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by Alice Noble and Mary Ann Chirba

On Day Three of arguments about the constitutionality of the Affordable Care Act, the Supreme Court turned its attention to the question of severability. Should the Court find that the ACA's minimum coverage requirement is indeed a proper exercise of Congress's right to regulate interstate commerce, today's arguments were all for naught. However, if the Court strikes down the minimum coverage requirement – the so-called "individual mandate" – it will need to determine whether that mandate can be "severed" from the Act's remaining provisions, leaving the remaining provisions intact.

Yesterday, we reflected on the need to read between the lines of written and oral argument to fully appreciate the issues raised, the arguments made, and the potential answers. Today's proceedings tell a different and much more obvious story, since there is no need to read between the lines to discern the answer. The legalities of congressional intent and statutory interpretation that consumed the Justice's attention have been thoughtfully discussed by our colleagues. Our goal, having studied the thousands of pages of statutory provisions and proposed and final regulations, is to assure everyone that severability is indeed possible, since a mandate that would not take effect until 2014 has done nothing to derail the busy timeline for implementing the Act so far.

In our view, whether the individual mandate can be severed from the overall Act without causing the Act to implode is not a hard question. The reason? Many provisions are in place and gradually changing the nature of the debate. Access to health care is increasing, quality is gaining a new emphasis, and costs increases are receiving closer scrutiny. This is all happening years before the individual mandate will take effect in 2014. A few examples deserve mention.

Small Employers: Among the Affordable Care Act's earliest initiatives to make insurance more affordable and accessible, the small employer tax credit took effect on January 1, 2010. It makes some 4 million small employers eligible for tax credits of up to 35 percent of their contribution to paying for employee health insurance.

Commercially Insured: Young adults now enjoy broader and more accessible coverage since they can now remain on their parent's policies until age 26. According to HHS estimates, 105 million Americans no longer face life-time limits on the dollar value of their health benefits. Individuals are now receiving many preventive care services with no out-of-pocket costs to them.

As of January 1, 20ll, the insured will no longer see excessive portions of their health care premiums devoted to administrative expenses. Because of the Affordable Care Act, commercial insurers must

devote between 80 percent to 85 percent of premium dollars to paying for health care or improving its quality. Insurers' premium rate increases are getting greater scrutiny and, as of January, 2012, the Secretary of HHS has already found premium rate increases in 5 states to be unreasonable. Incentivized by $250,000,000 in grants under the Affordable Care Act, numerous States are developing their own capacity to identify and block unreasonable premium increases.

Medicare and Medicaid: In crafting the Affordable Care Act, Congress used its Spending Power to make the federal Medicare and federal-state Medicaid programs more responsive to the needs of program participants and more cost-effective in the process. Since January 1, 2011, elders have been entitled to annual wellness visits, personalized preventive care plans, and numerous free preventive services that previously carried sizeable out-of-pocket costs. The proverbial "doughnut hole" or coverage gap in Medicare's Part D prescription drug coverage is well on its way to closing for good in 2020, and seniors have already seen their out-of-pocket costs go down.

As of January 1, 2011, for example, Medicare's "Community Care Transitions Program" has been improving the coordination of care during hospital discharges and follow-up in order to reduce hospital readmissions and improve the accessibility of home and community services. In October, 2011, Medicaid's "Community First Choice Option" expanded care options for the disabled and increased State flexibility to direct Medicaid dollars to home-based and community services.

Patients and Providers: Medicaid and Medicare beneficiaries are not the only ones who have benefitted from the Affordable Care Act's program-specific initiatives to promote quality care, cost efficiencies and innovation. Rather, because of Medicare incentives and adjustments to Medicare reimbursement, new innovative health delivery programs are up and running across the country, with many more providers and systems about to join the ranks.

As of January 1, 2012, 32 organizations were participating in the Pioneer Accountable Care Organization (ACO) Model, bringing innovations in coordinated care to over 850,000 Medicare beneficiaries and all other patients who receive care from the providers and facilities participating in this program. Medicare reports that 50,000 Medicare providers are involved in projects to improve patient safety, coordinate care across different health care settings, and working under new bundled payment systems. Improving coordination will not only save money, but lives. *Although Congress may have incentivized these and other improvements by exercising its Spending Power for specific government-sponsored programs, current and future gains will benefit many additional patients through spillover effects.*

The Affordable Care Act As A Three-Lane Highway

These are just a few of a much larger array of changes that have already taken hold under the Affordable Care Act. The Act is ambitious and complicated; the growing compendium of proposed and final regulations is daunting. Hundreds of regulations have already taken effect. The ACA will have changed the landscape of health care in the United States long before the individual mandate is a part of it.

We think of the issue of severability in terms of "Triple Lanes." To finance the ends of the Affordable Care Act, Congress constructed a triple lane highway consisting of employer-sponsored coverage, government–sponsored insurance, and for those who qualify for neither, individually obtained insurance. Striking down the individual mandate will not demolish the entire highway. One lane is obstructed. Congress may repair it or close it down permanently.

The other lanes of employer- and government-sponsored coverage continue to operate. Will they be affected? Probably, just as closing one lane on a highway can affect traffic flow in the other two. But will closing down the individual mandate inevitably destroy the Act's ability to accomplish its other objectives? To answer that question, one need only look at the Act in operation today, a full two years before the individual mandate is scheduled to take effect and three years before it can be enforced. Today two lanes are open, and traffic is flowing.

Editor's note: *For more on the severability oral arguments, see additional* Health Affairs *Blog posts by Timothy Jost, Wendy Mariner, and William Sage*.

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