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The Constitutionality of the Affordable Care Act: *NFIB v. Sebelius*

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The enactment in March 2010 of the Patient Protection and Affordable Care Act, or ACA, prompted the filing of numerous lawsuits challenging its constitutional underpinnings. On June 28, 2012, the United States Supreme Court, in *National Federation of Independent Business v. Sebelius*, 567 U.S. ___ (2012), upheld all but one of the ACA's provisions. By a 5-4 margin, the Court held the ACA's individual mandate is authorized by Congress's taxing power. Although the individual mandate is a tax under the U.S. Constitution, the Court held that litigation challenging it is not barred by the Anti-Injunction Act. While the Court's holding allows implementation of the ACA to proceed, it also recognizes new limits on Congress's legislative power. By a 5-4 margin, the Court held that the individual mandate was not a valid exercise of its powers under the Commerce Clause. A 7-2 majority of the Court held that a provision authorizing the Secretary of Health and Human Services (HHS) to withhold all of a state's Medicaid funds if the state does not expand its Medicaid program in accordance with the terms of the ACA constituted impermissible coercion. Finally, a five-member majority concluded that the unenforceability of the provision authorizing the HHS Secretary to cut off Medicaid funding to states that do not expand their programs means that each state has the option of either expanding its Medicaid eligibility and receiving additional federal funds or keeping its existing eligibility standards and existing level of funding.

Background

One of the ACA's primary objectives is to increase the number of Americans with health care coverage. This goal is to be met by implementing changes in both the private health insurance system and public health coverage programs. In the insurance system, a variety of incentives (such as tax credits), sanctions (such as the individual mandate), and market reforms (including health benefit exchanges) are expected to add about 15 million to the roll of persons with private health coverage. Expansions to Medicaid and other public programs are intended to extend coverage to another estimated 15 million people nationwide.

The individual mandate refers to the provision of ACA that, beginning in 2014, requires nonexempt individuals who fail to have minimum essential health coverage to

make a shared responsibility payment to the Internal Revenue Service. The minimum coverage requirement does not apply to persons with religious objections or who participate in a qualifying health care sharing ministry, persons not lawfully present in the United States, and the incarcerated. Some individuals who are subject to the coverage mandate are nonetheless not required to make a shared responsibility payment, including people for whom coverage is calculated to be unaffordable, who earn too little income to require filing a tax return, who are members of an Indian tribe, who experience only short gaps in coverage, and who, in the judgment of the HHS Secretary, have suffered a hardship with respect to the capability to obtain coverage. Many individuals will receive the required coverage through their employer or from a government program such as Medicaid or Medicare. Individuals who are not exempt and do not receive health coverage through a third party may purchase insurance from a private company.

The shared responsibility payment is to be paid with an individual's taxes and is assessed and collected in the same manner as tax penalties. The amount owed by people who do not have minimum essential coverage (and who are not exempt) is based on a floor amount that varies by year, household income, and the average annual premium for qualifying private health insurance. For 2014, the assessment is the greater of $95 or one percent of the taxpayer's gross income over the tax return filing threshold for the taxpayer's filing status. For 2015, it is the greater of $325 or two percent of income. For 2016 and thereafter, it is the greater of $695 (indexed for inflation in future years) or 2.5 percent of income. The amount is capped at the national average cost of a bronze-level health plan sold in an exchange. Additional payments, generally half the amount assessed for adults, are assessed for uninsured dependents, subject to a family cap of three times the flat dollar amount for adults.

The Commonwealth has already implemented some of the ACA's provisions. In the 2011 Session, the General Assembly enacted House Bill 1958 to conform inconsistent and conflicting requirements of Virginia's health insurance laws to corresponding provisions of the ACA that became effective on September 23, 2010. In the same session, the General Assembly enacted House Bill 2434, which declares that it is the intent of the General Assembly that the Commonwealth create a state-run health benefits exchange that meets the relevant requirements of the ACA. Virginia's administrative actions to date include updating infrastructure for program eligibility determinations and planning for a state-run health benefit exchange.[1]

Lower Court Proceedings

Florida and 12 other states filed a complaint in the U.S. District Court for the Northern District of Florida alleging among other things, that the individual mandate exceeded Congress's powers under Article I of the Constitution.[2]

On January 31, 2011, the district court held that Congress lacked constitutional power to enact the individual mandate. 780 F. Supp. 2d 1256 (N.D. Fla. 2011). In Judge Vinson's view, failing to buy health insurance is not an act of interstate commerce, and the Necessary and Proper Clause does not allow Congress to impose this individual mandate. The Medicaid expansion was found not to be coercive to the states. Because the individual mandate could not be severed from the remainder of the ACA, the entire ACA was unconstitutional. Id. at 1305–1306.

The U.S. Department of Health and Human Services appealed to the Eleventh Circuit Court of Appeals, which agreed with some but not all of Judge Vinson's opinion. 648 F. 3d 1235. The court affirmed Judge Vinson's decision that the individual mandate was unconstitutional. The court also affirmed that the Medicaid expansion is a valid exercise of Congress's power under the Spending Clause. However, the court reversed Judge Vinson's finding regarding the severability of the individual mandate from the ACA's other provisions, and allowed those other provisions to remain intact. 648 F. 3d. at 1264, 1268.

NFIB v. Sebelius

On November 14, 2011, the U.S. Supreme Court granted certiorari to portions of three cross-appeals of the Eleventh Circuit's opinion relating to the individual mandate and the Medicaid expansion.[3] The Court asked the parties to address four questions, which may be paraphrased as:

- Does the Anti-Injunction Act bar pre-enforcement challenges to the ACA's individual coverage mandate?
- Does Congress have the power under Article I of the Constitution to mandate that virtually every individual have health insurance coverage?
- Does the provision that cuts off Medicaid funding in states that do not expand their Medicaid programs as contemplated by the ACA exceed the federal government's ability to compel states to enact or administer a federal regulatory program?
- If Congress does not have the power to enact a provision of the ACA, can its other provisions be severed from the invalid provision and take effect?

The pithiest summary of the Court's answers to these questions is provided by Chief Justice Roberts:

> The Affordable Care Act is constitutional in part and unconstitutional in part. The individual mandate cannot be upheld as an exercise of Congress's power under the Commerce Clause. That Clause authorizes Congress to regulate interstate commerce, not to order individuals to engage in it. In this case, however, it is reasonable to construe what Congress has done as increasing taxes on those who have a certain amount of income, but choose to go without health insurance. Such legislation is within Congress's power to tax.
>
> As for the Medicaid expansion, that portion of the Affordable Care Act violates the Constitution by threatening existing Medicaid funding. Congress has no authority to order the States to regulate according to its instructions. Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer. (Opinion at 58)

The Court's analyses of each of the four questions follows:

1. Does the Anti-Injunction Act bar pre-enforcement challenges to the ACA's individual coverage mandate?

Before tackling the question of the constitutionality of the individual mandate, the Court rejected the suggestion that the Anti-Injunction Act prevents courts from addressing challenges at this time. The Anti-Injunction Act provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. § 7421(a). This statute means persons challenging the validity of a tax must first pay it and then sue for a refund.

The Fourth Circuit Court of Appeals had determined that, because the individual mandate's penalty is a financial assessment collected by the IRS through the normal means of taxation, the Anti-Injunction Act prevents courts from considering the merits of that

question until after payments are made starting in 2014. *Liberty Univ., Inc. v. Geithner*, 671 F. 3d 391 (2011).

The Court rejected this argument because the ACA labels the shared responsibility payment as a "penalty," and the Anti-Injunction Act applies to suits for the collection of a tax. The argument that the payment should be treated as such a tax under the Anti-Injunction Act because it functions like a tax was rejected on grounds that "[w]here Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally." (Opinion at 12)

The Court's labeling of the shared responsibility payment as a penalty rather than a tax for purposes of the Anti-Injunction Act became a point of contention with regard to the Court's holding that the individual mandate was a constitutionally valid exercise under the Taxing Clause. The majority addressed this alleged discrepancy by suggesting that while Congress cannot change whether an exaction is a tax or a penalty for constitutional purposes simply by describing it as one or the other, it has greater latitude. "The Anti-Injunction Act and the Affordable Care Act," the Court noted, "are creatures of Congress's own creation. How they relate to each other is up to Congress, and the best evidence of Congress's intent is the statutory text." (Opinion at 13)

Justices Scalia, Kennedy, Thomas, and Alito filed a joint unsigned dissenting opinion. With regard to the applicability of the Anti-Injunction Act, the dissenting justices contend that the question of whether the required payment provision is a tax is more appropriately addressed in the context of whether it is an exercise of Congress's taxing power. Because they would find that it is not such an exercise, they "have no difficulty in deciding that these suits do not have 'the purpose of restraining the assessment or collection of any tax.'" They describe the position that the shared responsibility payment is not a tax for purposes of the Anti-Injunction Act but is a tax for constitutional purposes as a "remarkable argument" and a "rhetorical device" that "carries verbal wizardry too far, deep into the forbidden land of the sophists." (Joint dissent at 26–28)

2. Does Congress have the power under Article I of the Constitution to mandate that virtually every individual have health insurance coverage?

a. The Commerce Clause and Necessary and Proper Clause

After dismissing the challenge to its authority to opine on the merits of the individual mandate, Chief Justice Roberts rejected the government's principal arguments that the enactment of the individual mandate was a valid exercise of a power vested in Congress under Article I of the Constitution. Justices Scalia, Kennedy, Thomas, and Alito agreed; Justices Ginsberg, Breyer, Sotomayor, and Kagan did not.

The first justification to fall was the assertion that the individual mandate was a valid exercise of Congress's power to "regulate Commerce" under Article I, § 8, cl. 3. Under that theory, Congress may order individuals to buy health insurance because the failure to purchase insurance has a substantial and deleterious effect on interstate commerce by creating the cost-shifting problem.

By a 5-4 margin, the Court balked at such an expansion of the Commerce Clause powers, noting that Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product. "The power to regulate commerce," per the Chief Justice's opinion, "presupposes the existence of commercial activity to be regulated." Rather than regulating existing commercial activity, a majority found that the individual

mandate "instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce." Construing the Commerce Clause to permit Congress to regulate individuals "precisely because they are doing nothing would open a new and potentially vast domain to congressional authority." In the Chief Justice's view:

> The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to "regulate Commerce." (Opinion at 27)

The Court next rejected the government's assertion that the individual mandate can be sustained under the Necessary and Proper Clause as an integral part of the ACA's guaranteed-issue and community-rating insurance reforms. This clause authorizes Congress to "make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers." Art. I, § 8, cl. 18.

The Court rejected a reading of the Necessary and Proper Clause that would sustain the individual mandate as an essential component of the insurance reforms, finding that "it does not license the exercise of any 'great substantive and independent power[s]' beyond those specifically enumerated." Rather than being derivative of an express power, the individual mandate "vests Congress with the extraordinary ability to create the necessary predicate to the exercise of an enumerated power." (Opinion at 29)

The same result of this portion of the Chief Justice's opinion was reached by the authors of the joint dissent. In their view, the individual mandate "regulates" the failure to maintain minimum essential coverage, and that failure is an abstention from commerce. While the buying and selling of health insurance contracts is commerce generally subject to federal regulation, requiring citizens to buy an insurance contract directs the creation of commerce. The joint dissenters joined the Chief Justice's rejection of the position that the individual mandate is a regulation of activities that have a substantial relation to, or that substantially affect, interstate commerce.

b. The Taxing Clause

After rejecting the Government's primary justifications for the individual mandate, Chief Justice Roberts segued to the next issue with a note of understatement: "That is not the end of the matter." (Opinion at 31) The Court then found the individual mandate was authorized under another congressional power.

The Government had argued, as an alternative to its Commerce Clause argument, that the Court should uphold the individual mandate as an exercise of Congress's power to "lay and collect Taxes." Art. I, § 8, cl. 1. The theory posits that even if Congress lacks the power to direct individuals to buy insurance, the only effect of the individual mandate is to raise taxes on those who do not do so, and thus the law may be upheld as a tax.

Under the Taxing Clause argument, the individual mandate is no longer seen as a regulation requiring individuals to purchase health insurance. Instead, the mandate is construed as imposing a tax on those who do not buy that product. Notwithstanding the ACA's statement that individuals "shall" maintain health insurance, the Chief Justice, joined by Justices Ginsberg, Breyer, Sotomayor, and Kagan, found the Taxing Clause argument to be a reasonable one. 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. If the mandate is in effect just a tax hike on certain taxpayers who do not have health insurance, it may be within Congress's constitutional power to tax. Neither the ACA

nor any other law attaches negative legal consequences, such as criminal fines or imprisonment, to not buying health insurance; it only requires a payment to the IRS. In footnote 11, the Court explains:

> Those subject to the individual mandate may lawfully forgo health insurance and pay higher taxes, or buy health insurance and pay lower taxes. The only thing they may not lawfully do is not buy health insurance and not pay the resulting tax.

The Court's conclusion was guided by the fact that the shared responsibility payment looks like a tax in many respects: It is paid into the Treasury by taxpayers when they file their tax returns; does not apply to individuals who do not pay federal income taxes because their household income is less than the filing threshold in the Internal Revenue Code; is calculated based on taxable income, number of dependents, and joint filing status; is found in the Internal Revenue Code; and is assessed and collected by the IRS "in the same manner as taxes." Payments are expected to raise about $4 billion per year by 2017.

The fact that it is labeled as a penalty rather than as a tax does not curtail the Court's ability to determine whether the shared responsibility payment falls within Congress's taxing power. This conclusion is the obverse of the Court's rationale regarding the description of the shared responsibility payment for purposes of the Anti-Injunction Act. Aspects of the payment that indicate it is substantively a tax rather than a penalty include (i) the amount due will be far less than the price of insurance, and, by statute, it can never be more; (ii) the absence of a requirement of scienter, or knowledge of the wrongful nature of the act; and (iii) the payment is collected solely by the IRS through the normal means of taxation, except the IRS is not allowed to use those means most suggestive of a punitive sanction, such as criminal prosecution. The fact that the individual mandate's primary purpose is to affect individual conduct (i.e., purchasing health insurance) rather than raising general revenue is not determinative: "taxes that seek to influence conduct are nothing new." (Opinion at 36)

The majority dismissed several arguments against a reading of the individual mandate as an exercise of the taxing power. Because it is not a capitation or a tax on the ownership of land or personal property, the shared responsibility payment is not a direct tax that must be apportioned among the several states. It is not unprecedented as a "tax for not doing something," as the Constitution does not guarantee that individuals may avoid taxation through inactivity: "A capitation, after all, is a tax that everyone must pay simply for existing, and capitations are expressly contemplated by the Constitution." While the Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity, "the Constitution has made no such promise with respect to taxes." (Opinion at 42)

While it is risky to attempt to divine the process by which the Court reached the conclusion that the government's "fallback" argument was sufficient to save the ACA after the Commerce Clause argument was found inadequate, the Court recognized its duty to adopt a possible interpretation of an act that would save it rather than one by which it would be unconstitutional.

The joint dissent would not have addressed the issue of the validity of the individual mandate under the taxing power. In the view of these four justices, a statutory provision that constitutes an invalid penalty under the Commerce Clause cannot be a valid exercise of the taxing power. While Congress could have written the law as a tax, it did not do so, and "we cannot rewrite the

statute to be what it is not." They would have found that the individual mandate imposes an exaction for a violation of a law, and therefore is a regulatory penalty. The Chief Justice, in their view, is engaging in "judicial tax-writing." (Joint dissent at 24)

3. Does the provision that cuts off Medicaid funding in states that do not expand their Medicaid programs as contemplated by the ACA exceed the federal government's ability to compel states to enact or administer a federal regulatory program?

The ACA's Medicaid provisions require states to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty level (FPL). The federal government will pay 100 percent of the costs of covering these newly eligible individuals through 2016; thereafter, the federal payment level gradually decreases to a minimum of 90 percent. For the first time, the Court held an exercise of Congress's spending power to be unconstitutionally coercive. A seven-member majority (the Chief Justice, the four joint dissenters, and Justices Breyer and Kagan) found that the ACA's provision empowering the Secretary of HHS to withhold existing Medicaid funding for states that do not agree to the expansion serves no purpose other than to force unwilling states to sign up for the expansion in health care coverage effected by the Act.

The opinion addresses two charges that the Medicaid expansion is unconstitutional. First, states claim that Congress is coercing them to adopt the changes to their Medicaid programs by threatening to withhold all of a state's Medicaid grants unless the state accepts the new expanded funding and complies with the associated conditions. This, they argue, violates the basic principle that the "Federal Government may not compel the States to enact or administer a federal regulatory program." Second, it is asserted that the expansion exceeds Congress's authority under the Spending Clause's grant to Congress of the power "to pay the Debts and provide for the . . . general Welfare of the United States." Art. I, § 8, cl. 1.

The Chief Justice conceded that Congress may use the Spending Clause to grant federal funds to states and to condition such a grant upon the states' taking certain actions that Congress could not require them to take. However, he sees a limit on Congress's power: The legitimacy of Congress's exercise of the spending power rests on whether the state, as an independent sovereign in the federal system, voluntarily and knowingly accepts the terms of a contract with the federal government. States may "defend their prerogatives by adopting 'the simple expedient of not yielding' to federal blandishments when they do not want to embrace the federal policies as their own. The States are separate and independent sovereigns. Sometimes they have to act like it." However, in this case, the way Congress has structured the funding crossed the line distinguishing encouragement from coercion. Congress may condition the receipt of funds on the states' complying with restrictions on the use of those funds, provided that conditions that "take the form of threats to terminate other significant independent grants . . . are properly viewed as a means of pressuring the States to accept policy changes." (Opinion at 50)

The financial inducement offered by Congress is, in the Chief Justice's view, so coercive as to pass the point at which pressure turns into compulsion. He distinguished the case where the states faced the threat of the loss of five percent of highway funds if they did not raise the minimum drinking age, calling that measure "not impermissibly coercive, because Congress was offering only 'relatively mild encouragement to the States.'" (Opinion at 50)

In contrast, the ACA's financial inducement was found to be "much more than 'relatively mild encouragement' - it is a gun to

the head." (Opinion at 51) Medicaid spending accounts for over 20 percent of the average state's total budget, with federal funds covering 50 to 83 percent of those costs. The threat that the HHS Secretary may declare that further Medicaid payments will not be made "is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion." (Opinion at 52)

A critical element of the Court's decision is its finding that the Medicaid expansion contemplated by the ACA is not merely an incremental growth in the program, but instead is a new program. The fact that states agreed when they joined the Medicaid program that Congress could alter, amend, or repeal any provision of its terms is not determinative because the Medicaid expansion accomplishes "a shift in kind, not merely degree." In the Court's reasoning, Medicaid "is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage." (Opinion at 53-54) "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." (Opinion at 54)

Justices Scalia, Kennedy, Thomas, and Alito reached the same result. In their view, "it is a blatant violation of the constitutional structure when the States have no choice" but to have their powers employed and their employees enlisted in a federal scheme. In this case, the ACA's "dramatic expansion of the Medicaid program exceeds Congress' power to attach conditions to federal grants to the States." (Joint dissent at 28)

The joint dissent agrees with the Chief Justice that Congress's power to attach conditions to grants to the states has limits. Conditions "must be unambiguous," "related 'to the federal interest in particular national projects or programs,'" and "may not 'induce the states to engage in activities that would themselves be unconstitutional,'" and "Congress may not cross the 'point at which pressure turns into compulsion, and ceases to be inducement.'" (Joint dissent at 33) Coercing a state into accepting terms of a grant would be as invalid as coercing a private person into entering into a contract. Moreover, coercing states would risk destruction of the role of states in the federal system.

With regard to the question of identifying the point at which a condition ceases to be an inducement and becomes coercive, the joint dissent observes that "[w]hether federal spending legislation crosses the line from enticement to coercion is often difficult to determine, and courts should not conclude that legislation is unconstitutional on this ground unless the coercive nature of an offer is unmistakably clear." (Joint dissent at 38) In the dissenting justices' view, the legitimacy of attaching conditions to federal grants depends on the voluntariness of the states' choice to accept or decline the offered package: If states really have no choice other than to accept the package, the offer is coercive.

The risk of new taxes may be enough to constitute coercion. The average state, if forced out of the Medicaid program, would not only lose its annual federal Medicaid subsidy equal to more than one-fifth of the state's expenditures "but would almost certainly find it necessary to increase its own health-care expenditures substantially, requiring either a drastic reduction in funding for other programs or a large increase in state taxes." (Joint dissent at 28) Withdrawal from the program would likely force the state to impose a huge tax increase on its residents, and "this new state tax would come on top of the federal taxes already paid by residents to support subsidies to participating

States." (Joint dissent at 37) The joint dissent rejected the Court of Appeal's conclusion that "states have the power to tax and raise revenue, and therefore can create and fund programs of their own if they do not like Congress's terms" because a state would be very hard pressed to compensate for the loss of federal funds by cutting other spending or raising additional revenue. (Joint dissent at 40) Threatening to withhold an amount equal to 21.86 percent of all state expenditures combined would not be acceptable.

The joint dissent also notes that accepting the offer to expand the Medicaid program will impose very substantial costs on participating states. State spending is projected to increase by at least $20 billion by 2020 as a consequence of the Medicaid expansion, in addition to administrative costs.

In a concurring opinion, Justice Ginsberg (joined by Justice Sotomayor) rejected the majority's position. She would have held that Congress may expand the classes of needy persons entitled to Medicaid benefits by amending the existing program. Congress reserved the "right to alter, amend, or repeal" any provision of the Medicaid Act, and states agreed to amend their own Medicaid plans consistent with changes from time to time made in the federal law.

She rejects the Chief Justice's views that the Medicaid expansion is a new grant program rather than an addition to the existing program ("Congress styled and clearly viewed the Medicaid expansion as an amendment to the Medicaid Act, not as a 'new' health-care program"); that the expansion was unforeseeable by the states ("Since 1965, Congress has amended the Medicaid program on more than 50 occasions, sometimes quite sizably"); and that the threatened loss of funding is so large that states have no real choice but to participate in the Medicaid expansion (the Medicaid expansion will not "exorbitantly increase state Medicaid spending," citing a Congressional Budget Office projection that states will spend 0.8 percent more than they would have absent the ACA). (Ginsberg at 43)

Justice Ginsberg is critical of the failure of both the Chief Justice and the joint dissenters to "fix the outermost line where persuasion gives way to coercion." In her view, the coercion inquiry "appears to involve political judgments that defy judicial calculation":

> When future Spending Clause challenges arrive, as they likely will in the wake of today's decision, how will litigants and judges assess whether "a State has a legitimate choice whether to accept the federal conditions in exchange for federal funds"? . . . Are courts to measure the number of dollars the Federal Government might withhold for noncompliance? The portion of the State's budget at stake? . . . Does it matter that Florida, unlike most States, imposes no state income tax, and therefore might be able to replace foregone [sic] federal funds with new state revenue? Or that the coercion state officials in fact fear is punishment at the ballot box for turning down a politically popular federal grant? (Ginsberg at 58-59)

4. If Congress does not have the power to enact a provision of the ACA, can its other provisions be severed from the invalid provision and take effect?

The Supreme Court asked the parties to address the question of whether the individual mandate was severable from the ACA's other provisions. However, the Court did not need to address this question because it upheld the individual mandate. To the surprise of many Court-watchers, however, the Court addressed a distinct but related question: Does the invalidity of the provision authorizing the Secretary of HHS to withhold all Medicaid funds from states that do not expand their Medicaid eligibility render all, or any other portion, of the ACA invalid?

Seven justices found that the ACA unconstitutionally gives the HHS Secretary the authority to penalize states that choose not to participate in that new program by taking away their existing Medicaid funding. In the view of the Chief Justice, barring the Secretary from applying 42 U.S.C. § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion "fully remedies the constitutional violation we have identified." (Opinion at 56) He found authority to fashion this remedy in the severability clause in 42 U.S.C. § 1303.

The effect of the severance of the remedy of cutting off all Medicaid funds for states that do not expand Medicaid eligibility is to give states the option of continuing with the pre-ACA version of Medicaid (in which event they will continue to receive federal funding at existing levels). States that agree to expand Medicaid eligibility will be eligible to receive the new federal funds.

The Chief Justice rejected arguments that the entire ACA must fall as a result of the invalidity of the Medicaid expansion remedy. Limiting the financial pressure the Secretary may apply to induce states to accept the terms of the Medicaid expansion may lead some states to decline to participate. In light of the fact that other reforms Congress enacted will remain fully operative as a law and will still function in a way consistent with Congress's basic objectives in enacting the statute, he finds that Congress would not have wanted the whole Act to fall simply because some states may choose not to expand Medicaid eligibility.

Justice Ginsberg, joined by Justices Breyer, Sotomayor, and Kagan, agreed with the Chief Justice that application of the Medicaid Act's severability clause is the appropriate remedy. When a constitutional infirmity mars a statute, the Court "undertakes a salvage operation; it does not demolish the legislation." (Ginsberg at 40)

Justices Scalia, Kennedy, Thomas, and Alito would strike down all of the ACA. In their view, the legislation exceeds federal power both in mandating the purchase of health insurance and in denying nonconsenting states all Medicaid funding. These two provisions are "central to its design and operation, and all other provisions would not have been enacted without them. In our view it must follow that the entire statute is inoperative." (Joint dissent at 3–4)

The joint dissenters would find that the Medicaid expansion, and not merely the Secretary's remedy of cutting off existing funding for states that elect not to participate in the expansion, is unconstitutional. In their view, the "most natural remedy" would be to invalidate the Medicaid expansion entirely. Making the expansion optional would so change the intended operation of the ACA that the result is not, in their view, what Congress intended, and as a result any attempt to allow the remaining provisions to take effect would be an exercise in judicial legislating:

> We should not accept the Government's invitation to attempt to solve a constitutional problem by rewriting the Medicaid Expansion so as to allow States that reject it to retain their pre-existing Medicaid funds. Worse, the Government's remedy, now adopted by the Court, takes the ACA and this Nation in a new direction and charts a course for federalism that the Court, not the Congress, has chosen; but under the Constitution, that power and authority do not rest with this Court. (Joint dissent at 48)

Under their two-part severability analysis, the Court is required first to determine whether the parts of the statute that remain after the unconstitutional provisions are removed will operate in the manner Congress intended, and then—even

if the remaining provisions can operate as Congress designed them to operate—the Court must determine if Congress would have enacted them standing alone and without the unconstitutional portion. Applying this test, the joint dissenters would have held that major provisions of the ACA, including insurance regulations and taxes, reductions in federal reimbursements to hospitals, the exchanges and their federal subsidies, and the employer responsibility assessment, cannot remain once the individual mandate and Medicaid expansion are invalid. "Absent the invalid portions," they reason, "the other major provisions could impose enormous risks of unexpected burdens on patients, the health-care community, and the federal budget" and "would pose a threat to the Nation that Congress did not intend." (Joint dissent at 55–56)

The closing words of the Chief Justice's opinion illustrate the measured approach taken by the Court:

> The Framers created a Federal Government of limited powers, and assigned to this Court the duty of enforcing those limits. The Court does so today. But the Court does not express any opinion on the wisdom of the Affordable Care Act. Under the Constitution, that judgment is reserved to the people. (Opinion at 59)

The Supreme Court's dismissal of most of the constitutional challenges to the ACA removes one set of hurdles to the implementation of the ACA. The possibility remains that the ACA will be amended in ways that range from extending the deadlines imposed on states to repealing or defunding all or portions of the law. Nevertheless, the Court's decision puts the General Assembly in the position to make two major decisions that will affect how the ACA will be implemented in Virginia: Will the Commonwealth establish a state-run health benefit exchange? And will the Commonwealth expand Medicaid eligibility as contemplated by the ACA?

Establishment of a State-Based Health Benefit Exchange

Section 1311 of the ACA directs the establishment of health benefit exchanges. Exchanges will be virtual marketplaces, which may be websites, where individuals and small businesses can obtain information about prices, quality, and networks and buy policies from competing qualified insurers. Health benefit exchanges are expected to help control prices by facilitating competition.

While the primary role of an exchange is to serve as a portal where eligible persons can buy approved health care coverage, exchanges will also be responsible for deciding what health plans may be offered through the exchange; assigning ratings to each plan offered through the exchange on the basis of relative quality and price; providing consumer information on qualified health plans in a standardized format; creating an electronic calculator to allow consumers to assess the cost of coverage after application of any advance premium tax credits and cost-sharing reductions; determining whether an individual is eligible for an exemption from the individual mandate; and operating a website and toll-free telephone hotline offering comparative information on qualified health plans and allowing eligible consumers to apply for and purchase coverage.

Two other aspects of exchanges relate to the Medicaid expansion issue. First, exchanges provide the only mechanism for an individual to receive tax credits and cost-sharing reductions for private insurance. Under the ACA, premium tax credits are available to individuals and families with household income of at least 100 percent but not more than 400 percent of the FPL. Individuals qualifying for "minimum

essential coverage" are not eligible for this subsidy. Medicaid coverage constitutes one form of minimum essential coverage. Consequently, if a state's eligibility threshold for Medicaid coverage is 133 percent of FPL, a citizen with an income of less than that amount cannot receive a premium tax credit, and the only persons with incomes of between 100 and 133 percent of FPL who could get a premium subsidy are certain legal permanent residents ineligible for Medicaid. However, if a state decides not to expand its Medicaid eligibility threshold to 133 percent of FPL, citizens with incomes of between 100 and 133 percent of FPL would be eligible for a premium tax credit if they obtain coverage through the exchange.

Expanding the numbers of citizens who may obtain premium tax credits through the exchange may expose more employers to liability for penalties under § 1513 of the ACA. The ACA does not require employers to offer health care coverage to employees. However, under the measure's "pay or play" approach, an employer with an average of at least 50 full-time equivalent employees is subject to penalties if it either does not offer coverage or offers coverage that is not affordable—but only if an employee receives a government-funded subsidy through the exchange.

Second, exchanges will serve as a portal for determining if an individual is eligible for health care coverage under Medicaid or other public program. Under this "no wrong door" feature, the exchange is intended to provide a seamless and integrated eligibility and enrollment system for state health subsidy programs. As discussed below, the complexity of the questions that must be answered to determine an individual's eligibility for public programs will be affected by the decision of whether Virginia will expand its Medicaid eligibility.

The exchange would not be the only source for buying and selling health insurance coverage. However, an insurer must charge the same rates outside the exchange as it does through the exchange for a comparable product.

Exchanges are required to be operating by January 1, 2014. States have the option of establishing their own exchange. If a state elects to establish and operate its own exchange, it can make many decisions as to how the exchange will be structured and how it will operate. Examples include:

- Who will govern the exchange and write implementing regulations.
- Whether the exchange will actively negotiate with insurers and select which plans are offered through the exchange or allow all qualifying plans to be offered.
- Whether the individual and small business exchanges will be independently operated and have separate risk pools.
- What role insurance agents will play.
- Who will serve as navigators.
- How the exchange's operations will be funded starting in 2015.

In order to have its exchange approved to operate starting in 2014, a state must submit an application to HHS by November 16, 2012. The federal government is required to make a decision regarding the application for approval of a state exchange by January 1, 2013.

If HHS finds that a state's proposal for an exchange does not meet all requirements, but that the state is making significant progress toward these requirements and the exchange will be ready for open enrollment beginning October 1, 2013, HHS may conditionally approve the exchange. If conditional approval is issued, HHS and the state will develop a comprehensive agreement that sets out expected future milestones and dates for operational readiness reviews in order to ensure that the exchange continues to develop at a pace that will allow it to meet the ACA's deadlines.

If HHS finds that a state will not have an exchange able to enroll participants by October 1, 2013, and able to function by January 1, 2014, HHS is required to establish and operate the exchange. As an alternative to a fully federal exchange, states may enter into a partnership with a federally facilitated exchange. Under the partnership model, states have the option to administer plan management functions (including licensure, account management, and oversight of qualified health plans), consumer assistance functions (including in-person support and overseeing the navigator program), or both.

Yet another option is for states to create a multistate or regional exchange. Moreover, a state that does not receive full or conditional approval in 2013 may establish a state exchange in any year after 2014, to be effective after a 12-month transition period.

To date, Virginia has not applied for federal funds to establish an exchange. The application deadline for a Level II Establishment grant has been extended from June 29, 2012, to August 15, 2012.

Expanding Medicaid Eligibility

In light of the Supreme Court's ruling, Virginia will need to decide whether to accept the Medicaid expansion set out in the ACA. Acceptance or rejection of the Medicaid expansion each raises a complex set of issues.

1. Virginia Accepts Medicaid Expansion

Should the Medicaid expansion occur, an estimated 420,000 Virginians would gain Medicaid coverage. If the Commonwealth decides to accept the expansion, the increased federal medical assistance percentage (FMAP) for newly eligible individuals will be as originally contemplated by the ACA. The federal government is required to pay 100 percent of the added cost of the expanded coverage provisions for the years 2014, 2015, and 2016. After 2016, the FMAP will drop to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and subsequent years. Virginia's existing FMAP of 50 percent for existing enrollees will remain unchanged. The "newly eligible" are individuals age 19 to 64 with incomes at or below 133 percent of the FPL. This group includes childless adults, who previously have not qualified for Medicaid in Virginia. While these individuals are expected to make up the majority of the newly eligible group, they are typically the least expensive type of enrollees to cover.

One of the most important questions concerning Medicaid expansion is the cost to the state. Several factors complicate any estimation of these costs. First are the actual costs of providing coverage. The ACA dictates certain minimum standards for care required for new enrollees. However, to some extent these exact standards will be decided by the state. So while we can predict the number of Virginians who will be added to the Medicaid roles, the exact cost of covering these individuals may not be entirely clear. In addition to the cost of providing coverage, states may incur additional administrative costs.

Another factor in considering the cost of expansion is the cost of uncompensated care. Now both the federal and state governments appropriate funds to hospitals that provide uncompensated care to the uninsured. It is anticipated that the ACA will lead to smaller numbers of uninsured Virginians; this should in turn cause a decrease in the need for uncompensated care payments. The state also funds community services boards and behavioral health authorities that provide services to the mentally ill, many of whom are uninsured. Providing coverage to this group could also decrease uncompensated care costs. However, under the ACA, the federal government will be

decreasing its disproportionate share hospital (DSH) payments over several years as the Act is implemented. So while overall levels of uncompensated care may decrease, it is unclear how the state's share of these costs will change.

2. Virginia Rejects Medicaid Expansion

If Virginia decides not to accept the Medicaid expansion, our existing Medicaid program will continue undisturbed and we will continue to receive our existing FMAP. However, just as before this ruling, changes to the existing Medicaid program are possible. In its ruling on the ACA's Medicaid expansion, the Court recognized that the federal government has the power to amend existing spending programs and to hold the states accountable for compliance. In other words, future changes to the Medicaid program will be upheld, as long as they leave the states with an actual choice in whether to accept them. The Chief Justice admits that he is not sure where the line between persuasion and coercion falls. Part of the Court's reasoning in finding the expansion coercive was the percentage of the states' budgets that federal Medicaid funds compose. He also saw the expansion as a program separate from the existing Medicaid program, largely because it opened Medicaid to an entirely new class of beneficiaries: nondisabled childless adults. So while we know that future changes to the existing Medicaid program are allowable, they may be subject to challenge until the Court further defines the distinction between persuasive (constitutional) and coercive (unconstitutional).

The ACA obviously contemplated the implementation of the Medicaid expansion in every state. If a state declines to participate in the expansion, a certain population may be left without coverage. Those making less than 133 percent of FPL, but not currently eligible for Medicaid, may still be unable to afford coverage. In 2012, 133 percent of the FPL is $14,856 for one person and $30,657 for a family of four. It is also unclear how many in this group will qualify for an exemption from the individual mandate's shared responsibility payment based on income or the availability of "affordable" health care coverage.

It is also unclear how this population will affect uncompensated care costs to the Commonwealth. Presumably, uncompensated care costs would remain about the same or decrease, as this population is likely currently uninsured. We know that DSH payments will be reduced, but the ACA only gives aggregate numbers for each year of reduction; it is unclear how this reduction will be apportioned among the states.

Another complication of rejecting the expansion relates to the ACA's enrollment simplification requirement. By January 1, 2014, applicants must be able to apply for Medicaid, SCHIP, or any health plan offered through the exchange via a secure website maintained by the state, using one application and an electronic signature. Under the expansion, the Medicaid eligibility determination is made based only on questions about age and income. The current application process is much more complicated, requiring different applications for each eligibility category, along with documentation of income, and assets, and involving nonfinancial as well as financial factors. Making this complicated application accessible online may prove challenging.

Further Questions

The ACA contemplated that the implementation date for the Medicaid expansion would be January 1, 2014. However, many of the details as to how the expansion will be implemented will not be known until further guidance is issued by the

Secretary of HHS. Questions yet to be answered include:

- When will states need to decide whether or not to implement the Medicaid expansion?
- What type of state action will be required to accept or reject the expansion? Will it require legislative action? Executive action? Or will that decision be left up to the state?
- Will the Secretary require states to opt out, with an assumed opt-in, or vice versa?
- Will acceptance or rejection of the expansion be an all-or-nothing proposition, or can states choose to accept certain parts and not others? If so, how will those parts be funded?
- Will there be new options to expand the existing Medicaid programs for states that choose not to accept the ACA's expansion?
- If a state expands its Medicaid coverage from current levels to a level that is less than 133 percent of FPL, will it be eligible for any increase in federal funding available for newly covered populations?
- Once a state opts in, will it be allowed to later opt out? For example, could a state opt in through 2016, while the FMAP is 100 percent, and then opt out in 2017 or thereafter?
- Will there be other changes either to the expansion or to existing Medicaid programs in light of the Court's opinion?

Notes

[1] In the 2010 Session, the General Assembly enacted House Bill 10, which added Virginia Code § 38.2-3430.1:1, which provides that "[n]o resident of this Commonwealth, regardless of whether he has or is eligible for health insurance coverage under any policy or program provided by or through his employer, or a plan sponsored by the Commonwealth or the federal government, shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services where an individual is named a party in a judicial or administrative proceeding. No provision of this title shall render a resident of this Commonwealth liable for any penalty, assessment, fee, or fine as a result of his failure to procure or obtain health insurance coverage. This section shall not apply to individuals voluntarily applying for coverage under a state-administered program pursuant to Title XIX or Title XXI of the Social Security Act. This section shall not apply to students being required by an institution of higher education to obtain and maintain health insurance as a condition of enrollment. Nothing herein shall impair the rights of persons to privately contract for health insurance for family members or former family members."

[2] On March 23, 2010, Attorney General Cuccinelli filed a complaint in the U.S. District Court for the Eastern District of Virginia challenging the health care reform law on grounds that the individual mandate exceeds the enumerated powers conferred upon Congress by the U.S. Constitution and that, because PPACA lacks a severability clause, the entire act is therefore invalid. On December 13, 2010, the court ruled that the individual mandate was unconstitutional. On appeal, the Fourth Circuit Court of Appeals reversed on grounds that Virginia lacked standing, notwithstanding the enactment of Virginia Code § 38.2-3430.1:1. The Supreme Court denied Virginia's petition for certiorari. Virginia's case was not consolidated with the proceeding filed by Florida.

[3] The appeals for which certiorari were granted were by the NFIB (*Nat'l Fed. of Independent Bus. v. Sebelius*, No. 11-393), by the states (*Florida v. U.S. Dept. of Health and Human Svcs.*, No. 11-400), and by the federal government (*U.S. Dept. of Health and Human Svcs. v. Florida*, No. 11-398).

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