

The Supreme Court's ruling on the Affordable Care Act

A review of the decision and its impact on Ohio

Introduction

On June 28, 2012, the United States Supreme Court ("Court") issued an opinion upholding the constitutionality of the Patient Protection and Affordable Care Act (ACA), with the exception of one provision.¹ On the issue that many people thought was central to the case, the Court found that the "individual mandate" was constitutional — meaning that the federal government can require people to purchase affordable health care insurance coverage or face an income tax penalty.

On a separate but important issue, the Court found that Congress could increase funding to expand Medicaid coverage. However, the Court held that the federal government could not coerce states to expand their state Medicaid programs by threatening to eliminate existing Medicaid program funding for states choosing not to expand. Based on the Court's decision, States now can decide not to expand their Medicaid programs without losing all federal Medicaid funding.

Part One of this policy brief is intended to explain the Court's decision and Part Two of this brief will discuss the impact of the Court's decision on Ohio.

The Court's decision

In its opinion, delivered by Chief Justice John Roberts, the Supreme Court ruled that:

1. The Anti-Injunction Act does not bar the legal challenges to the Affordable Care Act
2. The individual mandate is constitutional
3. The Federal government may not coerce states to expand their state Medicaid programs with a threat of eliminating funding for existing Medicaid programs
4. The ACA, as a whole, is constitutional

Part One: Court proceedings and decisions

Previous Proceedings

On March 19, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law.² On the same day, Florida and twelve other states filed suit to strike down the ACA. Thirteen other states, including Ohio, several individuals, and the National Federation of Independent Businesses joined the lawsuit, arguing that the ACA was unconstitutional. Similar lawsuits were filed by other parties in other courts.

As the case proceeded through the courts, the Eleventh Circuit Court of Appeals found that the "individual mandate," the requirement that most Americans maintain "minimum essential" health care coverage or face a financial penalty, was unconstitutional and struck down the ACA in its entirety.³ In other cases, federal appeals courts in the Sixth and Fourth Circuits issued different decisions, holding that both the individual mandate and the ACA were constitutional.⁴ In all of the cases involving the constitutionality of the ACA, the litigants sought review by the Court. In response to these requests, on November 11, 2011, the Court agreed to review the Eleventh Circuit case and, in doing so, agreed to issue a decision that would serve as precedent for all other cases.

The United States Supreme Court Decision

When the Court agreed to accept the case for review, it announced that it would decide four key issues:

1. Whether the legal challenges to the individual mandate are barred by the federal Anti-Injunction Act
2. Whether the individual mandate is constitutional
3. Whether the Federal government may coerce states into expanding state Medicaid programs with the threat of withholding federal Medicaid funding for existing Medicaid programs
4. If the individual mandate is unconstitutional, whether the entire ACA should be struck down

In its opinion, delivered by Chief Justice Roberts, the Court's rulings on these four issues were explained as follows:

1. The Anti-Injunction Act does not bar the legal challenges to the Affordable Care Act

The Fourth Circuit Court of Appeals held that, under the federal Anti-Injunction Act (AIA), legal challenges to the individual mandate could not be considered until after the individual mandate went into effect in 2014.⁵ The AIA provides that taxes ordinarily cannot be challenged in a court of law until after they are paid.⁶ Under this legal theory, the individual mandate could not be legally challenged until after 2014.

Noting that that the consequence for not complying with the individual mandate was described in the ACA as a monetary “penalty” and not a “tax,” the Court held that the AIA did not apply to the individual mandate. Consequently, the Court determined it could hear the legal challenges against the individual mandate and decide the case on its merits.⁷

2. The individual mandate is constitutional

The 26 states challenging the individual mandate claimed that the individual mandate was unconstitutional because Congress was not granted constitutional power to issue the individual mandate. In response, the federal government argued that Congress had the power to enact the mandate under the Commerce Clause or, in the alternative, under Congress's power to “lay and collect Taxes.”¹⁰

The Court, in a majority decision, decided that the individual mandate was a valid exercise of Congress's power to “lay and collect Taxes.” In delivering the Court's opinion, Chief Justice Roberts noted that “[u]nder the mandate, if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes.”¹¹ As a result, Chief Justice Roberts held:

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.¹²

Justices Breyer, Ginsburg, Sotomayor and Kagan concurred with Chief Justice Roberts, making his opinion the judgment of the Court. Justices Scalia, Kennedy, Thomas and Alito dissented. The other issue before the Court — whether Congress had power to enact the individual mandate under the Commerce Clause — was not the deciding issue. Under the Court's decision, because Congress already had power to enact the mandate under its ability to “collect and lay Taxes”, it did not matter whether the Commerce Clause also bestowed that power. However, notably, a majority of the Court held that the individual mandate could not be sustained under

What is the Individual Mandate?

The “individual mandate” of the Patient Protection and Affordable Care Act (ACA) requires most Americans to have minimum coverage health care insurance or face monetary penalties beginning in 2014. For some individuals, this means they must purchase coverage from a private health insurance company. Others may enroll in Medicaid coverage. Beginning in 2014, people who do not comply with the individual mandate must pay a “shared responsibility payment” to the Internal Revenue Service as part of their annual income tax filings.⁸

Viewed as a centerpiece of the ACA, the individual mandate serves the purpose of expanding the population of individuals with health care insurance coverage and mitigating the risk of adverse selection in the health insurance market. Adverse selection occurs when less healthy people disproportionately enroll in an insurance risk pool, driving up insurance costs. With the individual mandate in place, along with subsidies obtained via health insurance exchanges and an expansion of Medicaid, Milliman projects the number of uninsured in Ohio falling from 1.5 million to 712,000 by 2017.⁹

the Commerce Clause. Chief Justice Roberts and the four dissenting Justices held that the Commerce Clause “gave Congress the power to *regulate* commerce, not to *compel* it.”¹³

3. The Federal government may not coerce states into expanding state Medicaid programs by threatening to withhold funding for existing Medicaid programs if a states chooses not to implement the expansion

Litigants challenged the Medicaid expansion on grounds that the federal government was illegally coercing states to implement a new federal program with threats to withhold all federal Medicaid funding. These litigants claimed that the threat to withhold all federal Medicaid funding violated the principle that the “Federal government may not compel the States to enact or administer a federal regulatory program.”¹⁷

The Court agreed, ruling that although Congress may offer increased

Medicaid funding to states, it could not coerce states to expand state programs with the threat of withdrawing all Medicaid funding.¹⁸ Noting that states opting out of the expansion lose not only the expansion funding, but all funding, the Court held that Section 1396c of the Affordable Care Act “is unconstitutional when applied to withdrawing existing Medicaid funds from States that decline to comply with the expansion.”¹⁹ As a result, states now have the choice to forgo the Medicaid expansion without the risk of losing Medicaid funding for current programs.²⁰

4. The entire Affordable Care Act, as a whole, is constitutional

The only aspect of the Affordable Care Act found unconstitutional is the provision that allows the federal government to withhold federal funding for existing Medicaid programs from states that choose not to provide expanded coverage. Given that it was not necessary to strike down the entire Act in order to preclude the federal government from imposing such a sanction, the Court held that the remainder of the ACA is constitutional and remains in effect.²¹

Medicaid and the Affordable Care Act

The Affordable Care Act sought to expand state Medicaid program eligibility, beginning in 2014, to all individuals under age 65 with incomes below 133% of the federal poverty level (plus a 5% income disregard).¹⁴ Currently, the federal government requires state Medicaid programs to cover certain discrete categories of individuals, including low income pregnant women, children, and families, and aged, blind and disabled individuals meeting certain requirements. The federal government does not require mandatory coverage for most adults without dependent children (commonly referred to as “childless adults” for purposes of Medicaid eligibility) and, in most states, coverage of parents is limited to very low income individuals.

State Medicaid programs are funded through a combination of state and federal funds. To help defray the cost of expansion, the ACA grants the federal government authority to pay 100% of the cost of covering newly Medicaid-eligible individuals through 2016. In subsequent years, the federal match gradually decreases to a minimum of 90%.¹⁵ The ACA also provides that the federal government may withhold all existing Medicaid funding from states that do not agree to implement the expansion.¹⁶ This provision was found to be unconstitutional by the Court.

Part Two: What is the impact of the Court’s decision on Ohio?

The insurance market reforms in the Affordable Care Act were upheld by the Court and will take effect in Ohio.

The fact that the Court upheld the Affordable Care Act, with the exception of one aspect of the Medicaid expansion, means that insurance market reforms and other health care cost and quality initiatives contained in the ACA will go into effect in Ohio. The box on page 4 contains a list of the insurance market reforms in the ACA that were upheld by the Court.

The Court’s decision creates uncertainty about whether Ohio will expand its Medicaid program to cover more Ohioans.

The only aspect of the Affordable Care Act that was struck down was the provision that allowed the federal government to withhold federal Medicaid funding for existing programs from states that choose not to implement the Medicaid expansion. This means that Ohio can decide not to expand

Ohio and health insurance exchanges

Given that the private insurance market reforms were not struck down, Ohio is faced with a number of decisions regarding implementation of the ACA. These decisions include whether Ohio will defer to a federally-facilitated health insurance exchange, opt for a partnership exchange or elect to establish a state-based exchange. On January 1, 2014, exchanges must be in operation in each state.²²

Although Governor John Kasich and Lieutenant Governor and Insurance Commissioner Mary Taylor have suggested that Ohio will not opt for a state-based exchange, there is some time for further consideration of this issue. The United States Department of Health and Human Services (HHS) has set a November 16, 2012 deadline for states to (1) submit plans to establish a state-based exchange, (2) cede all exchange responsibility to the federal government for a fully federally-facilitated exchange, or (3) enter into a partnership with the federal government where the state retains certain functions of the exchange and the federal government administers the rest.

Notably, states may elect to operate a state-based exchange after January 1, 2014. However, states must work with HHS to develop a plan to transition from a federally-facilitated or partnership exchange to a state-based exchange. States are also required to obtain full or conditional approval from HHS at least 12 months prior to the exchange's first effective date of coverage.

HHS has also indicated that technical assistance and establishment grant funding is available to states opting to establish a state-based exchange, states electing for a partnership exchange and for states wanting to build linkages to a fully federally-facilitated exchange. However, federal grant funding for exchange establishment will only be awarded through 2014.

its Medicaid program without risking the loss of current funding.

This decision has trade-offs. On the one hand, a Medicaid expansion would cover more Ohioans entirely at federal expense for three years (CY 2014-2016). On the other hand, after the initial three years, there will be additional expense to the Ohio Medicaid program and Ohio taxpayers. The most significant cost to the state as a result of the ACA is the number of currently eligible, but not enrolled, individuals who will enroll in Medicaid, as there is not an increased federal match rate for these individuals.

To understand the choices faced by Ohio, it is helpful to review Ohio's current Medicaid program. The medical benefits currently provided by Medicaid cover lower income children, parents, pregnant women, and aged, blind and disabled Ohioans that meet certain requirements.

Insurance market reforms

All of the Affordable Care Act's private insurance market reforms, including exchanges and low income subsidies to purchase private coverage through the exchange, will be implemented in Ohio.

2010

- Insurers may not set lifetime dollar limits on health insurance coverage, or annual dollar limits that are lower than \$1.25 million.
- Insurers must cover all dependent children up to age 26.
- Insurers cannot rescind health coverage in absence of fraud by the insured.
- Insurers cannot deny coverage to children.
- Insurers cannot impose pre-existing condition exclusions on children.
- Preventive care, such as screenings and immunizations, must be covered with no co-pays or cost sharing.

2011

- Insurers must meet minimum loss ratios of 85% in the large group market and 80% in the individual and small group market, and if they do not meet such minimum ratios, they must provide refunds to customers.
- Health insurance rate increases that exceed 10% annually are subject to heightened review to make sure they are justified.

2014

- Insurers must offer coverage to everyone who applies for coverage.
- Insurers may not impose pre-existing condition exclusions limiting coverage.
- Insurers may only limit health insurance rates based on age and smoking status, and the highest rate must be no more than 3 ½ times the lowest rate.
- Insurers must include essential health benefits in coverage as defined by law.
- Individuals that can afford to buy coverage are required to purchase it or face a penalty.
- Individuals with incomes up to 400% of FPL are entitled to subsidies to help purchase coverage and pay for co-pays and deductibles.
- Employers with 50 or more employees are required to provide coverage to workers, or face a penalty.
- Health insurance exchanges become operational by January 2014, allowing consumers and small businesses to shop for, select, and enroll in private health insurance coverage.

Medicaid income eligibility

Covered Population	Income Guidelines
Children up to age 19	200% FPL or less
Parents	90% FPL or less
Pregnant Women	200% FPL or less
Workers with Disabilities	250% FPL or less
Non-workers with Disabilities	64% FPL or less
Seniors 65 and older	64% FPL or less
Institutional Level of Care	Income less than the cost of care

NOTE: Some eligibility categories consider resources other than income. For seniors and people with disabilities, deductions and exceptions may apply; ODJFS

The income limits for Ohio's Medicaid are set forth in the box above.

The ACA seeks to have states' Medicaid programs cover all individuals under the age of 65 with incomes below 133% FPL (plus a 5% income disregard).²³ For Ohio, this would mean that childless adults would become eligible for Medicaid and that the income limits for parents and aged, blind and disabled Ohioans would increase from current levels up to 133% of the FPL.

According to Ohio Medicaid estimates,²⁴ the Medicaid expansion will cause an additional 916,500 Ohioans (both children and adults) to enroll in Medicaid in 2014, at a total cost of \$4.3 billion dollars (state and federal share combined). Notably, however, the federal government will pay 100% of the cost of newly eligible individuals through 2016 and, in future years, will pay at least 90% of such coverage. Therefore, the state share of the Medicaid expansion is zero for CY 2014-2016 and is estimated to be \$203 million for CY 2017 and \$256 million for CY 2018.

However, there will likely be a "welcome mat" or "woodwork" effect that results from the expansion, meaning currently eligible individuals not enrolled in Medicaid will enroll. The calculation of the welcome mat effect is important because the state receives the regular federal match rate for this population, resulting in a higher cost to the state than that for people who are newly eligible. For example, according to Ohio Medicaid, of the 916,500 Ohioans expected to enroll in Medicaid in CY 2014 under a Medicaid expansion, 319,000 are estimated to be children and adults who are currently eligible but not enrolled.

2012 Federal Poverty Guidelines					
(by household size)					
	100%	138%	200%	250%	400%
1	\$11,170	\$15,415	\$22,340	\$27,925	\$44,680
2	\$15,130	\$20,879	\$30,260	\$37,825	\$60,520
3	\$19,090	\$26,344	\$38,180	\$47,725	\$76,360
4	\$23,050	\$31,809	\$46,100	\$57,625	\$92,200

Note: Annual guidelines for all states except Alaska, Hawaii and DC
Source: Federal Register, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035

Other estimates of ACA-related Medicaid enrollment have been released over the last two years. These have included estimates from the Heritage Foundation, the Urban Institute and the Kaiser Family Foundation. Variability in these estimates results from differences in accounting for various factors, including:

- How many currently eligible, but not enrolled, people there are who may enroll in Medicaid (also know as the "welcome mat" or "woodwork effect")
- How many people are currently insured by employers but may enroll in Medicaid if offered the opportunity
- How the existence of a health insurance exchange and simplified application processes may impact Medicaid enrollment
- How outreach efforts, or the lack thereof, may impact Medicaid enrollment
- How the individual mandate may impact Medicaid enrollment

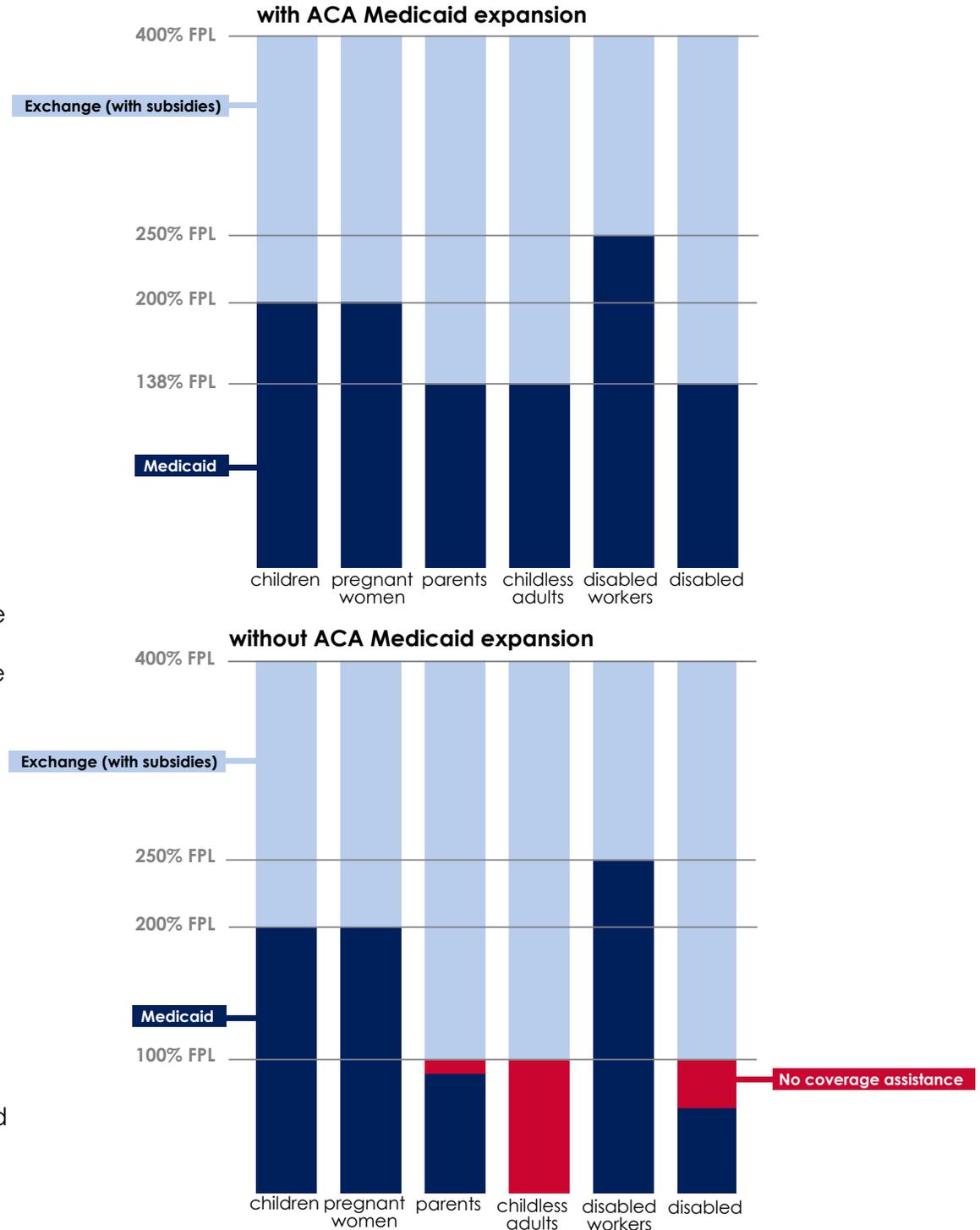
Also, Ohio Medicaid includes in its cost projections an extension of the primary care physician rate increase beyond CY 2013-2014, the years for which the federal government is funding the increase. While continuation of the increase is not a requirement of the ACA, the rationale for increasing payment in order to facilitate access to primary care services does not diminish at the end of CY 2014.

What happens if Ohio does not implement the Medicaid expansion?

If Ohio decides not to implement the Medicaid expansion, there will be two primary impacts:

- Estimated 5 year total state costs would be reduced from \$3.3 billion to \$2.87 billion
- Uninsured people with lower incomes will not have access to affordable insurance coverage

Health coverage sources for Ohioans in 2014

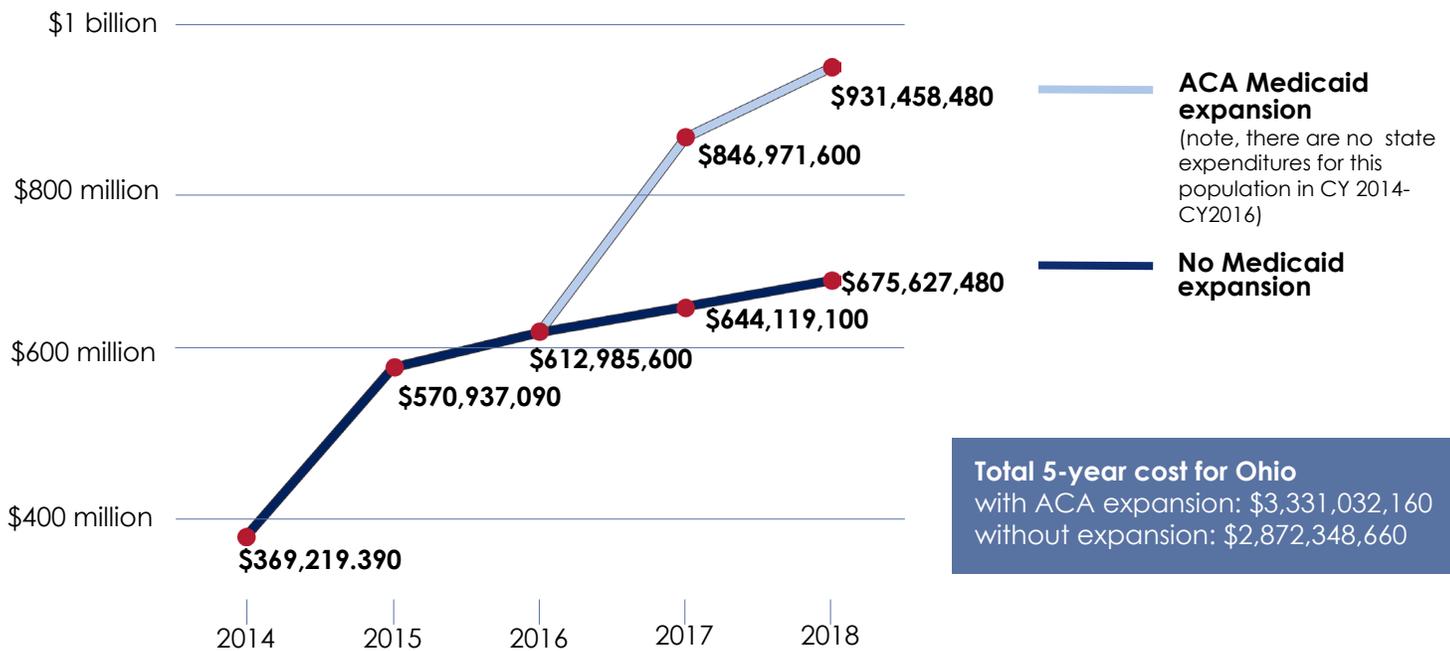


The ACA was designed to provide affordable health insurance coverage to all Americans beginning in 2014. For individuals earning up to 133% of FPL (plus a 5% income disregard), the coverage was to be provided by Medicaid. For individuals and families with incomes between 100% and 400% of FPL, the Affordable Care Act authorized federal subsidies to help pay for coverage for individuals

purchasing health insurance through the health insurance exchange. Beyond 400% of FPL, the Affordable Care Act makes coverage available on a guaranteed issuance basis, without pre-existing condition exclusions, but also without subsidies.

Under the plain language of the ACA, if Ohio decides not to go forward with Medicaid expansion, the federal government is authorized to provide low income subsidies on a sliding scale basis only to individuals and families purchasing health care insurance through the exchange with incomes greater than 100% of FPL.²⁵

State share of Medicaid cost associated with the ACA



Source: Ohio Medicaid

Note: Ohio Medicaid's cost projections include an extension of the primary care physician rate increase for CY2015-CY2018. The ACA only requires and pays for that increase through CY2014.

For an individual between 100% and 133% of FPL, the cost sharing is 2% of modified adjusted gross income. For an individual at 100% FPL (\$11,170 in 2012), that would be \$223 per year or \$18.50 per month. For a family of 4 (\$23,050 in 2012), it would cost \$461, or \$38.40 per month.²⁶

Most individuals earning less than 100% of FPL, who purchase health insurance through the exchange, are not eligible for federal subsidies under the ACA. Thus, in the absence of a Medicaid expansion, the following segments of Ohio's population will likely be ineligible for Medicaid, ineligible for subsidies, and will not be able to maintain minimum essential coverage:

- Childless adults with incomes below 100% of FPL
- Parents with incomes between 90% and 100% of FPL
- Non-workers with disabilities with incomes between 64% and 100% of FPL who do not meet spend-down requirements²⁷
- Seniors 65 and older with incomes between 64% and 100% of FPL

On July 10, 2012 the Secretary of Health and Human Services, Kathleen Sebelius, issued a letter to governors saying that if any state were not to expand Medicaid coverage, "the Affordable Care Act exempts individuals who Congress determined cannot afford coverage from the individual responsibility provision." The Secretary continues, "As to the very small number of affected individuals who would not qualify for the statutory exemption, Congress provided additional authority, which we intend to exercise as appropriate, to establish any hardship exemption that may be needed."

It remains to be seen if the federal government will attempt to make any additional accommodations either through legislation or rule-making if states decide not to expand Medicaid coverage, or desire to limit the expansion. In addition, more analysis is necessary to determine the extent of impact on Ohio's employers if Medicaid is not expanded. An example of a potential impact on employers with more than 50 employees is that their penalties may increase if workers earning between 100% and 133% of FPL obtain subsidies through the exchange.

Conclusion

The Supreme Court's decision to uphold the Affordable Care Act means that the ACA's private market insurance reforms, exchange subsidies for individuals earning between 100 and 400% FPL, and initiatives designed to improve the cost and quality of the health care system remain in effect. While the Court upheld Congress's ability to increase Medicaid funding to expand coverage and to place reasonable conditions on the use of such expanded funding, it ruled that the federal government could not coerce states into expanding their Medicaid programs with the threat of withholding all Medicaid funding for existing state programs.

While putting to rest many policy issues, the Medicaid decision now provides an option to states. Ohio's policymakers will need to give careful consideration to both the cost implications inherent in the Medicaid expansion, as well as the impact on Ohio's poorest citizens — those with incomes below 100% of FPL who, in the absence of Medicaid expansion, would be ineligible for Medicaid and ineligible for exchange subsidies to purchase private coverage.

Notes

1. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. ___, 2012 U.S. LEXIS 4876 (2012). A copy of the decision, known as a slip opinion, can be found at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.
2. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1311(b) (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 11-152 (2010), is referred to herein as the "Affordable Care Act."
3. *Florida v. United States HHS*, 648 F. 3d 1235 (11th Cir. 2011).
4. *Thomas More Ctr. v Obama*, 651 F. 3d, at 529 (6th Cir. 2011); *Seven-Sky v. Holder*, 661 F. 3d 1 (D.C. Cir. 2011).
5. *Liberty Univ., Inc. v. Geithner*, 671 F.3d 391 (2011).
6. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, slip opinion, at 11-12.
7. *Id.* at 15.
8. 26 U.S.C. §5000A(b)(1) and (g)(1).
9. Milliman Client Report. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange." August 31, 2011. Prepared for Ohio Department of Insurance, by Milliman, Inc. <http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf>
10. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, slip opinion, at 15; See also, U.S. Const., Art. I, §8, cl. 3 and Art. I, §8, cl. 1.
11. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, slip opinion, at 32.
12. *Id.* at 44.
13. *Id.* at 24.
14. 42 C.F.R. §1396a(a)(10)(A)(i)(VIII).
15. 42 C.F.R. §1396(y)(1).
16. 42 U.S.C. §1396c.
17. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, slip opinion, at 45.
18. *Id.* at 55-56.
19. *Id.* at 56.
20. *Id.* at 57-58.
21. *Id.* at 59.
22. Affordable Care Act, §1311(b)(1).
23. Under the ACA, income for most people applying for Medicaid will be calculated using the Modified Adjusted Gross Income standard (MAGI), which allows for a 5% income disregard. This puts the income eligibility at 138% FPL for the Medicaid expansion.
24. Estimates are from "Proposed Section 1115 Demonstration Medicaid Eligibility Modernization Project." Downloaded at <http://bit.ly/NUVEFR>.
25. 26 U.S.C. §36B(c)(1).
26. 26 USC §36B(b).
27. Seniors and people with disabilities, whose incomes exceed the income limit, may qualify for Medicaid only if they have medical bills that equal or are greater than their "excess" income. The process of subtracting those medical bills from the individual's income is called

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