Health Care ADVISORY

May 30, 2012

Potential Implications of the Supreme Court Decision on the Affordable Care Act

During the week of March 26, 2012, the Supreme Court heard an unprecedented three days of oral argument on the question of the constitutionality of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (the "Affordable Care Act," or ACA). The Court is expected to issue its decision in June.

Alston & Bird's April 4, 2012, Health Care Advisory[1] focused on oral argument before the Supreme Court on the primary issues presently being considered by the Supreme Court in the cases.[2] In this advisory, we focus on some of the implications and issues that may arise as a result of the Supreme Court's ruling and address such implications and issues arising from three potential outcomes of the cases before the Supreme Court:[3]

(1) The Supreme Court holds that the individual mandate is constitutional and upholds the ACA in its entirety.

(2) The Supreme Court holds that the individual mandate is unconstitutional, finds that the ACA is so intertwined with the mandate that no provision can be severed from the mandate, and strikes the ACA down in its entirety.

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1 Available at http://www.alston.com/Health_Care_Advisory_Supreme_Court.

2 In *National Federation of Independent Business, et al. v. Sebelius, et al.*, No. 11-393, *U.S. Department of Health and Human Services, et al. v. Florida, et al., No. 11-398, and Florida, et al. v. U.S. Department of Health and Human Services, et al.*, No. 11-400, the Supreme Court is considering the following issues: (1) Does the Anti-Injunction Act (AIA) preclude Supreme Court review of the "individual mandate" at this time? (2) If the AIA does not preclude judicial review, does Congress have the authority under the U.S. Constitution's Commerce Clause to require Americans to obtain health insurance or pay a penalty ("individual mandate")? (3) If the individual mandate is unconstitutional, what happens to the rest of the ACA? Does it remain good law, or are some or all of the other provisions of the ACA so intertwined with the individual mandate that they cannot be severed from the individual mandate and must fall with it? (4) Does Congress have the authority under the Spending Clause to impose expanded Medicaid eligibility and coverage on the states as a condition for the receipt of federal Medicaid funding or is such a condition so coercive as to become unconstitutional compulsion?

3 For purposes of this memorandum, we assume that the Supreme Court will conclude that the AIA does not preclude the Court from considering the constitutionality of the individual mandate. Similarly, we do not address in this memorandum the implications of the Supreme Court's decision on the Medicaid expansion provisions.

(3) The Supreme Court holds that the individual mandate is unconstitutional, finds that the ACA is severable from the mandate, and strikes down only the individual mandate.[4]

The Supreme Court Rules the Individual Mandate Constitutional

If the Supreme Court rules the individual mandate is a constitutionally permissible exercise of Congress's power under the Constitution's Commerce Clause, the ACA and all implementing regulations remain the law of the land and will remain in effect, at least for the time being.

Some states may choose to move forward with implementing the ACA (work on the establishment of state health insurance exchanges, begin expanding the Medicaid rolls, etc.). Other states may take a "wait-and-see" approach to the ACA requirements, waiting on the outcome of the 2012 elections and any subsequent congressional effort to repeal and/or replace the ACA. Health care providers, insurers and others implementing aspects of the ACA will experience some increased stability. However, it is important for all stakeholders and other interested parties to realize that the implementation of new programs is never easy. Given the magnitude of the changes, the shortness of the time in which such changes have to occur, and the delays in the development of the implementing regulations, it would be wise to expect at least some significant implementation and operational issues that will have to be addressed. One example is the exchanges. Will state exchanges be ready to operate on January 1, 2014? If not, will the federal fallback exchanges be ready to operate? Will the exchanges be ready to make determinations concerning eligibility for subsidies and for Medicaid coverage? Will they be prepared to transfer payment of subsidies to the appropriate health plan issuers on behalf of the appropriate enrollees?

A Supreme Court decision upholding the constitutionality of the individual mandate would not mark the end of litigation over the ACA, whether such litigation challenges the constitutionality of various provisions or the statutory authority under the ACA to impose certain regulatory requirements. There are a number of current lawsuits that illustrate this point. There will be continued litigation over the constitutionality of the Independent Payment Advisory Board (IPAB). The plaintiffs in *Coons v. Geithner*, pending in the U.S. District Court for the District of Arizona, have challenged the constitutionality of the ACA provision on the grounds that it constitutes an unconstitutional delegation of legislative authority to the IPAB and violates the separation of powers. The plaintiffs also contend that the IPAB provisions limiting the ability to repeal the board and congressional ability to reject an IPAB recommendation violates congressional Article I authority. There is also ongoing litigation, in *Physician Hospitals of America v. Sebelius*, over the limitations imposed on physician-owned hospitals. The challenges are raised under the due process and equal protection provisions of the Constitution's Fifth Amendment, as well as under the Takings Clause.

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[4] Any number of provisions could be held inseverable from the individual mandate and, thus, could be stricken if the Supreme Court holds the individual mandate unconstitutional. However, most of the implications of such variations are common to the other scenarios. For example, we note the various legal challenges that may arise if the ACA is upheld in its entirety. Many of these legal challenges also may arise if only the individual mandate is struck or if the Supreme Court strikes down the individual mandate and some limited set of ACA provisions as inseverable from the mandate. Similarly, if the Supreme Court strikes the individual mandate and the balance of Title I, the implications for hospitals and other provider groups with respect to taxes and fees would be similar to the issues that would arise if only the individual mandate is struck down.

Religious organizations and employers—including, most recently, 43 Catholic organizations (the Archdiocese of Washington, D.C., the University of Notre Dame, the Catholic University of America and others) in 12 lawsuits—are challenging, under the First Amendment's Free Exercise of Religion Clause and the Religious Freedom Restoration Act, the regulations requiring the provision of contraceptives as preventive services and the failure to provide a meaningful exemption for religious organizations. Once the federal government finalizes its proposed "accommodation," it is quite possible that there will be challenges to the anticipated requirement that insurers and third-party administrators that have contracted with religious organizations provide free contraception coverage to employees of objecting religious employers on numerous bases, including lack of statutory authority and the Constitution's Takings Clause. Religious employers may continue to challenge the regulatory provisions under the First Amendment and the Religious Freedom Restoration Act. There also may be Takings Clause challenges to the ACA's insurance market regulatory provisions and challenges under the Administrative Procedures Act to certain regulations implementing the insurance market reforms.

The Supreme Court Strikes Down the ACA in Its Entirety

A. General Implications

If the Supreme Court rules that the individual mandate is unconstitutional and that the remaining provisions of the ACA are inextricably intertwined with the mandate so as to be inseverable from it, the entire ACA will be struck down. Such a decision could have serious implications both prospectively and with respect to activities already under way.

Prospectively, a Supreme Court decision striking down the ACA would mean that the federal government no longer could take action on the basis of the authority provided in the ACA. This would require both the federal government and regulated entities to consider whether the U.S. Department of Health and Human Services (HHS) or other federal agencies have independent statutory authority—apart from the ACA—to undertake the activities, programs and/or regulatory schemes enacted in the ACA. And if there is such authority, does the department have the appropriated funds to continue to implement the programs authorized by the ACA?[5]

More difficult questions would arise with respect to government actions that occurred between March 23, 2010, the date on which the ACA was signed into law, and the date on which the Supreme Court ruling takes effect. The decision would come more than two years after passage of the ACA. Millions of dollars have been spent. Grants and contracts have been issued to carry out ACA directives. The Centers for Medicare & Medicaid Services (CMS) has created the Center for Medicare and Medicaid Innovation to encourage programmatic innovation and the Federal Coordinated Health Care Office to address issues unique to dual eligibles (people eligible for both Medicare and Medicaid). Numerous health insurance policies and health plans have been changed to comply with the ACA. What happens? Are the centers and offices disestablished? Are the programs undone? Do entities that received funds under ACA programs have to repay those funds? Would CMS be required to

[5] In many instances, the availability of funds may be the limiting factor with respect to ACA-authorized programs. In most instances, programs are created and appropriations are authorized in authorizing legislation and funds are actually appropriated to carry out the programs in appropriations legislation. In the ACA, however, there are over 40 instances in which monies are appropriated by the ACA to fund new and/or existing programs. *See* Congressional Research Service, Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act, R41301, December 10, 2010. If the Supreme Court strikes the ACA in its entirety, these appropriations would be terminated.

reimburse providers for reduced payments?

The Supreme Court has addressed issues of this nature in several instances where it has struck down important regulatory or judicial schemes on constitutional grounds. In *Chicot County Drainage District v. Baxter State Bank*, 308 U.S. 371 (1940), the Court noted:

> The courts below have proceeded on the theory that the Act of Congress, having been found to be unconstitutional, was not a law; that it was inoperative, conferring no rights and imposing no duties, and hence affording no basis for the challenged decree. . . . It is quite clear, however, that such broad statements as to the effect of a determination of unconstitutionality must be taken with qualifications. The actual existence of a statute, prior to such a determination, is an operative fact and may have consequences which cannot justly be ignored. The past cannot always be erased by a new judicial declaration. The effect of the subsequent ruling as to invalidity may have to be considered in various aspects, ... Questions of rights claimed to have become vested, of status, of prior determinations deemed to have finality and acted upon accordingly, of public policy in the light of the nature both of the statute and of its previous application, demand examination. . . . [I]t is manifest from numerous decisions that an all-inclusive statement of a principle of absolute retroactive invalidity cannot be justified.[6]

More recently, when the Supreme Court struck down as unconstitutional a bankruptcy law provision that gave bankruptcy judges jurisdiction over certain disputes, the Court declined to apply the decision retroactively and gave the decision only prospective application.[7]

Even if the Supreme Court does not address the issue, the nature of the decision and the principle of "reasonable reliance" would seem to lead to the conclusion that completed activities—contracts and grants that have been issued, payments that have been made, increases or reductions in reimbursements that have occurred—likely would not be undone. If the Court strikes the mandate as unconstitutional and the balance of the ACA's provisions as inseverable from the mandate, it would be saying that the other ACA provisions are not necessarily unconstitutional but are being stricken because they are inextricably intertwined with the unconstitutional mandate. Arguably, actions of federal agencies taken under such provisions of the ACA prior to it being struck down would be deemed valid because they were pursuant to valid statutory authority. Indeed, the Supreme Court has recognized in various instances in the past that the government can be held to the benefit of bargains struck with private entities in cases ranging from congressional rescinding of tax incentives to contracts related to terminated defense programs.[8] Accordingly, contracts and grants issued under the ACA—and other actions undertaken pursuant to the ACA—prior to a Supreme Court's decision

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6 *Chicot County Drainage Dist. v. Baxter State Bank*, 308 U.S. 371, 374 (1940) (citations omitted).

7 *See Northern Pipeline Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 87-88 (1982) (denying retroactive application of decision and staying decision for period of time to permit Congress to adopt legislation to reconstitute bankruptcy courts along constitutional lines). In that decision, the Court outlined three factors it considers when determining whether to give a decision retroactive effect—that is, effect back to the effective date(s) of the statute: (1) whether the holding decided an issue of first impression, (2) whether retroactive application of the decision would further or retard the operation of the holding in question and (3) whether retroactive application could produce substantial inequitable results in individual cases. *Id*. These factors would suggest that a Supreme Court ruling striking the individual mandate and some or all of the other provisions of the ACA should be given only prospective application.

8 *See,* e.g., *United States v. Winstar Corp.,* 518 U.S. 839 (1996); *General Dynamics Corp. v. United States*, 563 U.S. __, 131 S. Ct. 1900 (2011).

striking down the ACA are unlikely to be undone.

B. Potential Effect on Specific Actions under the ACA

Below are potential implications for particular programs and policies if the ACA is struck in its entirety.

Provider Reimbursement Reductions. The ACA imposed a number of Medicare provider reimbursement reductions, including productivity adjustments (that reduce reimbursements based on assumed increases in productivity) and reductions in market basket updates. Some of these payment reductions have taken effect, while others are scheduled to occur in the future. If the ACA is struck down in its entirety, these provisions will be voided. Future reductions required by the ACA would not occur. Absent new authorization, rates likely would be restored to what they would have been in the absence of the ACA-required reductions. To the extent that reduced payments have already occurred, however, it is unlikely that CMS would be required to make up the difference between the amounts that providers received and the amounts that they would have received in the absence of the ACA-required reductions.

Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office. HHS and CMS have inherent authority to create new offices and centers and/or to reorganize existing offices and centers to address issues within their statutory purview or to administer and operate programs more efficiently. They have exercised this inherent authority in the past—in the reorganization and renaming of the Health Care Financing Administration to the Centers for Medicare & Medicaid Services; the creation of the HHS Office on Disabilities, the Office of Minority Health, the Office of Women's Health and the Office of Preparedness and Response; and, most recently, in April 2012, in the creation of the Administration for Community Living to house the Administration on Aging, the Office on Disabilities and the Administration on Developmental Disabilities. All of these offices were created or reorganized initially without statutory direction. Accordingly, even without ACA authorization, CMS would be able to create an office to address the coordination and provision of Medicare and Medicaid services to dual eligibles and to create a center to develop and experiment with innovations to improve the Medicare and Medicaid programs.[9]

New CMS Programs. CMS may be able to carry out certain programs authorized by the ACA utilizing its demonstration or waiver authorities.[10] It has the authority, directly or through grant or contract, to develop and engage in experiments and demonstration projects to determine whether changes in the methods of payment or reimbursement for health care and services under the Medicare or Medicaid programs would have the effect of increasing the efficiency and economy of health services under such program without adversely affecting the quality of such services. It similarly has waiver authorities under which it is authorized to waive selected Medicare and Medicaid requirements, as well as to approve waivers to permit participation by individuals not otherwise eligible for Medicaid. CMS could conduct, or could continue for an interim period, programs such as accountable care organizations, dual eligibles demonstrations, bundled payments, provision of family planning services and others as demonstration projects or pursuant to its waiver authority.

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[9] This analysis does not consider whether there would be sufficient funds for these offices to carry out the programs authorized by the ACA or whether such restructurings would constitute reprogramming of funds or a reorganization that might require notice to Congress.

[10] There may be limitations imposed by virtue of the availability of funds to support these programs.

Public Health and Public Health Grant Programs. Assuming availability of funds, some of the public health and public health grant programs authorized by the ACA potentially could be conducted under pre-ACA authorities contained in the Public Health Service Act. Under the Public Health Service Act, HHS has authority to (1) conduct (and enter into public-private partnerships to engage in) activities for health promotion and disease prevention, including educational/public awareness campaigns and dissemination of information; (2) make grants for the creation and/or construction of community health care facilities; (3) make grants to support community-based care for low income populations; and (4) issue grants, including grants to local governments and Indian tribes, to promote/provide public health community interventions. Under these authorities, HHS potentially could conduct such ACA-authorized programs as the community-based collaborative care grants, the healthy aging/living well program, and grants for school based health centers.

Health Insurance Market Reforms. There are certain ACA health insurance market reforms that are in effect and that are reflected in current health insurance policies and group health plan documents. Thus, as a matter of contract law, a health insurer or employer-sponsored group health plan may be obligated to continue to provide such benefits for the balance of the policy year, unless the policy or contract provides an exception for changes in law. Health insurers also would need to consider state health insurance laws. Does state law contain the same or similar requirements that would continue to be applicable? If so, the state law may impose an independent obligation to continue to provide certain benefits or meet certain requirements. In addition, insurers or employers sponsoring group health plans may want to consider whether there are any benefits or services that it makes sense to continue to offer employees or policyholders, based on a cost/benefit analysis or in terms of the goodwill that it may lead to among policyholders/enrollees and regardless of whether there is independent statutory obligation to provide such benefits or services.

ACA Transitional High-Risk Pools. By virtue of the fact that the current high-risk pool participants enrolled in the program and have paid and are paying premiums, there may be a contractual or quasi-contractual obligation to continue to provide benefits to them for a certain period of time, in accordance with program/plan documents.[11]

The Supreme Court Strikes Down Only the Individual Mandate

If the Supreme Court holds that the individual mandate is unconstitutional but strikes down only the individual mandate, the remaining provisions of the ACA would remain in effect. Similarly, all government actions taken pursuant to the remaining provisions of the ACA to date, including regulations and contracts, would remain in effect. In addition, government agencies could continue to take prospective action, such as enacting new regulations, pursuant to the remaining provisions of the ACA.

Because the individual mandate that individuals purchase health insurance does not take effect until January 1, 2014, nothing would change immediately for health care providers and insurers who have been affected by

[11] There are certain provisions in the ACA—e.g., Indian Health Care Improvement Act Reauthorization, the biosimilars approval pathway, the elder justice provisions—that likely would have been adopted anyway and were inserted into the ACA because it was an available legislative vehicle. If the Supreme Court strikes down the ACA in its entirety, those provisions would be also struck down.

other provisions of the ACA. What potentially could affect health care providers and insurers are challenges brought to provisions of the ACA that remain in place.[12]

Health Insurance Issuers. If the Supreme Court struck down only the individual mandate, the ruling could have serious consequences for the health insurance industry. The individual mandate was designed to prevent adverse selection from the insurance market reforms. Without the individual mandate, the combination of the insurance market reform provisions—especially community rating, the prohibition of preexisting condition exclusions and on discriminating against individuals on the basis of health status, and the requirement for guaranteed issuance and renewability—could create a free rider problem and guarantee adverse selection. That is, many people would purchase health insurance only when they get sick or otherwise desire to purchase health care. This could lead to large increases in insurance premiums and could present tremendous challenges for some insurance companies.

The individual mandate was intended to increase the ranks of the insured (and the resulting premium revenue) to offset the increased costs associated with the insurance market reforms in the ACA. The combination of the previously mentioned reforms plus others, including the minimum loss ratio requirements and rate review provisions, potentially could serve as the basis for a Takings Clause challenge to the ACA. An interested party could argue that the federal and state governments effectively have converted the health insurance industry into a public utility and have effected a takings by so heavily regulating the industry that it prevents the industry—or at least certain individual companies within the industry—from earning a reasonable risk-adjusted rate of return on its accumulated capital.[13]

Hospitals and Other Provider Groups. There also could be significant implications for hospitals if only the mandate is struck down. Under the ACA, Medicare and Medicaid Disproportionate Share Hospital payments (payments for uncompensated care) were reduced because, with the individual mandate, more people would have insurance and there would be less uncompensated care. Hospitals also were willing to accept reductions in Medicare market basket updates for similar reasons. If the Supreme Court strikes only the mandate, it would leave hospitals with lower Medicare and Medicaid payments without the compensating increase in private insurance payments.

Taxes and Fees. The ACA contains a number of taxes and fees imposed on particular industries and employers, including the health insurance tax, the tax on "Cadillac" health plans, the pharmaceutical industry fees and the medical device tax. These taxes and fees were included to help pay for the ACA's subsidies and coverage expansions. If only the individual mandate falls, these taxes and fees would remain on the books, and the revenues would be available for repurposing. The various affected industries would lose any potential offsetting benefit from the ACA-mandated coverage expansion.

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12 *See supra* at 2-3.

13 *See generally Federal Power Commission v. Hope Natural Gas Co.,* 320 U.S. 591 (1944); *Duquesne Light Co. v. Barasch*, 488 U.S. 299 (1989) ("A state's regulation of an industry's rates will constitute a taking where the resulting rates are insufficient to permit the company to realize a reasonable rate of return or are insufficient to ensure investors' confidence in the ongoing financial integrity of the company.").

What Are Your Options if the Ruling Impacts Your Business?

There are many potential complications no matter how the Supreme Court ultimately rules in this case. Although the precise actions a given company or industry should take to respond to the ruling will depend on how it positively or negatively impacts such company or industry, the following are potential steps to consider:

- **Seek out advice from health care regulatory counsel to determine exactly what effect the ruling is likely to have on your company or industry.**
  - Consider the nature of your rights or obligations under the ACA:
    - Is there other law—federal or state—that could provide independent authority?
    - Do you have a legal interest from a contract, grant or other binding document?
    - Is there a contract, grant or other document associated with your interest that might address your rights or obligations—or provide termination provisions?
    - Are you subject to fees or taxes under the ACA?
  - Are there programs that you would like to see continued (or ended)?
    - Is there other authority under which such program could proceed?
    - Are there appropriated monies to carry out the program?
- **Consider if there is a need to educate Executive Agencies on:**
  - continuing authority for favored programs
  - how appropriated monies can be used for such programs
  - why continuing authority should not be exercised with respect to other programs
- **Consider if there is a need to educate Congress on:**
  - the need to act to remedy problems or inconsistencies created by the ruling
  - the need to appropriate monies to replace monies appropriated under the ACA
- **Monitor agency action following the ruling and seek guidance from agencies about how they intend to respond to the ruling.**
- **Contact Congress to request legislation to address any problems or inconsistencies that are created by the ruling.**
- **If circumstances warrant, consider possible litigation options:**
  - challenges to implementation of the ACA, both statutory and constitutional
  - challenges to remaining ACA provisions
  - challenges to government attempts to withdraw vested contracts or grants
  - suits seeking reimbursement of payment reductions

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