federal health care funds or mandate-related penalties. AM. COLL. OF EMERGENCY PHYSICIANS, supra note 183.


\textsuperscript{189} Hodge, supra note 150.
individual health care services through insurance reforms, PPACA contains many provisions to directly promote the public’s health. Under PPACA, the federal government will:

- develop a national strategy to improve health care services, patient health outcomes, and population health;\(^{190}\)
- fund or establish a variety of public health awareness campaigns, educational programs, training,\(^{191}\) and research;\(^{192}\)
- attempt to measure the quality of health services and federal health programs;\(^{193}\)
- improve monitoring of infectious diseases and congenital health disease;\(^{194}\)
- provide state assistance for recommended immunizations for high-risk populations;\(^{195}\)
- set nutritional labeling of standard menu items at chain restaurants;\(^{196}\)
- focus on preventive care through Medicare/Medicaid coverage\(^{197}\) and through grants to states and other entities;\(^{198}\)
- support community and school-based health centers, community-based health teams, and nurse-managed health clinics;\(^{199}\) and
- establish corps of medical and public health personnel ready to serve in national emergencies.\(^{200}\)

\(^{190}\) PPACA § 3011.
\(^{191}\) Id. § 5314 (Fellowship Training in Public Health); id. § 5315 (U.S. Public Health Sciences Track).
\(^{192}\) Id. § 2952 (Postpartum Depression); id. § 2953 (Personal Responsibility Education for Adolescents); id. § 4004 (Preventive Benefits); id. § 4102 (Oral Healthcare Prevention); id. § 4305 (Pain Care); id. § 10413 (Young Women’s Breast Cancer).
\(^{193}\) Id. § 3011 (National Strategy); id. § 3013 (Quality Measure Development); id. § 3504 (Design and Implementation of Regionalized Systems for Emergency Care); id. § 4402 (Effectiveness of Federal Health and Wellness Initiatives); id. § 4302 (Understanding Health Disparities: Data Collection and Analysis); id. § 4301 (Research on Optimizing the Delivery of Public Health Services).
\(^{194}\) Id. § 4304 (Epidemiology-Laboratory Capacity Grants); id. § 10411 (Congenital Heart Disease).
\(^{195}\) Id. § 4204 (Immunizations).
\(^{196}\) Id. § 4205 (Nutrition Labeling of Standard Menu Items at Chain Restaurants).
\(^{197}\) Id. § 4103 (Medicare Coverage of Annual Wellness Visit); id. §§ 4104–06 (Preventive Services in Medicare); id. § 4108 (Preventive Services in Medicaid); id. § 4202 (Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries); id. § 4107 (Medicaid Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women).
\(^{198}\) Id. §§ 4001–03, 4201 (Research on the Effectiveness of Preventive Care Services); id. § 4206 (Demonstration Project for Individualized Wellness Plan).
\(^{199}\) Id. § 3502 (Community Health Teams); id. § 4101 (School-based Health Centers); id. § 10503 (Community Health Centers and the National Health Service Corps Fund); id. § 5208 (Nurse-Managed Health Clinics).
\(^{200}\) Id. § 5210 (Ready Reserve Corps).
By design these federal efforts include active input, participation, and buy-in of state, tribal, and local public health authorities. Collectively, however, they further the role and funding prowess of federal health authorities in setting national public health priorities and programs. Nationalizing public health services may be synergistic with efforts to nationalize health care. Improving the nation’s public’s health will arguably improve individual’s health outcomes. Yet, traditional public health responsibilities at the state (and local) levels may lead some states to resist what may be characterized as federal intrusions in PPACA, designed to reshape state-based public health programs and priorities. Though largely powerless to contest Congress’ use of its spending powers to set conditions for state receipt of federal public health funds, states may generate unique legal arguments grounded in federalism to stymie efforts to nationalize the protection of the public’s health, especially if state-based public health officials perceive their role is diminished or unheard in implementing PPACA’s public health measures. Potentially lost in these types of claims is the realization that PPACA, though structured as a health care measure, is quintessentially a public health act designed to improve chronic public health outcomes stemming from lack of access and inequitable care.

V. CONCLUSION

Few disagree that the current U.S. health care system underperforms and is unsustainable. The enactment of PPACA represents a historic and notable change in U.S. policy regarding how health care and health insurance are provided, what they must cover, and who is entitled or required to get them. National health care reforms, however, face considerable challenges grounded in states’ resistance to increased federal control and mandates over individual decisions and market choices. To the extent that PPACA displaces states’ roles in determining how best to protect individual and communal health of its residents, federalism-based arguments will arise. State-based attempts to derail PPACA’s individual mandate provisions as unconstitutional expansions of Congress’ commerce power or improper uses of its taxing power reflect states’ concerns over their rights and roles in a federalist system. Resolution of existing and future state-based judicial claims, legislative maneuvers, and elections will ultimately reshape how health care and public health services are delivered.

in the United States. While states challenge the validity of PPACA, they are faced simultaneously with the conflicting need to implement its provisions.²⁰² Hanging in the balance is the health of millions of Americans who are counting on government and the private sector to finally get it right.

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²⁰² See Sack, supra note 90.