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Recommended Citation

Chirba, Mary Ann & Noble, Alice. "The Supreme Court On The Affordable Care Act: What We Are Waiting For." *Health Affairs Blog*, June 1, 2012.

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The Supreme Court On The Affordable Care Act: What We Are Waiting For

June 1st, 2012



by **Alice Noble** and **Mary Ann Chirba**

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With the U.S. Supreme Court poised to rule on the Affordable Care Act (ACA) it is worth reminding ourselves of what, exactly, we have been waiting for.

We await a judicial opinion that could deliver a decisive blow to all or part of a massive piece of legislation and the hard-fought battles that led to its enactment, or salvage the near-century-old quest for health care reform. At the same time we await an opinion that may reshape our fundamental understanding of the Court, the power of Congress, and long-standing principles of federalism.

More specifically, we await the Court's resolution of the issues raised by the parties to two cases, *Florida, et al. v. Department of Health and Human Services* and *National Federation of Independent Business v. Sebelius*, concerning the constitutionality of the ACA's so-called "individual mandate" and, should it be invalidated, the viability of the rest of the ACA, as well as the validity of the Act's expansion of the state-and-federally funded Medicaid program.

Cases Before the Supreme Court

President Obama signed the Patient Protection and Affordable Care Act into law in March, 2010 and unleashed a flurry of lawsuits in the process. Less than two years later the Supreme Court granted certiorari to the cases brought by Florida and 25 other states and by the National Federation of Independent Business, both arising in the 11th Circuit Court of Appeals. The Supreme Court consolidated the cases and directed the litigants to brief and argue the following four issues:

1. **Anti-Injunction Act:** *Whether the federal Anti-Injunction Act, 26 U.S.C. § 7421(a) bars consideration of the ACA's minimum coverage or "individual mandate" before that mandate's penalties takes effect in 2015?*
2. **Constitutionality of Individual Minimum Coverage Mandate:** *If the individual mandate is considered, whether it exceeds Congress' powers under Article I of the U.S. Constitution?*
3. **Severability:** *If the individual mandate is considered and invalidated, whether some or all of the remainder of the ACA also must be invalidated as non-severable from the unconstitutional individual mandate?*
4. **Coercion and Medicaid Expansion:** *Whether Congress exceeded its enumerated powers and violated basic principles of federalism by conditioning a state's receipt of any federal Medicaid funding*



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on acceptance and implementation of the ACA's sizeable — and costly — expansions to Medicaid's eligibility and benefits provisions?

A Brief Overview of the Issues:

The ACA's Minimum Coverage Provision, or "Individual Mandate"

From its earliest days of congressional debate, the minimum coverage provision, also known as the "individual mandate" or "individual responsibility requirement," was one of the most contentious sections of the Affordable Care Act. Section 1501 of the ACA adds a § 5000a to the Internal Revenue Code to mandate, with certain exceptions, that every individual and any dependents have health insurance that meets the requirements of "minimum essential coverage" by January 1, 2014. Failure to maintain minimum essential coverage under the terms of the provision for one or more months in a given year will result in the imposition of a "shared responsibility payment." This penalty will be assessed and collected by the Internal Revenue Service (IRS) through the annual income tax payment process.

Despite the IRS's role in administering this portion of the ACA, Congress originally anchored the minimum coverage requirement in its power to oversee interstate commerce as opposed to its powers to tax and spend, reasoning that minimum coverage is economic in nature and substantially affects interstate commerce. Describing the shared responsibility payment as a penalty may have been necessary to overcome legislative resistance to imposing new taxes. This has nevertheless had profound and unexpected implications for the viability of the individual mandate and the ACA itself.

Striking the individual mandate will jeopardize the ACA's insurance market reforms. Requiring almost everyone to obtain health insurance enabled Congress to persuade health insurers to support a law that would prohibit common insurance practices. For example, because of the ACA, health insurers can no longer deny coverage due to an individual's preexisting conditions. In addition, insurers must employ a modified form of community rating which restricts the factors that can be considered in determining an individual's premium to tobacco use, age, geographical area and other express limitations.

Mandating that all obtain minimum essential coverage, even when employer-sponsored or government subsidized coverage is not available, supports the creation of Exchanges where individuals and families can go to purchase affordable coverage. The viability of state and regional health insurance Exchanges to facilitate individual access to coverage depends on a large and heterogeneous risk pool. Requiring everyone to purchase insurance reduces the problem of adverse selection (i.e., healthy people putting off the purchase of insurance) and enables payers to spread the added costs of ignoring pre-existing conditions and health status when granting coverage and setting premiums.

From a legal standpoint, requiring an individual to pay money is nothing new; it happens with each paycheck's federal and state payroll deductions. Directing individuals to pay money to a private entity – such as a private health insurer – in order to avoid the shared responsibility payment is not quite as simple. Imposing this requirement through Congress's powers to tax, spend, or regulate interstate commerce may be a good idea to health economists, but it raises thorny legal issues that can only be resolved by parsing the language of the statute, combing its legislative history for indicia of congressional intent, and evaluating decades of judicial precedent on the proper reach and exercise of Congress's Article I powers, particularly the Commerce Clause.

The Anti-Injunction Act. Before determining whether the individual mandate exceeds Congress' constitutional authority, the Court will decide whether the shared responsibility payment qualifies as a federal tax even though Congress characterized it differently when it enacted the ACA. The federal Anti-Injunction Act prohibits lawsuits seeking to "restrai[n] the assessment or collection of any tax...." 26 U.S.C. §7421. Thus, a court cannot resolve a federal tax challenge until after the tax has been paid and administrative remedies have been exhausted. If the ACA's shared savings payment is a tax this "pay first, litigate later" rule would bar judicial review until 2015 when penalties must be paid for lacking minimum coverage after January 1, 2014.

The AIA does not apply unless the shared savings penalty qualifies as a tax. That the payment can be viewed as either a tax or a penalty is demonstrated by the government's own shifts in drafting §5000a and defending it in the lower courts. Congress openly debated whether this payment would

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be a tax or a non-tax penalty. Having settled on a penalty, Congress nevertheless charged the IRS with collecting it as other assessable penalties which are generally subject to the AIA's ban on pre-payment challenges. HHS had previously invoked the AIA as a procedural bar, but decided to waive this defense before the Supreme Court.

This prompted the Court to appoint an amicus curiae to address the AIA's potential jurisdictional obstacles; he argued as follows:

1. The shared savings penalty is a tax because it is calculated and collected as part of the federal tax system.
2. The AIA therefore applies.
3. The AIA is a jurisdictional (as opposed to a claims processing) statute.
4. Accordingly, the AIA cannot be waived since it deprives the Court of subject matter jurisdiction to determine the individual mandate's constitutionality until payments are due in 2015.

The basic arguments against any AIA bar to reaching the merits of the individual mandate were:

1. The AIA does not apply because the States, the NFIB and private individuals challenge the underlying mandate and not the penalty. The government insists, however, that the mandate cannot be considered independently of its penalty for non-compliance.
2. All parties (as opposed to the amicus) agree that the shared savings penalty is not a tax under the AIA (even though in the government's view, it can be conceptualized as a tax when deciding whether Congress had the constitutional authority to impose it). Although the payment will be calculated and collected by the same agency that administers the federal tax system, it is not a revenue-raising measure and would not be paid at all should everyone obtain coverage. Further, the ACA bans the IRS from using levies or tax lien notices as it can when enforcing tax penalties. Working against this argument is that the agency can file litigation and offset penalty amounts against tax refunds as it does with other tax penalties.
3. If the AIA does apply, it is a mandatory claims processing statute that can be waived since it does not affect the Court's subject matter jurisdiction to decide the merits of the individual mandate issue.
4. If the AIA applies and would normally preclude jurisdiction, it will not do so where judicial relief would otherwise be unavailable. For instance, since the shared savings penalty is imposed on individuals, States would have no judicial recourse for challenging it even after it takes effect in 2015 even though State moneys will be needed to subsidize a significant portion of individuals in need of coverage.

Commerce Clause To avoid the political fall-out of a health reform "tax," Congress invoked its Commerce Clause powers in adopting the individual mandate. In general, Congress has the power to regulate activities that are in the stream of commerce among the States or substantially affect interstate commerce. The Necessary and Proper Clause empowers Congress to enact laws that are "necessary and proper" for executing its enumerated powers including its powers to regulate interstate commerce, and tax and spend.

The basic grounds for defending the individual mandate as proper under the Commerce and Necessary and Proper Clauses are:

1. The individual mandate is one of several ACA *methods of financing health care* and thus qualifies as economic regulation. Everyone eventually needs health care; consequently, the uninsured do participate in the health care market even though their costs shift to the insured market participants. Requiring individuals to purchase insurance or pay a penalty simply requires free riders in this market to internalize the risks and costs of their health care. This is classic economic regulation of economic conduct.
2. The individual mandate qualifies as economic regulation since it regulates the *timing of the purchase* because all individuals will need health care at some point. The ACA simply requires that payment in the form of health insurance be made in advance as opposed to later at the point of sale.
3. As part of the ACA's broader scheme of economic regulation, the mandate is necessary and proper to effectuate the ACA's comprehensive insurance market reforms.

The individual mandate's challengers argue:

1. Uninsured individuals are not in the insurance market and there is no economic activity to be regulated under the Commerce Clause.
2. Because the Commerce Clause provides no power to regulate economic "inactivity" by compelling individuals to enter a market, the individual mandate cannot be justified as Necessary and Proper to effectuate the exercise of the power to oversee interstate commerce.
3. Permitting Congress to require an individual to purchase insurance is an unprecedented expansion of the Commerce Clause with *no limiting principles* for evaluating other federal mandates.

Resolving the individual mandate dilemma should lead the Court to explain whether this is a matter of overseeing the method of timing payment for health care or is instead an unprecedented requirement to compel participation in a market. If the latter, it will be interesting to see whether the special attributes of the health care and/or health insurance markets are sufficient to satisfy the search for limiting principles.

[Another option before the court that has been discussed by some scholars](#) is to find the individual mandate facially valid, but allow the door to remain open to challenges by individuals (an "as-applied" challenge) once the provision is in effect.

Severability. Those who challenge the constitutionality of the individual mandate argue that it cannot be severed from the rest of the ACA. Thus, because its role in the ACA's achievement of near universal coverage is so central, the entire ACA must be invalidated if the mandate does not survive.

The Court-appointed amicus argued against severance of any provision beyond the individual mandate itself, should the individual mandate be found unconstitutional.

Instead of arguing that striking the mandate as unconstitutional would affect no other part of the ACA, the government acknowledged that certain provisions may indeed be jeopardized although most of the statute could remain intact. Consequently, if the individual mandate falls, it may be followed by the guaranteed issue requirement that insurers make policies available to everyone, and community-rating restriction on using health status to determine premiums.

Medicaid Expansion Provisions

The Supreme Court will also decide whether the ACA's expansion of the state and federally funded Medicaid program is so coercive as to amount to an unconstitutional exercise of congressional spending power. Since its inception in 1965, Medicaid has functioned as a federal and state partnership, with both sharing the costs. Under Article I's Spending Clause, Congress has no authority to compel States to participate in the Medicaid program although Congress can require them to meet eligibility and other program criteria in order to receive federal Medicaid dollars. Currently, all States participate in Medicaid.

The ACA significantly expands Medicaid, including:

- simplifying application, enrollment and renewal procedures
- raising household income eligibility thresholds for non-elderly adults from 100% to 133% of the federal poverty limit
- broadening non-income based eligibility categories
- increasing covered benefits
- increasing prescription drug rebates
- refining calculation of disproportionate share hospital payments

State Medicaid rolls will also be increased by previously eligible, but un-enrolled individuals who must satisfy the ACA's individual minimum coverage mandate.

While these and other measures are intended to make the Medicaid program more accessible and cost efficient, the 26 States assert that full compliance will be economically catastrophic. Under the ACA, though, anything short of full compliance by 2014 will lead a State to lose all of its federal Medicaid funding. For this reason, the States argue that the ACA's Medicaid expansions are

unconstitutionally coercive.

In response, the federal government argued:

1. The ACA is within the well-established Congressional authority to attach conditions to federal spending in furtherance of federal policy objectives.
2. Since its inception, the Medicaid program has required that participating states provide a minimum amount of covered services to certain population groups. Congress has reserved the right to alter and expand such requirements, and has repeatedly done so throughout the history of the Medicaid program.
3. The federal government has assumed nearly all costs of the ACA's Medicaid expansions and, therefore, claims of economic coercion are grossly over-stated.

That many States filed amicus briefs in support of the ACA's Medicaid expansions may further undercut claims of federal coercion. Since the unconstitutional coercion argument elicited skepticism from many commentators and gained little traction in the lower courts, the Supreme Court's decision to consider it was somewhat surprising. The chances of a victory by the petitioning States may seem slight, but it is important to remember that when it comes to the Supreme Court and health care, nothing is predictable or impossible.

Severability Part Deux. Whether the ACA's Medicaid provisions can be isolated and severed from the rest of the statute is unclear since dismantling the ACA's Medicaid expansions would affect the individual mandate, state Exchanges, and Medicare reforms. Striking either the individual mandate or the Medicaid expansions may tear unforeseen holes in the ACA's fabric, while striking both will leave the ACA threadbare for sure.

Scorecard: ACA Issues Before the Supreme Court

To keep track of the possible permutations, one needs a score card. Below, in fact, are two scorecards (click to enlarge). One for issues involved in the debate over the constitutionality of the individual mandate –

CONSTITUTIONALITY OF ACA'S INDIVIDUAL MANDATE			
1. Threshold Issue: Is the Mandate a Tax?			
Yes		No	
Is AIA Jurisdictional?		Proceed to merits.	
Yes.	No		
No subject matter jurisdiction before payment in 2015.	Can still proceed to merits where parties lack recourse.	Proceed to merits	
2. Merits: Is the Individual Minimum Coverage Mandate a Valid Exercise of Congress's Article I Powers?*			
Commerce Clause? Or at least Necessary & Proper?		Tax & Spend?	
Yes. Mandate stands.	No. Mandate is unconstitutional. Consider severability.	Yes. Mandate stands	No. Mandate is unconstitutional. Consider severability.
3. Severability of Individual Mandate from All or Part of ACA ?			
4.			
No severability. Entire ACA fails.	Complete Severability. Rest of ACA Survives.	Partial Severability. Portions of ACA Fail, but Rest Survives.	

**Possibility that the Court may leave door open for a later "as applied" challenge if it upholds the individual mandate.*

– and one for the issues involved in the debate over the ACA's Medicaid expansion.

CONSTITUTIONALITY OF ACA'S MEDICAID EXPANSIONS		
1. Is the ACA Unconstitutionally Coercive in Predicating Receipt of <u>Any</u> Federal Medicaid Funding on Full Implementation of New Medicaid Expansions?		
Yes. Consider Severability	No	
2. Severability of Medicaid Expansions from All or Part of ACA?		
No severability. Entire ACA fails.	Complete Severability. Rest of ACA Survives.	Partial Severability. Portions of ACA Fail, but Rest Survives.

What's Next?

In the short term, the Supreme Court's eagerly awaited resolution of *Florida v. Department of Health and Human Services* and *National Federation of Independent Business v. Sebelius* may bring some clarity, but the long term will remain cloudy. Short of striking the entire statute – probably the most radical and least likely outcome – whatever the Court decides will be followed by ongoing ACA implementation at the state and federal levels, continued litigation over whatever remains of the ACA's ten Titles and over 400 sections, and mounting calls by presumptive GOP candidate Mitt Romney to repeal the individual mandate and basic reform template that he so zealously championed in Massachusetts.

One thing is clear, however. The length and scope of the ACA, the dozens of briefs by the parties with hundreds more from amici, and three days of oral arguments in late March have given members of the Court much to ponder and debate. Transcripts of those oral arguments reveal how thorny these issues are and how difficult it is to discern correct solutions. Unprecedented media attention attest to the importance of this case to our health care system and national economy just as a hotly-contested presidential race is shifting into high gear. Nevertheless, despite the glare of the spotlight and the need for answers, the Court's ruling may not reach every question. Our best hope is that whatever it does decide will be attended by a concrete and thorough explanation as to what it has done, why it has done so, and lend guidance as to where and how to proceed from here.

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