

Dead on Arrival: The Health Insurance Industry’s Bleak Prognosis due to Unconstitutional Ratemaking in the Patient Protection and Affordable Care Act

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I. INTRODUCTION

“Without some relief from the proposed [medical loss ratio] requirements . . . we fear there will ultimately be little room for meaningful competition in all the states”¹

- Kevin S. Wrege, Regional Director of State Affairs for the Council for Affordable Health Insurance (CAHI), writing on behalf of CAHI

In the face of a downturned economy and rising costs of health care, the United States is in dire need of some sort of solution.² Although comprehensive health care reform seems to be a viable solution to the health care problems every American faces, the Obama Administration’s Patient Protection and Affordable Care Act (PPACA) is only damaging an already broken system.³ Despite strong opposition, PPACA was rapidly pushed through Congress by marginal votes and ultimately became law on March 23, 2010.⁴ PPACA is designed to reform the health insurance industry and largely ignores health care providers.⁵ While the enactment of PPACA was viewed as a triumph for the Obama Administration, it casts a much darker shadow on the future of the health insurance industry that it regulates. Through provisions requiring minimum covered benefits, rate justifications, limits on selecting eligible enrollees, and most notably, an excessively high minimum medical loss ratio, this law involves substantial regulation of the health insurance industry that rises to the level of systematic coercion. The control that the United States Legislature exerts over the insurance industry through PPACA is tantamount to that of a public utility. As such, in creating this law, ratemaking was wrongly implemented and unconstitutionally applied in a manner that strips the health insurance industry of its Fifth Amendment right to receive a reasonable rate of return on its investments. Although the purported goals of health care reform, such as lowering health care costs, increasing health care quality, and simplifying health care trans-

1. Letter from Kevin S. Wrege, Regional Director of State Affairs for the Council for Affordable Health Insurance (“CAHI”), writing on behalf of CAHI, to the National Association of Insurance Commissioners (“NAIC”) (May 7, 2010), *available at* http://www.naic.org/documents/committees_e_hrsi_comments_CAHI_5-7.pdf.

2. In 2008, the U.S. Census Bureau reported that 15.4% of U.S. residents were uninsured. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, 21 (Sept. 2009), *available at* <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

4. *Id.*

5. *Id.*

actions, are undoubtedly noble, the resulting legislation overreaches constitutional legislative power and will ultimately prove to be a death knell for the health insurance industry.

While states have standing and are challenging the constitutionality of PPACA under the Commerce Clause and General Welfare Clause of Article I, Section 8 of the United States Constitution,⁶ the Takings Clause of the Fifth Amendment⁷ affords insurance companies standing to seek relief because of the mandated medical loss ratio (MLR) provision in section 2718 of PPACA.⁸ This Comment argues that the ratemaking portion of PPACA deprives insurance companies of their property without just compensation, in violation of the Takings Clause of the Fifth Amendment. Part II discusses the newly enacted health care reform law, PPACA, including a brief history and major provisions affecting the health insurance industry. Part III explores the various constitutional challenges that have already been brought against the federal government questioning the validity of PPACA. It outlines various constitutional provisions that the enactment of PPACA allegedly violates, as well as both judicial and legislative efforts to repeal the law. Part IV explains the constitutional analysis used by the Supreme Court in deciding ratemaking cases under the Fifth Amendment. It outlines the contexts in which ratemaking usually occurs, as well as describes several tests historically used by the Supreme Court to determine whether a mandated rate of return is confiscatory, including those in *Smyth v. Ames*,⁹ *FPC v. Hope Natural Gas Co.*,¹⁰ and *Duquesne Light Co. v. Barasch*.¹¹ Part V analyzes the ratemaking portion of PPACA in a constitutional context using ratemaking case law. It analogizes the aggregate effect of provisions in PPACA to the facts and circumstances of ratemaking case law, details why legislative ratemaking was wrongly applied in drafting PPACA, and argues that PPACA violates health insurance companies' Fifth Amendment rights.¹² Part VI concludes that the mandated minimum MLR in PPACA deprives health insurance companies of a reasonable rate of return, thus failing any Fifth Amendment Takings Clause analysis, and should be struck down as an unconstitutional taking of property without just compensation.

6. U.S. CONST. art. I, § 8. See also Health Law Resources - PPACA, AM. HEALTH LAWYERS ASS'N, <http://www.healthlawyers.org/Resources/Health%20Law%20Wiki/PPACA.aspx> (last updated Aug. 6, 2010).

7. U.S. CONST. amend. V.

8. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718, 124 Stat. 119, at 136-137 (2010).

9. 169 U.S. 466 (1898).

10. 315 U.S. 575 (1942).

11. 488 U.S. 299 (1989).

12. See *Duquesne*, 488 U.S. at 308; *Smyth*, 169 U.S. at 466; *Hope Natural Gas*, 315 U.S. at 575.

II. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act, enacted on March 23, 2010,¹³ along with the Health Care and Education Reconciliation Act, enacted on March 30, 2010,¹⁴ are the results of the health care reform efforts of the Obama administration.¹⁵ In light of the particularly high cost of health care and health insurance in the United States, the number of Americans who go without health insurance each year¹⁶—by choice or by necessity—and the perception of corruption in the industry that has been presented to the American public, the Obama Administration introduced these health care reform instruments as a solution to every American's health care concerns.¹⁷ These new federal laws were enacted as an attempt to increase health care coverage in the United States while minimizing costs and increasing quality.¹⁸ In doing so, they provide for extensive federal regulation of the health insurance industry of a kind never before imposed on any industry by the federal government.¹⁹

A. HISTORY OF HEALTH CARE REFORM

The discussion surrounding these health care reform efforts began preceding the 2008 Democratic presidential primary election, when then-Senator Barack Obama laid out the foundations for his comprehensive reform plans.²⁰ After assuming the presidency, President Obama formally began the health care reform process by holding a White House forum with congressional and industry leaders and pushing for enactment before the congressional summer recess in 2009.²¹ However, in large part due to

13. Pub. L. No. 111-148, 124 Stat. 119 (2010).

14. Pub. L. No. 111-152, 124 Stat. 1029 (2010).

15. See Pub. L. No. 111-148, 124 Stat. 119 (2010); Pub. L. No. 111-152, 124 Stat. 1029 (2010).

16. The U.S. Census Bureau reported that 15.4% of U.S. residents were uninsured in 2008. U.S. CENSUS BUREAU, *supra* note 2.

17. See *Remarks of President Barack Obama - Address to Joint Session of Congress*, WHITEHOUSE.GOV, (Feb. 24, 2009), <http://www.whitehouse.gov/the-press-office/remarks-president-barack-obama-address-joint-session-congress>.

18. See *id.*

19. Pub. L. No. 111-148, 124 Stat. 119 (2010); Pub. L. No. 111-152, 124 Stat. 1029 (2010). See also Richard A. Epstein, *Impermissible Ratemaking in Health-Insurance Reform: Why the Reid Bill is Unconstitutional* 1-25 (Univ. of Chi. Law & Econ., Olin Working Paper No. 506; Univ. of Chi., Pub. Law Working Paper No. 288, Dec. 2009), available at <http://ssrn.com/abstract=1527128>.

20. *The First Presidential Debate*, N.Y. TIMES, Sept. 26, 2008, <http://elections.nytimes.com/2008/president/debates/transcripts/first-presidential-debate.html>.

21. *Timeline: Milestones in Obama's Quest for Health Care Reform*, REUTERS, (March 22, 2010) <http://www.reuters.com/article/idUSTRE62L0JA20100322>.

strong Republican opposition, and despite urges from the Obama Administration for quick action, this deadline passed without enactment of any health care reform legislation.²² Even with this setback, health care reform efforts continued in Congress, and on November 7, 2009, the House of Representatives passed its version of the health care reform bill, titled the Affordable Health Care for America Act, by a narrow vote of 220-215.²³

The bill then proceeded to the Senate for review.²⁴ While in the Senate, the House bill was discarded, and instead, the Senate completely incorporated its health care reform agenda into a separate House bill regarding housing taxes, effectively transforming the bill into the earliest version of PPACA that was ultimately enacted.²⁵ Despite filibuster threats, and after several amendments to gain further support, the Senate passed this health care reform bill on December 24, 2009, by a party-line vote of 60-39.²⁶

Following the Senatorial vote, President Obama presented his own version of health care reform, which was largely similar to the Senate bill and proposed a consolidation of each of these two bills.²⁷ The consolidated bill continued to receive stiff opposition, largely from the Republican party, and as a result, President Obama issued an Executive Order reaffirming the Hyde Amendment.²⁸ Because of this Order, the bill gained enough support in the House to pass by a vote of 219-212 on March 21, 2010.²⁹ Almost immediately following the House vote, legislation was introduced to repeal the bill.³⁰ Regardless, on March 23, 2010, President Obama signed PPACA into law.³¹

B. THE FINAL VERSION

Contained in the final 2,700-page bill are hundreds of provisions addressing a wide variety of topics in health care that completely restructure the health care industry.³² In addition, the bill contains over four hundred

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. *Timeline: Milestones in Obama's Quest for Health Care Reform*, REUTERS, (March 22, 2010) <http://www.reuters.com/article/idUSTRE62L0JA20100322>.

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Timeline: Milestones in Obama's Quest for Health Care Reform*, REUTERS, (March 22, 2010) <http://www.reuters.com/article/idUSTRE62L0JA20100322>.

32. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 1501, 124 Stat. 119, 1029 (2010). *See also* Commonwealth *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010).

provisions and riders that are completely unrelated to health care.³³ All of these provisions go into effect on differing dates, with most effective dates spanning a four-year period from the date the bill was signed in 2010 into the year 2014.³⁴ Some provisions contained in the bill, however, will not go into effect until the year 2018.³⁵ Although a vast majority of these provisions will have a profound impact on the health insurance industry, there are several key provisions that will prove to be particularly damaging for the industry,³⁶ and are worth discussing for the purposes of this Comment.

1. *The Minimum Essential Coverage Provision*

The Minimum Essential Coverage Provision, found in section 1501,³⁷ has become, by far, the most widely known, fiercely debated, and extensively litigated provision contained within PPACA.³⁸ As summarized in the most recent judicial decision involving this provision, *Commonwealth ex rel. Cuccinelli v. Sebelius*,³⁹ “[t]he Minimum Essential Coverage Provision requires that every United States citizen, other than those falling within specified exceptions, maintain a minimum level of health insurance coverage for each month beginning in 2014. Failure to comply will result in a penalty included with the taxpayer’s annual return.”⁴⁰

Section 1501 is incorporated into and enforced as a part of the Internal Revenue Code.⁴¹ It details what types and features of health insurance plans qualify as the “minimum essential coverage” required,⁴² and it applies to every U.S. citizen who does not fall within one of the exceptions de-

33. § 1501, 124 Stat. 119, 1029. *See also Cuccinelli*, 728 F. Supp. 2d at 789.

34. § 1501, 124 Stat. 119, 1029.

35. *Id.*

36. *See Epstein*, *supra* note 19, at 8.

37. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 242 (2010).

38. *See, e.g., Florida ex rel. McCollum v. U.S. Dep’t of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010); *Commonwealth ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).

39. 728 F. Supp. 2d 768 (E.D. Va. 2010).

40. *Id.* at 770.

41. *Id.*

42. Medicare, Medicaid, CHIP, Tricare, veteran and Peace Corp volunteer programs, individual and group (or employer-sponsored) plans, and grandfathered plans (or health insurance coverage that was effective on March 23, 2010) are all included as “minimum essential coverage.” However, section 2707 lists benefits that must be included in all individual and small-group plans, called an “essential health benefits package.” *See infra* Part II. Certain excepted benefits detailed in section 2791 of the Public Health Service Act do not qualify as “minimum essential coverage” under section 1501 of PPACA. The Secretary of Health and Human Services is given discretion on determining whether or not a plan qualifies as “minimum essential coverage,” Pub. L. No. 111-148, § 1501, 124 Stat. 119, at 242.

scribed.⁴³ The dollar amount of the penalty for failure to maintain such coverage phases in over a three-year period: it starts at the greater of \$95.00 or 1% of the taxpayer's income in 2014, rises to \$350.00 in 2015, and finally caps at \$750.00 for every subsequent year beginning in 2016.⁴⁴ This amount, however, may be adjusted based on the taxpayer's income.⁴⁵ The Minimum Essential Coverage Provision is currently being litigated in two separate cases.⁴⁶

2. Provisions Restricting the Underwriting Process

PPACA also places heavy restrictions on the underwriting process in the health insurance industry.⁴⁷ Underwriting, in the context of the health insurance industry, is the process that an insurer uses to assess the financial risks involved in covering any given applicant, based on a number of factors. Prior to the passage of PPACA, insurers assessed various factors including an applicant's age, gender, and medical history, among other things, to determine the applicant's eligibility for coverage and to set rates for the coverage that they provided. Under PPACA, however, insurers may only consider four factors when setting rates:⁴⁸ the type of plan being offered (family versus individual plan), the geographical region where the plan is sold,⁴⁹ the applicant's age,⁵⁰ and the applicant's tobacco use.⁵¹ According to section 2705 of PPACA, "health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or source of injury . . . or any other

43. Members of certain religious groups, organizations, or Indian tribes, incarcerated persons, and persons who cannot afford coverage (as defined within section 1501) are among those that qualify for exemptions and/or adjustments. *Id.* at 246-47.

44. *Id.* at 245.

45. *Id.* at 246.

46. See *infra* Part III.A; Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120 (N.D. Fla. 2010); Commonwealth *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010).

47. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2701, 124 Stat. 119, 155 (2010).

48. *Id.*

49. Rate variations based on geography are to be established by each state individually, subject to review by the Secretary of Health and Human Services, and not by insurers. *Id.* Premium rates are often sensitive to the areas in which they are being sold, in that a reasonable rate for residents of a given city, for example, could be extremely expensive for residents of another. See Epstein, *supra* note 19.

50. Variation for an applicant's age is allowed up to a 3-to-1 ratio, meaning the rate may not vary by more than three times the rate for a non-risk age group. See Epstein, *supra* note 36, at 18.

51. Variation for an applicant's tobacco use is allowed up to a 1.5-to-1 ratio, meaning the rate may not vary by more than one and a half times the rate for non-tobacco users. See Epstein, *supra* note 19, at 18.

health status-related factor determined by the Secretary [of Health and Human Services]” may not be taken into account when evaluating the eligibility or setting premium prices for applicants.⁵² These requirements are without exception.⁵³

In addition, section 2704 of PPACA prohibits insurers from “impos[ing] any preexisting condition exclusion” to any insurance plan that the insurer provides.⁵⁴ In other words, during the period of coverage, insurers must cover any and all medical conditions an applicant may have under the terms of the insurance policy, regardless of when the condition developed.⁵⁵ Similarly, section 2704 also requires that all insurance coverage be “guarantee-issue,” meaning insurers must accept and provide health insurance coverage for every eligible individual who applies for coverage.⁵⁶ If an insurer becomes financially unable to provide additional coverage, that insurer may deny an eligible applicant only if they can demonstrate to the applicable state authority their inability to financially underwrite such coverage.⁵⁷ In addition, the insurer must show that their denial of coverage is not based upon one of the prohibited factors listed in section 2702 of the Public Health Service Act, and once the insurer does deny coverage, they must remain out of that market for 180 days unless the state allows them to reenter.⁵⁸ Similarly, section 2703 of PPACA prohibits insurers from refusing to renew or continue coverage for any insured that wishes to renew or continue their coverage.⁵⁹ Rescission⁶⁰ of a policy already in force may only occur in cases where the insured has committed “fraud or ma[de] an intentional misrepresentation of material fact as prohibited by the terms of the plan.”⁶¹

52. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2705, 124 Stat. 119, 156 (2010).

53. See Epstein, *supra* note 19, at 18.

54. § 2705, 124 Stat. at 154.

55. *Id.*

56. § 2704, 124 Stat. at 154.

57. *Id.*

58. *Id.*

59. § 2703, 124 Stat. at 156.

60. Rescission is the process by which insurers terminate coverage as of the effective date, as if the policy had never existed. Under PPACA, this is the only way an insurer may discontinue a policy without the consent of the insured, and is limited to cases involving fraud or intentional misrepresentations of material facts (on an application). Harold Reutter, *BCBS's Website Tracks Health Care Changes*, THE INDEPENDENT, Jan. 22, 2011, <http://www.theindependent.com/articles/2011/01/22/news/local/doc4d3b77ad6b82a980693990.txt>.

61. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2712 124 Stat. 119, 131 (2010).

3. *Essential Benefits Package*

In addition to severely limiting insurers' underwriting ability, PPACA requires that certain benefits be covered under all individual and small-group plans sold.⁶² These "necessary" benefits, named an "essential health benefits package," include coverage for "ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, [and] pediatric services, including oral and vision care."⁶³ This provision impacts the industry two-fold: it means not only that insurers are required to cover each of these benefits, but also that every insured must be covered for every one of these services.⁶⁴

4. *State Exchanges*

An integral part of PPACA is the establishment of State Exchanges within each state.⁶⁵ Through federal grants given to each state that requests one, PPACA requires every state to establish governmental agencies or nonprofit entities called State Exchanges to "facilitate[] the purchase of qualified health plans."⁶⁶ A "qualified health plan" is one that meets the specific requirements detailed in section 1301 of PPACA, as well as the additional requirements set by the Secretary of Health and Human Services.⁶⁷ Qualified health plans must be certified by the Secretary, periodically recertified as a qualified health plan, and may be decertified for any number of reasons.⁶⁸ By way of general tax increases together with new levies on certain industries, the federal government plans to subsidize the cost of purchasing qualified health plans through these State Exchanges.⁶⁹

Once a plan is certified as a qualified health plan, it may choose to join the State Exchanges or not, but will only be allowed to access consumers that qualify for the federal subsidies by joining.⁷⁰ Once operating within the State Exchanges, however, a qualified health plan is subject to extensive regulation by the state and federal government. Specifically, qualified

62. § 2707, 124 Stat. at 161.

63. *Id.*

64. *Id.*

65. § 1311, 124 Stat. at 173.

66. *Id.*

67. § 1301, 124 Stat. at 162.

68. *Id.*

69. *Id.*

70. *Id.*

health plans face disclosures and justifications for rate increases, and state approvals for such increases.⁷¹ In addition, plans operating within State Exchanges will be rated by the Secretary of Health and Human Services for quality and price, which will be distributed to consumers who are purchasing such plans.⁷² In essence, plans that submit themselves to State Exchanges have access to consumers who qualify for federal subsidies, but are subject to extensive regulation. By contrast, plans that operate outside State Exchanges may not sell plans to consumers who are using federal subsidies, but at the same time continue to be heavily regulated by the state and federal government.⁷³

5. *The Minimum Medical Loss Ratio*

Finally, section 2718 of PPACA mandates a minimum MLR of eighty percent for small group and individual business and eighty-five percent for large group business.⁷⁴ According to the Congressional Budget Office, “[a] medical loss ratio, or MLR, is the proportion of premium dollars that an insurer spends on health care; it is commonly calculated as the amount of claims incurred plus changes in reserves as a fraction of premiums earned.”⁷⁵ Under the health care system in place before the passage of PPACA, the standards for MLRs⁷⁶ in the individual market ranged from fifty-five to sixty-five percent, depending on the type of plan.⁷⁷ The rate-making portions of PPACA, found in section 2718, require insurance companies to have a minimum MLR of eighty percent for small group and individual business, and eighty-five percent for large group business.⁷⁸ This means that for every dollar insurance companies receive in premium payments, they must pay out a minimum of \$0.80-\$0.85, depending on the type of business, in claims and other “activities that improve health care quality.”⁷⁹ In addition, if an insurance company does not maintain such mini-

71. § 1311,124 Stat. 119 .

72. *Id.*

73. *Id.* See also Epstein, *supra* note 19.

74. *Id.*

75. Congressional Budget Office, BUDGETARY TREATMENT OF PROPOSALS TO REGULATE MEDICAL LOSS RATIOS, Dec. 14, 2009.

76. *Id.*

77. “The NAIC standards for individual market loss ratios vary between 55%-65%, depending on the type of plan. In fact, most guaranteed renewable plan loss ratios are set by the states at 60% or less.” Council for Affordable Health Insurance, Letter to the National Association of Insurance Commissioners, May 7, 2010, http://www.naic.org/documents/committees_e_hrsi_comments_CAHI_5-7.pdf.

78. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718, 124 Stat. 119, at 136-137 (2010).

79. *Id.*

mum MLR, under section 2718 of PPACA, it must return the difference to their insurance enrollees in the form of an annual rebate.⁸⁰

The National Association of Insurance Commissioners (NAIC), along with the Secretary of Health and Human Services, have been charged with the task of establishing regulations with regard to MLR requirements in PPACA, including definitions of terms in section 2718 and methods of calculation for MLRs.⁸¹ This task bears significant weight due to the notable ambiguity in much of PPACA absent explanatory regulations such as these.⁸² It is important for insurers to have guidelines on which expenses qualify as claims and other “activities that improve health care quality,” and which must be included as “non-claims expenses,” in order to accurately calculate their yearly MLR and operate their businesses accordingly.⁸³

On October 27, 2010, the NAIC publicly presented their fifteen pages of regulations for MLRs to the Secretary for approval, included with standardized forms for reporting rebate calculations, credibility tables, and listed expenses that may or may not be calculated in with a company’s loss ratio.⁸⁴ For example, “federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act” are deducted from the premium and therefore calculated in with a company’s loss ratio, whereas “[f]ederal income taxes on investment income and capital gain” are not.⁸⁵ It is important to note that *all* expenses that do not qualify as claims or other “activities that improve health care,” (including customer acquisition, agent compensation, claims adjudication, premium administration, employee costs, all additional administrative expenses required under PPACA such as MLR calculations and rebate administration on a state by state basis, and all other general expenses) may not be calculated as a part of a company’s loss ratio.⁸⁶ Therefore, the remaining twenty percent is not pure profit, because insurance companies must allocate that amount accordingly to cover *all* of these “non-claims” expenses, or suffer a loss.⁸⁷

Section 2718 does allow for some adjustment of the MLR at the discretion of each state and of the Secretary of Health and Human Services.⁸⁸

80. *Id.*

81. *Id.*

82. *See* Epstein, *supra* note 19.

83. Letter from the National Association of Insurance Commissioners to Kathleen Sebelius, Secretary of Health and Human Services (Oct. 27, 2010), *available at* http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf.

84. *Id.*

85. *Id.* at 33.

86. *Id.*

87. *Id.*

88. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718, 124 Stat. 119, at 136-137 (2010).

However, states are only afforded the discretion to require a *higher* MLR percentage than what is required by PPACA, thereby further restricting insurance companies.⁸⁹ The Secretary, on the other hand, may adjust the MLR to require a *lower* percentage, but only within the individual market, and only if it is determined that the rates set out within section 2718 will “destabilize the existing individual market” in that state.⁹⁰

The purpose behind this requirement, first and foremost, is to maximize the value for patients’ health care dollars.⁹¹ By requiring that a percentage of premiums paid by the insured be used either for claims made by the insured or for “activities that improve health care quality,”⁹² PPACA makes certain that premium dollars are used toward the benefit of each insured.⁹³ Further, such a requirement effectively limits salaries that CEOs and other executive members of insurance companies may earn, a concern that was central for some lawmakers to the addition of the ratemaking provision in PPACA.⁹⁴ In addition, the ratemaking portion of PPACA is an attempt to improve patient health care overall by streamlining and simplifying the process.⁹⁵ PPACA includes expenses for “activities that improve health care quality” in determining each insurance company’s MLR⁹⁶ to incentivize the use of premium dollars to improve the quality and efficiency of health care.⁹⁷

89. *Id.*

90. *Id.*

91. See Council for Affordable Health Insurance, Letter to the National Association of Insurance Commissioners, *supra* note 1.

92. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718, 124 Stat. 119, at 136-137 (2010).

93. See Council for Affordable Health Insurance, Letter to the National Association of Insurance Commissioners, *supra* note 1.

94. Senator Jay Rockefeller of West Virginia argued that,

For too long, health insurance company CEOs have been pocketing astronomical salaries all the while denying care and coming up with foolish reasons to kick people off their insurance policies If we want to change the culture of health insurance companies and how they treat individuals and families in need of health care, then we need to change the way they do business.

Chris Silva, *AMA, State Societies Back Plan Limiting Insurers' Administrative Spending*, Aug. 30, 2010, <http://www.ama-assn.org/amednews/2010/08/30/gv120830.htm> (quoting Sen. Jay Rockefeller, from an Aug. 16, 2010 statement).

95. See Council for Affordable Health Insurance, Letter to the National Association of Insurance Commissioners, *supra* note 1.

96. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2718, 124 Stat. 119, at 136-137 (2010).

97. See Council for Affordable Health Insurance, Letter to the National Association of Insurance Commissioners, *supra* note 1.

Despite the obvious value of each of these goals to the American public, the ratemaking requirements in PPACA are too severe to achieve any one of them.⁹⁸ An eighty to eighty-five percent mandated MLR leaves insurance companies with fifteen to twenty percent, depending on the type of business, for overhead, agent commission, underwriting expenses, fraud prevention expenses, employee salaries, etc., and finally, profit.⁹⁹ Agent commission alone can amount to up to twenty percent of the first-year premium price,¹⁰⁰ leaving insurance companies with a deficit. The effects of this requirement are already being felt by several many companies across the nation.¹⁰¹ For example, Maine became the first state to receive a waiver of the MLR provisions in PPACA due to their inability to meet these requirements.¹⁰² This allows insurers in the state of Maine to maintain the current 65% loss ratio for three years, provided they can show a need for such waiver.¹⁰³ As of the publication of this Comment, over 900 waivers had been granted in total, with many more companies, organizations, and states applying each day.¹⁰⁴

In addition, the Council for Affordable Health Insurance (“CAHI”) sent a letter to the National Association of Insurance Commissioners (“NAIC”),¹⁰⁵ explaining the detrimental effects that the MLR would have, especially on the individual market.¹⁰⁶ They also explained how an MLR set at the rate it currently is under PPACA would work to counteract some of the policy reasons for implementing such a provision, namely, that “[e]xcluding many cost containment tools from the consideration of either

98. *See id.*

99. *See Silva, supra* note 94.

100. “[Agent] commissions usually range between 4 and 8 percent of the premium, depending on the state, but sometimes are 20 percent of the premium in the first year of a policy before dropping to the normal range.” Uwe E. Reinhardt, *On Health Care, the Devil’s in the Details*, N.Y. TIMES, Sept. 3, 2010, <http://economix.blogs.nytimes.com/2010/09/03/on-health-care-the-devils-in-the-details/>.

101. *See* Ken Terry, *What the NYT Keeps Getting Wrong about McDonald’s and Healthcare Reform*, BNET.COM, Oct. 7, 2010, <http://www.bnet.com/blog/healthcare-business/what-the-nyt-keeps-getting-wrong-about-mcdonald-8217s-and-healthcare-reform/1902>.

102. Julian Pecquet, *Maine Gets First State Waiver From Healthcare Law Provision*, THE HILL, Mar. 8, 2011, <http://thehill.com/blogs/healthwatch/health-reform-implementation/148179-maine-gets-reprieve-from-health-reform-insurance-requirement>.

103. *See id.*

104. Roger Stark, *National Health Care Reform: First Year Report Card*, KPBJ.COM, Apr. 4, 2011, http://kpbj.com/business_weekly/2011-04-04/national_health_care_reform_first_year_report_card.

105. The NAIC has been charged with the task of defining various parts of PPACA, including what constitutes an expense for “activities that improve health care quality.” *See* Pub. L. 111-148; Reinhardt, *supra* note 100.

106. *See* Council for Affordable Health Insurance, Letter to the National Association of Insurance Commissioners, *supra* note 1.

medical claims costs or activities that ‘improve health care quality’ under the new reform law will only harm patients, while removing an important incentive for carriers to spend consumer dollars on health claims in a consistently wise and prudent manner.”¹⁰⁷ Thus, the minimum MLR provision will ultimately affect health insurance companies by driving many of them out of business, effectively disrupting the market, and ultimately eliminating competition.¹⁰⁸

III. CURRENT CONSTITUTIONAL CHALLENGES TO PPACA

A. *VIRGINIA V. SEBELIUS* AND OTHER ARTICLE I, SECTION 8 CHALLENGES

Currently, twenty-one states¹⁰⁹ have filed suit against the federal government in two separate lawsuits challenging the constitutionality of provisions within PPACA, and the number of plaintiffs continues to grow.¹¹⁰ Each of these lawsuits challenge the constitutionality of the Minimum Essential Coverage Provision of PPACA, found in section 1501, under the Commerce Clause and General Welfare Clause of Article I, Section 8 of the United States Constitution.¹¹¹ The substantial number of states that have

107. *Id.*

108. *See, e.g.*, Chris Silva, *AMA, State Societies Back Plan Limiting Insurers' Administrative Spending*, AM. MED. NEWS (Aug. 30, 2010) <http://www.ama-assn.org/amednews/2010/08/30/gvl20830.htm>; Council for Affordable Health Insurance, Letter to the Nat'l Ass'n of Ins. Comm'rs, May 7, 2010, http://www.naic.org/documents/committees_e_hrsi_comments_CAHI_5-7.pdf.

109. *See* Kevin Sack, *Oklahoma: State Will Challenge Health Care Law*, N.Y. TIMES, Jan. 8, 2011, at A14, available at http://www.nytimes.com/2011/01/08/us/08brfs-STATEWILLCHA_BRF.html?ref=politics; Health Law Resources – PPACA, AM. HEALTH LAWYERS ASS'N, <http://www.healthlawyers.org/Resources/Health%20Law%20Wiki/PPACA.aspx>.

110. Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Nevada, North and South Dakota, Pennsylvania, South Carolina, Texas, Utah, and Washington together were the first to file a single lawsuit against the federal government on March 23, 2010—the day PPACA was signed into law. Florida *ex rel.* McCollum v. U.S. Dep't of Health & Human Servs., 716 F. Supp. 2d 1120, 1127 n.1 (N.D. Fla. 2010). Two private citizens and one private organization are plaintiffs in this lawsuit as well. *Id.* at 1127. Kenneth Cuccinelli, II, the Attorney General of Virginia, filed a separate lawsuit against the federal government on behalf of Virginia. Commonwealth *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010).

111. *See* University Advancement Staff, *Liberty Counsel Files Health Care Reform Bill Lawsuit*, LIBERTY UNIV. (Mar. 22, 2010) <http://www.liberty.edu/index.cfm?PID=18495&MID=17033>; Thomas More Law Center Files Court Challenge Moments After Obama Health Care Signed Into Law, THOMAS MOORE L. CTR. (Mar. 23, 2010) http://www.thomasmore.org/qry/page.taf?id=18&_function=print&sbtblct_uid1=773&month=03&year=2010; Health Law Resources – PPACA, AM. HEALTH LAWYERS ASS'N, (Aug 6, 2010) <http://www.healthlawyers.org/Resources/Health%20Law%20Wiki/PPACA.aspx>.

challenged PPACA to date has been used by some experts as evidence that these challenges will eventually succeed.¹¹² However, although each of these challenges has survived thus far,¹¹³ several experts doubt that such efforts will prove to be successful in ultimately repealing PPACA.¹¹⁴ The high cost that states face in challenging the law¹¹⁵ coupled with the common law precedent following the New Deal of allowing the federal government significant deference in what it chooses to regulate under the Commerce Clause leads many experts to believe that the challenges will fail.¹¹⁶

Two courts—the United States District Court in Pensacola, Florida,¹¹⁷ and the United States District Court for the Eastern District of Virginia¹¹⁸—have been asked to rule on the constitutionality of PPACA in some capacity.¹¹⁹ In *Florida ex rel. Bondi v. U.S. Dep’t of Health and Human Servs.*, twenty states together with two private individuals and one private organization brought suit against the federal government, alleging that the passage of PPACA overreached Congress’s Article I Commerce Clause and General Welfare Clause powers.¹²⁰ Specifically, plaintiffs took issue with the Minimum Essential Coverage Provision, the establishment of State Exchanges, and the provisions expanding the availability of Medicaid, arguing that each of these provisions “violate the Constitution and state sovereignty by coercing and commandeering the states and depriving them of their ‘historic flexibility’ to run their state government, healthcare, and Medicaid programs.”¹²¹ On January 31, 2011, Justice Roger Vinson ruled on cross motions for summary judgment, holding that the Minimum Essential Coverage provision was an unconstitutional exercise of Congress’s Commerce Clause

112. See Kevin Arts, *Legal Challenges to Health Reform: An Alliance for Health Reform Toolkit*, 2, May 18, 2010, available at http://www.allhealth.org/publications/Uninsured/Legal_Challenges_to_New_Health_Reform_Law_97.pdf.

113. See Rosalind S. Helderman, *Va. Health-care Suit Can Go Forward*, *Federal Judge Rules*, WASHINGTON POST, Aug. 2, 2010, http://voices.washingtonpost.com/virginiapolitics/2010/08/federal_judge.html.

114. See, e.g., Arts, *supra* note 112.

115. See *id.*

116. *Id.*

117. See *Florida ex rel. McCollum v. U.S. Dep’t of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010) (denying the United States Department of Health and Human Services’ motion to dismiss).

118. See *Commonwealth ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).

119. See *McCollum*, 716 F. Supp. 2d at 1126-28; *Cuccinelli*, 728 F. Supp. 2d at 771.

120. See *McCollum*, 716 F. Supp. 2d at 1130.

121. *Id.* at 1129.

power, and that this provision was not severable from the rest of PPACA.¹²² As a result, PPACA as a whole was rendered unconstitutional.¹²³

After surviving a motion to dismiss, the plaintiff's claims were narrowed down to two counts.¹²⁴ Specifically, plaintiffs:

challenge the "individual mandate" set forth in Section 1501 of the Act, which, beginning in 2014 will require that everyone (with certain limited exceptions) purchase federally-approved health insurance, or pay a monetary penalty. The individual mandate allegedly violates the Commerce Clause, which is the provision of the Constitution Congress relied on in passing it. . . . [T]he state plaintiffs [also] challenge the Act to the extent that it alters and amends the Medicaid program by expanding that program, inter alia, to: (i) include individuals under the age of 65 with incomes up to 133% of the federal poverty level, and (ii) render the states responsible for the actual provision of health services thereunder. This expansion of Medicaid allegedly violates the Spending Clause and principles of federalism protected under the Ninth and Tenth Amendments.¹²⁵

Although plaintiffs argued that the Medicaid Provisions found in the Act are so coercive that they have no choice but to participate in the program, Justice Vinson first found that the Medicaid Provisions in the Act did not exceed Congress's Spending Clause powers.¹²⁶ He reasoned that "state participation in the Medicaid program under the Act is-as it always has been-voluntary," and, while states would lose significant federal funding if they chose to withdraw from the program, states maintain their ability to withdraw, even under the new requirements found in PPACA.¹²⁷ Second, the court analyzed the Minimum Essential Coverage provision using existing Commerce Clause case law on economic activity.¹²⁸ Justice Vinson outlined three broad categories of activity that Congress may regulate under the Commerce Clause: channels of interstate commerce, instrumentalities of (or persons or things in) interstate commerce, and activities having substantial relation to interstate commerce.¹²⁹ In his analysis, he categorized the

122. Florida *ex rel* Bondi v. U.S. Dep't of Health & Human Servs., No. 3:10M—cv—91—RV/EMT, 2011 WL 285683 at *40 (N.D. Fla. 2011).

123. *Id.*

124. *Id.* at 11.

125. *Id.* at 11-12.

126. *See id.* at 15.

127. *Bondi*, 2011 WL 285683 at *4.

128. *See generally id.*

129. *Id.* at *18.

decision of whether or not to purchase health insurance as “passive inactivity”, stating that

If [Congress] has the power to compel an otherwise passive individual into a commercial transaction with a third party merely by asserting-as was done in the Act-that compelling the actual transaction is itself ‘commercial and economic in nature, and substantially affects interstate commerce’ . . . it is not hyperbolizing to suggest that Congress could do almost anything it wanted.¹³⁰

Citing several cases, the court noted that the Commerce Clause has always applied to some sort of activity: “[The Supreme Court] has uniformly and consistently declared that [the Commerce Clause] applies to ‘three broad categories of *activity*’”;¹³¹ “the third category [of activity which can be regulated has been described as] ‘the power to regulate those *activities* having a substantial relation to interstate commerce.’”¹³² The court held that Congress may not regulate “passive inactivity” such as this, and because the Minimum Essential Coverage Provision was so integral a part of PPACA (as the federal government conceded), this invalidated the whole of PPACA as unconstitutional.¹³³

The Virginia Court was asked to determine specifically whether the Minimum Essential Coverage Provision, contained in Section 1501 of the Act, constituted an unconstitutional exercise of power by Congress by way of a motion for summary judgment.¹³⁴ In this case, Virginia argued that: (1) Congress does not possess the power to require individuals to purchase health insurance under the Commerce Clause or Necessary and Proper Clause of Article I, Section 8 of the United States Constitution;¹³⁵ (2) the penalty contained in the Minimum Essential Coverage Provision is, in fact, a penalty and not a tax, and as such does not fall within Congress’ General Welfare Clause powers;¹³⁶ and (3) the Minimum Essential Coverage Provision conflicts with the Virginia Health Care Freedom Act,¹³⁷ and consequently, violates Virginia’s state sovereignty rights under the Tenth Amendment.¹³⁸

130. *Id.* at *21-22 (citing § 1501 of PPACA).

131. *Id.* at *22 (citing *U.S. v. Lopez*, 514 U.S. 549, 558 (1995), emphasis in original).

132. *Bondi*, 2011 WL 285683 at *22 (citing *Lopez*, 514 U.S. at 558-59).

133. *See generally Bondi*, 2011 WL 285683.

134. *See Commonwealth ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 770-71 (E.D. Va. 2010).

135. *Id.*

136. *Id.*

137. *Id.* at 771 (citing VA. CODE ANN. § 38.2-3430.1:1 (2010)).

138. *Cuccinelli*, 728 F. Supp. 2d at 771.

The Secretary of Health and Human Services refuted each of these arguments.¹³⁹ First, as summarized by Justice Vinson in *McCollum*,¹⁴⁰ the Secretary argued that Congress acted within its Commerce Clause, or alternatively, Necessary and Proper Clause, powers in enacting PPACA, through the reasoning that “(1) because the majority of people will at some point in their lives need and consume healthcare services, and (2) because some of the people are unwilling or unable to pay for those services, (3) Congress may regulate everyone and require that everyone have specific, federally-approved insurance.”¹⁴¹ In addition, the Secretary asserted that the Minimum Essential Coverage Provision constitutes a tax, and not a penalty, due to its incorporation into the Internal Revenue Code, assessment on a taxpayer’s annual tax return, and revenue-raising properties, and as such, falls within Congress’ power to lay taxes under the General Welfare Clause.¹⁴²

On December 13, 2010, J. Hudson found the Minimum Essential Coverage Provision, contained in Section 1501 of PPACA, to be an unconstitutional exercise of power by Congress under both the Commerce Clause and General Welfare Clause of Article I, Section 8 of the United States Constitution.¹⁴³ He declined to discuss Virginia’s state supremacy argument, stating that “[t]he Court . . . need not specifically reach this issue.”¹⁴⁴ The court’s holding rested heavily on the determination that the Minimum Essential Coverage Provision regulates neither economic activity nor economic inactivity, both of which have traditionally fallen within Commerce Clause powers.¹⁴⁵ Instead, Congress is trying to regulate an individual’s decision whether or not to participate in commerce by purchasing insurance.¹⁴⁶ In addition, the court noted that extending Commerce Clause powers to a degree such as this opens the doors for the federal government to have unrestricted power to regulate.¹⁴⁷

Turning to the question of the “tax penalty” assessed under the Minimum Essential Coverage Provision, the court cited numerous instances in which the federal government specifically asserted that it was not a tax.¹⁴⁸ In addition, the penalty does not operate like a tax, in that it generates no

139. *See id.*

140. *Florida ex rel. McCollum v. U.S. Dep’t of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1162 (N.D. Fla. 2010).

141. *Cuccinelli*, 728 F. Supp. 2d at 773 n.2 (citing *McCollum*, 716 F. Supp. 2d at 1162).

142. *Id.* at 774.

143. *See id.* at 788.

144. *Id.* at 774, n.4.

145. *See id.* at 772.

146. *Cuccinelli*, 728 F. Supp. 2d at 781.

147. *Id.* at 788.

148. *Id.* at 786-87.

revenue if the law is operating as it is meant to (in other words, everyone purchases insurance, therefore nobody pays the penalty), and its primary purpose is to regulate, and not to tax.¹⁴⁹ For these reasons, the penalty must be tied to an independent enumerated power within the Constitution in order to be upheld.¹⁵⁰ Because of the penalty's regulatory purpose, the determination that PPACA exceeds Congress' Commerce Clause powers, according to the court, in turn necessitated the determination that Congress exceeded its General Welfare Clause powers as well.¹⁵¹ In so holding, the court granted summary judgment in favor of Virginia, and severed the Minimum Essential Coverage Provision from the whole of PPACA.¹⁵²

Because both courts concluded that Congress has never before extended its Commerce Clause powers to a degree such as that asserted in the Minimum Essential Coverage Provision,¹⁵³ these opinions are revolutionary in the Constitutional Law field, as they outline new and clearer boundaries to Congress' power under this Clause.¹⁵⁴ Even so, the "atypical and uncharted"¹⁵⁵ nature of this case indicates that both cases are sure to be appealed all the way to the United States Supreme Court.¹⁵⁶

B. PRIVATE ORGANIZATION FREEDOM OF RELIGION CLAUSE CHALLENGES

In addition to those Article I, Section 8 claims brought by the states Liberty University and Thomas More Law Center, two private organizations, challenged PPACA as violating freedom-of-religion rights afforded by the First Amendment.¹⁵⁷ Because certain provisions of PPACA require participation in nationalized health insurance and provide for abortions, each of these organizations argues that these provisions violate certain religious beliefs, and therefore infringe on their right to freedom of religion.¹⁵⁸ In addition, certain provisions in PPACA provide for exemptions for certain religious groups, such as the Amish and Old Order Mennonites, but not for others.¹⁵⁹ Although both of these cases were ruled in favor of the federal

149. *Id.* at 787.

150. *Cuccinelli*, 728 F. Supp. 2d at 788.

151. *Id.*

152. *Id.* at 790.

153. *See id.* at 788.

154. *See id.*

155. *Id.* at 790.

156. "This case, however, turns on atypical and uncharted applications of constitutional law interwoven with subtle political undercurrents . . . [a]nd the final word will undoubtedly reside with a higher court." *Cuccinelli*, 728 F. Supp. 2d at 790.

157. *See* Warren Richey, *Healthcare Reform Law Challenged on Religious Grounds, too*, CHRISTIAN SCIENCE MONITOR, Mar. 26, 2010, available at Westlaw, 2010 WLNR 7558168.

158. *See id.*

159. *See id.*

government, appeals have been filed by both plaintiffs, continuing the discussion of PPACA's constitutionality under the First Amendment.¹⁶⁰

C. LEGISLATIVE ATTEMPTS AT REPEALING PPACA

In addition to the lawsuits that have been filed, Virginia, Idaho, Arizona, Georgia, Missouri, and Louisiana have each enacted statutes exempting their citizens from the Minimum Essential Coverage Provision in PPACA.¹⁶¹ Arizona and Oklahoma have enacted constitutional amendments to the same effect. In total, thirty-eight states have filed or pre-filed similar legislation, the model law of which has become known as the Freedom of Choice in Health Care Act, and legislators in at least three additional states have publicly announced intentions to do the same.¹⁶² Laws such as these implicate the Tenth Amendment under the assertion that the Minimum Essential Coverage Provision is an unlawful infringement on state sovereignty, and are essentially inviting a lawsuit from the federal government.¹⁶³ Both *Virginia ex rel. Cuccinelli*¹⁶⁴ and *Florida ex rel. McCollum*¹⁶⁵ involve the Tenth Amendment arguments arising out of laws such as these, but the courts in each of these cases have yet to address the matter.¹⁶⁶

Legislation to repeal PPACA was also introduced almost immediately following the final House vote, on March 22, 2010.¹⁶⁷ Representative Steve King of Iowa introduced House Bill 4972 on March 25, 2010, which seeks to repeal PPACA and any laws amending or repealing provisions of PPACA.¹⁶⁸ This bill provides that, “[e]ffective as of the enactment of the

160. Emily Root, *More Constitutional Decisions on PPACA*, TRIAGE HEALTH LAW BLOG (Dec. 13, 2010) <http://www.triagehealthlawblog.com/ppaca/more-constitutional-decisions-on-ppaca/>.

161. See, e.g., The Virginia Health Care Freedom Act, VA. CODE ANN. § 38.2-3430.1:1 (2007 & Supp. 2010); see also *ALEC's Freedom of Choice in Health Care Act: How Your State Can Protect Patients' Rights*, AMERICAN LEGISLATIVE EXCHANGE COUNCIL, http://www.alec.org/AM/Template.cfm?Section=ALEC_s_Freedom_of_Choice_in_Health_Care_Act1&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=29&ContentID=13527 (last visited Jan. 8, 2011).

162. See AMERICAN LEGISLATIVE EXCHANGE COUNCIL, *supra* note 156.

163. See *Commonwealth ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010). See also Monica Davey, *Health Care Overhaul and Mandatory Coverage Stir States' Rights Claims*, N.Y. TIMES, Sept. 29, 2009, at A25, available at http://www.nytimes.com/2009/09/29/us/29states.html?_r=1.

164. 728 F. Supp. 2d 768 (E.D. Va. 2010).

165. *Florida ex rel. McCollum v. U.S. Dep't of Health and Human Serv.* 716 F. Supp. 2d 1120 (N.D. Fla. 2010).

166. The court in *Virginia ex rel. Cuccinelli* declined to address the Commonwealth's Tenth Amendment argument. See generally 728 F. Supp. 2d 768 (E.D. Va. 2010).

167. See H.R. 4972, 111th (2010), available at <http://www.gpo.gov/fdsys/pkg/BILLS-111hr4972ih/pdf/BILLS-111hr4972ih.pdf>.

168. *Id.*

Patient Protection and Affordable Care Act, such Act is repealed, and the provisions of law amended or repealed by such Act are restored or revived as if such Act had not been enacted.”¹⁶⁹ To date, ten bills have been introduced into the House or Senate to repeal, amend, or limit funding for PPACA.¹⁷⁰

IV. RATEMAKING CASE LAW IN A HISTORICAL CONTEXT

Ratemaking, or imposing limitations on the rates companies may charge for their products or services, is a power that has historically been afforded to the legislature to implement in situations involving public utilities.¹⁷¹ A public utility is a private company that is providing a public service, and generally has been given a monopoly by the state government.¹⁷² Traditionally, two things are required in order for a legislature to have the power to ratemake.¹⁷³ First, a monopoly generally must exist, although this qualification is not universal.¹⁷⁴ The ultimate goal of ratemaking is to limit the returns a company can receive for their services in markets where there is a lack of competition.¹⁷⁵ In other words, by ratemaking, the legislature is attempting to bring the rates that companies operating within a non-competitive market charge back to a competitive level.¹⁷⁶ Keeping this goal in mind, it would be illogical and unnecessary for a legislature to ratemake in an already competitive market.¹⁷⁷ Therefore, it flows rationally that a monopoly must exist for ratemaking to occur.¹⁷⁸ Second, when the legislature sets rates, they must allow the regulated company to receive a reasonable rate of return on their investments.¹⁷⁹ If rates are too restrictive, the company will not have the means to serve their customers adequately, if at all, and will be forced out of business.¹⁸⁰ For the same reason, then, it would never be acceptable for the legislature to set rates so as to bring the rate of return that a company receives down to zero, because that company

169. *Id.*

170. See BenefitMall, *Legislative Alert: House Actions to Repeal PPACA* (2010), available at <https://www.benefitmall.com/portal/EmailArchive/ce1f35ed-06d6-4425-897e-994d96867059.pdf>.

171. 64 AM. JUR. 2d, *Public Utilities* § 68 (2001).

172. *Id.*

173. See Epstein, *supra* note 19, at 15.

174. See *id.*

175. See *id.*

176. See *id.*

177. See *id.*

178. See Epstein, *supra* note 19, at 15-16.

179. See *id.*

180. See *id.*

would then be unable to provide any service.¹⁸¹ Since the ultimate goal is to limit the company's rate of return to that it could receive in a competitive market, a general rule is that a rate set by the legislature may not fall below the competitive rate, taking into account the level of risk involved in conducting that type of business.¹⁸²

From a constitutional standpoint, setting and regulating the rates that these utilities may charge constitutes a governmental regulation of the property of these companies.¹⁸³ It is only proper for the judiciary to adjust the rates set by the legislature when the rates are found to be excessive or confiscatory.¹⁸⁴ An analysis under the Takings Clause of the Fifth Amendment¹⁸⁵ follows when there is a question of whether an attempt by the legislature to set rates for a company would be considered excessive or confiscatory.¹⁸⁶ The Fifth Amendment affords regulated companies protection against the taking of private property without just compensation.¹⁸⁷ If the rates are found to be excessive or confiscatory, "the rate regulation would constitute a taking of the property of the utility" under the Fifth Amendment,¹⁸⁸ and as such will be held unconstitutional, and will either be struck down or adjusted by the judiciary to what would be considered a reasonable rate.¹⁸⁹

The Takings Clause of the Fifth Amendment states that "private property [may not] be taken for public use, without just compensation."¹⁹⁰ This clause has generally been interpreted as applying to two categories of takings: physical takings and regulatory takings.¹⁹¹ In the case of a physical taking, the Fifth Amendment requires just compensation when "the government authorizes a physical occupation of [private] property (or actually takes title) . . ."¹⁹² A regulatory taking, also known as eminent domain,¹⁹³ on the other hand, does not involve physical possession of private property, but instead occurs when the government regulates the use of that proper-

181. *See id.*

182. *See id.*

183. JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW §11.12, at 536-537 (7th ed. 2004).

184. *Id.*

185. U.S. CONST. amend. V.

186. "The guiding principle has been that the constitution protects utilities from being limited to a charge for their property serving the public which is so 'unjust' as to be confiscatory." *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307 (1989).

187. U.S. CONST. amend. V.

188. *See NOWAK, supra note 178*, at 537.

189. *See id.*

190. U.S. CONST. amend. V.

191. *Yee v. City of Escondido*, 503 U.S. 519, 522 (1992).

192. *Id.*

193. *See NOWAK, supra note 178*, at 538.

ty.¹⁹⁴ To determine whether a regulation constitutes a taking under the Fifth Amendment, courts consider the facts and circumstances surrounding the regulation and the affected property, including the purpose of the regulation, and the extent to which the regulation deprives the property owner of economic use of the property.¹⁹⁵ In the ratemaking context, courts examine “the value of the company and the return upon prudent investments” when determining whether the rate regulation constitutes a taking.¹⁹⁶

While courts have consistently held that rates that are so unreasonable as to be considered “confiscatory” will be struck down as a taking, they historically have had much difficulty in settling on what exactly should be considered in determining whether a rate is “confiscatory.”¹⁹⁷ The “value of a company”¹⁹⁸ depends on several factors that may be difficult to quantify, such as current assets, investments, “good will,” historical financial well-being, etc.¹⁹⁹ Without first having an accurate determination of the value of the company, it is extremely difficult to determine whether a rate regulation substantially deprives a company of economic use of their property.²⁰⁰ As a result, ratemaking case law has evolved to take several different approaches.²⁰¹

A. THE “FAIR VALUE” RULE

Early utility rate regulation case law examined rates as a return on the “fair value” of the utility, using the “present value of the assets employed by the utility”²⁰² In other words, only investments that are currently used or usable in the business are included in determining the value of the company.²⁰³ In *Smyth v. Ames*,²⁰⁴ plaintiffs, stockholders of the Union Pacific Railway Company and stockholders of the Chicago & Northwestern Railroad Company, challenged the constitutionality of a Nebraska statute which reduced the rates that each of these companies could charge for local freights.²⁰⁵ The plaintiffs argued that the statute deprived railroad compa-

194. *Yee v. City of Escondido*, 503 U.S. 519, 522 (1992).

195. *See, e.g., Penn Central Transp. Co. v. New York City*, 438 U.S. 104, 123-125 (1978).

196. *See NOWAK, supra* note 178, at 538.

197. *See NOWAK, supra* note 178, at 538.

198. *Id.*

199. *Id.*

200. *See, e.g., Yee v. City of Escondido*, 503 U.S. 519 (1992).

201. *See NOWAK, supra* note 178. *See also Smyth v. Ames*, 169 U.S. 466 (1898); *Fed. Power Comm'n v. Hope Natural Gas, Co.*, 320 U.S. 591 (1944); *Missouri ex rel. Sw. Bell Tel. Co. v. Public Serv. Comm'n*, 262 U.S. 276 (1923).

202. *NOWAK, supra* note 178, at 537.

203. *See Epstein, supra* note 36, at 20.

204. 169 U.S. 466 (1898).

205. *Id.*

nies of the right to receive a competitive rate of return without just compensation by reducing the rates that each company could charge to an amount that was unjust.²⁰⁶ The Court found the regulation to be unconstitutional, stating that “under pretense of regulating fares and freights, the state cannot require a railroad corporation to carry persons or property without reward”²⁰⁷ The Court held that the reasonableness of rates must be determined by looking at the “fair value of the property being used . . . for the convenience of the public,”²⁰⁸ taking into account all investments currently used by the company, including,

the original cost of construction, the amount expended in permanent improvements, the amount and market value of its bonds and stock, the present as compared with the original cost of construction, the probable earning capacity of the property under particular rates prescribed by statute, and the sum required to meet operating expenses.²⁰⁹

The Court in *Smyth*²¹⁰ adopted this test as an attempt to balance the interests of the public with the constitutional right that each company has to operate as a business.²¹¹ A “company is entitled to ask . . . a fair return upon the value of that which it employs for the public convenience,” while, on the other hand, “the public is entitled to demand . . . that no more be exacted from it for the use of [the property] than the services rendered by it are reasonably worth.”²¹² By taking into account only investments that are currently used in the business to calculate the value, companies take the risk of making investments that will go to waste.²¹³ In return for this risk, however, the “fair value” rule allows for a higher rate of return, or, in other words, allows companies to charge more for their products and services.²¹⁴ The court in *Missouri ex rel. Southwestern Bell Telephone Co. v. Public Service Commission* stated that:

[i]t is impossible to ascertain what will amount to a fair return upon properties devoted to public service, without giving consideration to the cost of labor, supplies, etc., at the time the investigation is made. An honest and intelligent

206. *Id.*

207. *Id.* at 523 (citing *R.R. Comm'n Cases*, 116 U.S. 307).

208. *Id.* at 546.

209. *Id.* at 546-47.

210. 169 U.S. 466.

211. *Id.* at 547.

212. *Id.*

213. See Epstein, *supra* note 36, at 20.

214. *Id.*

forecast of probable future values, made upon a view of all the relevant circumstances, is essential. If the highly important element of present costs is wholly disregarded, such a forecast becomes impossible. Estimates for to-morrow cannot ignore prices of to-day.²¹⁵

However, several problems arise in attempting to apply the “fair value” rule.²¹⁶ When determining what assets or property items to take into account in determining the value of the company, items may be inappropriately included or excluded, even though they are or are not used and valuable within the business.²¹⁷ For example, a court may fail to take into account the value of something like a company’s logo, despite the good will it may provide for that company. In addition, the value of a thing within the company and together with other assets could potentially be vastly different than the value of that same thing outside of the company.²¹⁸ For example, a system of codes within a company, such as those used for billing in the insurance industry, would be extremely valuable for streamlining business, but that code set outside of the company would be essentially worthless. Because of the uncertainties and inconsistencies that arise in applying the “fair value” rule, contemporary courts have attempted to establish alternative means of calculating the “value” of companies in ratemaking cases.²¹⁹

B. THE “HISTORICAL COST” OR “PRUDENT INVESTMENT” PRINCIPLE

In his concurring opinion in *Missouri ex rel. Southwestern Bell Telephone Co. v. Public Service Commission*, Justice Brandeis held that what is being appropriated for public use is not the property that the company owns, but the “capital embarked in the enterprise.”²²⁰ As such, Brandeis stated that the economic value of the property owned by the company is irrelevant, and the court must instead look at the presumed compensation that the company would earn under the challenged rate regulation.²²¹ To determine this, courts must look at the “historical cost,” or the costs at which the company historically has conducted business.²²²

215. 262 U.S. 276, 287-88 (1923).

216. See, e.g., *Missouri ex rel. Sw. Bell Tel. Co. v. Public Serv. Comm’n*, 262 U.S. 276, 290-294 (1923) (Brandeis, J., concurring).

217. See *id.* at 290.

218. See *id.*

219. See, e.g., *id.*; see also *Duquesne Light Co. v. Barasch*, 488 U.S. 299 (1989); *Fed. Power Comm’n v. Hope Natural Gas, Co.*, 320 U.S. 591 (1944).

220. *Missouri ex rel. Sw. Bell*, 262 U.S. at 290.

221. *Id.* at 291.

222. See *id.*; see also NOWAK, *supra* note 178, at 537.

In *Missouri ex rel. Southwestern Bell Telephone Co.*,²²³ appellee, the Public Service Commission (PSC), issued an order reducing Southwestern Bell Telephone Co. (Southwestern Bell)'s rates while eliminating certain fees and charges.²²⁴ Southwestern Bell argued that the rates were unjust due to the fact that their property had increased in value, which, they argue, the PSC did not properly take into account.²²⁵ The Court held that the order reducing the rates constituted a taking of property without just compensation, and therefore was unconstitutional under the Fifth Amendment.²²⁶ Although the Court used the "fair value" rule in determining the reasonableness of the rates that were set, Justice Brandeis laid out the foundations of what several courts following this opinion adopted in place of the "fair value" rule, called the "historical cost" or "prudent investment" principle.²²⁷ Justice Brandeis stated that prudent investments, at their value at the time the investments were made, should be considered in determining the value of Southwestern Bell's business. He established a four-part test:

the tribunal must determine both what sum would be earned under it and whether that sum would be a fair return. The decision involves ordinarily the making of four subsidiary ones: (1) What the gross earnings from operating the utility under the rate in controversy would be. (A prediction.); (2) What the operating expenses and charges, while so operating, would be. (A prediction.); (3) The rate base; that is, what the amount is on which a return should be earned. (Under *Smyth v. Ames*, an opinion, largely.); (4) What rate of return should be deemed fair. (An opinion, largely.)²²⁸

The "historical cost" or "prudent investment" principle was used by several later courts, including that in *Federal Power Commission v. Hope Natural Gas, Co.*,²²⁹ as a replacement for the flawed "fair value" rule.²³⁰ The value of the "historical cost" or "prudent investment" principle lies in the fact that "the utility is compensated for all prudent investments at their actual cost when made—their "historical" cost—irrespective of whether individual investments are deemed necessary or beneficial in hindsight."²³¹ This

223. 262 U.S. 276 (1923).

224. *Id.* at 282.

225. *Id.*

226. *Id.* at 281-82.

227. *Id.* at 289-312.

228. *Missouri ex rel. Sw. Bell*, 262 U.S. at 291.

229. 320 U.S. 591 (1944).

230. *See id.*

231. *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 309 (1989).

method involves less risk, since all investments are accounted for, and as a result, allows for a lower rate of return, because the base rate is broader.²³²

In *Federal Power Commission v. Hope Natural Gas, Co.*,²³³ the Federal Power Commission (FPC) contended that the defendant, Hope Natural Gas Co.'s rates were unreasonable and therefore unlawful, and issued a rate order reducing the rates that Hope Natural Gas Co. would be allowed to charge.²³⁴ Hope Natural Gas Co. argued that the FPC did not have the right to regulate the rates they charged, and additionally that the rates they were requiring were unjust and unreasonable.²³⁵ The Court reversed the judgment of the lower court, finding that the FPC had the right to regulate the rates that Hope Natural Gas Co. charged.²³⁶

In addition, the Court held that the rates they were requiring were just and reasonable, stating that “[r]ates which enable [a] company to operate successfully, to maintain its financial integrity, to attract capital, and to compensate its investors for the risk assumed certainly cannot be condemned as invalid, even though they might produce only a meager return on the so called ‘fair value’ rate base.”²³⁷ The court reasoned that “‘fair value’ is the end product of the process of rate-making not the starting point . . . [and] that rates cannot be made to depend upon ‘fair value’ when the value of the going enterprise depends on earnings under whatever rates may be anticipated.”²³⁸ In so holding, the court abandoned the *Smyth*²³⁹ reasoning in favor of the “historical cost” or “prudent investment” principle laid out by Justice Brandeis.²⁴⁰

C. OTHER ALTERNATIVES

While each of these tests that can be, and sometimes today are, used in determining reasonable rates, legislatures alternatively may institute a system of rate caps across an entire industry.²⁴¹ Rate caps effectively limit the percentage by which companies within an industry can raise rates, or impose a maximum rate increase.²⁴² In other words, the legislature “caps” rate increases for an industry, such as the insurance industry.²⁴³ The logic be-

232. See Epstein, *supra* note 19, at 20.

233. 320 U.S. 591 (1944).

234. See *id.* at 593-94.

235. *Id.* at 594.

236. *Id.* at 605.

237. *Id.*

238. *Fed. Power Comm'n*, 320 U.S. at 601.

239. *Smyth v. Ames*, 169 U.S. 466 (1898).

240. *Missouri ex. rel. Sw. Bell Tel.*, 262 U.S. at 289-312.

241. See Epstein, *supra* note 19, at 20.

242. See *id.*

243. See *id.*

hind imposing rate caps lies in the economy of business.²⁴⁴ As rates increase, the efficiency at which an industry does business also increases.²⁴⁵ The increased efficiency at which the industry is conducting business causes a decrease in the unit cost of supplying the services that the business provides.²⁴⁶ Therefore, the cost of supplying the services balanced against the increased rates will even out at some point, which the legislature may calculate.²⁴⁷ It is at that point that the legislature will “cap” rate increases for the industry since there would presumably be no need for any increases beyond that point.²⁴⁸

Contemporary courts have taken a different approach in coming up with a method of analyzing ratemaking cases under the Fifth Amendment.²⁴⁹ The court in *Duquesne*²⁵⁰ was the first to abandon the body of thinking that it was the method behind which the rates were created that determined whether the rate was reasonable or not.²⁵¹ Instead, the *Duquesne* court found that no single formula for fixing utility rates was mandated by the Constitution.²⁵² They abandon both the *Smyth*²⁵³ reasoning and that of Justice Brandeis,²⁵⁴ in favor of a modified approach.²⁵⁵ According to the court in *Duquesne*, the Constitution simply requires that the utility be allowed to receive a rate of return that is not so unjust as to be confiscatory, regardless of the method used in determining that rate.²⁵⁶ Instead of evaluating the “base rate”²⁵⁷ by using either the “fair value” rule or the “historical cost” principle, the court must evaluate several considerations surrounding the facts and circumstances of each case, including the “value of the company and the return upon prudent investments.”²⁵⁸

244. *See id.*

245. *See id.*

246. *See* Epstein, *supra* note 19, at 20.

247. *See id.*

248. *See id.*

249. *See, e.g.,* *Duquesne Light Co. v. Barasch*, 488 U.S. 299 (1989).

250. *Id.*

251. *See id.* at 315.

252. NOWAK, *supra* note 178, at 538.

253. *Smyth v. Ames*, 169 U.S. 466 (1898).

254. *Missouri ex. rel. Sw. Bell Tel. Co. v. Pub. Serv. Comm'n*, 262 U.S. 276, 291-92 (1923) (Brandeis, J., concurring).

255. *See generally Duquesne*, 488 U.S. 299.

256. *See* NOWAK, *supra* note 183, at 538.

257. *See, e.g., Missouri ex. rel. Sw. Bell Tel.*, 262 U.S. at 291-92.

258. *See* NOWAK, *supra* note 183, at 538.

V. ANALYSIS

A. DOES RATEMAKING APPLY TO PPACA?

There are several arguments that can be made against the application of ratemaking case law to PPACA. First, the health insurance industry pre-PPACA could not and never was characterized as a public utility.²⁵⁹ Health insurance companies have always been private companies operating within a free market, and competing with each other to provide health plans for consumers at the best possible price.²⁶⁰ Public utilities, on the other hand, are private organizations that are given monopolies in an industry to provide a public service.²⁶¹ Due to their advantaged position within a non-competitive market, these companies are subject to heavy regulation.²⁶² Under PPACA, and especially by implementation of the State Exchanges established by PPACA, health insurance companies essentially become de facto public utilities.²⁶³

Both the federal and state governments now have extremely integral roles within the insurance industry, which is evident through the various provisions detailed previously.²⁶⁴ For example, through the State Exchanges, insurers must submit any proposed rate increases to an applicable state authority along with a justification for such increase.²⁶⁵ In turn, the state will determine whether or not such rate increase is “reasonable,” and will decide whether or not to allow the insurer to implement such a rate increase.²⁶⁶ Additionally, if a state believes that any qualified health plan is “unreasonably” increasing rates, that state may decertify that plan as a qualified health plan, rendering such plan unable to access federal subsidies.²⁶⁷ To use another provision, the rating system in place for qualified health plans, and even the certification process for qualified health plans, allows the federal government to pick and choose which companies should receive the most business, and which companies should be rendered insolvent.²⁶⁸ Even outside of the State Exchanges, insurance companies are subject to substantial regulation, such as the requirement that all plans must contain the Essential Health Benefits Package detailed in section 2707 of

259. See Epstein, *supra* note 36, at 1.

260. *Id.*

261. 64 AM. JUR., 2D *Public Utilities* § 68 (2001).

262. *Id.*

263. See Epstein, *supra* note 19, at 2.

264. See *supra* Part II.B.

265. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1311, 124 Stat. 119, 173 (2010).

266. *Id.*

267. *Id.*

268. *Id.*

PPACA.²⁶⁹ The federal and state governments essentially have unbridled control over the manner in which all insurance companies do business.²⁷⁰ This substantial amount of control over both business operations and revenues, along with the considerable subsidies provided to qualified health plans within State Exchanges, effectively transforms the health insurance industry into a governmental program, making the health insurance industry analogous to public utilities.²⁷¹

Second, the MLR provision in PPACA does not explicitly set rates for insurance companies, but instead places a hard cap on the profits any company may receive.²⁷² In theory, when one analyzes the MLR provision alone, insurance companies may charge whatever rates they choose, as long as their non-claims expenses do not exceed the maximum allowable percentage for those expenses, or their expenses for claims and other activities that improve health care quality amount to a minimum of eighty to eighty-five percent of the premiums they take in.²⁷³ However, when all the provisions are taken in the aggregate, PPACA severely limits insurance companies' ability to increase rates.²⁷⁴ The most obvious illustration of this is the requirement that qualified health plans submit and justify any proposed rate increases to the state authority for approval.²⁷⁵ Not only do insurance companies face the very real possibility of having their rate increases deemed "unreasonable," resulting in either the state not allowing them to implement the rate increase or the decertification of their qualified health plan, but also the insurance companies must incur the time and expense involved in going through the drawn out process of rate justifications and approvals, requiring the company to continue to suffer losses, extending the time that plans are inadequately priced, and not allowing the company to adequately respond to the market.²⁷⁶ In addition, any rate increases that insurance companies manage to implement to cover additional costs will simply have to be rebated back to the insureds at the end of the year.²⁷⁷

Finally, it is proper to apply ratemaking case law to PPACA because the ultimate goal that the Supreme Court is trying to achieve is the same: under the Fifth Amendment Takings Clause, companies should be allowed

269. § 2707, 124 Stat. at 161.

270. See generally Epstein, *supra* note 19.

271. *Id.* at 2.

272. Patient Protection and Affordable Act, Pub. L. No. 111-148, § 1331, 124 Stat. at 200.

273. See *id.*

274. See Epstein, *supra* note 19, at 16.

275. § 1311, 124 Stat. at 173.

276. See Epstein, *supra* note 19, at 18.

277. See Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation*, 2009-2010, (Dec. 2010) available at, <http://www.cbo.gov/ftpdocs/120xx/doc12033/12-23-SelectedHealthcarePublications.pdf>.

to receive a reasonable rate of return on their investments.²⁷⁸ The federal government has never before tried to regulate an entire industry in a manner as extensive as PPACA.²⁷⁹ Ratemaking case law is the most analogous precedent that can be applied to the actions being taken through PPACA, because it seems clear that ratemaking was what the legislature intended to do through the MLR provision, and therefore, should suffice to achieve a just outcome based in the Constitution.

B. WHY RATEMAKING WAS WRONGLY IMPLEMENTED IN DRAFTING PPACA

Legislatures traditionally implement ratemaking laws to limit the rates of return monopolies receive in noncompetitive markets.²⁸⁰ The overarching goal in implementing ratemaking legislation is to bring a company's rates down to those that they could reasonably receive in a competitive market.²⁸¹ The health insurance industry, on the other hand, has never been a monopolized market, but instead has always involved free competition among various insurance companies.²⁸² In an industry where there is existing competition, the goals behind implementing ratemaking legislation become moot—they have already been achieved, since each company is already operating at competitive rates within that market.²⁸³ Because there existed competition within the market before the implementation of the MLR provision in PPACA, Congress wrongly applied ratemaking legislation in trying to regulate the health care industry.

In addition, Congress asserted that their goal in implementing a minimum MLR in PPACA was to minimize costs involved in the health care industry, and increase efficiency.²⁸⁴ There is no doubt that the health care industry is laden with high-cost services and procedures all conducted through complicated transactions.²⁸⁵ However, implementing ratemaking legislation accomplishes neither of these goals.²⁸⁶ In fact, ratemaking legislation almost always increases costs within an industry because of the large amounts of administrative costs involved in complying with these new laws.²⁸⁷ Additionally, ratemaking legislation often reduces efficiency within an industry because it takes away incentives for these companies to find

278. See *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 307-08 (1989).

279. See Epstein, *supra* note 36, *passim*.

280. See *id.*; see also *Duquesne*, 488 U.S. at 313.

281. *Duquesne*, 488 U.S. at 314-15.

282. See Epstein, *supra* note 36, at 20-21.

283. *Id.* at 21.

284. *Id.*

285. See *Florida ex rel. McCollum v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D. Fla. 2010).

286. See Epstein, *supra* note 36, at 21.

287. *Id.*

ways to increase efficiency.²⁸⁸ PPACA takes away the incentive for insurers to provide important and beneficial services, such as customer service, convenience, clarity, support, etc., since these expenses must be taken out of the twenty percent left to the insurers for “profit”. It also takes away the incentive to prevent fraud—which costs the health care industry billions of dollars a year. Because ratemaking legislation achieves none of the goals that Congress set out to accomplish, it is inappropriate for remedying the problems within the health care industry.

C. PROBABLE RESULTS OF INSTITUTING THE MLR

Taken in conjunction with the various other provisions contained in PPACA, the minimum MLR places substantial burdens on the health insurance industry through regulation of an unconstitutional magnitude. In applying Fifth Amendment ratemaking case law, the MLR must allow insurance companies the ability to receive a reasonable rate of return on their investments.²⁸⁹ Regardless of the test used, the MLR provision in PPACA clearly fails.²⁹⁰ According to *Duquesne*, a court must simply assess the facts and circumstances surrounding the business and the ratemaking law in order to determine whether the rate is excessive or confiscatory.²⁹¹ The high level of regulation placed on companies within the insurance industry, the level of coercion involved, and the high probability that most insurance companies will not be able to survive in a post-PPACA era without becoming a governmental program leads to the conclusion that the MLR provision rises to the level of an unconstitutional taking of property under the Fifth Amendment.

First, the MLR provision is essentially a hard cap on the profits that insurance companies may retain, but incorporates no assurance that a company will receive a minimum rate of return.²⁹² This in and of itself makes it impossible for any insurance company to receive a reasonable rate of return.²⁹³ Even if the eighty to eighty-five percent MLR was determined to be at the competitive level, “it is not constitutionally permissible to impose an annual rate cap just at the competitive level, while leaving the carrier obligated to eat the losses in poor years.”²⁹⁴ By failing to incorporate a minimum rate of return, PPACA puts insurance companies in the very real dan-

288. *Id.*

289. *See, e.g., Duquesne Light Co. v. Barasch*, 488 U.S. 299 (1989).

290. *See Epstein, supra* note 36, at 4.

291. *See generally, Duquesne*, 488 U.S. 299.

292. Patient Protection and Affordable Act, Pub. L. No. 111-148, § 2718, 124 Stat. at 136-137.

293. *See Epstein, supra* note 19, at 22 n.3.

294. *Id.* at 22.

ger of having to operate at a loss, year after year.²⁹⁵ Moreover, insurance companies run the risk of operating at a loss, while *still* not attaining the MLR mandated by PPACA, in which case they would owe their insureds the rebate, and fall further into insolvency. Except in the highly improbable instance where a company receives exactly the competitive rate every year, a system such as this necessarily deprives every company in the industry of their constitutionally guaranteed reasonable rate of return over time.²⁹⁶ Notwithstanding any other provision within PPACA, this fact alone invalidates the MLR provision.²⁹⁷

When various other provisions of PPACA are taken into account, however, it becomes even clearer that the MLR infringes on the constitutional rights of companies within the health insurance industry.²⁹⁸ In fact, the federal government has conceded that “the Act will have serious negative consequences, e.g., encouraging people to forego health insurance until medical services are needed, increasing premiums and costs for everyone, and thereby *bankrupting the health insurance industry*.”²⁹⁹ For example, insurers may not deny coverage to anyone who applies for it, unless they can positively demonstrate that they do not have the financial capacity to underwrite further coverage.³⁰⁰ However, there are numerous administrative costs involved in this process, and the time required to go through the filing process and respond to questions slows speed to market, thereby slowing down the ability of a company to respond to changes in the marketplace. This requires the company to continue to suffer losses, extend the time that plans are inadequately priced, and not even allow the company to *reduce* prices quickly and efficiently. Even after all of this, there is still no guarantee that state administrators will find in favor of the insurer.³⁰¹ Additionally, further burdens are placed on insurers who deny coverage for lack of financial capacity in that they cannot re-enter the market for 180 days subsequent.³⁰²

Insurers are further restricted in their ability to adjust rates.³⁰³ Not only are insurers restricted from denying coverage to anyone, but they are also restricted from rating for any reason other than the type of plan, geography,

295. *Id.*

296. *Id.*

297. *Id.*

298. See Epstein, *supra* note 36, at 22-23.

299. Florida *ex rel* Bondi v. U.S. Dep’t of Health & Human Servs., No. 3:10M—cv—91—RV/EMT, 2011 WL 285683 at *31 (N.D. Fla. 2011) (emphasis added).

300. *Id.*

301. *Id.*

302. Patient Protection and Affordable Act, Pub. L. No. 111-148, § 2704, 124 Stat. at 154.

303. *Id.*

age, and tobacco use.³⁰⁴ This means that insurers must provide coverage at the same or a similar rate for every person, regardless of the risk involved in covering such person.³⁰⁵ The Essential Health Benefits Package that insurers are required to provide for every applicant simply adds to the financial burden placed on insurance companies.³⁰⁶ Insurers must provide benefits that their insureds do not need (such as coverage for pregnancy for men) and that the insurers cannot afford, without raising prices for these benefits.³⁰⁷ “Any system that reduces revenues, raises costs, and increases uncertainty cannot possibly meet the applicable constitutional standard.”³⁰⁸

In essence, PPACA requires insurance companies to cover more, higher-risk people, and more medical conditions, without allowing them to adjust rates accordingly.³⁰⁹ In addition, PPACA places countless new administrative costs on the insurer that are not accounted for in the MLR provision.³¹⁰ When taken in the aggregate, it becomes clear that a majority of companies in the health insurance industry will be driven into insolvency due to their inability to meet the MLR.³¹¹ As a result, the MLR provision likely constitutes an unlawful taking of property under the Fifth Amendment.

VI. CONCLUSION

The minimum medical loss ratio provisions in PPACA should be held as an unconstitutional taking of property without just compensation under the Fifth Amendment for several reasons. The health insurance industry is not monopolized, and as such, regulates rates itself through competition in the free market.³¹² Legislative ratemaking is used in the public utility context to prohibit monopolies from receiving rates of return significantly higher than those that they could obtain in a competitive market, without eliminating the market all together by imposing so small a rate of return as to drive companies out of business.³¹³ Therefore, ratemaking in the health insurance industry makes little sense.³¹⁴ There is no need for the legislature

304. *See supra* Part II.B.

305. *See* Epstein, *supra* note 19, at 17.

306. § 2707, 124 Stat. at 161; *see supra* Part II.B.3.

307. *Id.*

308. Epstein, *supra* note 19, at 23.

309. *See id.*

310. *Id.*

311. *Id.*

312. *Id.*

313. Epstein, *supra* note 19, at 19-20.

314. *Id.*

to regulate rates in an industry that is not monopolized and is already effectively regulated by competition in the free market.³¹⁵

The minimum loss ratio imposed necessarily deprives insurance companies of their constitutional right to earn a reasonable rate of return, because it fails to account for “bad years” by forcing health insurance companies to rebate the extra earned profit in “good years,” as well as rebate eighty to eighty-five percent even while operating at a loss in some cases.³¹⁶ Therefore, over a period of several years, insurance companies necessarily receive lower than a competitive rate, except in the highly improbable instance that they earn exactly the competitive rate of return every year.³¹⁷ This strict, non-fluctuating eighty to eighty-five percent minimum loss ratio takes no annual factors into account, such as the economic environment of that year, sickness epidemics that would require higher claims payouts, and other varying factors. By not allowing insurance companies to keep extra profit in “good years” to offset deficits in “bad years,” PPACA is essentially forcing insurance companies into bankruptcy.

In addition, the MLR currently in place under PPACA is excessively high, and certain to be ruinous for the health insurance industry. An eighty to eighty-five percent minimum loss ratio deprives insurance companies of their constitutional right to earn a fair, competitive rate of return.³¹⁸ Under all Fifth Amendment Takings Clause tests, the minimum loss ratio would be considered confiscatory, because insurance companies financially will not be able to handle the increased cost involved in the presumed influx of business and increase in administrative costs caused by the various requirements imposed by PPACA, while maintaining such a significantly higher loss ratio.³¹⁹

REBECCA J. KOPPS*

315. *Id.*

316. *Id.*

317. *Id.*

318. *See generally Duquesne*, 488 U.S. 299.

319. *See id.*

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