The U.S. Supreme Court's ACA Decision

NATIONAL FEDERATION OF INDEPENDENT BUSINESS ET AL. v. SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL. No. 11-393 (June 28, 2012)


In a 5-4 decision, the Court (a) upheld the challenge to provisions of the Patient Protection and Affordable Care Act ("ACA") referred to as the individual mandate as a constitutional tax, but (b) limited the authority of Congress and the Department of Health and Human Services to penalize states that choose not to implement or later discontinue the ACA's Medicaid expansion. Below, we briefly address the two key holdings of the Court and assess the impact of the decision on the physician and provider community.

**Individual Mandate**

Chief Justice John Roberts, writing for the majority, concluded that the individual mandate operates as a lawful tax. This conclusion removes the central obstacle to implementation of the ACA's remaining insurance market reforms, slated to take effect in 2014-15. While some anticipated that the individual mandate would be upheld, few observers predicted that the Court would do so on the basis of the Taxing power. In fact, at oral argument and in the parties' written briefs, most of the discussion of the individual mandate's constitutionality focused on Congress' Commerce Clause and Necessary and Proper Clause powers.

Under the ACA, individuals that can afford insurance but fail to obtain insurance coverage are subject to "shared responsibility payments." While challengers argued that this individual mandate compels individuals to purchase health insurance, the Court concluded that the individual mandate instead operates as a tax. Chief Justice Roberts wrote that the
individual mandate functions as a tax instead of a penalty because the shared responsibility payments will generally be "far less than the price of insurance," will be imposed without consideration of individuals' knowledge or culpability, and will be collected "through the normal means of taxation."

Had the individual mandate been treated as a penalty designed to punish unlawful acts or omissions, it could have only been upheld as an exercise of Congress' Commerce Clause powers. A majority of the Court would not uphold the individual mandate under the Commerce Clause; The Chief Justice and the dissenting justices (Justices Scalia, Kennedy, Thomas, and Alito) concluded Congress' Commerce Clause powers cannot be used to compel individuals to purchase health insurance (or apparently broccoli as was the example presented to the Court at oral argument). However, with a majority concluding that the individual mandate operates as a tax, the Commerce Clause analysis is of little import, to the ultimate result, upholding the individual mandate and almost all of the rest of the Act, although it indicates that this iteration of the Court may be more willing than its predecessors to limit Congress' ability to regulate the economy.

Challengers had argued that even if the individual mandate is a tax, it is nonetheless unlawful as a "direct tax" that is not apportioned among the States, which is prohibited under the Constitution's grant of taxing authority to Congress. This contention failed to persuade a majority of justices. Chief Justice Roberts, joined by four justices, concluded that the shared responsibility payment does not fit within recognized categories of direct taxes: It is not a capitation because it only applies to individuals in "specific circumstances-earning a certain amount of income but not obtaining health insurance," and it is "not a tax on the ownership of land or personal property. Therefore, it is "not a direct tax that must be apportioned among the several States." The dissenting justices did not reach the apportionment issue, but strongly criticized the majority for failing to "demand more than fly-by-night briefing and argument before deciding a difficult constitutional question of first impression."

Finally, every justice agreed that the Court could resolve the merits of this challenge without waiting until individuals had paid shared responsibility payments. Normally, under the Anti-Injunction Act, an individual cannot challenge a tax until he or she has paid the tax. No shared responsibility payments will be collected until 2015, and the Fourth Circuit had concluded that the Anti-Injunction Act barred challenges to the individual mandate until that date. But the Supreme Court held that Congress, in declining to explicitly call the shared responsibility payment a tax, did not intend for it to be treated as a tax for purposes of the Anti-Injunction Act. The Court
noted, however, that while Congress' label of the shared responsibility payment as something other than a tax decided the issue for purposes of the Anti-Injunction Act, the Court would examine how the shared responsibility payment actually would operate for purposes of determining whether the individual mandate constituted an exercise of Congress' Taxing power.

By upholding the shared responsibility payment as a lawful tax, the Court ensures that the ACA will function as Congress intended by encouraging adequate risk pooling and discouraging "free loaders" who might otherwise forgo insurance until sick or injured. But, the Court's decision may prevent Congress from substantially increasing the amount of the shared responsibility payments in the future. Should Congress do so, it runs the risk of converting the payments from lawful taxes to unlawful penalties.

Justice Ginsburg, joined by Justices Breyer, Sotomayor, and Kagan, would have upheld the individual mandate and shared responsibility payments as both a lawful exercise of Congress' Commerce Clause powers and Taxing powers. Meanwhile, Justices Scalia, Kennedy, Thomas, and Alito would have held that the individual mandate and shared responsibility payments exceed the scope of Congress' Commerce Clause and taxing clause power and would have overturned the ACA in its entirety. The Court is thus clearly divided on the scope of Commerce Clause and Taxing powers. In the future, Congress need not clearly designate a tax as such in order to exercise its Taxing powers. But, when Congress attempts to exercise its Commerce Clause powers, the courts may have to wrestle with the distinction between permissible regulations of commercial activity and impermissible regulations of commercial inactivity.

Chief Justice Roberts concluded his opinion by reflecting on the proper balance between the elected and democratically accountable branches of government and the courts. In his words, "The Framers created a Federal Government of limited powers, and assigned to this Court the duty of enforcing those limits. The Court does so today. But the Court does not express any opinion on the wisdom of the Affordable Care Act. Under the Constitution, that judgment is reserved to the people."

**Limitation on the Enforcement of the Medicaid Expansion**

Twenty-six states challenged Congress' authority to expand Medicaid Eligibility on the ground that such expansion exceeded its authority under the Spending Clause: the "Federal Government may not compel the States to enact or administer a federal regulatory program." Under ACA, Medicaid
eligibility is expanded to cover all individuals under the age of 65 with incomes below 133% of the Federal Poverty Level ("FPL"). Currently, the mandatory Medicaid population excludes childless adults and includes only needy pregnant women, children, needy families, the blind, the elderly, and the disabled. The ACA expands benefits to provide to this population an essential health benefits package.

Under the ACA the federal government pays most of the cost of the expansion:

(A) 100 percent for calendar quarters in 2014, 2015, and 2016;

(B) 95 percent for calendar quarters in 2017;

(C) 94 percent for calendar quarters in 2018;

(D) 93 percent for calendar quarters in 2019; and

(E) 90 percent for calendar quarters in 2020 and each year thereafter.

Nonetheless, the States argued that the ability of the federal Medicaid agency to cancel all federal funding of a state Medicaid program, even the funding available to states before ACA, constitute unconstitutional undue influence under the Spending Clause in a dual sovereign system. The Court noted that the legitimacy of Congress' exercise of the Spending Clause "rests on whether the State voluntarily and knowingly accepts the terms of the contract." Premising receipt of prior Medicaid funding on participation in the Medicaid expansion would cross that line in the view of seven members of the Court. Consequently, the Court announced that any action to threaten the traditional Medicaid funding of the States, under 42 U.S.C section 1396c, founded on participation in the expansion would be unconstitutional. Justices Ginsburg and Sotomayor would have allowed Congress and the federal Medicaid agency to terminate all federal Medicaid funding to a state that chose not to participate in the Medicaid expansion.

The Impact of the Decision Limiting Enforcement of the Medicaid Expansion on Healthcare Providers and Patients

The limit on the ability of Congress and CMS to sanction states that do not participate in the expansion of Medicaid will have some impact on the total insured population and on the level of uncompensated care that providers
and physicians will continue to absorb. If a state elects not to engage the expansion, it appears that some persons left out of Medicaid still will be eligible to receive subsidies to purchase health insurance through the health insurance Exchanges created by the ACA, with more generous subsidies available for lower-income individuals.

The Medicaid expansion was intended to cover somewhere between 10 and 18 million (reports vary) Americans of the about 46 million who are uninsured now. The Premium Assistance Tax Credits ("PATC") and Cost-Sharing Reduction Payments ("CSRP") that apply to individuals who seek to purchase insurance through the Exchanges do not capture the traditional Medicaid eligible persons. But Section 1401 of the ACA adds Section 36B to the Internal Revenue Code ("IRC") and provides special treatment for a portion of the potential Medicaid expansion population with respect to such individuals' abilities to qualify for increased health insurance subsidies:

(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.-If a taxpayer's household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer's applicable percentage shall be 2 per cent.

(iii) INDEXING.-In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

Congress apparently contemplated some leakage from the Medicaid expansion and increased the subsidy for that population. But, even for this population, the help they can receive through traditional insurance purchased through an Exchange may be a poor substitute for Medicaid. Even the transaction costs of learning about these programs and signing up will be a barrier for eligible individuals. Also, it is unclear whether this additional cost under the subsidy will be more or less than the cost the federal government would have absorbed under the Medicaid expansion.

Ironically, absent amendments to the subsidy provisions, lawfully present aliens earning less than 100% of the FPL will be eligible for federal subsidies but (arguably) citizens earning 100% of the FPL or less and
living in states that do not expand Medicaid will not be eligible for the subsidies. Under IRC section 36B(c)(1)(B), "alien[s] lawfully present" in the U.S. and earning below 100% of the FPL will be treated as having a household income equal to 100% of the FPL for purposes of premium assistance tax credits and cost sharing reduction payments. From a policy perspective, this provision was included because these individuals are not eligible for Medicaid. But Congress apparently did not contemplate the absence of Medicaid coverage to persons with incomes at or below 100% of the FPL, including for example, childless adults (a large population in some states).

While unclear at this stage, the impact on the healthcare provider community as a result of the limitation on enforcement of the expansion may or may not be negligible. We say may in this context because we do not yet know the number of persons who are citizens with incomes at or below 100% of the FPL that do not qualify for Medicaid (absent the expansion), and who will not qualify for the PACT and CSRP. There also may be an upside for providers in those states that choose not to engage the Medicaid expansion because it is likely payments will be greater from the health plans that participate in the Exchanges than from the state Medicaid programs.

Whether any states will choose not to engage the Medicaid expansion is questionable. The schedule above shows the federal match diminishing over time, with the States' cost share rising from 5 percent in 2017 to 10 percent in 2020 and thereafter. According to the Court, the expansion will cost the federal government about $100 billion per year. That suggests that at worst, beginning in 2020, the States in the aggregate will absorb about $10 billion in costs per year for the expansion. While this is a substantial sum, will it cause a state opt out of the expansion after 2016? In light of the Court's limit on enforcing the expansion, that option is open but could be a problem politically for the then existing administration of many states. But even if this occurs, many of these individuals would revert to the Exchanges at that point and the cost would become essentially fully federal. Would the insurers lobby to prompt the States to do this so that they can cover this population? Perhaps that result is not particularly problematic and may result in increased payments to providers.

Finally, the only other payment issue related to limits on federal enforcement of the Medicaid expansion is how a limited expansion, and the movement of only some of those individuals to the Exchanges, will impact cuts on Medicaid and Medicare disproportionate share payments under Sections 2551 and 3133 of the ACA. Those cuts, and some of the
replacement payments for measured uncompensated care, are formula-driven by the increase and in some respects decrease in the insured population, defined as individuals covered by private and governmental programs, from a base period. The Court's limit on enforcement of the Medicaid expansion would appear to be neutral for the most part, except perhaps in instances when a state initially engages the expansion and then drops out. Some of this impact could be attenuated by how CMS defines key terms for this calculation. Such rulemaking has yet to be proposed.

Please contact John Hellow, Lloyd Bookman, or Jordan Keville in Los Angeles at 310.551.8111; Mark Reagan, Craig Cannizzo, Paul Deeringer or Katrina Pagonis, J.D., Ph.D. in San Francisco at 415.875.8500; Kitty Juniper in San Diego at 619.744.7300 or Robert Roth in Washington D.C. at 202.580.7700, with any questions.

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