Three Roads from the Supreme Court by Paul Starr

Sitting in the Supreme Court on March 27, I was stunned by the oral argument on the Affordable Care Act (ACA). From their first questions to Solicitor General Donald Verrilli, the conservative justices seemed to embrace the arguments against the individual mandate that the opposing lawyers had set out in their briefs. When it was over, I was not 100 percent sure that Justice Anthony Kennedy would vote to overturn the mandate and related penalties. But if he does, the Court may well strike down the law's other critical provisions, staging what amounts to a conservative judicial coup.

What then? Three general alternatives stand out for health-care reform. Let's call them the minimalist bypass, the great mountain highway, and the road through the states.

The minimalist bypass would be a means of getting around the Court's constitutional objections by revising or replacing the mandate. Even the attorneys opposing the law acknowledged that Congress could impose an insurance mandate when an individual first consults a health-care provider and thereby enters the health-care market. Their objection is that by requiring healthy people to insure, the law creates commerce so as to regulate it. So the constitutional issue seems to hinge on timing. The primary basis for hope that Kennedy will vote to uphold the mandate was his acknowledgment that the healthy are "proximate" to the market since they may get sick or injured at any time. In his summation, Verrilli insisted that it would be infeasible to impose a mandate on first entry into the market because the rates at that point would be exorbitant.

But while delaying the mandate to first contact is not ideal, it could work in combination with other measures. The rates for late enrollees can be higher without being unconscionable. This is how Medicare Part D works; seniors who don't insure during the initial open enrollment pay somewhat higher premiums if they sign up later.

What earlier would have been easy fixes for the mandate now look infeasible.

But the political difficulties in revising the mandate are obvious. A Court ruling against it this year will delegitimize what is already an unpopular idea. It's hard to see Congress adopting a first-contact mandate even if the revised version satisfies constitutional objections.

What about replacing the mandate? While the law was under debate, I argued that the mandate was a mistake because it would stir up a backlash. Other health-insurance programs, such as Medicare Part B and Part D, succeed without mandates mainly by making the coverage overwhelmingly attractive. In fact, the subsidies for coverage in the ACA are substantial and will drive most of the new enrollment in the exchanges. Many people are under the mistaken impression that the mandate is indispensable because it will result in everyone becoming insured. This is far from the case; millions will remain without coverage, partly because Congress was hesitant to provide enforcement powers. If you don't pay the fines for failing to insure, the government cannot impose any criminal penalties, garnish your wages, or seize your property—it can only withhold a tax refund.

During the congressional debate about the law, Democrats could have found alternatives to the mandate if they had grasped the peril it posed to the entire undertaking. Under the alternative I proposed at the time, individuals could opt out of the law without any penalty by signing a form on their taxes, but they would have to stay out of the program for five years. During that period, they would be ineligible to use the insurance exchanges and to receive subsidized coverage with no pre-existing condition exclusions. (If they had second thoughts, they could try to buy unsubsidized coverage in a market like the one that exists today—in other words, they'd be no worse off than they had been before.) My proposal would also allow individuals to preserve their eligibility for the program year to year by paying an annual penalty, but I'd raise that penalty and make it as enforceable as taxes are. This approach, I argued, was both more libertarian (no one would force you to insure) and more tough-minded (annual penalties would be for real).

The opt-out proposal could also be combined with procedures for automatically enrolling the uninsured in a low-cost plan. Research in behavioral economics suggests that setting the "default" as inclusion in coverage sharply raises enrollment rates (for example, in 401(k) plans). The combination of auto-enrollment and a five-year opt-out might well reduce the uninsured population even more than the ACA's weak mandate.

But what could have been done in the original legislation will be hard to do now, especially if the Court follows the administration's view that if the mandate falls, so must community rating (equal insurance rates regardless of health) and

guaranteed issue (a requirement for insurers to cover anyone who seeks coverage). In that case, Congress would face so many controversial issues all over again that it's unlikely to be able to agree on anything. A minimalist bypass might be feasible only if three conditions are satisfied: The Court strikes down the mandate and nothing else, the president is re-elected, and Democrats regain full control of Congress.

THE RADICAL ALTERNATIVE to minimalism is to go up the great mountain highway—Medicare for all. That approach, which involves no role for the states, will gain even more support if the Court strikes down the Medicaid expansion. Without the ability to expand coverage through Medicaid, Democrats would have Medicare as the one clearly constitutional vehicle for universal health insurance.

But Medicare for all still faces the problems that have long made it a political dead end. Most daunting, it requires raising an enormous amount of money in new taxes to substitute for current insurance premiums. If most employees knew how much their current coverage costs and were confident that their employers would pass on that money in higher wages, a shift to a tax-financed program might be feasible. But lacking a clear picture of the situation or any confidence that they'd get corresponding wage increases, most people are likely to regard the new taxes for Medicare for all as a new burden. Many seniors would also insist that Medicare is for them, not for everyone, and extending the program to others would spread money around that was theirs.

Hospitals, doctors, and other health-care providers would also resist any expansion of Medicare to the under-65 population because Medicare pays less than private insurance. An additional complication is that the ratio of Medicare to private-insurance rates is particularly low in some states, such as Iowa and Minnesota, leading even some liberal representatives from those states to oppose Medicare expansion because of possible threats to the solvency of their health-care providers.

For health reform, the only immediate way forward may be through the states.

Paradoxically, though, Republican-supported changes to Medicare may make Medicare for all more widely acceptable. Medicare is no longer a single-payer system; private Medicare plans now account for about one-fourth of total enrollment. The more Medicare resembles an insurance exchange, the easier it will be for the private health-care industry to accept Medicare for all. Instead of facing a single payer with overwhelming market power, the industry would face a less threatening mix of plans. But if Medicare became the basis of universal coverage, it could still have a public option—the traditional Medicare plan.

Medicare for all, though, remains at best a long-range, low-odds goal. If the Court strikes down the major provisions of the ACA, the only available immediate route for health-care reform may be the third—the road through the states. No ruling by the Court should imperil the program adopted by Massachusetts; the case against the mandate in the ACA is strictly about federal powers. One crucial question is what will happen to the tax subsidies for health insurance authorized by the ACA; if Congress were to convert those subsidies into grants to the states, they might enable more states to develop their own universal-coverage programs. The planning for the ACA has already set important initiatives in motion, such as Vermont's plan to develop a single-payer system. If Republicans succeed in turning Medicaid into a block grant—a measure that should be resisted because it would eliminate the rights of low-income, chronically ill, and disabled people under federal law—the states will also have more flexibility. Many of the red states will use that flexibility to reduce coverage, but some of the blue states may seize the opportunity to create broader government insurance programs.

Other Republican proposals could also facilitate the development of reforms in the progressive states. In 2008, John McCain called for turning the current tax subsidy of employer-sponsored coverage into a flat tax credit for health insurance, amounting to $2,500 for an individual and $5,000 for a family. Eliminating the tax benefits of employer coverage would result in millions of workers losing their coverage and generate demands for government action. The credits wouldn't buy much in the current individual-insurance market, but they'd help finance coverage in state-sponsored programs.

Here's the ultimate irony. The individual mandate was originally a conservative idea, aimed at preserving private insurance. Medicaid is a mixed federal-state program, aimed at preserving more of a local role. If the Supreme Court strikes down the mandate and much of the rest of the ACA, including the Medicaid expansion, it will have eliminated a moderate, middle-of-the-road path in health policy. Reaction generates reaction. The right may be doing for the left what the left could never do on its own. ▣