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Client Alert

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SCOTUS Ruling on the Affordable Care Act: *Individual Mandate Upheld as a Tax, Limits Imposed on Medicaid Expansion*

On June 28, 2012, in the most highly anticipated ruling of this Term, the U.S. Supreme Court issued its opinion regarding the constitutionality of the Patient Protection and Affordable Care Act of 2010 (the ACA) in National Federation of Independent Business v. Sebelius (No. 11-393) (*see* **link to opinion**). By a 5-4 vote, the Court upheld the constitutionality of the "individual mandate"—doing so pursuant to Congress's power to impose taxes, while a different 5-4 majority rejected the government's position that the mandate is a valid exercise of Congress's Commerce Clause power. The Court also concluded that the ACA's expansion of individuals eligible for benefits under the Medicaid program is constitutional, but limited the penalties that the federal government may impose on states for failure to comply with such an expansion, thereby effectively providing states with an option to expand Medicaid eligibility or maintain the status quo. Other than this limitation to the Medicaid expansion provision, the Court's decision leaves the ACA valid and effective.

As such, the healthcare and life sciences industries are relatively unaffected by the Court's decision. Efforts to comply with the provisions of the ACA will continue with more direction and urgency now that the constitutionality of the ACA has been largely established. Also, the Obama Administration will likely accelerate ACA implementation efforts given the impending November election. In one area, however, the decision does create an element of uncertainty regarding whether all states will opt to expand eligibility for Medicaid. If not, large segments of the low-income population will remain uninsured in 2014—which is a departure from the one of the primary goals of the ACA—the access to affordable health insurance by most Americans. Developments in this area should be closely monitored at the state level. Depending upon state reactions to the watered-down Medicaid expansion provisions, life sciences manufacturers may need to adjust expectations regarding market access to their products by low-income individuals, as well as re-evaluate whether existing or modified patient assistance programs will be effective to meet demands of the uninsured and under-insured. Similarly, health care providers and suppliers may continue to be faced with uninsured low-income patients and the problems of uncompensated care, despite an overall expansion in coverage among the American population through the state-run health insurance exchanges. Thus,

the full economic intent of the statute for providers and suppliers may not be fully realized and challenges may persist, including in areas such as EMTALA compliance.

Individual Mandate

In an opinion authored by Chief Justice Roberts and joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan, the Court upheld the individual mandate, declaring that it was a valid exercise of Congress's taxing power under the Taxing and Spending Clause. The individual mandate requires most Americans to maintain "minimum essential" health insurance coverage starting in 2014. 26 U.S.C. § 5000A. Unless otherwise exempt, those who do not comply with the mandate would be required to pay a "penalty" to the U.S. Government in the form of a "[s]hared responsibility payment" that would be paid with the individual's income tax and "assessed and collected in the same manner" as a tax penalty by the Internal Revenue Service.

§§ 5000A(b)(1), (c), (g)(1). The Court observed that the shared responsibility payment resembled a tax, in that it was paid into the Treasury by taxpayers when they file their tax returns, determined based on factors such as taxable income, codified in the Internal Revenue Code, enforced by the Internal Revenue Service, and assessed and collected in the same manner as taxes. The Court did not find the fact that Congress referred to the payment as a "penalty" instead of a "tax" to be dispositive because, among other reasons, Congress is not required to name the enumerated constitutional power under which it acts. Also, the ACA did not attach negative consequences to failing to buy health insurance beyond requiring the payment. The Court further determined that the shared responsibility payment was not a direct tax that must be apportioned to the states.

The Court split along different lines with regard to whether the individual mandate was a valid exercise of Congress's power under the Commerce Clause, which was the government's primary argument in defense of the individual mandate. Chief Justice Roberts authored his own opinion in which he wrote that the Commerce Clause authorizes Congress to regulate commercial *activity*, and permitting Congress to regulate commercial *inactivity* (*i.e.*, failure to purchase health insurance) would "open a new and potentially vast domain to congressional authority" that would bring "countless decisions an individual could potentially make within the scope of federal regulation, and . . . empower Congress to make those decisions for him." Op. of Roberts, C.J., at 21. Chief Justice Roberts further held that the individual mandate was not a valid exercise of Congress's power under the Necessary and Proper Clause because it is not "derivative of, and in service to, a granted power" (*i.e.*, the Commerce Clause power), and instead, improperly expands Congress's power by "draw[ing] within its regulatory scope those who otherwise would be outside of it." *Id.* at 29–30.

Justices Ginsburg, Breyer, Sotomayor, and Kagan disagreed with the Chief Justice's position on the Commerce Clause power. In an opinion written by Justice Ginsburg, the four Justices concluded that Congress had a rational basis for concluding that the uninsured, as a class, substantially affect interstate commerce, which makes the decision to forgo insurance "an economic decision" that is "hardly inconsequential or equivalent to doing nothing." Op. of Ginsburg, J., at 16. The individual mandate bore a reasonable connection to Congress's goal of protecting the healthcare market from the uninsured by creating an incentive for both the sick and healthy to seek insurance. As such, these Justices concluded that the individual mandate "addresses a specific interstate problem in a practical, experience-informed manner" as required by Commerce Clause precedent. *Id.* at 18. They reasoned that because everyone will consume healthcare

products and services at some point and be active in the market, the individual mandate and related provisions regulate commercial activity and should be upheld as a valid exercise of Congress's Commerce Clause power.

Justices Scalia, Kennedy, Thomas, and Alito dissented in a joint opinion that found the individual mandate to be an invalid exercise of Congress's powers under the Commerce Clause and Necessary and Proper Clause and that the mandate was not a tax and thus not justified by the Taxing and Spending Clause. The Justices agreed with Chief Justice Roberts that the individual mandate is not a proper exercise of Congress's Commerce Power because it does "not apply only to persons who purchase all, or most, or even any, of the health care services or goods that the mandated insurance covers" and primarily targets non-participants in the market. These four Justices disagreed with the Chief Justice's position that the shared responsibility payment was a valid exercise of Congress's taxing power, because Congress clearly enacted a mandate that individuals maintain minimum essential coverage, enforced by a penalty, and a payment could not be both a penalty and a tax.

Medicaid Expansion

The Court also considered the issue of whether the law's expansion of Medicaid eligibility was an unconstitutional federal infringement on state legislative authority—specifically, whether Congress can require the states to comply with the law's new requirements for eligibility for Medicaid or risk losing all of their funding for Medicaid.

Medicaid is a joint federal and state program that provides health care for pregnant women, children, needy families, the blind, elderly, and disabled. The program is established and operated through a complex set of federal and state laws. Federal law creates certain eligibility and coverage requirements; if a state Medicaid program meets those requirements, the state receives federal funds for a percentage of the state's costs. Prior to the ACA, there was some state flexibility as to Medicaid eligibility requirements. Certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled—were required to be covered (the "must cover population"), and additional categories of individuals could receive Medicaid benefits at the state's discretion. See 42 U.S.C. § 1396a(a)(10). Section 2001 of the ACA substantially expands the "must cover population" by establishing a new category of Medicaid eligibility effective January 1, 2014—all persons with income at or below 133% of the federal poverty level (but 5% of an individual's income is disregarded, effectively raising the limit to 138% of the federal poverty level) who are not otherwise eligible for Medicaid or Medicare. § 1396a(a)(10)(A)(i)(VIII). Concurrently, the law increases federal funding to cover the states' costs in expanding Medicaid coverage through 2019. § 1396d(y)(1). However, if a state does not comply with the ACA's new coverage requirements, it may lose not only the federal funding for those requirements, but all of its federal Medicaid funds. § 1396c.

The Court's decision on this issue of Medicaid expansion was complex and divided among several opinions. Ultimately the Court ruled that it would be unconstitutional for the federal government to withhold all Medicaid funds for non-compliance with the Medicaid expansion provisions of the ACA—*i.e.*, states that do not comply with the additional requirements imposed by the ACA can only lose new Medicaid funding from the federal government, and not all of their federal funding for Medicaid, as the law originally provided.

Seven Justices (Chief Justice Roberts and Justices Scalia, Kennedy, Thomas, Breyer, Alito, and Kagan) found aspects of the Medicaid expansion unconstitutional, but five Justices (Chief Justice Roberts and Justices Ginsburg, Breyer,

Sotomayor, and Kagan) opined that only the provision allowing the federal government to withhold all Medicaid funding for non-compliance with the expansion program should be invalidated.

Chief Justice Roberts, Justice Breyer and Justice Kagan took the position that depriving a state of all of its Medicaid funding for refusing to agree to the new expansion would exceed Congress's power under the Spending Clause, and that if states refuse the Medicaid expansion, their other federal funding should not be compromised. They concluded that, although Congress may attach conditions to federal funds, it may not coerce states into accepting those conditions. Here, revoking all federal funding for a state's Medicaid program on the grounds that it disagreed with one condition of the funding—*i.e.*, expansion of eligibility requirements—would be coercive.

Justices Scalia, Kennedy, Thomas, and Alito agreed that withholding all federal Medicaid dollars for non-compliance with the program was unconstitutional, but would have held that the entire expansion program should be invalidated as a result, so that even states who chose to participate could not. Justices Ginsburg and Sotomayor viewed the entire Medicaid expansion program as constitutional, even the provision that threatened to cut off all funding unless states agreed to the expansion. Their votes created a majority of five Justices for the proposition that the overall expansion was constitutional, and that states could choose to participate in the expansion and would have to comply with the expansion conditions if they did.

Ultimately, the plurality held that the provision of the statute that authorized the Government to revoke all Medicaid funding for non-compliance with Medicaid expansion was unconstitutional. The result is that states can choose to participate in the expansion and must comply with the conditions attached to the new expansion funds if they accept those new funds, but states can also choose to continue to participate in the status quo, unexpanded version of the Medicaid program. Specifically, the plurality opinion stated that "nothing in our opinion precludes Congress from offering funds under the ACA to expand the availability of healthcare . . . What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding." Op. of Roberts, C.J., at 55.

The expansion of the class of individuals eligible for Medicaid benefits to all individuals with incomes up to 138% of the federal poverty level will particularly impact states in which Medicaid coverage was provided only to persons with much lower income thresholds (in some cases as low as 17 or 24% of the federal poverty level) prior to the ACA. States now have the option to serve this expanded Medicaid population on January 1, 2014, although the law permitted states to begin as early as April 1, 2010, and some states have already elected to do so (*e.g.*, Connecticut). As a practical matter, if states decline to implement the Medicaid expansion provisions, they will lose billions in additional federal funding that would provide health insurance coverage for some of their poorest residents who would otherwise remain uninsured. Nevertheless, if states exercise their option to forgo this funding and continue to operate their Medicaid programs under the status quo, a significant portion of their low-income populations could remain without health insurance, as they likely would not have the resources to participate in the health insurance exchanges or otherwise obtain health insurance, notwithstanding the individual mandate.