

How the Patient Protection and Affordable Care Act (PPACA) Supports Federalism

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Since its enactment on March 23, 2010, much of the commentary on the Patient Protection and Affordable Care Act (PPACA) has focused on whether the Act unduly eviscerates long-enshrined views of federalism¹. While conventional wisdom is that PPACA is a watershed moment in the federal government's usurpation of state powers, this criticism adopts an unduly narrow view of states' rights and the notion of federalism. Rather than rebuking federalism, the PPACA actually augments federalist principles in important ways. Ultimately, by putting aside the federalism attacks, both proponents and opponents of the legislation can focus on and debate the merits of the legislation.

The PPACA and its "Affront" to Federalism

The PPACA, colloquially derided by its critics as "ObamaCare", was signed into law on March 23, 2010². The lengthy legislation attempts to solve the full panoply of the nation's healthcare problems: it purports to reform certain aspects of the private health insurance industry and public health insurance programs, increases insurance coverage of pre-existing conditions, expands access to healthcare insurance, and increases projected national medical spending while lowering projected Medicare spending³.

The Act is divided into ten titles and contains provisions that became effective immediately, 90 days after enactment, and six months after enactment, as well as provisions that will become effective in 2014, 2017, and 2018. The "real meat" of the Act is provisions that become effective by January 1, 2014. In particular, by that date, the following two new requirements go into effect:

- States "shall" establish individual health insurance exchanges so that all residents can buy healthcare insurance. If a state chooses not to establish an exchange, the federal government will step in and set up such an exchange for that state⁴.
- States are required to expand Medicaid coverage to include all individuals with income up to 138% of the poverty line, including adults without dependent children⁵.

With respect to the first change, under Section 1311, the Secretary of Health and Human Services (HHS) is to make grants to state officials so that they can establish an American Health Benefit Exchange in each state. The Secretary is authorized to determine the grant amount and to renew it for a state that is "making progress" in implementing the federal insurance rules and meeting "other such benchmarks as the Secretary may establish." With the Secretary's approval, states may also establish multi-state exchanges. Under Section 1321(c) (1), the Secretary is required to establish and run an exchange in states that do not (or cannot) do so by January 1, 2014. The exchanges are to facilitate the purchase of a "qualified" health plan.

¹See, e.g., The Never-Ending Dispute, Harvard Political Review, April 5, 2011, available at <http://hpronline.org/united-states/12591/>.

² See <http://www.govtrack.us/congress/bills/111/hr3590>.

³ See <http://www.whitehouse.gov/healthreform>.

⁴Section 1311 of PPACA.

⁵Section 2001(a) of PPACA.

With respect to the second change, Section 2001(a) of PPACA requires states to increase Medicaid eligibility to cover all Americans below 138 percent of the Federal Poverty Level (FPL) beginning January 1, 2014. Section 1201 of the reconciliation bill (H.R. 4872) specifies that the federal government will pick up 100 percent of the cost of providing coverage for the expansion population (those who qualify under the new requirements but were ineligible under the previous state eligibility criteria) between 2014 and 2016. The federal reimbursement for the newly eligible will gradually decline thereafter until 2020, when the federal share of the cost will stay at 90 percent.

While PPACA purports to do much more to influence healthcare policy, it is these two provisions, in particular that have caused much angst amongst those who believe in states' rights and the principles of federalism. These two provisions, therefore, are the chief focus of this article.

To be sure, other provisions have attracted considerable more criticism. For example, under Section 1501 of the Act, individuals will be assessed a monetary penalty if they do not purchase a health insurance plan that meets the federal definition of "minimum essential benefits". This "individual mandate" has been widely criticized for violating personal liberty and for a vast overreach of Congressional power. This provision is the lion share argument before the U.S. Supreme Court's case dealing with PPACA in *National Federation of Independent Businesses v. Sebelius* and *Florida v. DHHS* (Department of Health and Human Services). While some have tried to fashion the "individual mandate" provision a question of "federalism," it more appropriately is a question as to whether Congress has the power, under Article I of the Constitution, to enact these minimum coverage requirements. Thus, the question relates to Congressional power over individuals, as opposed to Congressional power to commandeer states. Therefore, the individual mandate provision is outside the scope of this article.

The Laurels of Federalism

Broadly, federalism in the United States is the evolving relationship between the powers of the state governments and the federal government. As explained by the founding fathers of the country, the

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states and national government “are in fact but different agents and trustees of the people, constituted with different powers”⁶.

The initial amendments to the U.S. Constitution recognized the importance of states’ rights. Indeed, the Tenth Amendment specifically notes that, “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people”⁷.

While initially designed as a check against oppressive federal influence, federalism today recognizes the idea that local governments, which are closer to the people and issues, should have the ability to fashion practical, local-based solutions⁸. Thus, federalism embraces the idea that Hawaii, for example, should be able to craft a solution to problems facing Hawaiians without undue influence from a central government.

Federalism can have many prudential benefits for the people. For example, division of work between the federal and the regional governments may lead to optimum utilization of resources. The federal government can concentrate more on international affairs and defense of the country while the provincial government can cater to the local needs. Moreover, federalism allows room for innovation and experimentation. Two local governments can have two different approaches to bring reforms in any area of public domain. The comparison of the results of these policies can give a clear idea of which policy is better and thus, can be adopted in the future.

To those critical of the PPACA, the Act encroaches on the core values of federalism by coercing states into to be agents of the federal government and by forcing states to adopt broad one-size fits all solutions to the nation’s healthcare epidemics⁹. But, as demonstrated below, this view of federalism is unduly narrow. Rather than limit and encroach federalism, PPACA actually augments the federalist spirit by embracing experimentation, innovation, and a spirit of cooperation. To understand this, we review the details of the two provisions above and outline how each provision embraces and encourages the principles of federalism.

How the Health Insurance Exchanges Augment Federalism

According to PPACA, by 2014, states will be required to establish a health insurance exchange in accordance with the federal rules and guidelines. If a state chooses not to establish an exchange, the federal government will step in and set up such an exchange for that state. Under Section 1311(d) (4), the states are to set up the exchanges to meet the minimum functions defined in law, subject to the Secretary’s regulation. This includes:

- Certification of health plans as “qualified plans” to be offered in the exchange;
- Marketing rules for health plans;

- A requirement that a plan has a sufficient number of providers in addition to a network of “essential community providers” to serve low-income persons;
- A requirement that a health plan meet federally approved quality standards;
- Implementation of a health plan “quality improvement” strategy as defined by federal officials;
- Use of a “uniform enrollment form” for qualified individuals and employers;
- Use of a standard format for the presentation of health benefit and plan options;
- Provision of appropriate information to enrollees or prospective enrollees in the exchange;
- Development of a rating system for health plans on the basis of quality and price;
- Development of a consumer satisfaction survey to determine the “level of patient satisfaction” with health plans offered through the exchange;
- Preparation of a template for Internet use for plan comparisons and federal subsidies for coverage; and
- Provision of “open enrollment procedures” in accordance with the Secretary’s determinations.

It is these minimum requirements of the health insurance exchanges that have sparked the most concern among federalists¹⁰. These requirements are seen as not necessarily overly burdensome but rather as a federal effort to commandeer the states into providing health insurance coverage¹¹. However, this view reflects an unduly narrow view of federalism.

To understand why this view of federalism is unduly narrow, it is important to start with the threshold notion that the federal government has the constitutional power to establish broad insurance programs such as Medicare and Medicaid. These programs have been a cornerstone of the federal government’s healthcare policy for more than 60 years. Similarly, in enacting PPACA, Congress could have created a wholesale federal health insurance exchange program. Yet, its restraint in not doing so – and instead imposing minimum guidelines for states to use in creating their own individual programs – actually promotes federalism. That is, the federal government has set a minimum floor on insurance coverage. It has now left it to states’ well-informed discretion to fashion a local practical program. By exercising restraint and not adopting a monolithic federal health insurance exchange, the PPACA very much supports the ideals of federalism.

The common retort to such an argument is that the federal government has nonetheless overreached in that it has effectively required states to offer some type of healthcare insurance options to all individuals, not just the poor or elderly. Indeed, that is true – the whole thrust of PPACA was to expand healthcare insurance coverage to all Americans. Yet, once that threshold decision was made, the next analytical question was whether the federal government should impose a national insurance framework or allow each state to craft its own solution to this vexing problem. By opting for the later course, the

⁶ See Federalist No. 46.

⁷ Tenth Amendment, U.S. Constitution.

⁸ The Value of Federalism in Defining Essential Health Benefits, Alan Weil, N Engl J Med 2012; 366:679-681

⁹ The Case Against Obamacare: Health Care Policy Series for the 112th Congress, Heritage Foundation, available at <http://www.heritage.org/research/projects/the-case-against-obamacare#ref6>.

¹⁰ See, e.g., Robert Moffit, Obamacare and Federal Health Exchanges: Undermining State Flexibility, available at <http://www.heritage.org/research/reports/2011/01/obamacare-and-federal-health-exchanges-undermining-state-flexibility>

¹¹Id.

PPACA augments federalism and embraces a spirit of innovation and experimentation¹².

Lastly, it is of no avail to suggest that the federal government abrogated federalist principles by suggesting minimum standards that all state health insurance exchanges must meet. The federal government has set a minimum floor for all insurance exchanges. But, the minimum is so low and ambiguous that almost any exchange will effectively meet these requirements. Moreover, if a state feels it is unable to meet these minimum requirements, it may effectively “do nothing” and allow the federal government to craft a workable framework.

Thus, opponents of PPACA who cite the undue burden on federalism would be better served by realizing that the PPACA model actually augments the spirit of federalism and, in many ways, should serve as the basis for future federal programs. Instead of invoking the federalist retorts, PPACA’s opponents should focus on the merits of the Act and discuss those provisions. Doing so would not only be more candid but would also allow an intelligent debate on the substance, rather than the process, of the legislation.

How Expanding Medicaid Coverage Augments Federalism

PPACA’s requirement that states expand Medicaid coverage to include all individuals with income up to 138% of the poverty line has caused angst among proponents of federalism¹³. To these individuals, the federal government’s insistence that states cover more individuals under Medicaid simply shifts financial burdens to the states and further limits state flexibility.

As a threshold matter, it is useful to note that the Reconciliation Bill which implemented PPACA specified that the federal government will pick up 100 percent of the cost of providing coverage for the expanding population (those who qualify under the new requirements but were ineligible under the previous state eligibility criteria) between 2014 and 2016¹⁴. Further, the federal reimbursement for the newly eligible will gradually decline thereafter until 2020, when the federal share of the cost will stay at 90 percent. Thus, state governments will bear only a modest additional financial burden of these new enrollees.

But, more fundamentally, the idea that expanding Medicaid coverage somehow encroaches federalist principles is somewhat misguided. By expanding coverage to those individuals and families making 138% of the poverty line, the federal government has simply done transparently what it could have done opaquely: that is, the government made a policy determination that individuals making slightly above the federal poverty limit cannot afford to purchase their own healthcare coverage. It is axiomatic that the federal government could have simply inflated to the poverty line by 38% and swept these individuals into Medicaid’s ambit. Instead of doing that and obfuscating the real issues, the government made a policy decision to explicitly require Medicare coverage to be more expansive.

Ultimately, whether one believes in the principle of Medicaid or believes the government should scrap the program altogether, the conclusion is the same: expanding coverage to include those individuals somewhat above the federal poverty line does not abrogate the concepts of federalism. Rather, the PPACA’s requirement to expand Medicaid reflects a reality that the poverty line is not a perfect barometer to delineate those individuals who can afford healthcare coverage and those who cannot.

Rather than disagree with PPACA as an affront to federalism, critics would be better served by focusing on the real issues: whether Medicaid is the best way to provide healthcare coverage to the poor, why healthcare insurance costs so much, and whether the government can do anything to curb healthcare costs. Conversely, by focusing on the illusions of an attack on federalism, PPACA critics are obfuscating the real issues.

Conclusion

The PPACA is an ambitious government legislation that may or may not solve the healthcare challenges in the United States. Notwithstanding the merits of the Act, critics of the Act are incorrect in arguing that the Act abrogates federalism and unduly encroaches on states’ rights. Critics of the legislation would be better served by focusing on the real flaws in the bill; indeed, by doing so, these opponents would ensure a more robust debate on the merits of the legislation’s goals.

¹²This is not to suggest one way or the other that healthcare coverage should be available, through government programs, to all individuals. But, by resolving the federalist attack on PPACA, it is our hope that a discussion can be held on these more substantive issues, rather than these red herring arguments.

¹³Previously, Medicaid coverage was limited to those individuals up to 100% of the poverty line.

¹⁴Section 1201 of PPACA.