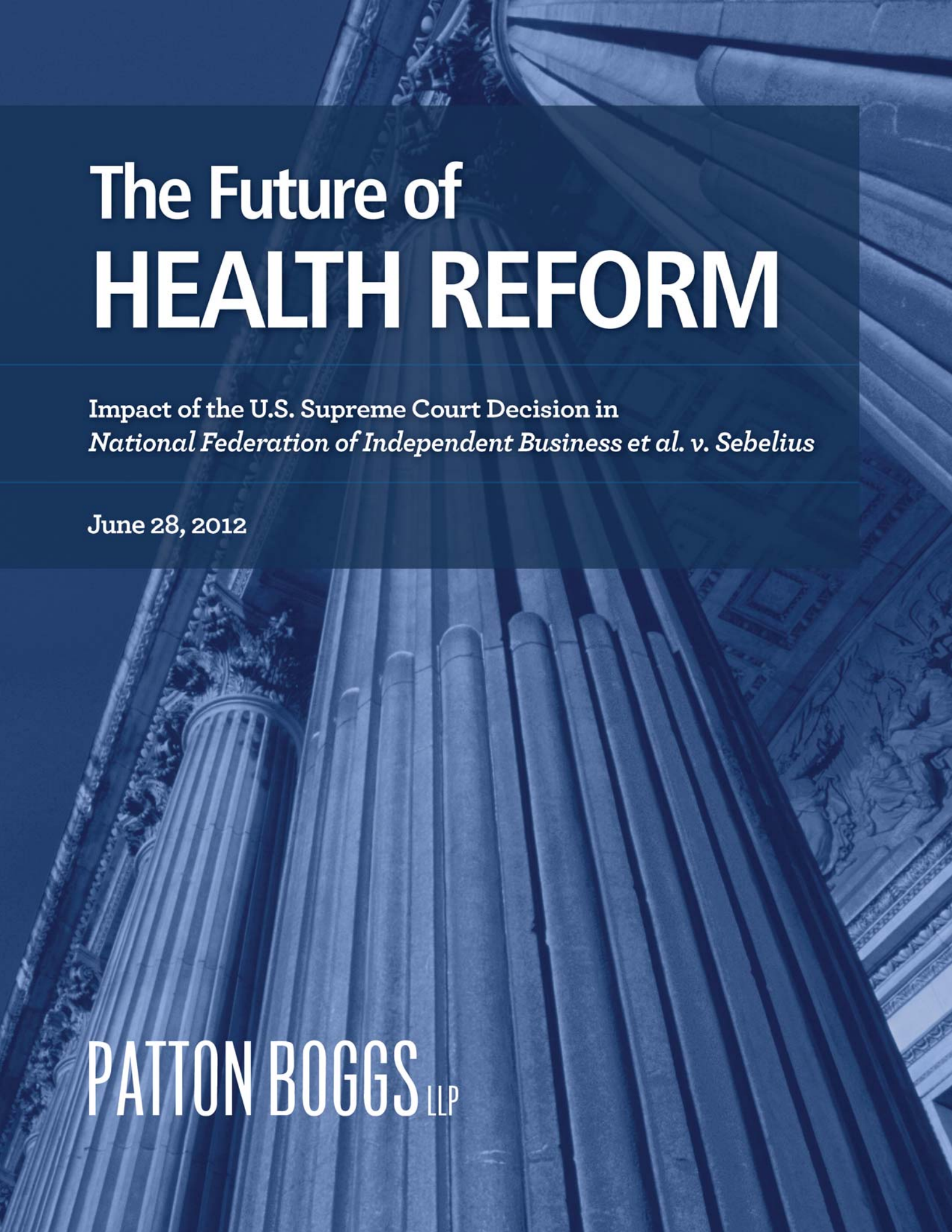

The Future of HEALTH REFORM

Impact of the U.S. Supreme Court Decision in *National Federation of Independent Business et al. v. Sebelius*

June 28, 2012

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- **The U. S. Supreme Court upheld the Affordable Care Act (ACA) in large part, including the individual mandate, by a vote of 5 to 4.**
- **The decision bars the Department of Health and Human Services (HHS) from denying all Medicaid funding to states that opt out of ACA's Medicaid expansion, but it allows states to obtain additional funding in exchange for opting in and complying with ACA's standards.**
- **Implementation of health insurance exchanges and other provisions will continue, but delays are very likely, because so many states have yet to reach consensus on exchange design.**
- **If states elect to opt out of Medicaid expansions, millions of low-income Americans who would have obtained coverage may now remain uninsured, and providers will continue to face significant uncompensated care burdens.**
- **Opponents of the law will continue to pursue efforts on multiple fronts – in Congress, in the states and in the courts – to defund, derail or overturn the law, in whole or in part.**
- **Industry-specific provisions enacted to finance the expansion of health coverage will remain in effect, but they may be challenged in Congress and in the courts based on the smaller-than-anticipated population of newly-insured individuals.**
- **Policy-makers remain intensely focused on deficit reduction and reducing health care spending, and Medicare and Medicaid reimbursement streams are at significant risk for additional cost-cutting.**

Introduction

Following enactment of the Patient Protection and Affordable Care Act (ACA) in March 2010, several states, organizations, and individuals filed lawsuits challenging various provisions of ACA. After four federal appellate courts ruled on multiple aspects of the legal challenges, on November 14, 2011, the United States Supreme Court agreed to hear arguments and review four issues related to the constitutionality of ACA.

The four issues before the Court arose out of litigation in Florida that was heard on appeal and decided by the U. S. Court of Appeals for the Eleventh Circuit. The Court granted *certiorari* on three petitions arising out of the Eleventh Circuit decision: an appeal by the states (*Florida v. Department of Health and Human Services*), an appeal by National Federation of Independent Business (NFIB) (*National Federation of Independent Business v. Sebelius*), and an appeal by the federal government (*Department of Health and Human Services v. Florida).* In *Florida v. Department of Health and Human Services,* the Eleventh Circuit overturned the individual minimum coverage requirement (the "individual mandate") as unconstitutional, but upheld the remainder of ACA, concluding that the individual mandate provision could be severed from the rest of the statute.

The Supreme Court consolidated the appeals and agreed to consider four questions:

- Whether the Anti-Injunction Act precludes the Court from considering challenges to ACA's monetary sanctions, for failure to purchase a minimum level of health insurance, prior to their implementation;[1]

- Whether ACA's individual mandate (to purchase a minimum level of health insurance) exceeds Congress' power under the Commerce Clause of the Constitution;

- If the individual mandate is unconstitutional, whether the individual mandate may be severed from some or all of the other provisions of ACA; and

- Whether ACA's Medicaid expansion provisions violate principles of federalism by coercing the states to participate?

The first three of these questions deal with the individual mandate and related provisions, while the fourth question deals with the expansion of Medicaid.

Over three days in March 2012, the Court heard more than six hours of oral argument – the most time devoted to a case in over 45 years. The Court's decision, released on June 28, 2012, held that the individual mandate, which requires most Americans to purchase health insurance

[1] ACA's individual and employer penalties do not take effect until 2014, and they must be paid on federal tax returns by April 2015. An 1867 federal law, the Anti-Injunction Act, bars most lawsuits challenging a tax that has not yet been paid.

or pay a penalty beginning in 2014, is constitutional based on the right of the federal government to levy taxes. The Court's decision upheld the law in its entirety, except that the Court held that the federal government cannot revoke a state's existing Medicaid funding if the state does not participate in ACA's Medicaid expansion. The following is an overview of the Court's decision, including concurring and dissenting opinions, as well as an initial analysis of its implications.

Overview of the Supreme Court's Decision

While the decision presents the Court's rulings on each of the challenges, parsing out the implications of these rulings is much more complicated and we expect constitutional lawyers, appellate experts, Administration officials, Members of Congress, governors, state Medicaid officials, health policy analysts, providers, and consumer groups to weigh in on the decision's broader implications for health reform.

Question #1: Whether the Anti-Injunction Act precludes the Court from considering challenges to ACA's tax penalties for failure to purchase insurance prior to their implementation?

ACA imposes a monetary sanction on individuals who, beginning in 2014, are required to purchase a minimum level of health insurance, but fail to do so. The 1867 Anti-Injunction Act (AIA) precludes any court from considering the imposition of a federal tax prior to its enforcement. AIA applies only to taxes and not to other sanctions contained in the federal tax code, such as non-tax penalties. In general, taxes are enacted to raise funds (to support the government) while penalties comprise punishment for unlawful acts. Accordingly, as a preliminary matter, the Court invited oral argument on whether ACA's monetary sanction is a tax or a penalty. If the former, the Court would not yet have jurisdiction to hear challenges to this part of ACA. Interestingly, because neither the government nor the states had briefed the position that the AIA applied, the Court appointed special counsel to argue this position.

- The Court ruled that the Anti-Injunction Act does not bar consideration of the case.

- The Majority opinion, written by Chief Justice John Roberts, held that Congress did not intend the shared responsibility payment to be treated as a "tax" for purposes of the Anti-Injunction Act. Accordingly, the Majority held that the Anti-Injunction Act does not apply to this suit.

- The concurring opinion on this issue, written by Justice Ginsburg and joined by Justices Sotomayor, Breyer, and Kagan found that the Anti-Injunction Act does not bar the Court's consideration of the case.

- The dissent on this issue, written by Justices Scalia, Kennedy, Thomas, and Alito referenced the Anti-Injunction Act to demonstrate the inconsistency between the Government's argument that ACA is not a tax for purposes of the Anti-Injunction Act, but is a tax for constitutional purposes.

Question #2: Whether ACA's individual mandate exceeds Congress' power under the Commerce Clause of the Constitution?

Beginning in 2014, the minimum essential coverage provision of ACA, known as the "individual mandate," requires most people to maintain a minimum level of health insurance coverage for themselves and their tax dependents. Failure to do so would trigger a monetary sanction in the form of a "penalty." (See Question #1.) The question considered by the Court was whether Congress may use its constitutional authority, under the Commerce Clause, to regulate interstate commerce in order to enact this requirement. During oral argument, questions from several Justices focused on whether Congress could "create" commerce, where none previously existed, for the purpose of regulating it. The Court also questioned whether the underlying "commerce" at issue was the use of health care services, or rather, the sale of health insurance. The Solicitor General argued that two other ACA insurance reforms, "guaranteed issue" and "community rating," could not exist without the individual mandate.

- By a vote of 5 to 4, the Court upheld the individual mandate as a proper exercise of Congress' taxing power. The Court found it reasonable under a constitutional analysis to construe the shared responsibility payment as a tax on individuals who choose to go without health insurance. The Court found that the Constitution permits such a tax.

- Because the Court upheld ACA under Congress' tax power, that is sufficient for the law to survive. Nevertheless, there were several opinions analyzing the Commerce Clause implications. Chief Justice Roberts argued that the individual mandate exceeds Congress' Commerce Clause and Necessary and Proper Clause power.

- The concurring opinion on this issue, written by Justice Ginsburg and Joined by Justices Sotomayor, Breyer, and Kagan, would have upheld the individual mandate on Commerce Clause grounds, but agreed with Chief Justice Roberts that the individual mandate is also authorized under Congress' taxing power. The concurrence disagreed with Chief Justice Roberts' and the joint dissenters' argument that the minimum coverage provision will open the flood gates of Commerce Clause power. Writing for the concurrence, Justice Ginsburg emphasized the unique nature of the health care market, noting that everyone will inevitably participate in the market and cannot predict when and how. She also noted that the inevitable participation by the uninsured impacts the market price of health care and increases costs for the insured population.

- A dissenting opinion by Justices Scalia, Kennedy, Thomas, and Alito noted that the regulation of the failure to buy insurance exceeds Congress' power under the Commerce Clause. Congress reached too far when it used healthier individuals to offset the consequences of incorporating sicker (and thus more expensive) individuals into the insurance market via the mandate. The dissenting Justices also rejected the government's argument that there is already universal participation in the health care market. They define the market narrowly, as consisting of goods and services that the younger people affected by the individual mandate do not purchase. Additionally, the dissent reasoned that ACA involves a regulatory penalty, and not a tax, and that the terms "penalty" and "tax" are mutually exclusive. Because Congress framed the minimum-coverage provision as a regulatory penalty, not as a tax, the individual mandate cannot be upheld under Congress' taxing power.

- In an additional dissenting opinion, Justice Thomas reiterated his continuing objection to the Court's use of the "substantial effects" test under the Commerce Clause. Justice Thomas cited ACA as an example that the test would grant Congress a power that has "virtually no limits" under the Commerce Clause and, thus, is inconsistent with the

original understanding of Congress' powers under the Commerce Clause and the Necessary and Proper Clause.

Question #3: If the individual mandate is unconstitutional, whether the individual mandate may be severed from other non-related provisions of ACA?

Congress passed ACA without a "severability clause" that would have automatically preserved other provisions in the law if any one provision were to be found unconstitutional. Although there is precedent for the Court to sever only one provision from a law in the absence of a severability clause, the states argued that, without the individual mandate, the rest of ACA (*e.g.*, the provisions for "guaranteed issue" and "community rating") would not function as Congress had intended. Thus, they argued, Congress should be given a clean slate to rewrite the entire law.

The government argued that, were the individual mandate to be struck, only ACA's provisions for "guaranteed issue" and "community rating" need also fall, because the rest of ACA's provisions, some of which already have taken effect, are wholly unrelated to the individual mandate. During oral argument, a number of Justices noted that there was a dividing line between the challenged provision and other provisions in the law and that these other provisions could stand alone, without the individual mandate.

- The Majority relied on an existing severability provision in the Social Security Act to uphold the optional Medicaid expansion under ACA.

- The concurring opinion, written by Justice Ginsburg and Joined by Justices Sotomayor, Breyer, and Kagan, does not reach the severability issue because the individual mandate and all other provisions were constitutional in their view.

- The dissent reasoned that because the individual mandate and the Medicaid expansion are invalid, ACA must fall. ACA was designed to balance costs and benefits amongst a variety of regulated parties: as a "shared responsibility." Without the individual mandate and the Medicaid expansions, the dissenting justices found that Congress' scheme of shared responsibility would be undermined due to imposed risks on insurance companies and their customers.

Question #4: Whether ACA's Medicaid expansion provisions violate principles of federalism by coercing the states to participate?

ACA is replete with provisions that increase access to affordable health insurance by expanding eligibility for Medicaid benefits. The Medicaid program is jointly funded and regulated by the federal and state governments. While the program is voluntary for states, all presently participate. Participating states have a number of options they may elect, but must follow certain federal rules – including rules as to groups of individuals entitled to "mandatory coverage." Beginning in 2014, ACA expands the Medicaid program's mandatory coverage requirements. Initially, the federal government would cover 100 percent of the incremental costs of this expansion, but would begin to transfer financial responsibility back to the states in the year 2020.

The question presented to the Court was whether these expansion provisions of ACA comprise a valid exercise of Congress' spending power under Article I, Section 8 of the U.S. Constitution. Some of the participating states argued that by conditioning their access to federal funding for existing Medicaid programs on their ACA-mandated Medicaid expansion, Congress exceeded the permissible bounds of its spending power and engaged in unlawful coercion of state action. The government argued that Congress may lawfully attach conditions to the receipt of federal funds, and some participating states filed an *amicus* brief generally in support of the government's position.

- In a fractured opinion, the Medicaid expansion was upheld in part by the Court.
- A majority of the Court upheld the Medicaid expansion as optional, rather than mandatory, and concluded that the Secretary of the Department of Health and Human Services (HHS) may not revoke existing Medicaid funding for states that decline to participate in the expansion.
- The concurring opinion on this issue, written by Justice Ginsburg and joined only by Justice Sotomayor, concluded that the Medicaid expansion is constitutional in its entirety. Because a plurality of the court determined that the ACA's grant of authority to the Secretary to withhold existing Medicaid funds from States that did not comply with the expansion was not constitutional, however, Justices Ginsburg and Sotomayor

ultimately agreed that the most appropriate remedy going forward would be to strike down this narrow component of the Act.

- The dissent reasoned that the coercive nature of the Medicaid expansion is "unmistakably clear." Because Congress offered no other "backup scheme" to expand coverage for those who could only afford it via the Medicaid expansion, the Justices reasoned that Congress felt certain the grant could not be refused by the states. Thus, it was not a real choice.

Initial Analysis of Implications

Stumping the pundits, the Supreme Court upheld the majority of ACA's provisions, including the "individual mandate." Significantly, the Court ruled invalid ACA's requirement that states expand Medicaid to individuals with household incomes up to 133 percent of the federal poverty level (FPL) or forfeit all of their federal Medicaid funding. The Court upheld Congress' authority to offer additional funding to states that choose to expand Medicaid coverage under ACA, however, and to impose related conditions under the statute.

The Court found that the individual mandate exceeded Congress' authority to regulate "inactivity" as commerce, but it nonetheless construed the "individual responsibility" payment as a tax on individuals who choose not to purchase health insurance. The Court ultimately ruled that Congress has the power under the Constitution's Tax and Spending Clause to require individuals to pay money to the federal government.

Prior to ACA, states were only required to provide Medicaid coverage to certain discrete categories – *i.e.,* children, pregnant women, families with dependent children, the elderly, and disabled – who met financial eligibility requirements. ACA expanded the mandatory coverage categories to include childless adults under age 65 with household incomes up to 133 percent FPL.

The Court found that Congress exceeded its constitutional spending authority by attempting to force states to accept additional conditions for participation in Medicaid, which essentially transforms the program retroactively by establishing a new category of eligible individuals (childless adults) and requires a new set of "essential health benefits." The Court reasoned that

the loss of all federal funding for Medicaid in states that fail to expand coverage under ACA went beyond "encouragement" and essentially represents a "gun to the head."

The practical implication of this ruling is that once a state elects to participate in ACA's Medicaid expansion, it must comply with all of ACA's related provisions. States enjoy discretion to make the decision, however, without fear of jeopardizing federal funding for their existing Medicaid programs. States that are politically hostile to ACA's Medicaid expansion or that fear it will not be financially sustainable over time as federal funding declines, now may elect not to participate. The result is likely to result in a hodge-podge of state expansions, with uninsured adults in some states receiving access to Medicaid, while others in states that opt out will not.

The Court's decision does clear the way for further implementation of various components of ACA and assures a degree of continuity in changes that began within months of its enactment in March 2010. Requirements for insurers to cover young adults up to age 26 on their parents' policies, to prohibit pre-existing conditions as a barrier to children's coverage, and to eliminate lifetime limits on coverage for children became effective in September 2010.

The Centers for Medicare and Medicaid Services (CMS) already has disbursed substantial funds for states to modernize their Medicaid income eligibility systems and to plan for the introduction of health insurance exchanges in 2014. CMS also launched numerous projects funded through the Center for Medicare and Medicaid Innovation (the "Innovation Center"), designed to strengthen the health care workforce, improve quality of care, integrate health care services to high-cost populations, and better coordinate care for dual-eligible beneficiaries. The Agency also has funded various types of payment reforms, including accountable care organizations and medical homes.

At the same time, much of ACA rested on the assumption of expanded coverage to millions of Americans as a result of the individual mandate and the Medicaid expansion. Those numbers now will be fewer than anticipated, while hospitals and other health care providers will continue to face a significant burden of uncompensated care in states that do not expand Medicaid coverage to low-income childless adults.

Informal agreements reached with key stakeholders also remain in place – including agreements accepted by hospitals, insurers, and the pharmaceutical industry – to absorb the costs of various payment cuts, fees, and taxes in order to finance coverage expansions. Along

with employer and individual penalties, these amounts will help fund subsidies for the purchase of insurance and enhanced federal payments to the states that choose to pursue Medicaid expansions.

These agreements, too, were premised on a large volume of newly-insured. They remain controversial and will be subject to legislative efforts by constituencies seeking to undo the "deals" and reduce industry stakeholders' liabilities (*e.g.,* repealing the medical device excise tax). At the same time, other advocates may continue to view them as targets for expansion (*e.g.,* imposing drug rebates under Medicare Part D).

At least for the present, hospitals will still have to absorb market basket cuts, productivity adjustments, and significant reductions in disproportionate share hospital (DSH) payments. These reductions are premised on a sizeable decrease in the uninsured population that, it was assumed, would accompany the Medicaid expansions and the subsidized purchase of insurance through state or federally-run health insurance exchanges. The level of coverage to be achieved is now less certain, however, and will depend in large part on states' responses to the now-optional Medicaid expansion. The success of education and outreach efforts may also play a key role in reducing the number of the uninsured. Accordingly, hospitals likely may seek to challenge the validity of the assumptions underlying these DSH reductions, and thus the reductions themselves, in the courts or through legislative initiatives.

Additionally, while the Court reviewed the broader constitutional challenge to ACA, other lawsuits challenging distinct provisions of the law were put on hold in lower federal courts. Those cases may now proceed, and other suits may be filed to target the constitutionality of pieces of the statute left standing, such as legal challenges to: the authority to pay low-income subsidies for coverage purchased through a federally-run health insurance exchange; the power of the Independent Payment Advisory Board (IPAB) to make spending and policy decisions without the consent of Congress; the ability to restrict Medicare payments to physician-owned hospitals; and the requirement that religious organizations provide their employees with free preventive services, including contraception, among other provisions.

Implementation delays appear all but certain. Many states deferred actions to plan for individual and small business health insurance exchanges pending the Court's decision. In addition, many states have yet to pass authorizing legislation for exchanges, develop Medicaid enrollment and income verification systems, or achieve consensus on state exchange design. Faced with these

realities, policy-makers may also be pressed to postpone the law's effective dates. This could reduce federal spending while giving Republicans a perceived political victory.

The remaining planning time for the statutorily-required January 1, 2014 onset of health insurance exchanges is now very short – and unless states act quickly, many will initially find themselves only able to participate in a federal exchange. Ironically, a federally-facilitated exchange is more likely to be required in politically "red" states that have delayed any action to date. The pace may accelerate quickly in other states. Kentucky Governor Steve Beshear, for example, announced recently that if the Supreme Court upholds ACA, he will immediately issue an executive order to implement a state-run health insurance exchange.

Beyond legal challenges, many practical considerations remain as obstacles to the successful implementation of ACA. A few examples include: limited resources and the absence of political will in many states to pursue the Medicaid optional expansion; funding constraints for staffing and information technology; conflicting policy goals and agency priorities (*e.g.*, antitrust concerns about market consolidation versus the need to ensure network adequacy); severe shortages in the health care workforce; patient demographics; and the untested concepts and inherent uncertainties involved in pilot projects and demonstrations, which require major investments with no guarantee of a return.

Further, in 2013 and 2014, state Medicaid programs will be required to reimburse primary care providers at rates comparable to Medicare and will receive 100 percent federal funding to cover the increased costs. This provision of ACA creates a new payment "cliff" similar to the looming Medicare physician payment cuts under the sustainable growth rate (SGR) formula. Unless individual states act to fill the gap in Medicaid payments – unlikely in most instances given their tight budgets – primary care providers will push hard for Congressional action to maintain the enhanced payment levels.

In the wake of the Court's decision, employers will focus intently on the likely Congressional response, forthcoming regulations, and unimplemented provisions of the law as they make significant decisions in anticipation of the upcoming open enrollment season. Clarification of the regulatory rules of the road is needed to facilitate timely decision-making regarding employee benefits and tax planning for the next year and beyond. Key areas in which federal guidance is lacking include large employers' responsibilities to offer affordable health coverage; minimum value standards for coverage; the definition of full-time employees and requirements for auto-

enrollment into default health plans; and the excise tax on insurers of employer-sponsored, high-value or "Cadillac" plans.

While the Court left most provisions of ACA intact, opponents in Congress are expected to continue to target unpopular and controversial provisions of the law for repeal or "defunding." To date, only modest changes to ACA have been enacted. Examples include: repeal of the Form 1099 filing requirement for purchases greater than $600; inclusion of Social Security benefits in Medicaid income eligibility calculations; increased recoupment of overpaid subsidies for health insurance; $5 billion in funding cuts to the Prevention and Public Health Fund; a $2.5 billion reduction in Medicaid disaster payments; a $2.2 billion decrease in budget authority for Consumer Owned and Operated Plans (CO-OPs); and a $10 million rescission of funds for the IPAB in Fiscal Year 2012.

The Republican-controlled House, with support from some Democratic Members, recently passed legislation to overturn the 2.3 percent medical device tax, to abolish the IPAB, a creation widely criticized by members of both political parties, and to repeal the Community Living Assistance Services and Supports (CLASS) Act.[2] In this election year, the Democratic-controlled Senate is unlikely to take up any of these House-passed bills, and the White House has already announced its opposition.

House Republican Leaders immediately promised to hold a vote to repeal any ACA provisions left standing by the Court. Republicans specifically identify a number of concerns in addition to the individual mandate, including: employer and state mandates; new and higher taxes; Medicare payment cuts; higher health costs; conscience protections; government control of the patient-doctor relationship; costs of the law; and more than 150 new boards, agencies and programs. Congressional Republicans are not expected to advance alternative health reform legislation before the elections, but prior proposals have included market-based insurance reforms that would expand coverage incrementally (*e.g.,* through high-risk and small business

[2] On October 14, 2011, Secretary Sebelius advised Congress that U.S. Department of Health & Human Services (HHS) could not identify a viable design to implement a financially sustainable, voluntary, and self-financed long-term insurance program under the CLASS provisions, so this portion of ACA will not be implemented regardless of the Court's ruling.

purchasing pools, tax credits or deductions to purchase insurance, association health plans, and other mechanisms to purchase insurance across state lines), along with more controversial proposals for tort reform, Medicaid block grants, and a Medicare premium support option.

Going forward, Republicans have many tools in their legislative toolkits that could potentially disrupt or derail ACA's successful implementation. Beyond efforts to repeal the law in its entirety, Republicans could seek to target particular initiatives (*e.g.,* by blocking appointments to the IPAB). Consideration of the annual appropriations bills will provide an opportunity to deny federal funding for key agencies and specific implementation efforts.[3] Depending on the outcome of the election, the budget reconciliation process could also provide a vehicle for the next Congress to target key provisions of ACA for repeal, including a range of taxes, industry fees, and employer penalties. Regardless of the elections' outcome, Republicans will likely seek to create new battlegrounds in state legislatures across the nation.

The Administration will continue to issue regulations and guidance called for under ACA at a rapid pace, while seeking to accommodate concerns and the desire for flexibility of states and providers. For example, CMS previously announced that it will give "provisional" certification to states' health insurance exchange plans, and the Agency already indicated it will allow states to use the benefit structure in plans with the largest enrollment of state employees to further define ten categories of essential health benefits required under ACA.

A flurry of activity is also underway to advance dual-eligible demonstrations and other health delivery system initiatives through the Innovation Center, but it will take at least a few years for those efforts to yield results that could translate into policy changes and demonstrable savings. States will become liable for greater Medicaid and exchange costs over time and face continued budgetary pressures in the near-term. In response, states may seek to further expand and accelerate their planned dual-eligible demonstrations, shift additional populations into Medicaid managed care, cut provider payments, and pressure drug manufacturers for increased rebates.

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[3] ACA is somewhat unusual in that it mandates appropriations, or requires the Secretary of HHS to transfer from the Medicare Part A and Part B Trust Fund, billions of dollars to support new or existing grant programs, and other activities.

While the Supreme Court's announcement leaves virtually all of ACA's provisions in place, many practical challenges and policy questions still cloud the outlook for ACA's implementation – notably including the states' responses. The Court's decision comes during a Congressional session marked by bitter partisanship, few accomplishments and as both parties gear up for their conventions and the November general election. With the Presidency and control of Congress and state governments in play, the outcome of federal and state elections will significantly impact the implementation process going forward, when newly-elected candidates will face obligations to fulfill their related campaign promises.

Looking ahead, policy-makers will remain intensely focused on reducing the federal deficit and reining in health care costs. Congressional leaders already signaled that serious consideration of broader tax and entitlement reforms is likely in the next Congress. Fraud and abuse remain particularly ripe targets, and the bar is already raised high for program compliance and enforcement. Congress likely will return after the elections for a lame duck session to consider replacements for looming sequestration cuts, as well as extensions of expiring tax and Medicare provisions that require offsetting reductions in spending. While Medicaid is exempted from automatic sequestration, it nevertheless remains a target for deficit reduction and longer-term savings, along with Medicare.

In this context, the interests of every stakeholder in the Medicare and Medicaid reimbursement streams will remain at significant risk in the aftermath of the Court's decision to uphold ACA.