As described in the Author’s Note that follows the book’s Preface, various individuals, organizations, and states filed a series of legal challenges to the Affordable Care Act (ACA) following its passage by Congress. At the time the book went to press, those challenges were pending in multiple federal courts across the country. I am providing this web resource for readers to use as a supplement to the book itself, in order to identify those sections of the book affected by the Court’s decision.

Seven different Circuit Courts of Appeal heard various cases involving ACA that had been appealed from District Courts. In March 2012 the Supreme Court held three days of hearings, each day focusing on different aspects of the legal challenge to ACA. There were four central questions the Court considered:

1) Do court challenges to ACA violate the federal Anti-Injunction Act?
2) Does Congress have the authority under the Constitution to establish and enforce the individual mandate for the acquisition of health insurance coverage?
3) Is the Medicaid expansion under ACA overly coercive, in that it would penalize states inappropriately for electing not to participate?
4) If the Supreme Court determines that some portion of ACA is unconstitutional, does that finding invalidate the entire ACA?

On June 28, the final day of its 2011-12 term, the Supreme Court released its opinion, referred to as *National Federation of Independent Business v. Sebelius*. The full text of the Court’s opinion is available at [http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf](http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf).
In its decision, the Court left ACA largely intact, altering only one aspect of it: the federal government’s authority to withhold all Medicaid funding from states that elect not to participate in the expanded Medicaid eligibility authorized by ACA.

Below, I describe how the Court addressed each of the four central questions, and then provide a description of those sections of the book that need to be amended as a consequence of the Court’s action.

1) **Do court challenges to ACA violate the federal Anti-Injunction Act (AIA)?**

   AIA is an existing law that prevents courts from hearing legal challenges to new taxes until after those taxes have actually been levied. By a unanimous vote of all nine justices, the Court dismissed this challenge to ACA in the following words:

   “…Congress did not intend the payment to be treated as a ‘tax’ for purposes of the Anti-Injunction Act. The Affordable Care Act describes the payment as a ‘penalty,’ not a ‘tax.’ That label cannot control whether the payment is a tax for purposes of the Constitution, but it does determine the application of the Anti-Injunction Act. The Anti-Injunction Act therefore does not bar this suit.” (p. 2)

   The Court’s reasoning is very interesting, in light of its ruling on the following question.

2) **Does Congress have the authority under the Constitution to establish and enforce the individual mandate for the acquisition of health insurance coverage established by ACA?**

   The short answer the Court provided is, Yes, Congress has the authority to apply the individual mandate. The longer answer is somewhat more complex.

   Article I, Section 8 of the U.S. Constitution states:
“The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States;… To regulate Commerce with foreign Nations, and among the several States…[and] To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers.”

(Source: http://www.archives.gov/exhibits/charters/constitution_transcript.html)

The constitutional issue before the court was whether the federal government is authorized to mandate that an individual either maintain a minimum level of health insurance or face a monetary penalty, either under Congress’ authority to regulate interstate commerce, or its authority to levy taxes. Many observers assumed the issue would be resolved by determining whether an individual’s decision to acquire or not to acquire health insurance affects “commerce…among the several states” to a degree sufficient to warrant federal regulation of that decision.

The Court’s response to this specific question was, No, the Constitution does not allow the federal government to regulate individual choices of this type. As stated in the opinion, “Even if the individual mandate is ‘necessary’ to the Act’s insurance reforms, such an expansion of federal power is not a ‘proper’ means for making those reforms effective… The commerce power thus does not authorize the mandate.” (p. 30)

However, the Court then went on to address a second, related issue. Given that the federal government is not authorized to require an individual to make a specific choice of this type, does the Constitution allow the government to levy a financial penalty on an individual who elects not to acquire health insurance? Rather than addressing the regulation of interstate commerce, this question addresses the issue of Congress’ “power to lay and collect taxes.”
While preventing Congress from mandating a specific decision regarding health insurance, the Court nonetheless determined that the Constitution allows Congress to assess a financial penalty for those who decide, of their own accord, not to take a specific action – in this case, not acquiring health insurance. As stated in the Court’s opinion,

“The Affordable Care Act’s requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.” (p. 44)

The vote among the justices in support of this outcome was 5-4, with Justices Breyer, Kagan, Ginsburg, and Sotomayor joining Chief Justice Roberts in support. Justices Scalia, Kennedy, Thomas, and Alito wrote a dissenting opinion, arguing that the individual mandate under ACA did not affect interstate commerce and that the “penalty” for non-compliance assessed under ACA did not involve a tax as intended by the Constitution. Accordingly, they argued in their dissent that the individual mandate should be struck down.

It is interesting to note that in addressing question (1) above, the Court determined that labeling the financial assessment for those electing not to acquire health insurance as a penalty and not as a tax “cannot control whether the payment is a tax for purposes of the Constitution, but it does determine the application of the Anti-Injunction Act.” Apparently the AIA and the Constitution apply differing standards as to what is a tax and what is not.
3) Is the Medicaid expansion under ACA overly coercive, in that it would penalize states inappropriately for electing not to participate?

As described at the beginning of Chapter 7, Medicaid was established in 1965 as a joint federal/state program to provide health insurance to certain high-risk populations among those who are poor. These populations have included those who are poor and are elderly, blind, or disabled, and poor families with young children. The costs for this program are shared between state and federal governments, with the state’s share in 2011 ranging from 43% in higher income states to 20% in the lowest income states.

As described in Chapter 7, about two-thirds of the cost of the Medicaid program goes to provide care for poor individuals who are elderly or disabled. These high-cost individuals comprise only 25 percent of all Medicaid beneficiaries. Fifty-five percent of all Medicaid spending goes to provide care for the sickest 5 percent of enrollees. The 75 percent of beneficiaries who are either non-disabled children or non-disabled, non-elderly adults account for only one-third of Medicaid costs.

This differentiation of average per capita costs among Medicaid beneficiaries is important to acknowledge, in light of the population that will become newly eligible for Medicaid under ACA. Those newly eligible will be non-disabled adults over the age of 18 but younger than 65. While many of these individuals may have chronic medical problems, their overall costs will be relatively low. Nationally, per capita Medicaid spending in 2009 averaged $13,186 for the elderly, $15,453 for the disabled, $2,926 for non-disabled adults, and $2,313 for children. The Congressional Budget Office (CBO) has estimated that the annual cost for newly eligible individuals could be as much as $6,000. Even at this level, the state’s share (10% after 2019)
of the cost of extending coverage to those newly eligible can be expected to be low relative to
the overall cost of the existing Medicaid program.

From its inception, state participation in Medicaid has been voluntary. It was only in 1982
17 years after enactment – that all 50 states had elected to participate. State participation
continues to be voluntary. However, any state that does participate must meet the coverage
standards established by the federal government. If a state were to reduce its coverage below
established federal levels, without first obtaining a federal waiver for that reduction, it could
lose all funding under the program.

ACA applies this same standard to the expansion of Medicaid to all persons who are
citizens or permanent residents and who have incomes below 133% of the federal poverty line
(FPL). As originally written, ACA did not offer states the option of maintaining the previous
program of eligibility and funding while opting out of the new expansion. The state either had
to accept the new expansion of eligibility (and the much lower state share of costs that goes
along with it) or drop out of the Medicaid program altogether. Given that few if any states
could afford the cost of continuing to provide coverage to the poor without federal cost
sharing, ACA gave states little real choice as to whether to participate in the new Medicaid
expansion.

Is this requirement to join in the expansion or lose all Medicaid funding overly coercive?
Yes, it is, the Supreme Court has determined.

“The threatened loss of over 10 percent of a State’s overall budget is economic
dragooning that leaves the States with no real option but to acquiesce in the Medicaid
expansion…A State could hardly anticipate that Congress’s reservation of the right to
‘alter’ or ‘amend’ the Medicaid program included the power to transform it so
dramatically. The Medicaid expansion thus violates the Constitution by threatening
States with the loss of their existing Medicaid funding if they decline to comply with
the expansion.” (p. 5)

This decision does not alter the terms of the Medicaid expansion called for in ACA, other than
to make it voluntary for states to participate. If a state elects not to participate, it will maintain
all preexisting federal funding (so long as the state continues to follow previous federal
guidelines). This finding had the support of seven of the Court’s justices, with only Justices
Ginsburg and Sotomayor dissenting, arguing that the removal of all funding for non-
participating states is permissible under the Constitution.

In the text of the book, I address the changes ACA makes to Medicaid in two places: at the
end of Chapter 7 (pp. 189-190), and in the Appendix that provides the Summary of the
Changes Contained in the Affordable Care Act (pp. 326-327). In both places, I describe the
changes to Medicaid eligibility and funding, without explicitly discussing the requirement that
every state participate in the expansion or face loss of all Medicaid funding. Accordingly,
none of the current text in the book is inaccurate as written. However, as a supplement to this
material it is important to acknowledge that no state will be penalized for failing to adopt the
expansion in eligibility called for in ACA.

Following the release of the Court’s ruling, the governors of several states have announced
publically that their states would not participate in the expansion of eligibility, despite the
enhanced federal cost-sharing. It remains to be seen whether these states will follow through
on this threat once the heated political rhetoric of the 2012 presidential and congressional
elections subsides. Consider the following:
• As described above, those newly eligible for Medicaid will generally have low per capita costs, relative to the elderly and disabled individuals who account for the bulk of Medicaid spending. The actual levels of new state funding required of states (10% starting in 2019) are quite small, relative to the cost of maintaining the previous program.

• The federal government currently provides supplemental funding to hospitals that provide a disproportionate share of uncompensated care to those who are uninsured. ACA calls for substantial reductions in these “disproportionate share hospital” (DSH) payments, on the assumption that many if not most of previously uninsured patients will qualify for Medicaid. The hospitals involved will have substantially increased revenues from Medicaid for the care of these patients, which justifies substantial reductions in DSH payments.

• Even if a state elects not to participate in the Medicaid expansion, reductions in DSH payments will still take place. Accordingly, hospitals within these states will face no reduction in the demand for uncompensated care, yet will receive substantially less federal support for providing that care. News reports have already suggested that, within the states announcing non-participation in the Medicaid expansion, hospitals within those states are arguing for full participation. How this political dynamic within the states will play out is yet to be seen.

• Finally, it is important to appreciate that uninsured individuals within states that elect not to participate in the Medicaid expansion are still eligible to acquire insurance in the state’s health benefit exchange. However, as ACA is currently written, only those individuals with incomes at or above 100% of FPL will qualify for the federal premium subsidy. Those with incomes below 100% of FPL do not qualify for the premium subsidy. The CBO
has estimated that two-thirds of individuals potentially eligible for Medicaid under the ACA expansion will have incomes below 100% of FPL, and thus will be ineligible for federal subsidies in states electing not to participate in the expansion of eligibility. This situation has the potential of creating an additional level of political discord within these states regarding future participation.

(The CBO Report on the predicted impact of the Supreme Court’s decision on the expected outcomes of ACA is available at http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.)

4) With the Supreme Court determining that the revocation of state Medicaid funding called for in ACA is unconstitutional, does this finding invalidate the entire ACA?

The Court addressed this question in fairly short order, stating,

“the Court would have no warrant to invalidate the funding offered by the Medicaid expansion, and surely no basis to tear down the ACA in its entirety. When a court confronts an unconstitutional statute, its endeavor must be to conserve, not destroy, the legislation.” (p. 6)

Accordingly, the only change to full implementation as originally written is the removal of the threat of loss of all Medicaid funding for any state that elects not to participate in the expansion of Medicaid eligibility called for under ACA. As described above, while certain governors have threatened not to participate in the expansion despite its generous additional funding, this decision may end up hurting hospitals and poor individuals in their own state. Whether this is a viable political option for the long term remains to be seen.
Changes to the information contained in *Introduction to U.S. Health Policy, 3rd edition*

As described above, the only change I would like to make to the information contained in the book is to acknowledge that no state will be penalized for failing to adopt the expansion in Medicaid eligibility called for in ACA, while questioning whether this option is viable in the long term.