Supreme Court Finds Affordable Care Act Constitutional: Now What?

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The U.S. Supreme Court voted yesterday to uphold the Patient Protection and Affordable Care Act ("ACA"), bringing an end to a long and hard-fought legal battle between the Obama Administration and a host of plaintiffs, including 26 states and the National Federation of Independent Business.

In a 5-4 decision, the Court held that the law's individual mandate to purchase health insurance is an unconstitutional exercise of Congress' Commerce Clause authority, but **is** a valid exercise of Congress' taxing power.

Chief Justice John Roberts, writing for the majority in a 193-page opinion, held that the punishment for not complying with the individual mandate was a tax because the law attaches no "negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS." It is within Congress' power to increase taxes on those who have a certain amount of income but choose to go without health insurance, Roberts wrote.

The Court did, however, strike down ACA's mandated Medicaid expansion. Congress sought to expand the program by at least 16 million people, but the Court held that Congress could not cut off funding for those states that refused to comply with the law's new eligibility rules.

The far-reaching implications of ACA will affect most facets of the healthcare industry, and every party to a healthcare transaction may be impacted, including the average citizen, employers, insurance companies, and health care providers.

Implications for the Individual

Most persons are familiar with the more publicized features of the healthcare law. For example, insurers cannot exclude anyone because of pre-existing medical conditions, and dependent children may remain on their parents' insurance plan until their 26th birthday. But the most important feature of the law for the average citizen is arguably the individual mandate.

The mandate will take effect in 2014, at which time all citizens must prove on their federal taxes that they have health insurance. Coverage may be through a private company or with a newly-created, state-based Health Benefit Exchange, through which individuals and small businesses with up to 100 employees can purchase qualified

coverage. Those who earn less than 400% of the federal poverty level and do not have employer-sponsored coverage will be eligible for federal assistance when purchasing insurance through the exchanges.

Individuals who don’t purchase health insurance will face a fine (now officially a tax). The tax will be the greater of approximately $700 per individual, $2,085 per family, or 2.5% of household income. The individual mandate exempts American Indians, people with religious objections, and those for whom the lowest cost exchange plan exceeds 8% of income.

For the Employer

The most significant change ACA will bring to employers is the requirement to provide health insurance coverage to employees, or else pay a fee. Specifically, the law assesses employers with 50 or more employees that do not offer health insurance a fine of $2,000 per employee, excluding the first 30 employees. Employers do not have to pay the fine for employees who earn in excess of 400% of the federal poverty level.

Employers who do offer health insurance may still face a fee if any of their employees opt out of the employer coverage in order to receive tax credits to purchase insurance through the exchanges. This fee is the lesser of $3,000 per employee who receives the tax credits or $2,000 per employee. Beginning in 2014, some small business (fewer than 25 employees) may receive a subsidy of up to 50% of the costs of providing coverage.

For the Insurer

Under ACA, the federal government will take an even more active role in the regulation of insurance business practices. In addition to the pre-existing benefits rule, the law places a cap on out-of-pocket spending limits for the insured and prohibits insurance companies from rescinding coverage or using cost-sharing for preventative services.

The law establishes four variables that insurance companies may use to formulate the cost of a plan: 1) age; 2) geographic area; 3) tobacco use; and 4) family size. Any consideration beyond these four factors is prohibited. ACA also allows the federal government to more closely regulate how insurance companies communicate plan information to customers.

For the Provider

Much of the ACA is aimed at lowering the costs of health care while improving its quality, and as a result, many provisions in the law pertain to providers. These laws have implications for most aspects of a provider's operation: provision of care, reimbursement, tracking costs, reporting information, tax status, and so on. Below is a sample of the implications of the ACA for providers:

- Accountable Care Organizations (ACO) – The reform law creates ACOs, which are groups of health care providers that contract with each other to collaborate and share in Medicare savings that come from improvements in quality and efficiency.

- Electronic Health Record (EHR) program – The law implements the EHR program to provide more than $3.1 billion to providers in incentive payments to adopt EHR technology and use it in a "meaningful way."

- Increased transparency – ACA adds new requirements for non-profit hospitals to maintain 501(c)(3) status. Among the requirements are mandatory community health needs assessments and financial assistance policies.

- Physician Payment Sunshine Act – Requires drug, medical device, and other manufacturers to annually report payments made to physicians and teaching hospitals in excess of $10 for consulting, research, speaking, entertainment, travel, or food.

- Bundled payment program – ACA created various payment programs to improve the inefficiencies of the current fee-for-service payment model. Under the bundled payment program, a provider receives a single payment for an episode of care and is reimbursed for quality, not quantity, of care.

- Overpayment rules – Requires hospitals to report and return an overpayment within 60 days of its identification. Failure to do so subjects a provider to liability under the Federal False Claims Act.