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Prescriptions for Excellence in HEALTH CARE

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The Supreme Court and Health Reform: A Practical Perspective

By Howard A. Burde, Esq.

On June 28, 2012, the US Supreme Court issued its holding in the initial challenges to the constitutionality of the Patient Protection and Affordable Care Act (“ACA”) in the case of *National Federation of Independent Business (NFIB) et al v. Sebelius* (Slip Opinion of Case 11-393 on certiorari to the Supreme Court.) This decision will dramatically impact both the future of the nation’s health and the nature of relationships for US health care programs.

The 900-page ACA legislation (or “Obamacare” as it is known, derisively or colloquially depending upon the user’s political perspective) promised to extend universal health insurance coverage to all Americans and was touted as the long-awaited health reform to cure manifest problems with cost, access, and perverse incentives in the health care system. In reality, it was and is far less. In fairness, it was and is a consequential attempt to extend health insurance coverage to a large number of adults formerly not covered by insurance, either by choice or circumstance. However, the ACA provides little in the way of systemic, structural, or payment reform. Thus, the ACA is about coverage, not reform. The purpose of this article is to describe the components of the ACA at issue in the *NFIB v. Sibelius*, and to discuss

the implications of the decision on the ACA itself, state and federal governments, consumers, employers, providers, and payers.

Background

The ACA attempts to increase access to health insurance coverage while expanding federal and private health insurance market requirements, and requires the creation of health insurance exchanges (HIEs) to provide individuals and small employers with access to insurance. Among other provisions, ACA increases access to health insurance coverage by: (1) expanding Medicaid eligibility by mandating that individuals obtain health coverage and that employers provide it, (2) extending funding for the Children’s Health Insurance Program (CHIP), and (3) subsidizing private insurance premiums and cost sharing for certain lower-income individuals enrolled in exchange plans. These costs are projected to be offset by increased taxes and other revenues and reduced Medicare and Medicaid spending. The law also includes measures to collect information and to explore new ways to enhance delivery and quality of care.

The major expansion and reform provisions in ACA take effect in 2014. State Medicaid programs will

be required to expand coverage to all eligible non-pregnant, non-elderly legal residents with incomes up to 133% of the federal poverty level (FPL). The actual percentage works out to be 138% because the first 5% of income is disregarded for Medicaid eligibility determinations. The federal government will initially cover all the costs for this group, with the federal matching percentage phased down to 90% of the costs by 2020. The law requires states to maintain the current CHIP structure through fiscal year (FY) 2019, and provides federal CHIP appropriations through FY2015, thus extending CHIP funding by 2 years.

States are incentivized to establish HIEs that provide access to private health insurance plans with standardized benefit and cost-sharing packages for eligible individuals and small employers. In 2017, states may allow larger employers to purchase health insurance through the exchanges, but are not required to do so. The Secretary of Health and Human Services (HHS) is empowered to establish HIEs in states that do not create their own approved exchange.

Premium credits and cost-sharing subsidies will be available to individuals who enroll in HIE plans,

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provided their income is generally above 100% and no more than 400% of the FPL and they meet other requirements. Also beginning in 2014, most individuals will be required to have health insurance or pay a tax penalty (the “individual mandate”). Employers with more than 50 employees that do not offer health insurance may be subject to penalties. Such employers that do not meet the law’s requirement by offering qualified health insurance products, or whose full-time workers enroll in HIE plans and receive premium subsidies, will pay a penalty.

ACA’s federal health insurance requirements are further expanded in 2014, with no annual dollar limits permitted on essential health benefits and no exclusions permitted for preexisting conditions or the patient’s age. Plans offered within HIEs and certain other plans also must meet criteria of essential benefit standards (eg, covering emergency services, hospital care, physician services, preventive services, prescription drugs, and mental health and substance use disorder services). Premiums may vary by limited amounts based on age (3:1), family size, geographic area, and tobacco use (1.5:1). Plans must sell and renew policies to all individuals and may not discriminate based on health status.

Employers face additional – and costly – new requirements such as new increases in benefits and premium costs, and new taxes on premiums passed through to employers. Moreover, the ACA contains a number of new “soft costs” that are rarely discussed in the public arena but which add significantly to the employer burden regardless of the insurance changes (eg, withholding changes, mandates for reporting the value of health coverage, uniform summary of benefits and coverage, summaries of material modifications, auto-enrollment, new taxes on high earners, new taxes on high-benefit plans).

(Note: The material in the foregoing section is derived from the language of the ACA and from Congressional Research Services reports, most notably *PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges* [Chaikind H, et al. CRS March 2, 2011].)

Summary of the Supreme Court’s Decision in *NFIB v. Sebelius*

The Supreme Court considered 4 questions:

1. Does the Anti-Injunction Act preclude consideration of the mandate as a tax prior to 2014?
2. Is it constitutional for Congress to mandate that all individuals purchase or maintain health coverage?
3. If the mandate were unconstitutional, would it be severable from the remainder of the ACA, or would the entire Act be unconstitutional?
4. Is the Medicaid expansion under the ACA constitutional?

Initially, the Supreme Court held that the Anti-Injunction Act does not preclude consideration of the mandate as a tax because Congress called the mandate a penalty.

Having satisfied the threshold question, the Supreme Court decided that the individual mandate was unconstitutional under Congress’ Commerce Clause powers, but that it could be read as a tax and therefore was constitutional under Congress’s power to tax and spend. This is the most controversial component of the decision. Indeed, only Chief Justice Roberts held this opinion. Four Justices agreed that the individual mandate was unconstitutional under the Commerce Clause (Kennedy, Scalia, Alito, and Thomas), making a majority for that part of the Chief Justice’s

decision. Even though they believe it is constitutional under the Commerce Clause, the 4 other Justices (Ginsberg, Breyer, Kagan, and Sotomayor) agreed to uphold the individual mandate as a tax, making a majority opinion to uphold the individual mandate. Because the individual mandate was ruled constitutional, the severability question was moot.

Finally, the court held that Congress could not condition a state’s receipt of funds for an existing program or the expansion of that program or a new program. Therefore, the Medicaid expansion to new populations was ruled to be unconstitutional if mandatory for states. States may opt to expand, but cannot be forced to do so.

What the Supreme Court’s Decision Means

The Individual Mandate

To understand the Court’s decision, it is helpful to understand the underlying provision of the Constitution. The opening paragraph of Article I, Section 8, which provides the powers of Congress, states that, “Congress shall have the power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States.” Several additional clauses “enumerate” the powers of Congress to which the opening paragraph applies, and among these enumerated powers is the power under Article I, Section 8, Clause 3, to “regulate commerce with foreign nations and among the several states and with Indian tribes.” This is known as the “Commerce Clause.”

In defending the mandate, Congress and the Obama administration asserted that the Commerce Clause was plenary and without limitation because every act or non-act would impact commerce. Indeed, the history of the Supreme Court Commerce Clause jurisprudence since the New

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Deal is one of steady expansion of Congress' authority to regulate under the Commerce Clause. Chief Justice Roberts noted that "the power of Congress over interstate commerce is not confined to the regulation of commerce among the states but extends to activities that 'have a substantial effect on interstate commerce.'"

The Chief Justice further noted that Congress's power is "not limited to the regulation of an activity that by itself substantially affects interstate commerce, but also extends to activities that do so only when aggregated with the activities of others." "But," the Chief Justice noted, "Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product."

The court held that the power to regulate commerce "presupposes the existence of commercial activity to be regulated." There must be actual activity and Congress does not have the authority to compel activity to then regulate. Moreover, the Chief Justice held that Congress cannot regulate individuals because they are not engaged in an activity, or as he stated, "doing nothing." "Every day individuals do not do an infinite number of things" and "Congress is not empowered to regulate that absence of activity or to mandate activity under the Commerce Clause."

By contrast, Congress' power to lay and collect taxes is considered plenary. It is accepted jurisprudence that Congress' power to tax is virtually unlimited constitutionally, but is generally limited politically. The Chief Justice notes that the ACA does not describe the penalty for not having health coverage as a tax. Indeed, central to the political debate leading to passage of the law was the insistence of Congress and the President that the law did not raise taxes, but that the mandate was a "shared responsibility payment." The fear, of course, was that if the

mandate were considered a tax, it would have been more difficult to get the votes to pass the bill.

On July 24, 2012, the Congressional Budget Office announced that the decision itself changed the tax calculus to add \$4 billion in new taxes on businesses and \$1.5 billion in new taxes for individuals. In fact, ACA raises over \$1 trillion in taxes, inclusive of the mandate being a tax, and diverts over \$500 billion from the Medicare program.

Ultimately, this part of the decision means that the mandate tax is now subject to a simple calculus for individuals. The question becomes one of whether it is more cost-effective to obtain coverage in advance or to risk paying the penalty and obtain the coverage only when needed. Because of the guaranteed issue provisions of the ACA, an individual can obtain coverage at any time. Without an enforceable law, there is only a tax to compel an individual to obtain coverage prior to an illness.

In a broader sense, the holding means that future expansions of federal authority likely would be justified as constitutional under the taxing and spending power, a higher bar to reach politically.

Medicaid Expansion

The Supreme Court also held that Congress could not mandate state expansion of the Medicaid program to new populations. Recall that half of the anticipated additional coverage, approximately 16 million lives, would have been through the Medicaid program. Given the problems with the Medicaid program as currently structured, 27 states representing approximately 40% of the anticipated new lives challenged the expansion. Although politics

may have played some part in the challenge, the Medicaid programs in most states are problematic from both administrative and budget perspectives. Even with a federal promise to pay for the increase of nearly all of the Medicaid expansion in the short term, adding 16 million more lives to the program was and is not considered practical for the governors of those states.

The Supreme Court's decision validated the challenge, reviving a state's ability to determine whether or not to participate in a federally funded program. To date, 7 states with 20% of the anticipated new lives to be covered have already opted out and another 9 are considered likely to do so. Two reasons predominate. First, the federal promise of full funding is ephemeral. Once an entitlement is in place it cannot be withdrawn without a huge political and legal battle. If the federal money were to be reduced, the states would be stuck with the bill and forced to either generate revenue through taxes or reduce other programs (eg, infrastructure, transportation, education) to pay for the federal mandate. State budgets are littered with unfunded or partially funded federally mandated programs. Adding another at a time when state budgets are already stressed makes no fiscal sense. Second, the limited budget reduction proposals from the Obama administration already call for a reduction of federal financial participation for the Medicaid expansion and for CHIP participation. Even though the Obama administration has not passed a budget for 3 fiscal years, it has already signaled to the states that the federal matching funds are at risk. Under such circumstances, it can be argued that implementation of the Medicaid expansion is political, while declining to do so is pragmatic.

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The Supreme Court's decision on the Medicaid expansion has further implications for the relationship between the federal and state governments. Programs such as nutrition, education, transportation, aging, and Medicaid are administered by states under formulas that include federal financial participation. The states must submit extensive "State Plans" for federal approval in order to draw down the federal funds. The states also file for waivers from federal requirements in order to run the programs in more effective ways. By limiting the federal leverage over states, the Supreme Court has created the opportunity for states to seek federal funds without significant bureaucratic conditions and with dramatically new structures.

The states argue that, being closer to the delivery of services, they know how to best deploy the resources without a layer of bureaucratic oversight. Indeed, there is no evidence that state bureaucrats are any less educated, dedicated, or able than federal ones. State bureaucrats simply work for less money in less exciting places. Effectively, the Court's decision creates the conditions for a new balance of federal and state authority with respect to federally funded programs. Note that several states are in the process of structuring alternatives to the Medicaid expansion for federal consideration. These alternatives may include revised benefit structures for both the new and existing components of the Medicaid population, such as the expansion of existing but less expensive programs like SCHIP, mini-med or catastrophic programs, or yet undetermined choices. This leads to issues of the flexibility of the ACA language to permit alternative structures and the willingness of the Department of HHS to grant waivers for

restructuring. Ultimately, the ability to offer alternatives is a positive opportunity to reach toward universal coverage without undermining state fiscal structures.

Impact on Consumers and Employers

The net impact of the Supreme Court decision on consumers is to make the individual mandate less compelling. Because the tax is both low and not subject to enforcement, there is little to compel individuals to purchase insurance before they need it. The annual tax for not having minimum essential coverage will be the *greater of* a flat dollar amount per individual *or* a percentage of the individual's taxable income. For any dependent younger than age 18, the penalty is one half of the individual amount. The flat dollar amount per individual is \$95 in 2014; \$325 in 2015, and \$695 in 2016. After 2016, the flat dollar amount is indexed to inflation. The flat dollar penalty is capped at 300% of the flat dollar amount. The percentage of taxable income is an amount equal to a percentage of a household's income (as defined by the Act) that is in excess of the tax filing threshold (phased in at 1% in 2014; 2% in 2015; 2.5% in 2016). The tax will be reflected as a federal tax liability on income tax returns and is enforced by the Treasury. Individuals who fail to pay the penalty will not be subject to criminal penalties, liens, or levies.

The essential benefit packages mandated by the ACA are very rich and include the costs associated with taxes on medical devices, on premiums, and on executive policies. So, individuals have a choice: They can purchase a rich benefit package with associated taxes from day 1, or risk paying a small tax and either purchase the insurance as they need it or purchase less expensive but adequate coverage outside the HIEs.

If an average individual policy is \$500 per month, skipping even 1 month makes economic sense. Because preexisting conditions cannot be used to deny coverage, an individual can wait until he or she is diagnosed with an illness. Other than to cover a potential accident that requires emergency room care, it does not make economic sense to purchase coverage. Even then, other insurance (eg, automobile, homeowners) might cover many of the potential accidents that would require emergency room care. Of course there are also strong reasons to obtain health insurance - in addition to satisfying the tax mandate, qualified coverage provides both peace of mind and rich benefits that help avoid preventable conditions and maintain health status.

It is worth noting that under the Medicare Part D benefit, those who decline to obtain coverage until they need it pay a surcharge, making it less economically beneficial to wait. This disincentive to wait combined with the fact that the eligible population is elderly and more likely to require prescription drugs on a regular basis has resulted in close to universal adoption and far lower than anticipated costs.

For employers, the economics are similar. The tax incentive applies to firms with more than 50 employees. Companies that do not offer health insurance and have at least 1 employee receiving insurance subsidies must pay a tax of \$2000 per employee not covered by insurance (excluding the first 30). For example, a firm adding a 51st employee would pay \$42,000 in new annual taxes plus an additional \$2000. Effectively, a company must view the new employee as worth more than \$42,000 in additional net profit (over the amount needed to justify the new employee in the first place) or the cost of providing health coverage to all employees, a massive disincentive for small businesses.

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Employers are not required to pay an assessment for employees who work less than 30 hours per week or employees hired for less than 120 days, seasonal employees, or retail workers hired exclusively during the holiday season. Taken to extremes, the employer-related mandates may lead to a system wherein people are employed by smaller employers or are employed on a part-time rather than full-time basis. Current employees or distinct components of businesses would be spun off into smaller companies or treated as independent contractors.

Large employers will need to make a slightly different calculation - determine the per-employee cost implications of providing health coverage and compare that cost to the cost of dropping the plan, paying the penalty, and reimbursing the employee for his or her employee mandate fee. Employers with more than 200 employees must automatically enroll all full-time employees as soon as they are eligible. The Supreme Court did not change this fundamental calculation but, by upholding the law, it forced companies to focus on the decision of whether or not, or how, to provide health coverage for employees. Because the first year of the Employer Mandate is 2014, the decision must be made in time for a benefits selection process in the fall of 2013.

All larger employers must report, but not tax, the cost of providing coverage on the W-2 forms of employees. More highly compensated employees are subject to additional Medicare payroll taxes of 3.8%. The new portion of the payroll tax will be devoted to ACA implementation. Smaller employers are entitled to grants and other incentives to provide care and will be eligible to obtain coverage through the state HIEs.

Payers and Providers

Payer community support for the ACA was based on an

understanding that the individual mandate would provide millions of new lives to cover; therefore, the mandatory essential benefit packages, medical loss ratio, premium taxes, guaranteed issue, and prohibition on preexisting conditions and on annual and lifetime benefits would be less pressing. Nothing in the law prohibits health plans from developing actuarially sound premiums to cover those costs, and nothing in the law actually limits costs. Frankly, health plans make money on each life and the higher the premium, the higher the profit. If a problem exists, it is with those individuals who obtain coverage only when they need it - and therein lies the rub of the Supreme Court opinion for payers. Because the decision makes it more likely that individuals will not obtain coverage until they need it, health plans will be unable to anticipate reserves for such individuals, adding uncertainty to the premium calculation. And fewer individuals obtaining coverage means less profit.

Because universal coverage was the incentive for hospitals to accept cuts in Medicare and Medicaid reimbursement, hospitals will suffer. The cuts include a 2% sequestration across the board; reductions in market basket updates for hospital care; decreases in imaging reimbursement; penalties for "potentially avoidable readmissions"; Disproportionate Share hospital reimbursement cuts; value-based purchasing for cardiac, surgical, and pneumonia services; hospital-acquired condition penalties; and the bundling of post-acute care services.

To the extent that states decide not to expand Medicaid, and individual

and employer mandates do not lead to anticipated increases in covered lives, the Supreme Court decision likely will have an adverse impact on hospitals. The reduction in anticipated covered lives and the willingness of Congress and the Department of HHS to reconsider the reductions will determine the extent of the adversity.

Conclusion

Although the public and media focus on the Supreme Court's *NFIB v. Sebelius* decision has been on determining winners and losers, a far more interesting dynamic is apparent. Inside Washington, DC, the bill's proponents and opponents remain unchanged. Outside the "Beltway," the states, businesses, and individuals dealing with the ACA are focused less on the politics and more on the financial, legal, and administrative implications. The ACA is an ambitious piece of legislation that covers a great range of health care issues. Its attempt to reach near universal coverage is a goal to which there is almost no opposition, yet the means to achieve it are incredibly burdensome. The wisdom of the Supreme Court's decision is that it creates the atmosphere for states to develop more creative approaches and forces the issue with respect to individuals obtaining coverage. However unintended, the decision is spurring a reconsideration of the means to achieve universal coverage.

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