PREVIEW
OF UNITED STATES SUPREME COURT CASES

Health Care and the High Court
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From the Editor

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From managed care for farmers to the ACA challenges, the history of health care in America. Includes a timeline.

The Legal Teams: A Scorecard of the Key Players
An inside look at the all-star lineup of veteran Supreme Court advocates the parties and amici have recruited to argue the ACA challenges.

The Health Care Challenges: A Short (if not Sweet) Road to the Supreme Court
In the short time since the ACA was enacted, the challenges have had an interesting history. Professor Bradley W. Joondeph follows the swift path they have taken from trial courts all the way to the highest court in the land.

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Experts’ Poll
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Another Perspective: The Corporate Practice of Medicine and Accountable Care Organizations
Offering a new lens to look at the ACA, Bruce Howell looks at the intersection between the corporate practice of medicine and accountable care organizations.

The Ebbs and Flows of Federalism at the High Court
With the ACA challenges, the Supreme Court once again wades into the murky waters of federalism. Professor Steven D. Schwinn traces the Court’s recent path on federalism cases and the possible implications of the trend on the ACA cases.
Health care: An issue that merits special consideration

In its 40-plus-year history, *Preview* has never before published a special edition dedicated entirely to a set of related cases. So what makes the challenges to the Affordable Care Act so unique? A number of things, including the six hours of argument the Court has set aside, the divisive political debate surrounding the passage of the ACA, and the countless newspaper articles, blog posts, and television news stories on the challenges.

The controversial topic of health care reform is inherently political, with the looming presidential election making the usual rhetoric all the more heated. But beyond the headlines and sound bites, it is important not to lose sight of the important constitutional issues at play: federalism, states’ rights, individual freedoms, and limits on our courts, just to name a few. We hope that this special edition of *Preview* gives you some new and valuable insight into the legal issues before the Court—questions that implicate the constitutional roles of all three branches of our government.

In putting together this publication, we have been struck by a number of things. First, how many academics and Supreme Court experts are willing to talk about these issues in an apolitical manner. Given how politically divisive the passage of the ACA was, it is refreshing to hear legal professionals discuss these important issues in a thoughtful, respectful way. Second, we have been somewhat taken aback by the fact that most, if not all, of those “in-the-know” seem to agree that the individual mandate presents the key issue, and that that provision will be upheld; they may disagree as to how we will get there, but the safe money seems to be on the individual mandate making it through the summer. Finally—the depth of the issues the ACA has put before the Court, given that this is just one Congressional act, is breathtaking. Delving into the ACA challenges is a bit like peeling an onion. To fully understand the challenges, one almost has to become an expert in tax law, jurisdiction, federalism, the Commerce Clause and, certainly, various aspects of the health care industry. Here we have gathered the analysis and the opinion of experts in all those fields to aid your understanding.

In this publication, you will find a mix of formal analysis of the four key issues before the Court and background and commentary. From the nitty-gritty of the Tax Anti-Injunction Act to some interesting facts about the attorneys who will be arguing, the following pages will give you a sense of the breath of variety of points of views surrounding the ACA and the dynamics of the cases before the Court. The four articles highlighted in the “Case Analysis” section also appear in the regular March Issue of *Preview*. For the non-*Preview* subscribers, these expert analysis pieces will give you a small taste of the value of a *Preview* subscription.

Throughout these pages, you will find the results of a survey we conducted in preparation for this issue. In doing so, we identified a select group of academics, journalists, and lawyers who regularly follow and/or comment on the Supreme Court. Each expert participant completed the questionnaire separately without knowing what anyone else's predictions would be. Experts were told their votes would be anonymous to encourage candid responses. We encourage you to use this edition of *Preview* to deepen your awareness of the ACA challenge. The ACA decision has the possibility of teaching us a lot about our current Supreme Court and its future direction. The Court’s decision will likely lay the groundwork for any future federalism challenges to Congressional actions, and, in the process, may teach us all a little something about the formally obscure Tax Anti-Injunction Act. We hope you enjoy this publication and welcome your feedback.

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How Did We Get Here?

America’s Health Care Journey: From Managed Care for Farmers to the ACA Challenges

By Dan Heilman

It’s generally agreed among presidential observers that, one way or another, whether over one term or two, Barack Obama’s White House legacy will revolve around health care.

President Obama made it a priority of his administration to overhaul the United States’s health care system. His 2010 Patient Protection and Affordable Care Act (ACA) provides for the phased introduction over four years of a comprehensive system of mandated health insurance. The ACA also features reforms designed to eliminate such insurer policies as pre-condition screening, premium loadings, and lifetime and annual coverage caps.

The ACA’s aim is to preserve private health coverage while making coverage accessible to more people via subsidies—and everyone has his or her thoughts about who the plan will or should affect most.

“The thing that strikes me as unrecognized by both policymakers and the public at large is the degree to which employers are at risk for their health benefits for employees and their dependents,” says Mark Lutes, a health care attorney with EpsteinBakerGreen in Washington, D.C.

The fate of the ACA has yet to be played out. But while we wait on the sidelines for that result, it’s worth pondering how we got to this point—how did the American-style employer-backed, supplemented health care model evolve?

Where the story begins depends upon whom you ask. Some say its rudiments were formed during the 19th century as the plains and western states were being settled, while others insist the model didn’t really start to take shape until World War II.

Coordinated health care coverage in the United States reaches as far back as the Patrons of Husbandry’s efforts to offer coverage to member farmers in the 1880s. But others point back exactly 100 years, to President Theodore Roosevelt’s national health insurance proposal in 1912. President Roosevelt supported health insurance for practical reasons, feeling that a country with too many sick and poor citizens could never be a significant power. While President Roosevelt started the discussion, many of his successors in the Oval Office resisted involving the government in the management of social welfare in general and health care in particular.

“If you say that health care in America has basically a 100-year history, that’s where you have to start—with Teddy Roosevelt,” says professor Rob Field, a member of the law school faculty at Drexel University in Philadelphia and the author of the book Health Care Regulation in America: Complexity, Confrontation, and Compromise.

1870s: The Grange (officially the Patrons of Husbandry) helps organize access to health care for member farmers in the Plains States.

1912: Roosevelt first proposes national health insurance.

1915: Progressive politicians propose bill to provide subsidized health coverage for the poor.

1930s: Blue Cross and Blue Shield expand the field of employer-backed health coverage.

1940s: FDR continues to support national health reform throughout his terms.
For the next few decades, the health care discussion was carried forward primarily by progressive groups. The American Association of Labor Legislation drafted a model bill in 1915 that would have provided coverage to, and only to, the working class and all others earning less than $1,200 per year, with costs to be shared between workers, employers, and the state. The reforms failed in the face of opposition from doctors, labor, insurance companies, and business interests, although the effort continued the conversation about compulsory national health insurance that continues today.

**FDR AND HEALTH CARE**

As the Great Depression wound down and World War II was heating up, a number of intertwined efforts toward national health insurance coincided with Franklin D. Roosevelt’s presidency. The 1943 Wagner-Murray-Dingell Bill, a consolidation of several previous related bills, called for compulsory national health insurance and a payroll tax.

But—in another sign of things to come—the bill was attacked as smacking of socialism. “Franklin Roosevelt decided not to include universal health care with Social Security for fear that it would be too contentious and sink the entire program,” says Field.

Around the same time, a major health care development was brewing in the private sector. Blue Cross and Blue Shield organizations began developing before World War II. They weren’t the giant organizations that we know today, but they did offer a fairly simple indemnity insurance for hospital care under the Cross label and doctor care under the Shield label.

“It was really during World War II when, in order to control the economics of the country during the war, wage and price controls were in place,” says Bruce Merlin Fried, a partner with SNR Denton in New York and a member of its Healthcare and Public Law and Policy Strategies practice. “The labor unions were able to negotiate for expanded benefits when they couldn’t negotiate for higher wages. That’s really where labor and employers really began to agree to offer this new benefit to their workforce: health insurance.”

In the late 1940s, President Harry S. Truman made an effort at developing a national health insurance program that, again, ended up drawing charges of Communism from the American Association of Labor Legislation. The discussion continued into the 1960s, as the debate focused on providing the means for older people to access health care.

“By this time, there was a more robust health care system, and coverage for workers and their families was just standard,” says Fried.

**THE “GREAT SOCIETY”**

It took Lyndon Johnson’s “Great Society” to spur the next great leap in American health care coverage. A congressional proposal to cover hospital costs for the aged spurred a major grass roots campaign that led to expanded legislation covering physician services. The results were Medicare and Medicaid, which have survived, though not without bruises, to this day.

“That was the biggest success from a policy standpoint,” said Field. “A lot of people thought that would be a first step toward getting universal coverage.”

The larger discussion mostly stagnated for the next couple of decades as priority was placed on containing health care costs rather than on expanded coverage. President Bill Clinton proposed a managed competition approach to health care. Under his plan, President Clinton called for universal coverage, employer and individual mandates, and competition between insurers, with government regulation to control costs. Opposition from both parties, along with a flurry of alternative proposals, killed President Clinton’s plan.

“That was the biggest failure because at the time he had a lot of political momentum and wasn’t able to use it,” says Field.

In terms of major health care developments in the United States, that brings us more or less up to date. The fight will go on, from the highest reaches of the judicial system to the trenches occupied by doctors and patients.

“In the ideal world, we would only have the patient-doctor relationship or the patient-doctor-hospital relationship,” says Gabriela Cora, M.D., MBA, a Miami doctor and speaker on health issues. “Payment systems would occur between patients and their doctors or patients and hospitals. Fees would be paid directly or through a bank. If there was a problem, it would be resolved through mediation or arbitration.”

Regardless of how ACA and other Obama health initiatives turn out, the consequence will likely be seen as a major step when health care observers in the next century look back.

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Dan Heilman is a writer and editor based in St. Paul, Minnesota.
A Scorecard of the Key Players

The parties and amici have retained five all-star high court advocates to argue their cases.

By Jane Pribek

Mike Carvin, one of the lawyers who will be arguing the constitutionality of the Patient Protection and Affordable Care Act (ACA) before the U.S. Supreme Court, said that when a movie is made about the cases, he thinks Brad Pitt should play him.

His casting in any future film probably isn’t exactly top-of-mind for Carvin, of the law firm Jones Day. He’s probably thinking more about jurisdiction, severability, and minimum coverage right about now. But it isn’t an unrealistic premise. After all, Carvin’s previous work representing President Bush before the Florida Supreme Court in Bush v. Gore was, um, recounted in the 2008 HBO movie Recount. Carvin wasn’t particularly pleased with the casting of Mike Pniewski, quipping, “I’m much better looking.”

If Bush v. Gore was movie material, certainly the ACA litigation compares, considering the political, economic, and social consequences that will stem from the high court’s anticipated June decision.

While most high court cases are argued for one hour on one day, this landmark litigation consists of three cases to be argued for six hours over three days. It merits extraordinary advocates, and the five Washington, D.C., lawyers involved universally fit that bill.

Carvin, representing the National Federation of Independent Business (NFIB), has argued before virtually every circuit of the U.S. Court of Appeals, and before the Supreme Court justices on five previous occasions. All five of Carvin’s prior high court cases have resulted in 5-4 rulings. That’s in part because he tends to argue cases with far-reaching constitutional public-policy ramifications.

Clement has more than seven years’ service in the Solicitor General’s Office, including serving in the top spot from 2005 until 2008. That’s the longest period of continuous service for anyone in that office since the 19th century, according to his firm’s website.

Clement has argued an astonishing 56 cases before the high court, three this term already, making him the most experienced before the justices of the ACA attorneys. At 45, he’s also the youngest. Clement said that, in preparing for the arguments, in some respects, it’s helpful that the Court has allocated time on particular topics; for most every other case he has argued before the justices, the parameters weren’t as clearly defined. On the other hand, it can be dangerous to try to read too much into the particular allotments. Just because jurisdiction has been given one hour and severability has been given an hour and a half doesn’t necessarily mean one is more important than the other, Clement noted.
Perhaps the most similar experience, and one that Clement considers a career highlight, was *McConnell v. FEC*, where the court allotted four hours’ argument. Then a deputy solicitor general, Clement and then Solicitor General Ted Olson successfully defended the constitutionality of the Bipartisan Campaign Reform Act, aka “the McCain-Feingold Act.”

Neal Katyal, former acting U.S. solicitor general, argued against Clement in the ACA cases for the government in the lower court battles before leaving that office last year. Katyal, now with Hogan Lovells in D.C., said Clement is “one of the most talented lawyers I’ve ever seen. He speaks with no notes. He has a wonderful conversational style with the justices. And he’s very careful, and colorful as well. He has a wonderful way of turning a phrase.”

Brad Joondeph, a professor at the Santa Clara University School of Law and the author of the ACA Litigation Blog, classified Clement as “a phenomenal advocate.”

“Although he doesn’t personally have a reputation as being particularly partisan, he’s found his way into some of the most partisan of disputes once these matters have gotten into the federal courts,” Joondeph said. He cited the January arguments in the Texas redistricting case, *Perry v. Perez*, the upcoming defense of Arizona’s immigration law, *Arizona v. U.S.*, and the ACA challenge. Joondeph also cited Clement’s involvement in *Windsor v. U.S.* and *Gill v. Office of Personnel Management*, cases currently making their way through the lower courts challenging the Defense of Marriage Act. In those cases, Clement currently argues on behalf of the House of Representatives in support of the act.

Clement said he votes and believes in the political process—but a case’s merits rather than ideology drive his case selection.

“I’ve had plenty of cases, both in and out of government, where people looking at it through a political lens might think, ‘He’s on the left,’” Clement said, citing *McConnell* as an example. “If you look at all the cases I’ve been in through a political lens, I think you could only conclude that I’m very confused. If you look at them through a legal lens, you’d say I’ve been very privileged to be involved in a lot of very interesting issues.”

The government’s ace Carvin and Clement’s principal ACA opponent is Solicitor General Donald Verrilli Jr., who is arguing on behalf of the government. Verrilli was confirmed solicitor general last June, after two decades with Jenner & Block. He has argued before the high court 16 times, four this term alone. He calls *Wiggins v. Smith* a career highlight. The 10-year pro bono representation concluded in 2003 with a 7-2 Supreme Court ruling that defense counsel must meet professional standards by reasonably investigating mitigating
evidence for the purposes of sentencing in death penalty cases. Verrilli’s client, Kevin Wiggins, ultimately was removed from death row.

Dahlia Lithwick, senior editor at Slate who covers the high court, said of Verrilli: “People compare him to Clark Gable. He’s the consummate gentleman. He’s very temperate. I would expect from him a ‘Just the facts, ma’am, straightforward presentation.’ It serves the government well in this case because it’s such an overheated political climate.”

TWOP TOP DRAFT PICKS
Also joining the fray will be two appointed amici to make arguments in support of lower appellate court rulings that none of the parties wishes to advance. “Appointed amici are a relatively rare occurrence,” Joondeph said.

Robert Long of Covington & Burling was appointed amicus curiae to argue that the Tax Anti-Injunction Act serves as a jurisdictional bar and requires the high court to defer ruling until the law takes effect. So held the Fourth Circuit Court of Appeals.

Long is another veteran Supreme Court litigator, having argued before it on 16 previous occasions. In his most recent high court case, Conkright v. Frommert, argued in 2010, Long successfully represented the Xerox Corporation pension plan in an ERISA dispute.

The other amicus is H. Bartow Farr III, who was appointed to argue that the individual mandate can be severed from the law, but the remainder can stand, in accordance with a ruling from the Eleventh Circuit.

Farr has argued before the high court 30 times, including PGA Tour v. Martin in 2001, in which he defended the association against golfer Casey Martin’s Americans with Disabilities Act challenge. At 67, Farr will be the oldest advocate on the cases and is the only small-firm practitioner among them. His firm, Farr & Taranto, has just two lawyers and doesn’t even have a website.

Joondeph said that the justices likely tapped Long and Farr because they wanted, first and foremost, extremely experienced appellate advocates, who wouldn’t be conflicted out secondarily, and thirdly, who don’t have strong partisan affiliations.

If a film is ever made of the ACA cases, it might require creative writers to manufacture some drama. Jurisdiction and severability are typically not words that lead to lines at the box office when you put them on a movie poster. “You’re not going to hear trashing Obama or the implication that this is about taking away people’s freedom,” said Lithwick. “What’s going to be argued is quite technical, complicated, and so in-the-weeds that people who’ve debated it in sound bites for the past two years will probably be very frustrated.”

Jane Pribek is an attorney, freelance writer, and movie buff who lives in Nashville, Tennessee.

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**BY THE NUMBERS**

- 3 Days over which the arguments will occur
- 5 Attorneys arguing the ACA cases
- 55 Average age of the ACA attorneys
- 123 Combined number of U.S. Supreme Court arguments made by the ACA attorneys
- 145 Total years of legal experience of the ACA attorneys
- 360 Number of minutes of argument allotted to the ACA cases

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The Health Care Challenges: A Short (if not Sweet) Road to the Supreme Court

By Bradley W. Joondeph

On March 23, 2010, President Obama signed into law Public Law 111–148, better known as the Patient Protection and Affordable Care Act (or ACA). Whatever its merits as a matter of policy, it was a historic legislative achievement. No prior administration had successfully pushed national health reform through Congress, despite several attempts, and President Obama had largely staked his presidency on its passage. Understandably, the mood at the act’s signing ceremony was festive, even raucous. But not all Americans were thrilled. Within minutes, 12 state governments had filed two separate lawsuits in Virginia and Florida claiming that the act is unconstitutional, and within weeks private parties had filed roughly 20 similar challenges elsewhere. Thus began the steady, collective march of ACA litigation, played out in federal courts across the county—a journey that everyone expected would ultimately end at the Supreme Court.

And so it has. The oral arguments scheduled for March 26, 27, and 28, and the Court’s subsequent decision, will likely mark the culmination of this two-year drama. (I say likely only because it is possible the justices will conclude that they lack jurisdiction over some of the questions presented, pushing a final resolution further into the future.)

How did we get here? In the beginning, the lawsuits raised a vast array of constitutional issues—such as whether the ACA violates the constitutional right to privacy, interferes with the free exercise of religion, or violates the Thirteenth Amendment’s prohibition on slavery. As the cases have inched forward, though, most of these claims have fallen by the wayside, as they generally lacked much merit. What remains today are the two questions that experts have identified from the start as the most problematic for the act’s defenders, the two substantive questions on which the Court has granted certiorari. The first is whether the ACA’s minimum coverage provision (also called the “individual mandate”)—which requires almost every person legally residing in the United States to acquire minimally adequate health insurance by January 1, 2014—exceeds Congress’s enumerated powers. The second revolves around the ACA’s expansion of the Medicaid program, particularly its requirement that participating states expand eligibility to all legal residents under age 65 earning up to 138 percent of the federal poverty level. The challengers claim this expansion effectively “commandeers” the states by forcing them to implement a federal legislative program. The Court has also asked for argument on two procedural questions: (1) whether the Anti-Injunction Act (AIA)—which generally bars federal courts from hearing any suit that seeks to enjoin the collection of a federal tax—precludes the Court from reaching the merits; and (2) whether, if the minimum coverage provision is unconstitutional, any of the ACA’s hundreds of other provisions are also unenforceable because they cannot be severed from the individual mandate.

BIRTH OF A CHALLENGE

When these lawsuits were first filed, most legal experts dismissed them as far-fetched. But the conventional wisdom started shifting in August 2010, when District Judge Henry Hudson (E.D. Va.) issued his ruling in Virginia v. Sebelius denying the United States’s motion to dismiss. Judge Hudson’s was the first decision from any court suggesting that the constitutional challenges to the ACA were viable. In particular, Judge Hudson concluded that the minimum coverage provision “literally forges new ground and extends Commerce Clause powers beyond its current high watermark. . . . Never before has the Commerce Clause and associated Necessary and Proper Clause been extended this far.”

Over the next year, lower federal courts issued a series of rulings that, considered together, offered a mixed bag. The Eastern District of Virginia (through Judge Hudson in Virginia v. Sebelius), the Middle District of Pennsylvania (Goudy-Bachman v. HHS), and the Northern District of Florida (Florida v. HHS) concluded that the minimum coverage provision is unconstitutional. By contrast, the Western District of Virginia (Liberty University v. Geithner), the Eastern District of Michigan (Thomas More Law Center v. Obama), and the District Court for the District of Columbia (Mead v. Holder) upheld the individual mandate as within Congress’s enumerated powers. On appeal, the Eleventh Circuit invalidated the minimum coverage provision(Florida v. HHS), while the Sixth and District of Columbia Circuits upheld it (Thomas More Law Center and Seven-Sky v. Holder). The Fourth Circuit, alone in this regard, held that the AIA bars jurisdiction (Liberty University v. Geithner).

Interestingly, these decisions have been less partisan than
many anticipated. Among Republican-appointed circuit judges, three have voted to uphold the individual mandate, and two have voted to invalidate it. Among Democratic appointees on the courts of appeals, three have voted to uphold it, and one has voted to invalidate it. Moreover, three circuit judges—two appointed by a Democrat and one by a Republican—have concluded that the AIA bars jurisdiction.

**FLORIDA AND FEDERALISM**

The plaintiffs challenged the constitutionality of the ACA's expansion of Medicaid only in *Florida v. HHS*, the case originating in the Northern District of Florida. It is no coincidence that the Supreme Court selected this case for review—not just because it is the sole case to present the Medicaid question, but also because it carries the institutional heft of 26 state governments as plaintiffs, and it features one of the best appellate advocates on the planet, Paul Clement, representing the states.

As originally filed, the plaintiffs in *Florida v. HHS* were 11 states. But the group has since grown to include 15 more states, four private individuals, and the National Federation of Independent Business. The first big moment in the case occurred in October 2010, when Senior District Judge Roger Vinson denied much of the United States's motion to dismiss. Specifically, Judge Vinson concluded that the “tax penalty” that the ACA imposes on persons failing to obtain minimally adequate coverage—an exaction to be remitted on one’s annual income tax returns—is a “penalty” rather than a “tax.” As a result, said Judge Vinson, (1) the AIA does not bar a court from hearing the challenge, since the AIA only applies to lawsuits seeking to restrain the collection of a “tax”; and (2) Congress cannot justify the individual mandate under its taxing power, as that power only gives Congress the authority to impose genuine “taxes.” Judge Vinson further held that the plaintiffs’ claims that the individual mandate and the ACA’s Medicaid provisions are unconstitutional were sufficiently meritorious to survive a motion to dismiss for failing to state a claim.

Three months later, Judge Vinson issued his decision on cross-motions for summary judgment, reaching three important conclusions. First, he held that—although Congress has the authority to regulate intrastate economic or commercial activity pursuant to its commerce power—the minimum coverage provision “seeks to regulate economic inactivity, which is the very opposite of economic activity. And because activity is required under the Commerce Clause, the individual mandate exceeds Congress’ commerce power.” Second, Judge Vinson concluded that there was “simply no support for the state plaintiffs’ coercion argument in existing case law,” and thus the ACA’s Medicaid provisions do not impermissibly “commandeer” the states. Finally, he held that, because the minimum coverage provision “and the remaining provisions are all inextricably bound together in purpose and must stand or fall as a single unit,” the mandate was not severable from the rest of the act, and hence the entire ACA was invalid. Judge Vinson granted the plaintiffs’ motion for declaratory judgment, but he refrained from issuing an injunction, calling such relief “unnecessary” given the “long-standing presumption” that the federal government “will adhere to the law as declared by the court.”

A few weeks of confusion ensued, as it was unclear whether the court’s order granting declaratory relief meant that any implementation of the ACA—including the hundreds of provisions which had already gone into effect—was unlawful. After some delay, the United States filed a rather awkward “Motion to Clarify.” Though Judge Vinson clearly took umbrage at the motion, he ultimately stayed his judgment on the condition that the government would expedite its appeal to the Eleventh Circuit. The government complied, and the Eleventh Circuit heard argument on June 8, 2011.

**THE STAGE IS SET**

The Eleventh Circuit panel, consisting of Chief Judge Dubina and Circuit Judges Hull and Marcus, affirmed the bulk of Judge Vinson’s judgment. First, all three judges agreed that the penalty imposed under the minimum coverage provision was not a tax, and thus could not be justified by Congress’s taxing power. (The court did not separately address the Anti-Injunction Act, but in reaching the merits, it implicitly concluded that the AIA imposed no jurisdictional bar.) Second, Chief Judge Dubina and Judge Hull concluded that the minimum coverage provision exceeded Congress’s power to regulate interstate commerce. They found that Congress’s assertion of authority “to issue an economic mandate for Americans to purchase insurance from a private company for the entire duration of their lives is unprecedented, lacks cognizable limits, and imperils our federalist structure.” Judge Marcus dissented on this point, arguing that the Supreme Court’s decisions over the past 75 years make clear that “this legislation falls within Congress’ interstate commerce power,” as “the target of the regulation is economic in nature” and “Congress had a rational basis to conclude that the regulated conduct has a substantial effect on interstate commerce.” Third, the panel unanimously concluded that the ACA’s Medicaid amendments were constitutional: “Existing Supreme Court precedent does not establish that Congress’s inducements are unconstitutionally coercive, especially when the federal government will bear nearly all the costs of the program’s amplified enrollments.” Finally, the panel rejected Judge Vinson’s severability analysis, holding that the minimum coverage provision was completely severable from the rest of the ACA.

In late September 2011, the United States, the state plaintiffs, and the private plaintiffs each filed separate petitions for writs of certiorari. On November 14, the Supreme Court issued its order granting review, setting out the four distinct questions to be resolved. And on December 19, the Court issued its order scheduling an extraordinary five-and-a-half (now expanded to six) hours of oral argument, spread over three days. The stage is thus set for one of the biggest judicial decisions of our lifetimes, a case with enormous implications for American politics, public policy, constitutional law, and the Court itself. By the end of June 2012, the curtain will likely have fallen—perhaps mercifully—on this thoroughly engrossing, high-stakes constitutional drama.

Bradley W. Joondeph is a professor of law at Santa Clara University.
On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (“Obamacare”), which is widely considered to be the most significant federal legislation since the enactment of Medicare and Medicaid in 1965.1 That same day, Virginia and Florida filed lawsuits challenging the constitutionality of this law, with 12 states joining Florida’s suit (eventually joined by 14 others, plus the National Federation of Independent Business and several individuals). Oklahoma later filed its own suit. Thus, we now have an incredible 28 states suing the federal government.

Contrary to many pundits’ initial dismissal of these challenges as legally frivolous and political sour grapes—recall Nancy Pelosi’s famous “are you serious?” response to a question about constitutional concerns—these were real lawsuits, with serious lawyers behind them. It was difficult to predict how courts would react, however, because the new law is unprecedented, both in its regulatory scope and its expansion of federal authority over states and individuals.

As the Congressional Budget Office said in 1994, “The government has never required people to buy any good or service as personal freedom. Conservative rhetoric attacking the law often is phrased in these terms, and the underlying basis for objection is likely that people should have the right to be uninsured without paying a penalty if they wish. But under post-1937 constitutional law, economic and social welfare legislation is upheld so long as it is reasonable. Rarely has any law been struck down as failing this “rational basis” test, and not even the law’s fiercest critics challenge the constitutionality of the individual mandate on this basis.

One question before the Supreme Court is whether Congress has the authority to require that individuals either purchase health insurance or pay a penalty. This is constitutional under Congress’s power, pursuant to Article I, Section 8 of the Constitution to regulate commerce among the states.

Since United States v. Lopez in 1995, the Court has used a three-part test for determining whether a federal law is constitutional under the commerce power. Under the third prong of this test, Congress may regulate economic activity that taken cumulatively across the country has a substantial effect on interstate commerce.

It is important to remember that the Supreme Court has said that all that is required is that Congress have a rational basis for believing that the regulated activity is economic activity that

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1I use the term “Obamacare” because most people colloquially refer to it that way, in large part because it’s much easier to say than “PPACA,” “Affordable Care Act,” or any other more technical term. While thought by some to be pejorative, I’ve never understood how that’s the case. Even the leading academic supporters of the law’s constitutionality, such as Yale law professors Akhil Amar and Jack Balkin, say “Obamacare.” The one accurate criticism I’ve heard is that the law was mostly written by Congress, not the White House. But that just means it would be better to call it Pelosi-Reid-care, which is no more or less pejorative. In any event, that ship has sailed—though an even more realistic name for the law would be the Libertarian Legal Scholar Full Employment Act.
The Health Care Law Will Be Upheld (cont)

has a substantial effect on interstate commerce. There are thus two questions in assessing whether the individual mandate is within the scope of the commerce power. First, could Congress reasonably believe that it was regulating economic activity? Second, if so, looked at in the aggregate, could Congress reasonably believe that there is a substantial effect on interstate commerce?

It is the former that opponents of the law, including judges who have struck it down, have focused on. They contend that people who do not wish to purchase health insurance are inactive and that Congress cannot regulate inactivity. They argue that it is unprecedented for Congress to require an economic transaction and that if Congress can require purchasing of health insurance, there is no stopping point in terms of what Congress can force people to buy.

The key flaw in this argument is its failure to recognize that literally everyone will at some point need to use the health care system. Children must be vaccinated to attend school. If a person contracts a communicable disease, the government can require that it be treated. If a person is in a car accident, the ambulance will take him or her to the nearest emergency room for treatment.

Therefore, everyone faces an economic choice: whether to purchase health insurance or whether to self-insure. Either is economic activity. Congress is regulating this economic choice by imposing a penalty on those who choose to self-insure in order to create a system where all can have access to the health care system. Opponents of the health care law say that if it is upheld, then the government can force people to buy an American car or to eat broccoli. But a person can opt not to drive or not to eat vegetables; no one realistically can opt out of health care.

The second question then becomes whether, taken cumulatively, the law has a substantial effect on interstate commerce. Health-related spending was $2.5 trillion in 2009, or 17.6 percent of the national economy. Health insurance is an $850 billion industry. In the last case to deal with the scope of Congress’s commerce clause power, Gonzales v. Raich in 2005, the Court held that Congress constitutionally could criminally prohibit and punish cultivation and possession of a small amount of marijuana for personal medicinal use. If Congress has the power to prevent Angela Raich from growing a small amount of marijuana to offset the ill effects of chemotherapy, then surely it has the authority to regulate a two-trillion-dollar industry.

Opponents of the health care law say that if it is upheld, then the government can force people to buy an American car or eat broccoli. But a person can opt not to drive or not to eat vegetables; no one realistically can opt out of health care.

Obamacare Will Lose a Close Fight (cont)

a condition of lawful residence in the United States.” Nor has it ever said that everyone faces a civil penalty for declining to participate in the marketplace. Never have courts had to consider such a breathtaking assertion of raw power under the guise of regulating commerce—not even at the height of the New Deal, when the Supreme Court ratified Congress’s regulation of wheat grown for home consumption on the awkward theory that such action, when aggregated nationally, affected interstate commerce. Even in that case, Wickard v. Filburn, the government claimed “merely” the power to regulate what farmers grew, not to mandate that people become farmers, much less to force people to buy wheat.

The state plaintiffs raised several other constitutional points, most notably that forcing states to expand Medicaid funding and bureaucracies was a coercive violation of federalism. In all, more than 30 lawsuits have been brought, triggering an intense legal and political debate about the first principles of our republic. Once the Virginia and multistate cases survived the government’s motions to dismiss, Obamacare’s supporters realized that they had a real fight on their hands; no respectable commentator any longer thinks that all this is frivolous. Indeed, of the district courts that have reached the constitutional claims, three struck down the individual mandate and three found it to be consistent with federal power. And on appeal four different courts have reached five different decisions.

The Supreme Court agreed to review the Eleventh Circuit ruling—which struck down the individual mandate, severed it from the rest of the law, and ruled for the government on the Medicaid-coercion issue—and set aside a historic five-and-a-half hours (now expanded to six hours) for argument. Here’s my quick-and-dirty take, and prediction, on each issue before the Court:

1. Anti-Injunction Act

The AIA bars courts from enjoining “any tax” before that tax is assessed or collected. One would think that such a law would have no application to a fine levied for not buying health insurance. Accordingly, most of the courts to consider the issue have found the AIA to be inapplicable. Moreover, the government itself has long conceded that the AIA does not bar these suits. A Fourth Circuit majority and the dissenting Judge Brett Kavanaugh in the D.C. Circuit, however, reached a contrary conclusion, reasoning that the AIA applies to all exactions assessed under the Internal Revenue Code. But the words “any tax” in the AIA do not include “penalties” simply because they may be codified in the Code. The Supreme Court has always held that “taxes” and “penalties” are not interchangeable, and all of the relevant (lower court) cases concern penalties that have been statutorily defined as taxes or that enforced substantive tax provisions.

Prediction: The Court, probably unanimously, will find that the AIA does not bar suit.

2. Individual Mandate

Under modern doctrine, regulating intrastate economic activity
The Health Care Law Will Be Upheld (cont)

Moreover, the Supreme Court has said that under the “necessary and proper clause” Congress can take any actions that are reasonably related to carrying out its authority. The individual mandate can be viewed as a means to regulating a significant part of commerce among the states. The Patient Protection and Affordable Care Act will provide health insurance for most of the 50 million individuals in the country who today are uninsured. The individual mandate is a crucial means to effectuating this.

Since 1936, not one federal law has been declared unconstitutional as exceeding the scope of Congress’s taxing and spending power and no spending program ever has been struck down because its conditions on the states are too onerous.

A second major issue is whether the increased burden on the states for Medicaid funding violates the Tenth Amendment. This argument has been rejected by every court to consider it, and it is likely to do no better in the Supreme Court.

No state is required to participate in the federal Medicaid program. Any state that chooses to do so must meet many requirements in terms of coverage. The Affordable Care Act increases the burdens on the states but also provides additional resources. The key, though, is that any state can opt out of Medicaid any time it chooses. Thus, no state is subjected to the type of coercion that the Supreme Court has found violates the Tenth Amendment.

The states argue, however, that there is great economic pressure on them to remain in the Medicaid program. But facing a hard choice is not the same as being coerced or commanded, and it is only the latter that has been deemed to violate the Tenth Amendment. Since 1936, not one federal law has been declared unconstitutional as exceeding the scope of Congress’s taxing and spending power, and no spending program ever has been struck down because its conditions on the states are too onerous.

Why then so much uncertainty surrounding what the Supreme Court will do? The reactions to the Affordable Care Act have been almost entirely defined by partisanship. Every Republican in Congress voted against it. With two exceptions, every federal judge appointed by a Republican president has voted to strike down the law, and with one exception, every federal judge appointed by a Democratic president has voted to uphold it.

But shouldn’t we expect more of Supreme Court justices than this? I think the Court will uphold the law and do so in a 6-3 or 7-2 ruling. The Court will emphasize that it is not ruling on the wisdom of the law; that is for the political process to decide. The justices will emphasize that the health care crisis requires a national solution and the Affordable Care Act is a constitutional effort to do just this.

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Obamacare Will Lose a Close Fight (cont)

...can be a “necessary” means of carrying out Congress’s regulatory authority if, in the aggregate, it has a substantial effect on interstate commerce. But regulating noneconomic activity cannot be “necessary,” regardless of its economic effects. And a power to regulate inactivity—to compel activity—is even more remote from Congress’s commerce power.

The government characterizes not being insured as the activity of making an “economic decision” of how to finance health care services, but the notion that probable future participation in the marketplace constitutes economic activity now pushes far beyond existing precedent. Further, that definition of “activity” leaves people with no way of avoiding federal regulation; at any moment, we are all not engaged in an infinite set of activities. Retaining the categorical distinction between economic and noneconomic activity limits Congress to regulating intrastate activities closely connected to interstate commerce—thus preserving the proper role of states and preventing Congress from using the Commerce Clause as a federal police power. The categorical distinction also provides a judicially administrable standard that obviates fact-based inquiries into the purported economic effects and the relative necessity of any one regulation, an exercise for which courts are ill-suited.

Upholding the mandate would fundamentally alter the relationship of the federal government to the states and the people; nobody would ever again be able to claim plausibly that the Constitution limits federal power.

Finally, the mandate violates the “proper” prong of the Necessary and Proper Clause in that it unconstitutionally commands the people—and in doing so, circumvents the Constitution’s preference for political accountability. The Constitution permits Congress to intrude on state and popular sovereignty only in certain limited circumstances: when doing so is textually based or when it relates to the duties of citizenship. For example, Congress may require people to respond to the census or serve on juries. In forcing people to engage in transactions with private companies, the mandate allows Congress and the president to evade being held accountable for what would otherwise be a tax increase.

Upholding the mandate would fundamentally alter the relationship of the federal government to the states and the people; nobody would ever again be able to claim plausibly that the Constitution limits federal power.

Prediction: The Court will strike the mandate in a 5-4 vote hinging on Justice Kennedy.

3. Severability

On one hand, the Court should avoid striking down an entire law when only one small part is declared unconstitutional.
On the other, the Court cannot go provision-by-provision and execute some sort of judicial line-item veto. The analysis boils down to two questions: (1) Can the remainder “fully operate as law”? and (2) Would Congress have passed the remainder? The plaintiffs make a compelling case that Congress wouldn’t have passed anything without the fundamental transformation of the national health care system that is predicated on the individual mandate. At the very least, Titles I and II—which contain all the key provisions relating to individual care—are inextricably tied to the mandate. Even the government concedes that the requirements that insurers cover people with preexisting conditions and that premiums be assessed by a “community rating” formula are inextricably tied to the mandate. Without an individual mandate, guaranteed-issue and community-rating provisions foster a “death spiral” because healthy people wait until they get sick or injured before buying underpriced insurance that they cannot then be refused, causing premiums to increase and costs to explode. In any case, there are many rings to this hell and many ways that the Court could go; the only indefensible position is the one the court below took, wholly severing the mandate.

**Prediction:** The Court will rule 5-4 (with Chief Justice Roberts as the limiting vote) that something more than the “core three” provisions but less than the whole law will fall.

### 4. Medicaid Coercion

States must accept a comprehensive reorganization of Medicaid or forfeit all federal Medicaid funding. But if Congress is allowed to attach conditions to spending that states cannot refuse in order to achieve an objective it could not outright mandate, the local/national distinction that is so central to federalism will be erased. *South Dakota v. Dole* prohibits such a coercive use of the spending power and recognizes that “in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’” Indeed, the states’ obligations, should they “choose” to accept federal funding and thus commit themselves to doing the government’s bidding, are far more substantial than those the Supreme Court invalidated in *New York v. United States* and *Printz v. United States* (which prohibit federal “commandeering” of state officials). Moreover, the Congress that enacted the original Social Security Act, to which Medicare and Medicaid were added in the 1960s, recognized that social safety has always been the prerogative of the states and should continue to be done under state discretion. Medicaid itself was narrowly tailored to serve particularly needy groups. In short, if “Obamacare” does not cross the line from valid “inducement” to unconstitutional “coercion,” nothing ever will.

**Prediction:** This issue is the hardest to predict because the precedent is so scant, and I can see anything from a 5-4 pro-states ruling to 8-1 pro-government. I’ll split the difference and say 6-3 pro-government, with extensive articulation of a new test for spending-power coercion.

Ilya Shapiro is a senior fellow in constitutional studies at the Cato Institute and Cato Supreme Court Review. He has filed ten amicus briefs in the ACA litigation, including four in the Supreme Court (one on each of the designated issues).
The Anti-Injunction Act Issue

By Bryan Camp and Jordan Barry

Docket No. 11-398
Argument Date: March 26, 2012
From: The Eleventh Circuit

Case at a Glance The Anti-Injunction Act, 26 USC §7421, says that “no suit for the purpose of restraining the assessment or collection of any tax may be maintained in any court by any person.” If the Anti-Injunction Act bars this lawsuit, the Supreme Court will not be able to decide whether the Patient Protection and Affordable Care Act (ACA) is constitutional and the lower court opinions will be vacated. The parties to this case all want the Supreme Court to decide the ACA’s constitutionality. They all argue that the Anti-Injunction Act (AIA) does not bar this lawsuit, but for different reasons. Three amici disagree and argue that AIA bars this lawsuit, but several amici join the parties in arguing that it does not.

Introduction
To decide a case, a federal court must have the power to adjudicate matters of that type. This concept is known as “subject matter jurisdiction.” Generally, federal courts only have subject matter jurisdiction when a federal statute gives it to them. And what Congress gives, it can also take away. The question in this case is whether 26 USC §7421, which prohibits “any person” from suing the federal government “for the purpose of restraining the assessment or collection of any tax,” strips federal courts of their power to decide this case at this time. This law is commonly called “the Anti-Injunction Act” because it prevents federal courts from hearing cases where taxpayers are seeking court orders, such as injunctions, to prevent the government from assessing or collecting federal taxes. So before the Supreme Court can address whether the ACA is a constitutional exercise of congressional power, it must first decide that the Anti-Injunction

Issues
1. Is the Anti-Injunction Act jurisdictional? That is, when the act applies, does it take away subject matter jurisdiction from federal courts or is it merely a defense that the federal government can raise if it chooses?

2. If the Anti-Injunction Act is jurisdictional, does it apply to this lawsuit?

Act (AIA) either (1) does not take away subject matter jurisdiction from the federal courts or (2) does not apply to this case. If the AIA is jurisdictional and does apply, courts likely will not be able to decide whether the ACA is constitutional until at least 2015.

Facts
In 2009 Congress enacted the ACA. Several provisions were codified in title 26, the Internal Revenue Code (the code), including one commonly called the individual mandate. This provision, codified in §5000A, requires individuals to have health insurance beginning in 2014. Individuals who fail to do so must report that failure on their tax returns and must pay an amount labeled a “penalty” along with their federal income and other taxes. In §5000A(g) Congress specified how the IRS must assess and collect this penalty.

Several states and some individuals sued the federal Department of Health and Human Services (the government) challenging the constitutionality of several provisions of the ACA, including §5000A. Initially, the government argued that AIA barred the plaintiffs’ suit. The
federal district court disagreed and went on to find the individual mandate unconstitutional. On appeal to the Eleventh Circuit Court of Appeals, the federal government dropped the AIA procedural argument. The Eleventh Circuit ruled the individual mandate unconstitutional. It did not discuss the AIA in its opinion.

Although the Eleventh Circuit did not address § 7421, three other Courts of Appeals have. The Sixth Circuit and the District of Columbia Circuit decided that the AIA does not prevent courts from reaching the merits of the constitutional issues and that the ACA is constitutional. Thomas More Law Center v. Obama, 651 F. 3d 529 (6th Cir. 2011); Seven-Sky v. Holder, 681 F.3d 1 (D.C. Cir. 2011).

However, the Fourth Circuit concluded that the AIA does bar challenges to the ACA at this time and did not reach the constitutional issues. Liberty University v. Geithner, 2011 U.S. App. LEXIS 18618; 2011 WL 3962915. 2011-2 U.S. Tax Cas. (CCH) & 50,613.

Because all of the parties contend that the AIA does not bar this suit, the Supreme Court appointed a special Amicus, Robert Long (Amicus Long), to argue that the AIA does bar the suit.

Case Analysis

This section will put the AIA into context and then explain the various positions the parties take as to each of the two questions presented. It does not discuss the related but separate question of standing.

Background: The General Rule of § 7421

The administration of taxes in the United States has historically been divided into two functions: (1) the determination of tax, which culminates in an act of assessment, and (2) the collection of taxes assessed. Section 7421 speaks in those terms, prohibiting suits seeking to restrain either the assessment or collection of taxes. Since the creation of the Internal Revenue Service (the IRS) in 1862, taxpayers have been required to pay assessed taxes before they could contest their liability for them. Enacted in 1867, the Anti-Injunction Act is part of the cement holding this “pay first, litigate later” regime together. As the Supreme Court explained in 1876:

There are provisions for recovering [a] tax after it has been paid. ... But there is no place in [the U.S. tax] system for an application to a court of justice until after the money is paid.

That there might be no misunderstanding of the universality of this principle, it was expressly enacted, in 1867, that “no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court.”

State R.R. Tax Cases, 92 U.S. 575, 613 (1876) (emphasis added)

Over time, Congress amended the AIA to create several exceptions to the general “pay first, litigate later” regime. Two are important to this case, the Deficiency Procedure and the Collection Due Process Procedure.

1. Deficiency Procedure

In 1924, Congress created a special procedure to allow taxpayers to restrain some assessments of certain types of taxes, notably income and gift taxes. It provided that, in some circumstances, the IRS must give taxpayers a “Notice of Deficiency” before making an assessment. Taxpayers then have a chance to challenge the Deficiency in the Tax Court. At the time it created this special procedure, Congress amended the AIA so that it did not apply to suits challenging Deficiencies.

There are many, many taxes that are not subject to this procedure. For example, employment taxes, which are imposed on employers for the privilege of employing workers, are not subject to the Deficiency Procedure. The IRS need not issue a Notice of Deficiency and can simply assess the tax and start collection activities.

Similarly, “Assessable Penalties,” a group of penalties imposed on taxpayers for various bad behaviors, do not trigger the Deficiency Procedure. Taxpayers wishing to contest Assessable Penalties must follow the general “pay first, litigate later” rule of the AIA. For example, § 6673 allows courts to impose a fine of up to $25,000 against taxpayers who advance frivolous arguments in court. The IRS then simply assesses that fine and starts collection. Section 6676 allows the IRS to assess a penalty against taxpayers who claim excessive refunds. Again, the IRS just assesses the penalty and starts collection. Many Assessable Penalties have little to do with tax liability and are more in the mold of nontax regulatory requirements. For example, tax preparers who fail to put their social security numbers on returns they prepare, employers who fail to furnish proper documentation to their employees, and parents who refuse to obtain social security numbers for their children are all subject to Assessable Penalties.

Although Assessable Penalties are called “penalties,” § 6671(a) makes clear that they are generally treated as taxes throughout the Code. This means that the AIA fully applies to Assessable Penalties. Thus, taxpayers must generally pay Assessable Penalties before contesting them—unless the Collection Due Process (CDP) Procedure applies.

2. Collection Due Process Procedure

In 1998, Congress created the CDP Procedure, a special procedure that allows taxpayers to restrain certain types of collection actions. Similar to the Deficiency Procedure, the CDP procedure requires the IRS to tell taxpayers that it proposes to collect an already-assessed tax. However, taxpayers who were not given a prior opportunity to contest the merits of their tax liability can also do that in a CDP proceeding. Thus, when the IRS is collecting an assessed Deficiency, taxpayers may not use the CDP process to get a second prepayment opportunity to contest the merits of the assessment because they already had that opportunity through the Deficiency Procedure. But, when the IRS is collecting an Assessable Penalty, taxpayers who are entitled to a CDP
proceeding are generally able to contest the merits of that assessment before having to pay it.

**Issue I: Is the Anti-Injunction Act jurisdictional?** That is, when it applies, does it take away subject matter jurisdiction from federal courts or is it merely a defense that the federal government can raise if it chooses?

Several parties and Amici attack the idea that the AIA takes away federal courts’ jurisdiction over suits seeking to restrain the assessment or collection of taxes. Instead, they say, it merely gives the federal government a defense to such suits. If the government waives the defense (as it has done here), courts have the power to decide such cases. Mounting this attack are (1) the Private Respondents; (2) the State Respondents; and (3) Amici Curiae Liberty University, Inc., Michele Waddell and Joanne Merrill. Defending the jurisdictional nature of the AIA are (1) the government; (2) Amicus Long; (3) Amici Curiae Mortimer Caplin and Sheldon Cohen, who are distinguished former Commissioners of the IRS (Amici Former IRS Commissioners) and (4) Amicus Curiae Center for the Fair Administration of Taxes (Amicus CFAT).

The chief arguments on both sides are summarized below, generally without attribution to the particular parties advancing them.

Those attacking the jurisdictional nature of the AIA note that the statute neither refers to courts’ power expressly nor uses the word “jurisdiction.” They cite various cases from the late 1800s through the late 1940s in which the Court did not treat the AIA as jurisdictional. They also point out that the Supreme Court recognized exceptions to the AIA in *Enochs v. Williams Packing & Nav. Co.*, 370 U.S. 1 (1962) and *South Carolina v. Regan*, 465 U.S. 367 (1984). They argue that these exceptions are inconsistent with the AIA being jurisdictional. They also raise policy arguments against treating statutory language choices.

Those defending the jurisdictional nature of the AIA assert that, in *Enochs*, the Court deliberately put an end to what it described as a history of vacillation about the nature of the AIA. In *Enochs*, the Supreme Court flatly stated that “The object of § 7421(a) is to withdraw jurisdiction from the state and federal courts to entertain suits seeking injunctions prohibiting the collection of federal taxes.” Since *Enochs*, the Supreme Court has consistently viewed the AIA as jurisdictional. Moreover, the defenders argue that while the AIA does not expressly say that courts do not have jurisdiction, the Court has interpreted other statutes with similar language as jurisdictional. They concede that the Supreme Court created exceptions to the AIA in *Enochs and Regan*, but argue that these exceptions are entirely consistent with the AIA being jurisdictional. They also raise policy arguments of their own. First, the defenders contend that treating the AIA as a waivable defense would invite taxpayers to ignore the statute and sue, hoping that they could convince the government to waive its defense or that the government might simply forget to assert it. Second, it would permit the executive branch to play favorites, or at least create that impression, by waiving the defense in some instances but not in others.

**Issue 2: If the Anti-Injunction Act is jurisdictional, does it apply to this lawsuit?**

Alliances shift on this issue. Between them, the State Respondents and Private Respondents raise four chief arguments explaining why the AIA does not apply to their suit, even if it is jurisdictional: First, they argue that the §5000A “penalty” is not a “tax” within the meaning of the AIA. Second, plaintiffs argue that they are only challenging the individual mandate itself, not the §5000A penalty. Since they are challenging the requirement to have insurance, not the penalty meant to enforce that requirement, they contend that they are not seeking to restrain the assessment or collection of a “tax” and, accordingly, the AIA does not apply. Third, the State Respondents assert that the AIA bars suits by “any person” and that a state is not a “person” within this definition. Fourth, the State Respondents argue that their lawsuit qualifies for the exception to the AIA that the Supreme Court recognized in *Regan*. Amicus Cato Institute and Amicus CFAT join the first and third arguments. The government is more selective. It supports the first argument but affirmatively argues against the others. The Court-appointed Amicus Long and Amici Former IRS Commissioners defend the applicability of the AIA from all the attacks. Amici Tax Law Professors dispute the first argument but do not address the others.

1. **The Anti-Injunction Act does not apply to the § 5000A penalty**

Those arguing that the AIA does not apply to the § 5000A penalty advance arguments based on statutory text and Congressional intent. Before looking at these issues, it is helpful to highlight a few aspects of § 5000A that provide support for each side’s arguments.

Congress debated whether to call the §5000A penalty a “tax” or a “penalty” and deliberately chose to call it a “penalty.” However, it placed the individual mandate and the penalty enforcing it within the Code. Congress charged the IRS with administering and enforcing the individual mandate and the penalty enforcing it: Congress instructed the IRS to assess and collect the §5000A penalty “in the same manner as an assessable penalty.” Recall that assessable penalties generally fall within the reach of the AIA. Congress also chose to make insurance status a part of what taxpayers must self-report to the IRS each year on their income tax returns and to have taxpayers submit the penalty with their income tax returns.

In addition, Congress distinguished the § 5000A penalty from other liabilities that the IRS is charged with collecting. Congress put three unique restrictions on the IRS’s ability to collect the penalty: It prohibited the IRS from seeking criminal sanctions against violators; it prohibited the IRS from using levies to enforce the § 5000A penalty; and it prohibited the IRS from filing notices of federal tax lien with respect to taxpayers’ liability for the § 5000A penalty.

As discussed below, the litigants have starkly differing opinions about the implications of these various actions and language choices.

- **The Textual Argument**

This argument is about the word “tax” in the AIA. It starts simple but quickly gets...
complex. Remember, the AIA is part of the code. Those attacking the AIA start by noting that Congress deliberated on what to call the provision and decided it was a penalty and not a tax. Thus, the § 5000A penalty is not a “tax” within the meaning of the AIA.

Those who defend the applicability of the AIA counter that § 5000A(g) provides that the § 5000A penalty is to be “assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.” The first sentence of § 6671(a) says that the assessable penalties of subchapter B of chapter 68 “shall be assessed and collected in the same manner as taxes.” Section 7421 applies to taxes, so the IRS can assess and collect taxes without judicial interference. Accordingly, they contend, in order for the § 5000A penalty to be assessed and collected in the manner that § 5000A(g) provides, the § 5000A penalty must constitute a tax for purposes of the AIA. The defenders assert that courts have routinely applied the AIA to Assessable Penalties and that they should apply it to § 5000A.

The attackers agree that the AIA applies to Assessable Penalties, but they argue that this is because of the second sentence of § 6671(a) instead of the first. The second sentence of § 6671(a) says that whenever the word “tax” is used in the Code, it includes the Assessable Penalties codified in subchapter B of chapter 68. The attackers argue that the second sentence of § 6671(a) does not apply to § 5000A because § 5000A is not codified within subchapter B of chapter 68, and § 5000A lacks any language that resembles the second sentence of 6671(a). Accordingly, while the word “tax” in the AIA includes certain Assessable Penalties, it does not include the § 5000A penalty.

The defenders disagree that the second sentence of § 6671(a) is the reason that the AIA applies to Assessable Penalties. In addition, they argue that § 6671 is not the only reason that the word “tax” in the AIA includes Assessable Penalties. Amici Former IRS Commissioners argue that when the word tax is used in the Code, it includes penalties and interest as a general matter. They point to §§6201 and 6202 as examples, among others. Amicus Cato Institute disagrees. It argues that in almost all of the examples given, Congress explicitly provided that the penalties were to be treated as taxes and that the bar of the AIA was to apply.

Amici Tax Law Professors support the Former IRS Commissioners by pointing to the limitations that Congress imposed on the IRS’s ability to use certain collection powers to collect the § 5000A penalty. The statutes creating those collection powers only allow the IRS to use them to collect “taxes.” The fact that Congress limited the IRS’s ability to use those tools with respect to the § 5000A penalty implies that those powers would otherwise have been available to the IRS, and that would only be true if the § 5000A penalty is a tax within the ordinary meaning of that term as it is used in the code.

* Congressional Intent
Congress forbade the IRS from using its administrative levy power or filing a notice of federal tax lien with respect to the § 5000A penalty. The attackers of the application of the AIA argue that pre-payment judicial review of the § 5000A penalty would not interfere with the IRS’s activities in the same way as it would with respect to other liabilities the IRS is charged with collecting. Thus, these unique assessment and collection provisions render the normal logic behind the AIA inapplicable. Accordingly, conclude the attackers, Congress could not have intended for the AIA to apply to the §5000A penalty.

The defenders respond with three reasons why the logic of the AIA still applies to § 5000A. First, the IRS can still collect the penalty. It can set off tax refunds, including those created by refundable credits, or file civil suits. Second, the IRS must still assess the penalty, and the AIA applies to suits that seek to restrict either assessment or collection actions. Moreover, Congress instructed the IRS to assess the penalty in the same manner as Assessable Penalties. If Congress had wanted the AIA not to apply, the defenders assert, it could easily have amended the AIA or instructed the IRS to assess the penalty in the same manner as a Deficiency. Third, Amici Tax Law Professors point out that the collection actions that Congress prohibited are precisely those that trigger the CDP Procedure. If Congress had allowed the IRS to use those collection tools, taxpayers would be able to avoid the AIA using the CDP exception described above. Thus, the restrictions on collection powers is as much a command that the “pay first, litigate later” rule applies as it is a restriction on the IRS.

2. Plaintiffs are not seeking to restrain the assessment or collection of the

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**EXPERT POLL**

**Does the AIA bar jurisdiction?**

**YES**

**NO**

Thomas (100%)  Scalia (100%)  Alito (87%)  Kennedy (87%)  Roberts (87%)  Breyer (71%)  Ginsburg (71%)  Kagan (71%)  Sotomayor (56%)

*Percentages indicate the proportion of experts polled who believe a justice will vote in a given way

Photos courtesy of the Collection of the Supreme Court of the United States
penalty but only the requirement to buy health insurance.

Private Respondents contend that even if the §5000A penalty is a tax, they are not seeking to enjoin its assessment or collection. Rather, they are seeking to enjoin the individual mandate—the requirement that they purchase health insurance. Private Respondents say that they will, in fact, acquire the required health insurance if they have to, so they won’t even incur the § 5000A penalty. That is, they are trying to avoid the legal obligation imposed by § 5000A, not the penalty for noncompliance.

The defenders of the applicability of the AIA counter that even if the Private Respondents plan to comply with the individual mandate and not incur the § 5000A penalty, other individuals would not comply and would incur the § 5000A penalty. As Amicus Long points out, in similar situations the Supreme Court has held that “a suit seeking to enjoin the assessment or collection of anyone’s taxes triggers the literal terms of § 7421(a).”

The defenders also argue that, since the individual mandate has no enforcement mechanism except the penalty, the two provisions cannot be separated. The attackers counter that the individual mandate and penalty provision can be separated because certain low-income taxpayers are required to have insurance but are exempt from the penalty if they do not.

Finally, the defenders say that the motives of the litigants are not important to the AIA; it applies to any lawsuit that would have the effect of restraining the assessment or collection of a tax. The attackers reject this interpretation of the AIA and submit that it applies only to suits whose purpose is restraining the assessment or collection of tax. Both sides invoke the same Supreme Court precedents to support their divergent views.

3. The AIA only bars suits by “any person” and a state is not a “person.”

The State Respondents suggest that the word “person” in the AIA does not include a “state.” They support their argument by noting that the word “person” does not usually include states and that § 7701, the Code provision defining the word “person” for tax purposes, includes many organizations and entities but does not mention states.

The government switches sides here and joins Amicus Long in defending the application of the AIA to states. Both point out that the term “includes” in § 7701 means the definition is not exclusive and could therefore encompass states as well. They further point out that the Supreme Court has found states to be “persons” for many other tax provisions and that the Court has previously recognized that § 7421’s “any person” language was not added to limit the reach of § 7421 but to broaden its reach to prevent suits by third parties that would interfere with the collection of others’ taxes.

4. Regan excepts the States’ lawsuit from the AIA.

State Respondents argue that their challenge to §5000A is not barred as it falls within the exception to the AIA recognized in South Carolina v. Regan, 465 U.S. 367 (1984), that exception applies when a plaintiff would not have any other way to obtain judicial review of the federal government’s actions. In Regan, South Carolina claimed that a federal statute that made interest on certain local bonds taxable instead of tax-free violated the Tenth Amendment. The only way for South Carolina to obtain judicial review was by seeking an injunction, so the Court held the AIA would not apply. The State Respondents argue that this exception should apply here because there is no other procedure for them to protect their interests.

The government and Amicus Long disagree. In Regan, the statute at issue applied to bonds issued by the state, but here the individual mandate does not apply to states, just to individuals. In Regan, South Carolina was defending its own interest in being able to issue bonds in the form it chose; here, the states are not directly affected by the individual mandate. Rather than seeking to protect their own constitutional rights under the Tenth Amendment, the states are seeking to protect the interests of their citizens.

Significance

A ruling that the AIA is jurisdictional and that it bars consideration of this suit would invalidate all the court rulings on the constitutionality of the ACA thus far. Federal courts would not be able to rule on that question until 2015 unless Congress passes a special statute.

The significance of a ruling that the AIA is jurisdictional but does not apply to this suit would depend on why the Court concluded that it does not apply. Both the government and Amici CFAT urge the Court to go this route and craft a very narrow ruling based on the unique nature of the assessment and collection provisions.

A ruling that the AIA is not jurisdictional and has been waived would be a surprise and would create significant uncertainty about who can waive the statute’s defense and how deliberate waiver must be.

There is yet another possibility. Some courts have postponed the AIA analysis until after they decide whether §5000A is a constitutional exercise of Congressional taxing power. They reason that if the § 5000A penalty is not a tax for purposes of the constitutional taxing power, it cannot be a “tax” within the meaning of the AIA. It seems doubtful the Supreme Court would go this route, however, and none of the briefs have argued for it. As the government’s brief points out, the constitutional meaning of “tax” may differ from the statutory meaning. For example, in the early 1920s Congress tried to use its taxing powers to regulate child labor. The Supreme Court held that the AIA barred prepayment lawsuits challenging the law but held that the law was not a constitutional exercise of the taxing power when the matter came properly before the Court.

PREVIEW Health Care and the High Court

Bryan Camp is George H. Mahon Professor of Law, Texas Tech School of the Law, and Jordan Barry is Associate Professor of Law, University of San Diego School of Law. Professors Barry and Camp prepared one of the Amici briefs in this case. Professor Camp was an attorney in the IRS Office of Chief Counsel for many years before entering teaching in 2001. Professor Barry was in private practice at Fried, Frank, Harris, Shriver & Jacobson before entering teaching in 2009.
Minimum Coverage Provision

Issue

By Elliott B. Pollack

United States Department of Health and Human Services et al.
v.
State of Florida et al.

Docket No. 11-398
Argument Date: March 27, 2012
From: The Eleventh Circuit

Case at a Glance A key component of the Patient Protection and Affordable Care Act is the individual mandate or minimum coverage provision requiring that all Americans, with limited exceptions, maintain a base level of health care coverage. Those who fail to do so are liable for a penalty assessed by the IRS. This challenge asks the Supreme Court to determine whether Congress has the power under the Constitution’s Commerce Clause to issue such a mandate and, further, if Congress has the right to assess a penalty and/or a tax against those who refuse or fail to meet the mandate.

Introduction
The 2010 Patient Protection and Affordable Care Act, sometimes referred to with the jaw-breaking acronym PPACA or the more palatable ACA, is seen by virtually all health care policy experts as the most important piece of health care legislation out of Washington since Medicare and Medicaid were enacted in 1965. The United States Supreme Court appears to agree.

As T. R. Goldman comments in the January 2012 issue of Health Affairs, “the high court’s commitment to filling its entire ... calendar with arguments about the law during the week of March 26, 2012, constitutes an extraordinary event. With five and one-half hours [now expanded to six] of argument over three days, the hearing will be one of the Court’s longest in decades.” Of the several questions the Supreme Court will consider, this article focuses on the “minimum coverage” requirement—health care coverage” beginning in 2014. Certain individuals whose religious beliefs preclude doing so, illegal aliens, and prisoners are exempted. Section 1502 imposes the obligation on insurance companies to file informational returns to identify the names of their insureds and the dates of coverage. The Internal Revenue Service is tasked to notify taxpayers who are not enrolled about accessing coverage through the health-benefit exchange operating in their state.

With generations of lawyers schooled about the virtually unlimited scope of the Commerce Clause and against the backdrop of U.S. Circuit Court of Appeals decisions which have both upheld (Sixth Circuit and District of Columbia Circuit) and rejected this claim (Eleventh Circuit), the Court’s anticipated ruling is of overwhelming importance. University of Texas Professor Lucas A. Powe Jr. looks back to the Supreme Court’s jurisprudence in 1936 and 1937, first ruling
against President Roosevelt’s New Deal programs and a year later supporting them, as the most recent relevant historical parallel with respect to Commerce Clause jurisprudence. If he is correct, we will have waited more than 80 years for the legal landscape to thunder so mightily again about this topic.

By way of background, the 2006 health care reform law approved by then Governor Mitt Romney in Massachusetts appears to have pioneered the individual mandate requirement with the exception that Massachusetts residents face up to a maximum of a $1,200 yearly penalty for failing to carry health coverage. Under the ACA, the penalty begins at $95 in 2014 and rises gradually to $695 annually in 2016.

**Facts**

In 1898, before his tenure on the Supreme Court, Louis D. Brandeis wrote that individuals have the right to be “left alone” by the government and private economic actors. 114 years later, do the sentiments espoused by Justice Brandeis, later recognized in constitutional rulings, trump the claim in the pending appeal that Congress has the authority under the Commerce Clause to require us to buy health insurance?

In *Wickard v. Filburn*, 317 U.S. 111 (1942), Congress’s Commerce Clause jurisdiction was upheld as to agricultural crop quota legislation even though farmer Filburn intended to use the grain for his family and not to sell it. According to the Court, by growing his own grain, Filburn could reduce his activity in the grain market. Fifty-three years after *Wickard*, United States *v. Lopez*, 514 U.S. 549 (1995), stands as the clause’s high-water mark; the *Lopez* Court tossed out the claim that Congress could prohibit guns in schools under the Commerce Clause on the basis that gun violence could affect the overall performance of the economy. The connection between the regulation of interstate commerce and the laudable objective of reducing gun-related deaths in schools was too remote to be approved by the Supreme Court.

In as much as the Court granted certiorari from the opinion of the Eleventh Circuit Court of Appeals on August 12, 2011, overturning the ACA entirely, the discussion here will begin with that ruling and that of the trial court with respect to the mandate.

**Judge Vinson’s Decision**

United States Florida Northern District Court Judge Roger Vinson declared the entire ACA unconstitutional last January. 750 F. Supp. 2d 1256. Preceded by various district court results out of Lynchburg and Richmond, Virginia, Detroit, and the District of Columbia, Judge Vinson held that the imposition of a penalty upon individuals for not purchasing health insurance improperly extends the Commerce Clause’s jurisdiction.

Being uninsured is not an act, he ruled. Congress may only require us to act or not to act under the Commerce Clause. Judge Vinson perceived the individual mandate as an unprecedented expansion of Commerce Clause jurisdiction, which would regulate the passive status of individuals. The reasoning that a decision not to acquire health insurance is active, rather than passive, and amounts to a decision as to how each person chooses to pay for health care was utterly unconvincing to Judge Vinson. (It did carry the day for Judge Laurence Silberman of the Sixth Circuit—a well-known conservative). The assertion that the nonpurchase penalty tax was a proper exercise of federal government’s taxation powers was also rejected by Judge Vinson as a penalty disguised as a tax.

Judge Vinson perceived the individual mandate as an unprecedented expansion of Commerce Clause jurisdiction.

Judge Vinson equated the ACA minimum coverage requirement with the compulsory consumption of a less than beloved vegetable. If the individual mandate is upheld, he wrote: Congress could require that people buy and consume broccoli at regular intervals, not only because the required purchases will positively impact interstate commerce, but also because those who eat healthier tend to be healthier and are thus more productive and put less of a strain on the health-care system.

As a sound bite, the broccoli analogy is wonderful. Does it hold up under closer scrutiny, or did Judge Vinson accurately describe the legal issue facing the Supreme Court—albeit in a culinary metaphor?

A 2-1 decision of the Court of Appeals for the Eleventh Circuit affirmed Judge Vinson’s ruling, thus generating this appeal.

**The Eleventh Circuit Decision**

Quoting James Madison’s comment in *Federalist Papers No. 45*, the Eleventh Circuit Court of Appeals placed a marker on the table that it would pick up later in its opinion. “The regulation of commerce, it is true, is a new power; but that seems to be an addition which few oppose, and from which no apprehensions are entertained.” The court’s trenchant coda to Madison was, “the commerce power has in a sense come to dominate federal legislation.”

*Lopez*, the court noted, delimits the “constitutionally mandated division of authority,” which was designed to ensure protection of fundamental liberties. The lesson of *Lopez*, Judges Dubina and Hull wrote (they co-authored the majority opinion) is that Congress must observe the “distinction between what is truly national and what is truly local” while not acquiring a general police power over the states.

The Eleventh Circuit agreed with the contention of the 26 state respondents and the individual plaintiffs who brought the pending litigation that the health insurance mandate effectively requires “individuals to enter into commerce so that the federal government may regulate them. . . .” An individual who chooses not to purchase insurance is not within commerce; her decision “is marked by the absence of a commercial transaction.” Judges Dubina and Hull noted further that power under the Commerce Clause operates on “existing or ongoing activity,” not on the absence of a transaction.

Fending off the claim that the Supreme Court had never held that activity is the predicate for congressional commercial
legislation under the Commerce Clause, the majority observed that this was probably the case “because (the Court) has never been faced with the type of regulation at issue here.”

Distinguishing *Gonzalez v. Raich*, 545 U.S. 1 (2005), the Supreme Court’s decision upholding the regulation of the growing of marijuana at home for personal use as relating to an activity “that substantially affect(s) interstate commerce,” the Eleventh Circuit kept returning to its characterization of the individual mandate as one that impacts the *absence* of behavior. Although *Gonzalez* did not purport to reach interstate commerce, Justice Scalia’s concurring comment in *Gonzalez* that “marijuana that is grown at home and possessed for personal use is never more than an instant from the interstate market” appears not to have impacted the Eleventh Circuit’s reasoning.

Americans have already been subjected, the court of appeals recognized, to “a limited set” of personal mandates before passage of the ACA. Affirmative demands to take action such as jury service, the military draft, filing tax returns, and answering census takers’ questions are distinguishable because they are “duties owed to the government attendant to citizenship.” The reference in the Constitution to the requirement of a periodic census (Article I, § 2), the power to lay and collect taxes (Article I, § 8), and the power to raise and support armies (Article III, § 2) stood out to the court as transcending the limitations of the Commerce Clause.

A health insurance mandate cannot equate with the military draft, the Eleventh Circuit stated. Without regard to the lack of a provision in the Constitution permitting Congress to make military service compulsory, the court observed that purchasing health insurance to control the cost of health care is not a duty owed to the government as a condition of citizenship.” No mention was made of the fact that health insurance, let alone any reasonable concept of health care, did not exist in the eighteenth century; bloodletting was to be a favored method of maintaining and restoring health well into the nineteenth century.

Another prong of the Eleventh Circuit’s opinion was its respect for the states’ long-established and powerful role in regulating insurance and the provision of health care—notwithstanding that Congress also has legislated extensively and powerfully in those arenas. Noting that insurance is more traditionally linked to the states’ as compared to the federal government’s activities, the court’s Commerce Clause analysis was thus fortified by its perception that Congress had encroached in this area so as to “[strength[e]n] … the inference that the individual mandate exceeds constitutional boundaries.”

The United States maintained before the court of appeals that the individual mandate was a necessary adjunct to a “broader regulation of the insurance health care market” and therefore appropriately relied on the Commerce Clause. Charactering *Gonzalez* as the only application of the “larger regulatory scheme doctrine,” the Eleventh Circuit rejected the notion that Congress’s acknowledged ability to regulate insurance companies would be enhanced by an individual mandate.

The Eleventh Circuit also rejected the argument that the individual mandate is necessary to avoid the consequences of adverse selection and cost shifting in the creation and underwriting of health care insurance mechanisms. “[A]n unconstitutional regulation ... [is not converted] into a constitutional means [to assist private insurance companies] engendered by Congress’ broader regulatory reform of health insurance products.”

The Commerce Clause could not support the insurance coverage mandate, the Eleventh Circuit ruled. The ACA obligation imposed upon Americans “to purchase insurance from a private company for the entire duration of their lives is unprecedented, lacks cognizable limits and imperils our federal structure,” it held.

An alternative claim was made by the United States: the individual mandate may survive constitutional scrutiny under the Taxing and Spending Clause of the Constitution. The government focused on the broad nature of the federal taxing power and the fact that “a tax ‘does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed.’” *United States v. Sanchez*, 340 U.S. 42 (1950).

It was erroneous for the United States to rely on the tax clause, Judges Dubina and Hull ruled, because the ACA repeatedly refers to the imposition individuals must suffer for not obtaining health insurance coverage as a penalty. Many other provisions in the hundreds of pages of the ACA text refer to taxes rather than penalties making it difficult to insist on the interchangeability of the terms, the Eleventh Circuit observed. The ACA legislative history discerned by the Eleventh Circuit also supported the conclusion that Congress intended to enact a penalty. While the committee and floor comments of various senators and congresspersons leading to the passage of ACA characterized the mandate as a tax, the court was unwilling to give weight to these “assorted statements” given the text of the law and other “more reliable indicators of congressional intent.”

Lastly, the substantial revenue projected from collecting the penalty from noninsurance buyers failed to impress the Eleventh Circuit. The receipt of revenue, it concluded, was simply incidental to the failure to obtain health care insurance.

**Case Analysis**

The amicus brief of Citizens’ Council for Health Freedom furnishes an interesting insight into the viability of the Eleventh Circuit’s rulings in light of its analysis as to the original intent behind the Commerce Clause. The council quotes Alexander Hamilton in *Federalist Paper No. 83*: “[The] specification of particulars [referring to the claim of enumerated powers] evidently excludes all pretension of a general legislative authority.” On this and similar authority, the council asserts *Wickard* must be overturned in order to...
overturn the ACA individual mandate. *Wickard*’s holding that Congress may regulate anything that *substantially affects* commerce under the Commerce Clause, the council argues, opened the floodgates to all manner of regulation since virtually everything can be said to have some effect on commerce. *Wickard* was effectively undercut *sub silentio* by *Lopez* and by *United States v. Morrison*, 529 U.S. 598 (2000), the council wrote. The Supreme Court must and should now expressly consign this “seminal case,” as Tevi Troy styles it in the February 2012 issue of Commentary, to the legal dustbin.

The Department of Health and Human Services (HHS) stresses the active, even if sometimes unintentional, extensive involvement of the federal government in health care and in insurance markets. Medicare and Medicaid, the Children’s Health Insurance Program, tax deductions given to employers for paying their employees’ health insurance premiums, the nontaxable status afforded to employees’ health insurance premiums, the regulation of employer-sponsored health coverage through the Employee Income Security Act, among others, demonstrate how thoroughly the government has already planted itself within the field of health insurance. Further, HHS points out that our current way of paying for health care on a national level has serious financial costs. According to HHS, 50 million people who lacked health insurance in 2009 consumed health care resources far above their ability to pay for services; 2008 data cited by HHS indicate that uninsured Americans pay for only 37 percent of their health care costs. As a result, the need for health care providers to capture these uninsured costs by inflating the charges to insured consumers, the so-called “cost shift,” increases health care insurance premiums for the balance of Americans; according to HHS, this cost shift certainly has an impact on commerce among the states.

Given these realities, the government maintains that the ACA “establishes a framework of economic regulation and incentives.” To reform the health care insurance system by broadening Medicaid coverage, encouraging an expansion of employer-sponsored insurance through tax measures and establishing “tax penalties” to incentivize the insured requires a minimum level of health insurance—and other measures as well. Characterizing the charge for not complying with the mandate as at bottom a “tax,” HHS argues that Congress assigned adverse tax consequences to the “alternative of citizens’ attempted self-insuring.”

Emphasizing that the minimum coverage provision is a key component of the ACA’s broad health care market reforms, HHS cites discriminatory underwriting practices in its Supreme Court brief as another important justification for the legislation. It notes that previous legal reforms carried out by states without the individual mandate largely failed. If Congress is entitled to reform the interstate market in health care insurance, HHS asserts, it must, by extension, be legally entitled to require that almost all individuals obtain coverage. As a “necessary component of a broader scheme of interstate economic regulation,” both the ACA and the individual mandate have a major impact on economic conduct which, in turn, substantially impacts interstate commerce.

**HHS notes that previous legal reforms carried out by states without the individual mandate largely failed.**

Congress has a broad discretion in determining how to achieve its constitutionally available targets. Since “insurance is by far the predominant means of paying for health care in this country,” HHS maintains that Congress was certainly entitled to employ health insurance as the same “mechanism” to deal with the problem of cost shifting.

HHS strongly disagreed with the Eleventh Circuit’s view that it would have been constitutional under the Commerce Clause for Congress to require health insurance when health care was being sought, rather than in advance. Mandating advance coverage, the petitioners

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**EXPERT POLL**

**Is the Individual Mandate Constitutional?**

**YES**

- Breyer (100%)
- Ginsburg (100%)
- Kagan (100%)
- Sotomayor (100%)

**NO**

- Roberts (69%)
- Thomas (100%)
- Scalia (62%)
- Alito (59%)

*Percentages indicate the proportion of experts polled who believe a justice will vote in a given way*
wrote, is unassailably reasonable given that it is frequently difficult, if not impossible, to obtain health insurance after the need arises. Established law mandates that those requiring emergency care have access to hospital and clinic emergency rooms even if they cannot pay or do not have insurance. This reality, HHS points out, makes it “infeasible as well as inhumane” to limit Congress’s power under so “semantic and formalistic” an analysis.

Lastly, HHS asserts that the taxing power, however characterized as a penalty in the statute, practically operates as a tax whose calculation, in part at least, is linked to income, with a floor and ceiling. The ACA requirement to report and to pay the tax on an individual’s income tax return filed with the Internal Revenue Service helps, it asserts, to support the argument. It is immaterial which word Congress uses in this context, concludes HHS. Whether characterized as a “penalty” or as a “tax,” the imposition of the charge was constitutionally permissible under the circumstances.

Twenty-six states led by Florida characterize the individual mandate as a “threat to liberty. ... “The states argue that through the ACA, Congress is asserting “the power to compel individuals to engage in commerce in order more effectively to regulate commerce.” This is the first time in the history of the country, they maintain, that Congress has asserted such an “unbounded power”; rejecting it will not imperil any other legislation or a sound health care policy.

It is significant, the states assert, that while individuals must obtain health care insurance by virtue of ACA, they are not required to use that insurance when obtaining health care. According to the states, this gap further demonstrates the weakness of the constitutional arguments asserted by the United States. The states contend that use would more closely relate to actions taken in commerce and therefore be more likely to survive scrutiny.

“If Congress not only can regulate individuals once they decide to enter into commerce, but can compel them to enter commerce in the first place ...”, the states hold that the concept of enumerated powers and limitations on Congress’s ability to act will no longer exist.

The historic quality of this litigation is also emphasized by the states, characterizing the individual mandate as “the first ever law of its kind.” To uphold the constitutionality of the ACA would grant Congress a “carte blanche” to violate the “structural limitations” of the Constitution.

The states further challenge the petitioners’ reliance on a tertiary definition of the term “regulate” in the Commerce Clause of “to order; to command” which derives from Samuel Johnson’s 1619 Dictionary of the English Language as presented in the 1773 edition of that text. The states demand: How could such a remote definition govern “the popular understanding of the power granted to the new federal government” in the Commerce Clause 220 years ago? Congress may well have the power to regulate, direct, or command individuals who may voluntarily engage in commerce, they agree. However, the ACA seeks to command individuals “to enter into commerce in the first place.” Congress was duly warned by the Congressional Budget Office almost 20 years ago, the states remind, that Congress had “never required people to buy any goods or services as a condition of lawful residence in the United States. ...” Wickard v. Filburn does not support the ACA, the states conclude. According to the states, that decision validated “an intricate system of quotas and subsidies to [prevent] wheat for on-farm consumption from having an indirect effect on prices.” Wickard did not force any individual to enter any market as does the ACA, the states argue.

Neither should reliance on the Necessary and Proper Clause of the Commerce Clause be conditioned inasmuch as the individual mandate conflicts with the states’ recognized powers to protect their residents, presumably from federal intrusion.

It is pointless, the states write, to argue that the individual mandate is simply the other side of a coin that could have imposed regulations and created federal subsidies to insurance companies to compensate for the “cost shift.” Since the public would oppose this approach, resorting to a financial tax/penalty in ACA was obviously the only choice available to Congress. However, by doing so, “Congress neatly avoided the political constraints that the Constitution contemplates will limit its power to enact unpopular regulations and general taxes.” Thus, the states argue, the ACA is nothing more than an end run around the Constitution.

Reinforcing the Eleventh Circuit’s conclusion that the “tax” as it is characterized by the petitioners is really a penalty for failure to comply with the mandatory health insurance requirement, the states reject the idea that the word “penalty” was “some linguistic oversight.” A “penalty” enforces a legal requirement; a “tax” is designed to support government operations, the states point out.

**Significance**

Is ACA a proper exercise of Congressional power to reform our staggering health care system consistent with Congress’s powers under the Commerce and Tax and Spending Clauses? Or is it a constitutionally improper effort “to compel the uninsured into engaging in economic activity that is harmful for them but beneficial to third parties,” as the private respondents’ brief asserts? Almost 50 years after the passage of the Medicare and Medicaid program and recognition by virtually all stakeholders that the shortcomings in our health care system require national solutions, the impact of a Supreme Court ruling that invalidates the individual mandate is difficult to predict, especially given the Court’s need to determine whether any potential constitutional defect in the individual mandate can be severed from ACA as a whole.

If anything, Professor Powe’s characterization of the significance of this case would seem to be vastly understated.

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The Severability Issue

By Erwin Chemerinsky

**Case at a Glance** One of the four issues that the Supreme Court has asked to be briefed and argued is “severability.” The issue before the Court is, if the minimum coverage provision—the individual mandate—is declared unconstitutional, is it severable from the rest of the Patient Protection and Affordable Care Act or does the entire act need to be declared unconstitutional?

**Facts**
The Patient Protection and Affordable Care Act is a large statute that does many different things. Its goal was to expand access to affordable health care, to regulate the terms on which health care is offered, and to control the costs of health care. It also contains many provisions concerning other aspects of health in the United States.

For example, one aspect of the act is to provide tax credits for small businesses to increase the subsidy for employee health coverage, while at the same time imposing a tax liability on large employers that do not provide adequate coverage to full-time employees. Another part of the act increases Medicaid coverage—the constitutionality of which is one of the separate issues before the Court—seeking to add as many as 10 million individuals to the Medicaid rolls in the next decade.

Additionally, the act regulates many aspects of the market for health insurance. For example, the act provides that insurers cannot rescind coverage absent fraud or intentional misrepresentation on the part of a policyholder. Insurers no longer may impose lifetime dollar limits on essential benefits and there are restrictions on the ability of insurers to impose annual dollar limits on coverage. Insurers are generally required to provide family coverage that includes adult children until age twenty-six. Also, the act bars insurers from denying coverage to individuals because of preexisting medical conditions.

The act changes aspects of Medicare payment rates and reimbursements. The goal of these provisions is to significantly reduce the costs of the Medicare program to the government.

The act also has a number of other provisions, which are not directly related to insurance but relate to the health care system. For example, the act requires chain restaurants to disclose nutritional information about standard menu items, establishes a National Prevention, Health Promotion, and Public Health Council, amends an aspect of the False Claims Act, and reauthorizes the Indian Health Care Improvement Act.

Except for the increased burden on the states with regard to Medicaid funding, none of these provisions are being challenged as unconstitutional. The provision being challenged is the “minimum coverage provision,” often called the individual mandate. This is the part of the act which establishes new tax penalties to be paid by nonexempted individuals who do not maintain a minimum level of health coverage for themselves. Congress determined that without the individual mandate, many individuals would not purchase health insurance.
until they needed care. This would increase premiums for those purchasing insurance and preclude many of the reforms in the act. To ensure coverage of the greatest number of people and to reform the provision of health insurance requires creating the largest possible risk pool.

The minimum coverage provision is challenged as exceeding the scope of Congress’s powers. If the Court were to declare this unconstitutional, there is then the question of whether the entire Act should be struck down or whether the minimum coverage provision is severable.

The petitioners on this issue are four individual plaintiffs, the National Federation of Independent Business, and 26 states. They filed suit in the United States District Court for the Northern District of Florida. The District Court found the individual mandate to be unconstitutional as exceeding the scope of Congress’s powers. The district court concluded that this provision is not severable from the rest of the act and declared the entire law unconstitutional. The district court stayed its ruling pending appellate review.

The United States Court of Appeals for the Eleventh Circuit affirmed the holding that the individual mandate is unconstitutional as exceeding the scope of Congress’s powers, but reversed on the question of severability. The court of appeals stated that “the lion’s share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance.” The court of appeals separately addressed two provisions of the act, the “guaranteed issue” and “community rating” provisions, which require insurers to enroll every applicant for insurance and prohibit insurers from denying, canceling, capping, or increasing the cost of coverage based on an individual’s preexisting health conditions, medical history, or past experience with respect to insurance claims.

Although the parties agreed that these provisions are not severable, the Eleventh Circuit disagreed and found that the provisions could be severed and the rest of the act upheld even though the court declared the individual mandate unconstitutional. The court of appeals said that it was “not persuaded that it is evident (as opposed to possible or reasonable) that Congress would not have enacted the two reforms in the absence of the individual mandate.” The court of appeals observed that these provisions were meant to “help consumers who need it the most” and concluded that Congress would have adopted these provisions even without the individual mandate.

**Case Analysis**

If the Supreme Court upholds the minimum coverage provision of the act or decides that it cannot rule on it because of the Anti-injunction Act, the Court will not need to address the severability question. But if the minimum coverage provision is declared unconstitutional as exceeding the scope of Congress’s powers, then the severability question will loom large and the Court will have to decide whether the entire Patient Protection and Affordable Care Act is unconstitutional.

The petitioners argue, “Severability does not involve a distinct challenge to the remaining provisions of an act that must be supported by independent standing. Instead, severability considers the consequences for the balance of the statute of the invalidation of the provisions that the challenger has already successfully attacked.” The state petitioners contend that imposing a separate standing requirement for the challenge to each part of the act “would frustrate the remedial powers of the courts.”

The Eleventh Circuit did not address the standing question in finding that the minimum coverage provision is severable from the rest of the act. The United States has raised it again in the Supreme Court.

Assuming that the Court addresses the severability question, all of the parties agree that ultimately the question of severability is one of legislative intent: Would Congress have enacted the rest of the statute without the part of the law declared unconstitutional? As the Supreme Court has explained, “After finding an application or portion of a statute unconstitutional, we must next ask: Would the legislature have preferred what is left of the statute to no statute at all?” Ayotte v. Planned Parenthood of New England, 546 U.S. 320 (2006). The inquiry for severability is whether the statute created in [the] absence [of the invalid provision] is legislation that Congress would not have enacted.” Alaska Airlines v. Brock, 480 U.S. 678 (1987).

The United States has agreed with the petitioners that the “guaranteed issue” and “community rating” provisions are not severable. That, though, is not necessarily determinative of the severability question as to these provisions. Although the United States made the same concession in the Eleventh Circuit, that court nonetheless found that these provisions were severable and concluded that “the touchstone of severability analysis is legislative intent, not arguments made during litigation.”

Not surprisingly, the parties disagree about the severability of the remainder of the act. Both the state petitioners and the private petitioners argue that the remainder of the Patient Protection and Affordable Care Act would not have been adopted without the minimum coverage requirements.
The United States argues that there is a strong presumption in favor of partial, rather than total, invalidation of a statute.

By contrast, the United States argues that except for the guaranteed issue and the community rating provisions, the remainder of the act is severable and should remain even if the individual mandate is struck down. The United States argues that it is incumbent on a court to strike down no more of a law than necessary to comply with the Constitution. The United States quotes a recent Supreme Court decision declaring “[w]hen confronting a constitutional flaw in a statute,” a court must “try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact.” Free Enterprise Fund v. Public Accounting Oversight Board, 130 S.Ct. 3138 (2010).

The United States argues that there is a strong presumption in favor of partial, rather than total, invalidation of a statute. The United States agrees with the Eleventh Circuit that the “lion’s share” of the act does not depend on or relate to the individual mandate. The United States argues that “[o]ther provisions can operate independently and would still advance Congress’s core goals of expanding coverage, improving public health, and controlling costs even if the minimum coverage provision were held unconstitutional.”

The United States also stresses that severability is strongly supported by the fact that many of the provisions of the act are already in effect even though the individual mandate does not become effective until 2014. The United States says “that time lag establishes conclusively that much of the act operates independently of the minimum coverage provision.”

Thus, there are two very different visions of the act being presented to the Supreme Court. The petitioners contend that the entire act was a hard fought compromise in Congress and that the individual mandate was the key without which the act would not have been adopted. The United States, by contrast, says that the act contains a myriad of provisions, some having nothing to do with the individual mandate, and that these likely would have been adopted...
even without the individual mandate.

In assessing severability, the Supreme Court has declared that it “must retain those portions of the Act that are (1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress's basic objectives in enacting the statute.” United States v. Booker, 543 U.S. 220 (2005). None of the parties deny that the vast majority of the act is “constitutionally valid”; the constitutional challenges are to the individual mandate and the increased burden on the states for Medicaid coverage.

There is disagreement between the parties over whether some of the other provisions could function independently, but the parties obviously agree that some of the portions which have nothing to do with the provision of care by insurance companies could do so. The major disagreement between the parties is whether Congress would have enacted them, and the act, without the individual mandate.

**If the Court strikes down the individual mandate as exceeding the scope of Congress’s powers, then the severability clause becomes key.**

**Significance**
The Supreme Court has allocated 90 minutes of oral argument to the issue of severability. This likely reflects its sense of the complexity and importance of the issue. If the Court upholds the individual mandate, it will not even address the severability question. But if the Court strikes down the individual mandate as exceeding the scope of Congress’s powers, then the severability clause becomes key as the Court has to determine whether to invalidate the rest of the act.

Although there have been many Supreme Court decisions concerning severability, none have concerned a statute with the political and social significance of the Patient Protection and Affordable Care Act. Even among judges who have found the individual mandate to be unconstitutional, only one, the district court judge in this case, declared the entire act unconstitutional. Declaring the entire act unconstitutional might seem drastic, even to justices who find the individual mandate unconstitutional. On the other hand, there is no doubt that the individual mandate is a key part of the act, and if it is unconstitutional, the Court must decide whether Congress would have adopted the remainder of the law without it.

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The Medicaid Expansion

Issue

By Steven D. Schwinn

State of Florida et al.
v. United States Department of Health and Human Services et al.

Docket No. 11-400
Argument Date: March 29, 2012
From: The Eleventh Circuit

Case at a Glance Medicaid is a cooperative federal-state program that funds medical care for needy individuals. Under the program, the federal government provides funds to participating states, and participating states agree to abide by certain federal standards. The Affordable Care Act, or the ACA, sets a new standard by expanding Medicaid eligibility to individuals with incomes up to 133 percent of the federal poverty level. While participating states must accede to this expansion, the federal government will pay for 100 percent of Medicaid costs associated with the expansion through 2016; the federal share then gradually decreases to 90 percent in 2020.

Introduction Congress has authority to spend funds to promote the general welfare. It also has authority to set conditions on those funds, even when the conditions apply to states. But while Congress can use these authorities to encourage states to adopt its conditions, Congress cannot use these authorities to compel states.

Facts Medicaid, established in 1965, is a cooperative federal-state program designed to fund medical care for needy individuals. Under the program, the federal government provides funds to states that elect to participate. Participating states, in turn, provide their own additional funds and agree to comply with certain federal requirements. While participation is optional, every state participates.

First and foremost, Medicaid requires participating states to fund the provision of certain health care benefits to specific categories of needy individuals. Beyond this basic requirement, states may elect to cover additional categories of individuals and to provide additional medical benefits. Every state has opted to extend Medicaid eligibility to some additional populations and to cover some additional medical benefits.

The Medicaid program puts states on notice that Congress can change the requirements. In the Social Security Act, Congress reserves the “right to alter, amend, or repeal any provision” of the act. 42 U.S.C. § 1304. And under the act, states agree to amend their own plans consistent with changes in federal law. Congress has changed the requirements many times since 1965, frequently expanding the scope of mandatory eligibility and mandatory benefits, sometimes dramatically, and states have changed their own plans accordingly.

The most recent change, the one at issue here, expanded eligibility to certain individuals under age 65, not receiving Medicare, with incomes up to 133 percent of the federal poverty level. Under the ACA, states must provide these individuals only with the Medicaid Act’s “benchmark” or “benchmark-equivalent” coverage provisions—provisions that allow states to choose options that may be less comprehensive than the traditional Medicaid benefit package.

Issue Does Congress unconstitutionally compel states to expand Medicaid eligibility by conditioning receipt of federal Medicaid funds on the expansion of Medicaid eligibility, even when Congress pays for the expansion?
The federal government will pay 100 percent of the cost of coverage for newly eligible individuals through 2016. Then the federal share gradually decreases to 93 percent in 2019. In 2020 and after, the federal government will pay 90 percent of these costs. (The typical federal contribution rates for the Medicaid program range from 50 percent to 83 percent of a state’s Medicaid expenditures.) Moreover, the federal government will pay 90 percent of the state administrative costs incurred to upgrade state systems to comply with the expansion until 2015. (The federal government ordinarily pays 50 percent of a state’s administrative costs.)

A group of 24 states, a state’s attorney general, and a governor sued the Department of Health and Human Services to halt implementation of the Medicaid expansion. (The petitioners are simply referred to as “the states” below.) The states argued that the expansion exceeded Congress’s power to set conditions on the receipt of federal funds—that the expansion was unduly coercive in violation of the Tenth Amendment and related federalism principles. The district court rejected their claim, and the court of appeals affirmed. This appeal followed.

**Case Analysis**

Congress has authority under Article I, Section 8, of the Constitution to spend money to promote the general welfare. It also has ancillary authority to set conditions on its spending programs, or to say how its money will be used. Congress can set conditions on its spending programs even when those conditions bind the states. Thus, federal spending programs work like a contract with participating states: the federal government agrees to give money to the states in exchange for their agreement to comply with the attached conditions. If a state declines or fails to comply with the conditions, it sacrifices the federal funds. The spending power is significant, because it allows Congress to affect policies indirectly (by way of conditioned spending to the states) that it could not affect directly (by way of its Commerce Clause authority, for example).

But the spending power is not absolute; there is a limit. While Congress can use its spending power to encourage the states to adopt certain policies, it cannot use its spending power to compel them to adopt those policies. In other words, states must be free to decline federal funds and the attached conditions; state choice is essential. Two leading cases illustrate this principle.

The first is *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937). In that case, Steward Machine Company challenged a federal tax-and-credit program under the Tenth Amendment. Congress imposed the tax on certain employers but allowed a 90 percent refund if the state imposed its own tax to create a state unemployment compensation program that satisfied certain federal requirements. The Court wrote that a federal program, like the tax-and-credit program, would violate the Tenth Amendment if it operated as a “weapon[] of coercion, destroying or impairing the autonomy of the states.” But it ruled that the program there did not go so far, and it upheld the program against the Tenth Amendment challenge.

The second case is *South Dakota v. Dole*, 483 U.S. 203 (1987). In that case, a state argued that a federal spending program violated the Tenth Amendment when it conditioned 5 percent of the state’s federal highway funds on the state’s establishing a 21-year-old legal drinking age. The Court, citing and quoting *Steward Machine Co.*, wrote that a condition “might be so coercive as to pass the point at which ‘pressure turns into compulsion’” and thus violates the Tenth Amendment. But, like the Court in *Steward Machine Co.*, the *Dole* Court ruled that the program there did not go so far.

The parties frame their arguments around that ill-defined point at which “pressure turns into compulsion.” The states argue that the massive amounts of federal money in the Medicaid program and the structure of the ACA make the Medicaid expansion compulsory on the states, while the government argues that the Medicaid program merely pressures states to accede to its many conditions, including the ACA’s expansion.

The states proffer three principal arguments. First, the states argue that the Court should reaffirm that Congress may not use its spending power coercively against the states. They say that interference with state sovereignty is a core limitation on congressional authority, and that the Court has long recognized that Congress may not intrude on state sovereignty. The states contend that Congress unconstitutionally coerces them when it eliminates the element of choice from a spending program, and that the Court must then enforce a limit on congressional authority.

Second, the states argue that the ACA’s Medicaid expansion is unconstitutionally coercive. The states say that the ACA itself is the best evidence of coercion. In particular, they say that the ACA’s universal coverage provision forces low-income individuals to purchase insurance, but that the expanded Medicaid program is the only insurance option for these individuals; as a result, states must accede to the expanded Medicaid program so that their low-income citizens can comply with the universal coverage provision. Moreover, the states argue that the ACA’s tax subsidies for low-income individuals who purchase health insurance apply only to those individuals who do not qualify for Medicaid, suggesting that Congress intended that states would accede to Medicaid expansion. And states contend that prior amendments to the Medicaid program illustrate that Medicaid expansion is unconstitutionally coercive: whenever Congress sought to expand Medicaid in the past, they say, Congress gave states an additional financial incentive for the incremental expansion, and did not, as here, threaten to take away all Medicaid funding for noncompliance with the expansion.

The states also argue that Medicaid’s sheer size makes the expansion unconstitutionally coercive. They say that their failure to comply with the expansion means that they would lose all of their federal Medicaid funding, including “pre-existing” Medicaid funding (i.e., funding available before the ACA expansion). They claim that the massive funds they receive under the Medicaid program make noncompliance with the expansion untenable and unconstitutionally coercive.
The states claim that they have no realistic option but to comply with the expansion. They argue that Medicaid is funded by their citizens’ own federal tax dollars, and that they cannot deprive their citizens of a return on those taxes by declining federal funding under the massive Medicaid program. And they say that they cannot reasonably replace Medicaid with their own programs, given the expenses of such programs, at least in the short run.

In sum, they argue that Medicaid expansion is unconstitutional under Steward Machine Co. and Dole. They argue that the programs challenged in those cases provided the states a reasonable option to decline the federal funds. In Steward Machine Co., states could reasonably decline the federal incentive to create a state unemployment compensation fund; in Dole, states could reasonably decline the paltry 5 percent of federal highway funding. In contrast, the states argue that they have no such reasonable option to decline the massive amounts of federal money under their entire Medicaid program, and that Medicaid expansion therefore looks more like unconstitutional commandeering of the states.

Third, the states argue that the Court could rule the Medicaid expansion unconstitutional without a wholesale invalidation of all federal spending legislation. They say that unconstitutional coercion is so clear here that the Court does not need to determine the precise point when encouragement becomes coercion in order to rule that Medicaid expansion exceeded it. Moreover, they say that Medicaid expansion is different than other run-of-the-mill federal spending conditions because it is inextricably tied to the universal coverage provision of the ACA, and because the Medicaid program involves so much more money than other federal spending programs. In short, the states argue that Medicaid expansion is no ordinary federal spending program, and that the Court could comfortably rule it unconstitutional while still preserving the vast majority of federal spending programs and attached conditions.

The government proffers three principal arguments in response. First, the government argues that Congress has broad authority under the Spending Clause and the Appropriations Clause to set conditions on the receipt of federal funds. The government points to a string of Supreme Court cases, including Dole, that say that the government can set the terms of its spending, even against the states, so long as it does not “compel States to implement federal programs.” The government says that it has set and expanded Medicaid qualification standards “many times,” and that states must accept each expansion as a condition of participating in the Medicaid program itself (and not merely as a condition of receiving incremental funding for a single offensive expansion). The government claims that the expansion here meets an important need, is a valid condition, and is an integral, nonseverable part of the overall Medicaid program. In short, according to the government, the overall Medicaid package now includes this expansion. States can take it or leave it, but they cannot peel off this expansion from the rest of the Medicaid requirements and hope to stay in the program.

Second, the government argues that the expansion to Medicaid is a valid and legitimate condition on this federal spending program. The government says that the Medicaid expansion in the ACA is not unprecedented, as the states claim—indeed, it is consistent with historical expansions of the Medicaid program—and that it is not especially burdensome on the states. The government points to the fact that it will initially pay 100 percent of the cost of expansion and reduce that amount to 90 percent in 2020—far greater percentages than the usual federal contribution rates for Medicaid. Moreover, the government contends that the projected increase in state spending will be offset by cost savings under other provisions of the ACA, and that states can still exercise their full flexibility in reducing Medicaid costs within the Medicaid program itself (e.g., through design of service delivery systems or through the rates they pay for care).
The government claims that the states’ mere reluctance to turn down Medicaid funding does not make the expansion unconstitutionally coercive. The government argues that it has wide authority to encourage states with federal funds, but “that doesn’t mean that the federal government, simply by offering, has coerced the State into accepting.” The government also says that setting the line anywhere short of outright compulsion would improperly require the courts to rule on a quintessential matter of policy. According to the government, the sheer size of the Medicaid program does not make it unconstitutionally coercive: it has always been the largest grant-in-aid program, and it has only grown over time, with the full assent of the states. Further, the government asserts that it belies common sense to say, as the states do, that the more generous a federal program is to the states, the more it unconstitutionally compels the states. The government contends that the Medicaid Act puts states on full notice that Congress can change program requirements from time to time, and that states do not have an option to accept or reject any particular change; instead, the government can withhold federal Medicaid funding in full for noncompliance with any portion of the act. The government says that the states’ argument that Medicaid is paid for by state taxpayers (and is therefore unconstitutionally coercive because state taxpayers seek a return on their tax payments) turns our federal system on its head: Medicaid is paid for by federal taxpayers, and states and their citizens can elect to participate, or not. Finally, the government claims that the states’ position would also render other pre-ACA features of Medicaid unconstitutional, and that their position is contradicted by the fact that Congress could dismantle Medicaid today and reenact the full Medicaid program, including the expansion, tomorrow without violating the Constitution.

The government argues that the states are wrong to say that other provisions of the ACA render the Medicaid expansion unconstitutionally coercive. The government says that the universal coverage provision does not render the Medicaid expansion unconstitutionally coercive because the universal coverage provision does not force low-income individuals to obtain coverage. (They may be exempt, or they can pay a tax penalty in lieu of coverage.) And the government contends that it is not relevant that it did not provide a “contingency plan”: the government reasonably anticipated, based on the states’ participation in Medicaid and their coverage beyond what the act requires, that states would accept the new generous federal benefits under the Medicaid expansion.

Third, the government argues that the Court should not strike the entire ACA

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**EXPERT POLL: Likely Outcomes**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Will the Supreme Court uphold the ACA?</td>
<td>85%</td>
<td>15%</td>
</tr>
<tr>
<td>What will be the deciding issue in the case?</td>
<td>Individual Mandate 91%</td>
<td>Anti-Injunction Act 9%</td>
</tr>
<tr>
<td>If the individual mandate is found to be unconstitutional, will the justices find that it is severable from the rest of the ACA?</td>
<td>YES 70%</td>
<td>NO 30%</td>
</tr>
<tr>
<td>Will the case have a major impact on the upcoming presidential election?</td>
<td>YES 64%</td>
<td>NO 36%</td>
</tr>
<tr>
<td>What will the end result be?</td>
<td>ACA Upheld 85%</td>
<td>ACA Struck Down in Part 15%</td>
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*Preview identified a select group of academics, journalists, and lawyers who regularly follow and/or comment on the Supreme Court. Each expert participant completed the questionnaire separately without knowing what anyone else’s predictions would be. Experts were told their votes would be anonymous to encourage candid responses.*
if it rules that the Medicaid expansion is unconstitutional. The government says that the states did not properly present this argument. But in any event, the government says that the Court should sever the Medicaid expansion from the rest of the ACA, if it holds the Medicaid expansion unconstitutional. (This is not the principal severability argument in the ACA challenges. That argument, over whether the universal coverage provision is severable, is covered in a different article.)

**Significance**

Most immediately, this case will impact needy individuals’ access to medical care. Medicaid expansion in the ACA sweeps in a substantial new population of eligible individuals—most notably, single adults who earn less than 133 percent of the federal poverty level—and pays for medical services for them. As both parties seem to agree, these individuals do not have meaningful health insurance options. A ruling for the government will ensure that they receive medical services and benefits under Medicaid; a ruling for the states will mean that they do not.

Outside of that most central aspect, the case is also important because it tests the limits of one of Congress’s most significant and wide-ranging authorities, the power to spend money. Congress’s power to spend money—along with its ancillary power to set conditions on that money—is enormous. This power allows Congress to operate vast programs and to effect sweeping policies in all areas of life, without respect to the bounds on other congressional authorities in the Constitution (such as the Commerce Clause). This power also allows Congress to operate any manner of cooperative federal-state programs, achieving joint policy aims through the combined and coordinated efforts of the federal and state governments. Many of these programs, such as Medicaid, have enjoyed a long history and have become embedded in our system of federalism.

At the same time, this broad power can threaten to encroach on state sovereignty. State governments often complain about the heavy hand of the federal government, federal requirements with which they disagree, and a lack of federal financial support for implementing federal requirements—the complaint about so-called unfunded mandates.

This case gives the Roberts Court a chance to jump into the fray and to take a crack at defining the scope of the enormous federal spending power in relationship to the states. In particular, it gives the Court a chance to better define the point at which “pressure becomes compulsion,” and thus to cabin federal power to condition its money on states’ adoption of certain policies. Because the Court has so far only identified a theoretical limit on this power, this case gives the Court a chance to actualize and concretize the limit set out in *Steward Machine Co. v. Dole*.

But drawing a line short of actual, direct compulsion—where, for example, the federal government directly commandeers the states—could be tricky business for the Court, as both parties recognize. This is more usually the stuff for the political branches. Moreover, that kind of line-drawing could create uncertainty about the validity of other cooperative federal-state programs—the kind of uncertainty that the Court may shy away from, especially considering the size and reach of some of these programs.

There is another problem with this case. The federal government pays for 100 percent of the Medicaid expansion through 2016, and then a declining portion to 90 percent in 2020. This hardly looks like a state-sovereignty-infringing condition; instead, it looks like a fully-funded federal program, at least until 2016. It is not even obvious why the states have standing to challenge this until 2016, when even then they only have to pony up a very modest contribution. The Eleventh Circuit seemed to reject the states’ challenge largely on this basis—the fact that the federal government fully funds the expansion through 2016.

There is one particularly interesting doctrinal component to the case. The states argue as if they could peel away the Medicaid expansion as one objectionable condition of the Medicaid program. The government contests this; it says that the Medicaid program, with all its conditions, is a unified whole. This case gives the Court an opportunity to fine-tune its *Dole* analysis by considering each additional, incremental condition to a cooperative program and whether that last condition tips the scale for the whole program. The states’ position also suggests that they believe that they should be able to opt out of the expansion without opting out of the pre-expansion Medicaid program. Treated the expansion as separate or severable from the rest of the Medicaid program could generate uncertainty in other cooperative federal-state programs, considering the variety of conditions and their evolution.

The Roberts Court has not yet ruled on a federalism challenge to a cooperative federal-state program. But its related cases, and the justices’ positions in other federalism cases that raise similar state-sovereignty concerns, suggest that, on the whole, it may not be entirely friendly to this challenge. Moreover, only Justice Scalia remains from the *Dole* Court; he joined the *Dole* majority opinion in full. (Chief Justice Roberts wrote an amicus brief in that case in support of the state, but his position as attorney for an amicus in *Dole* is a poor predictor of his position here.)

Finally, we cannot consider this case, or any challenge to the ACA, without considering the politics. These cases are obviously laden with politics, especially in this presidential election year. This case takes a back seat to the challenge to congressional authority to enact the universal coverage provision. Still, look for both parties to make hay out of whatever ruling the Court issues here. We can hear the sound bites already: states’ rights and federal mandates on the one side, and access to health care and economic justice on the other.

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The Corporate Practice of Medicine and Accountable Care Organizations

By Bruce F. Howell, J.D., M.S.

The Affordable Care Act of 2010 (the ACA) has presented the concept of hospitals and physicians working together in organizations which share profits and potentially put physicians into the role of employees through a concept known as an Accountable Care Organization (ACO). While such arrangements may be the wave of the future, the concept flies squarely in the face of the doctrine of the prohibition of the corporate practice of medicine.

The prohibition of the corporate practice of medicine began early in the twentieth century and sprang from a concern that the profit motive would cause physicians to render care in less than a professional manner. In sum, the prohibition prevents the employment of a physician by a layperson and the splitting of fees by physicians with laypersons. The essence of this prohibition is also found in state medical board regulations and American Medical Association ethics guidelines.

Many states have this prohibition in some form or another, ranging from simple fee-splitting statutes to complex arrangements defining how management companies can charge a percentage fee for managing a physician’s practice. Some states do not enforce the prohibition, and several states do allow the direct employment of physicians by hospitals. New York, California, Texas, Florida, and Illinois have the most stringent laws and the more complex system of arrangements.

For example, in California, one of the statutes concerning the prohibition carves out an exception for a management company to charge its fee based only on gross revenue and not net profit, since the latter would be to share in the “bottom line” of the medical practice.

In Texas, the method by which hospitals have aligned themselves with physicians is by use of an organization commonly known as a “501a,” a term which refers to the former statute of the Texas Medical Practice Act under which these organizations were formed. These nonprofit organizations which can be either tax exempt or nontax exempt and which can employ physicians directly. Since the organization is a nonprofit, none of the net income can inure to the benefit of any individual and the entity can be controlled through the device of the hospital being the “member,” and the board of directors being made up entirely of physicians. Such an arrangement supposedly alleviates the concern that pure profit motive will drive medical decisions.

It would surprise many to learn that, technically, a hospital does not practice medicine. The hospital delivers health care services in the form of nurses, managers, aides, technicians, tests, and other ancillary health services. Only physicians can practice medicine, which is generally defined as the diagnosis and treatment of disease.

Under the ACA, the concept of accountable care organizations has been brought forth as a method to cut the cost of the delivery of health care. The idea is that physicians and hospitals will align themselves in ACOs in order to deliver care in a more seamless and efficient manner. While regulations concerning ACOs have been recently promulgated, and while these regulations address the regulatory issues in these entities relating to the Stark antikickback and antitrust laws, the corporate practice prohibition is one left to the states and, presumably, will need to be addressed by state legislatures and/or regulators.

The question, then, is how the practice of medicine can be regulated without giving way to the pressure presented by the need to cut costs. In most states, physicians will say that the need for tests, tests, and more tests is to practice defensive medicine in light of malpractice suits. The corporate practice prohibition has created a specific division between the hospital which delivers all other services and the physician who is engaged in practice of medicine. When this line becomes blurred, the concerns of who is in charge will come directly to the forefront. And, in the case of liability, there is an issue of whether the physician can point to the administration saying that the policies and procedures promulgated by laypersons and driven by the bottom line caused the malpractice problem.

Although only seven pages long in the ACA, the ACO concept is getting a lot of attention. While the United States Supreme Court will hear the question of the constitutionality of other parts of the ACA there is a chance that the ACO concept could be declared unconstitutional since the ACA does not contain a severability clause. One of the questions before the Court is whether the individual mandate contained in the ACA can be declared unconstitutional and severed from the rest of the act. If the latter occurs or if the ACA is upheld in its totality, the ACO concept and the corporate practice of medicine will be an issue to consider.

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The Ebbs and Flows of Federalism at the High Court

By Steven D. Schwinn

With all the buzz about congressional authority to enact the universal coverage provision of the Affordable Care Act (ACA) under the Commerce Clause, you can be excused for missing another aspect of the case: federalism. Federalism is all about preserving a healthy balance of power between the federal government and the states. It means that both the federal government and the states enjoy some measure of sovereignty in our system, and it therefore seeks to protect the appropriate roles of each—all in the interest of preserving individual liberty. Federalism proponents often worry more about the balance shifting away from the states and toward the federal government (and not the other way around); federalism, therefore, often becomes shorthand for protecting the states’ prerogatives against an encroaching federal government. Here, according to the challengers, it means that the ACA’s expansion of Medicaid and its universal care provision upset the balance by unconstitutionally compelling the states to enact federal policy (through the Medicaid expansion) and invading an area traditionally reserved to the states (through the universal coverage provision).

Federalism is nowhere mentioned in the Constitution, but its spirit pervades the document. Most notably, the Tenth Amendment sets out a formula for the federal-state balance by announcing that “[t]he 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.” Because this doesn’t say much—and because it certainly doesn’t give us a determinate answer to any particular federalism problem—the Supreme Court has perhaps understandably struggled with it.

As a result, the Court’s Tenth Amendment and federalism jurisprudence has seen its ups and downs over time. For example, in the early twentieth century, the Court imposed broad federalism limits on congressional authority, ruling that federalism principles barred federal legislation relating to manufacturing and production, such as restrictions on child labor. In a string of cases, the Court imposed this federalism limit on congressional acts under the commerce authority, the taxing authority, and the spending authority. In short, this robust idea of federalism, with its thumb on the side of the states, was an all-purpose limit on congressional power and marked a high point in the Supreme Court’s federalism jurisprudence.

But this high point ended decisively in 1941, when the Court in *U.S. v. Darby*, 312 U.S. 100, upheld the Fair Labor Standards act of 1938, writing that the Tenth Amendment posed no bar to the act; instead, the Tenth Amendment “states but a truism.” Around the same time, in 1937, the Court ruled in *Steward*
machine Co. v. Davis, 301 U.s. 548, that the Tenth Amendment and related federalism principles did not prevent Congress from conditioning grants to states, except where they “are weapons of coercion, destroying or impairing the autonomy of the states.” Under Darby and Steward Machine, federalism appeared to pose almost no limit on any congressional act, under the commerce authority, the taxing authority, or the spending authority. And but for a brief hiccup between 1976 (when the Court ruled that the Tenth Amendment barred the application of federal minimum wage legislation to state governments in National League of Cities v. Usery, 426 U.s. 833) and 1985 (when the Court reversed course and overturned National League of Cities in Garcia v. San Antonio Metropolitan Transit Authority, 469 U.s. 528), this remained the norm until the 1990s.

Notably during this low period for federalism, the Court rejected a federalism challenge to a congressional act conditioning states’ receipt of federal highway funds on the adoption of a minimum drinking age. Chief Justice Rehnquist wrote for a seven-justice majority in 1987 in South Dakota v. Dole, 483 U.s. 203, that the Tenth Amendment did not bar Congress from conditioning federal funds, so long as the condition satisfied the now-familiar four-part test and was not unduly coercive on the states. The Court did not say when a congressional spending program might become unduly coercive, but it seemed to give Congress quite a bit of room short of outright commandeering the states. Only Justices Brennan and O’Connor dissented, arguing that the condition invaded an area reserved to the states. (Emphasis added.) (The Court’s other leading proponents of federalism principles—Chief Justice Rehnquist, and Justices O’Connor and Thomas—joined a dissent by Justice O’Connor, arguing that federalism principles did restrict Congress.)

Federalism and the ACA

While the federalism aspects of the ACA challenges have not been the main attraction that individual mandate is, they’re every bit as important, and maybe even more interesting. They come in two parts:

• Whether the Medicaid expansion crosses the line that the Supreme Court has drawn in federal spending cases between (acceptable) encouragement and (unconstitutional) compulsion; and

• Whether the universal coverage provision in the ACA invades an area of traditional state concern, “completely obliterat[ing] the Constitution’s distinction between national and local authority” in violation of the federalism principles in U.S. v. Morrison and U.S. v. Lopez.

Federalism saw a minor resurgence starting in the early 1990s. In 1992, the Court ruled in New York v. U.S., 505 U.s. 144, that Congress could not compel states to comply with national policy on the disposal of low-level radioactive waste (although the Court reaffirmed that Congress could encourage states through conditioned spending). The Court extended this principle in 1997 in Printz v. U.s., 521 U.s. 898, ruling that Congress could not compel state officials to comply with national gun registration policy. Still, short of outright commandeering states or their officers, the Court gave Congress wide berth in legislating before it ran up against a federalism limit.

Then, in 1995, in U.s. v. Lopez, 514 U.s. 549, the Court suggested that federalism may limit the scope of congressional authority under the Commerce Clause, even when the federal act does not commandeer the states. In Lopez, the Court ruled that Congress exceeded its Commerce Clause authority in enacting the Gun Free School Zone Act and worried (albeit mildly) that such power could encroach on the reserved powers of the states. The Court solidified this federalism concern as part of its Commerce Clause analysis five years later in U.s. v. Morrison, 529 U.s. 598. In that case, the Court overturned the Violence Against Women Act and more explicitly considered federalism as a limit on congressional authority. In particular, the Morrison Court worried that if Congress could regulate violence against women, it could regulate all manner of violence within a state, family law, and other areas of traditional state concern, obliterating the distinction between what is truly national and what is truly local.

But if the 1990s saw a minor resurgence in federalism, the Court seems to have backed off slightly in the 2000s. Thus, a unanimous Court ruled in 2003 in Sabri v. U.s., 541 U.s. 600, that federalism principles did not restrict Congress from criminalizing bribery of a local official of a municipality that received federal funds. And in 2005 the Court ruled 6-3 in Gonzales v. Raich, 545 U.s. 1, that federalism principles did not restrict Congress from criminalizing the local, private cultivation and use of marijuana, even though state law allowed it. Notably, Justice Kennedy, one of the Court’s leading proponents of federalism principles, joined the Court’s opinion in full. Just as notably, Justice Scalia flatly rejected the federalism argument in his concurrence, writing that “neither respondents nor the dissenters suggest any violation of state sovereignty of the sort that would render this regulation ‘inappropriate,’ except to argue that [it] regulates an area typically left to state regulation. This is not enough to render federal regulation an inappropriate means.” (Emphasis added.) (The Court’s other leading proponents of federalism principles—Chief Justice Rehnquist, and Justices O’Connor and Thomas—joined a dissent by Justice O’Connor, arguing that federalism principles did restrict Congress.)

More recently the Roberts Court roundly rejected a federalism challenge to congressional authority empowering a district court to order the civil commitment of a “sexually dangerous” federal prisoner, even beyond his original criminal sentence. In just a few curt paragraphs, the eight-justice Court in U.s. v. Comstock, 130 S. Ct. 1949, ruled that the federal statute did not
invade an area of traditional state concern in violation of the Tenth Amendment. Justice Breyer, a vociferous dissenter in \textit{Lopez} and \textit{Morrison}, wrote the opinion, joined in full by Chief Justice Roberts. (Chief Justice Roberts thus not only joined the majority, but assigned it to Justice Breyer, whom he knew was a vociferous dissenter in these two leading cases from the 1990s involving federalism principles.) Justice Kennedy wrote a separate concurrence reflecting his concerns about the Tenth Amendment and related federalism principles; and Justice Thomas dissented based in part on the Tenth Amendment and federalism principles. Justice Alito wrote a separate concurrence worrying about the vague breadth of congressional authority in the majority’s opinion, but not mentioning federalism limits.

Against this backdrop, the federalism challenges to the ACA face an uphill battle. First, the federalism challenge to Medicaid expansion seems weak against the Court’s rulings in \textit{Steward Machine} and \textit{South Dakota v. Dole}—rulings that say that Congress enjoys wide authority to condition its spending short of outright compulsion or commandeering of the sort in \textit{New York v. U.S.}. This is especially true because Congress will pay for the entire expansion in the first two years of the ACA, making the expansion look like a pure federal spending program only minimally intruding on the states. Second, the federalism challenge to the universal coverage provision is singularly weak against the Court’s rulings in \textit{Gonzales v. Raich} and \textit{Comstock}—rulings that seem to limit the scope of those areas of traditional state regulation, and not to protect them much against federal encroachment.

More generally, federalism challenges go against the trend in the Court’s jurisprudence. In the most recent cases, the Court seems to have stepped back slightly from its federalism resurgence in the 1990s. (Opponents of the ACA point to \textit{Bond v. U.S.}, 529 U.S. 334, the 2011 case holding that an individual, not just a state, can challenge a federal law under the Tenth Amendment. But \textit{Bond} only gives the individual standing; it says nothing about the merits.) And with Chief Justice Roberts and Justice Alito replacing two of the Court’s most prominent federalism proponents in the 1990s—and with Chief Justice Roberts joining Justice Breyer’s opinion in \textit{Comstock} and with Justice Alito concurring in the result—the center of the Court on federalism seems to have shifted back away from the states, even if only slightly. (This assumes that Justices Sotomayor and Kagan would rule like their predecessors, Justices Souter and Stevens.) It seems that there now could be as many as eight justices on the Court, excluding only Justice Thomas, who would reject federalism challenges to Medicaid expansion and to universal coverage.

None of this is to say that a majority of the Court will rule that Congress had authority to enact the universal coverage provision in the first place. This question turns in the first instance on the scope of congressional authority, not a federalism restriction. Instead, this is only to say, based on the Court’s jurisprudence, that federalism is an unlikely barrier to the ACA.

\textbf{Steven D. Schwinn} is an associate professor of law at The John Marshall Law School.

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**Federalism and the Supreme Court at a Glance**

<table>
<thead>
<tr>
<th>Year</th>
<th>Case</th>
<th>Summary</th>
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<tbody>
<tr>
<td>1937</td>
<td>\textit{Steward Machine Co. v. Davis}</td>
<td>Federalism does not ban federal incentives for the states, so long as they are not unduly coercive or destroy the autonomy of the states</td>
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<tr>
<td>1941</td>
<td>\textit{U.S. v. Darby}</td>
<td>Upheld the Fair Labor Standards Act of 1938 and found that the Tenth Amendment posed no bar to such legislation</td>
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<tr>
<td>1976</td>
<td>\textit{National League of Cities v. Usery}</td>
<td>Tenth Amendment bars application of federal minimum wage legislation to states</td>
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<tr>
<td>1985</td>
<td>\textit{Garcia v. San Antonio Metropolitan Transit Authority}</td>
<td>Overturned \textit{National League of Cities}</td>
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<tr>
<td>1987</td>
<td>\textit{South Dakota v. Dole}</td>
<td>Federalism does not bar conditioning the states’ receipt of federal highway funds on the adoption of a minimum drinking age</td>
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<tr>
<td>1992</td>
<td>\textit{New York v. U.S.}</td>
<td>Congress cannot compel states to comply with national policy on disposing radioactive waste</td>
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<tr>
<td>1995</td>
<td>\textit{U.S. v. Lopez}</td>
<td>Federalism may limit congressional authority in areas where states have traditionally been sovereign</td>
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<tr>
<td>1997</td>
<td>\textit{Printz v. U.S.}</td>
<td>Congress cannot compel state officials to comply with national gun registrations policies</td>
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<td>2000</td>
<td>\textit{U.S. v. Morrison}</td>
<td>Federalism limits congressional authority in areas of traditional state responsibility</td>
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<td>2003</td>
<td>\textit{Sabri v. U.S.}</td>
<td>Federalism does not restrict Congress from criminalizing the bribery of local officials</td>
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<td>2005</td>
<td>\textit{Gonzales v. Raich}</td>
<td>Federalism does not restrict a federal statute criminalizing the local private cultivation and use of marijuana</td>
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<tr>
<td>2010</td>
<td>\textit{U.S. v. Comstock}</td>
<td>Upheld a federal statute allowing a court to order the civil commitment of sexually dangerous federal prisoners</td>
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<tr>
<td>2011</td>
<td>\textit{Bond v. U.S.}</td>
<td>An individual, not just a state, can challenge a federal law under the Tenth Amendment</td>
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<tr>
<td>Chair</td>
<td>Rachel Moran</td>
<td>Los Angeles, CA</td>
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<tr>
<td>Dahlia Lithwick</td>
<td>David B. Salmons</td>
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### Standing Committee on Public Education

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<td>Linda Greenhouse</td>
<td>Neil Nicoll</td>
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Issue Highlights

• Expert analysis of the four issues being argued;
• Background on the legal teams making the arguments;
• Op-eds by University of California, Irvine School of Law professor Erwin Chemerinsky and Cato Institute senior fellow Ilya Shapiro debating the constitutionality of the ACA;
• A poll of more than a dozen experts on how the justices are likely to rule;
• A primer on the history of the health care system;
• And much more!

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