The Supreme Court Opens the Road to Health Care Reform, But Will California Meet the Challenge?

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Almost 28 months after President Barack Obama signed the Affordable Care Act ("ACA")[1] into law, the United States Supreme Court upheld the constitutionality of health care reform.[2] Though the underlying arguments set forth in the 59-page majority slip opinion venture deep into the labyrinth of constitutional law and test the traditional boundaries of federalism, the holding itself is clear and concise: (1) the ACA's individual mandate is constitutional;[3] and (2) the Medicaid expansion provisions found within the ACA survive, but the Federal Government is prohibited from penalizing "[s]tates that choose not to participate in [the Medicaid expansion] by taking away their existing Medicaid funding."[4] The decision promises to have a dramatic effect on California, as the country's most populous state.

In ruling that the individual mandate is constitutional, the Court rejected the Commerce Clause[5] and the Necessary and Proper Clause[6] in the Constitution as bases for upholding the mandate. The Court held that the Commerce Clause failed to provide a sufficient nexus between the requirement to purchase health insurance and its anticipated effect on interstate commerce to validate the individual mandate:

> No matter how "inherently integrated" health insurance and health care consumption may be, they are not the same thing: They involve different transactions, entered into at different times, with different providers. And for most of those targeted by the mandate, significant health care needs will be years, or even decades, away. The proximity and degree of connection between the mandate and the subsequent commercial activity is too lacking to justify an exception . . . .[7]

Chief Justice Roberts noted that the Commerce Clause does not give Congress the authority to compel an individual "to *become* active in commerce by purchasing a product, on the ground that . . . failure to do so affects interstate Commerce." [8] Likewise, the Court rejected the Necessary and Proper Clause as a means to sustain the individual mandate, finding it was not "an essential component of the insurance reforms."[9] The Court distinguished previous decisions upholding laws under the Necessary and Proper Clause, because the laws at issue in those cases "involved exercises of authority derivative of, and in service to, a granted power," while upholding the individual mandate under the Necessary and Proper Clause would have recognized in the Constitution a grant to Congress of the ability to create the "necessary predicate to the exercise of an enumerated power." The Court concluded: "Even if the individual mandate is 'necessary' to the Act's insurance reforms, such an expansion of federal power is not a 'proper' means for making those reforms effective."[10] Instead, the Court upheld the constitutionality of the individual mandate through Congress's authority to "lay and collect Taxes."[11] In so doing, the Court did acknowledge that Congress's taxing authority can exceed its power to regulate commerce, but the Court made the subtle distinction that the power to tax affords Congress less control over individual behavior than its power to regulate commerce.[12] Under its taxing power, Congress can only require that "an individual to pay money into the Federal Treasury, no more."[13]

California stands to gain more than any other state when its seven million[14] of the nation's estimated 50 million uninsured comply with the individual mandate in 2014,[15] although it remains to be seen how Californians will satisfy the ACA's most publicized provision in their quest for "minimal essential coverage."[16] The role employer-sponsored plans will play in providing health insurance throughout the state remains to be seen, especially as many businesses consider abandoning their own health plans in favor of the statutory penalty under the ACA.[17]

Under the ACA, beginning in 2014, individuals and small businesses will be able to "shop" for insurance through exchanges. California was the first state in the nation to create a health benefit exchange,[18] and its California Health Benefit Exchange is an independent public entity with a five-member board and 36 employees. It is the intention of California's Health Benefit Exchange to ensure that the state will be capable of plugging any holes that may sprout within the system. According to Peter V. Lee, executive director of the California Health Benefit Exchange: "We know buying insurance is really complicated. We want to make it as easy as buying a book on Amazon."[19] Such a tall order for America's most populous state will no doubt resonate throughout all major industries, and it will be incumbent upon California attorneys to guide their clients through any number of corporate, employment, insurance, constitutional and financial hurdles, not to mention the obvious health care uncertainties that remain in the wake of the Supreme Court's historic decision.

The second part of the Court's decision confirmed the constitutionality of the ACA's Medicaid expansion provisions, though this came at a price. The Court held that Congress has the authority to offer funding for states to expand Medicaid by 2014,[20] but that Congress will not be entitled to surprise states "with post acceptance or 'retroactive' conditions."[21] This limitation on the Medicare expansion provision prevents the Federal Government from withdrawing existing Medicaid funding should a state refuse to participate in the expansion provisions under the ACA.[22]

Chief Justice Roberts summarized the Court's ruling on the Medicaid expansion provisions as follows:

> The Court today limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion. As a practical matter, that means States may now choose to reject the expansion; that is the whole point. But that does not mean all or even any will. Some States may indeed decline to participate, either because they are unsure they will be able to afford their share of the new funding obligations, or because they are unwilling to commit the administrative resources necessary to support the expansion. Other States, however, may voluntarily sign up, finding the idea of expanding Medicaid coverage attractive, particularly given the level of federal funding the Act offers at the outset.[23]

For California, Medicaid expansion means that the Federal Government will cover 100 percent of the state's costs for insuring new Medi-Cal[24] beneficiaries accessing the program under the ACA in 2014, 2015 and 2016. Coverage under the ACA drops by one percentage point between 2017 and 2020, and after 2020 the Federal Government will cover ninety percent of California's new expenses under Medicaid.[25] Given the state of health care in California, coupled with the state's tenuous economy and current budgetary concerns, it would be difficult to imagine a scenario where California would reject this offer.[26]

At a minimum, Medicaid expansion would reduce the financial burden on hospitals in California hit hard by the fact that they must treat the uninsured. To many of the state's residents, emergency departments serve as a major, if not the only point, of access to health care, and under federal law hospitals are limited in the ways in which they can respond.[27] The 1986 Emergency Medical Treatment and Active Labor Act ("EMTALA")[28] requires nearly all hospitals in California to provide a specified level of care to anyone presenting for emergency medical treatment, regardless of citizenship, legal status, or ability to pay, or risk the imposition of hefty fines or loss of participation in federal health care programs such as Medicare and Medicaid.[29]

The California Hospital Association reacted favorably to the decision, announcing that the expansion of Medicaid "could extend coverage to an estimated 2 million low-income uninsured Californians," and that full implementation of the California Health Benefit Exchange is expected "to provide coverage to more than 2 million additional California residents."[30] The reaction from the California Medical Association ("CMA"), however, was mixed. While the CMA applauded the extension of insurance coverage to uninsured Californians, CMA President James T. Hay, M.D. remarked that the ACA "does not guarantee that these newly insured patients will have access to doctors because the Medicare and Medicaid programs were left grossly underfunded."[31] According to Dr. Hay: "Expanding coverage to more Californians, putting an end to insurance industry abuses, and support for primary care are essential for our patients and the future of medicine."[32] Dr. Hay added: "Despite these wins, the ACA builds reform on the broken foundations of Medicare and Medicaid without addressing the underlying problems and inadequate funding. CMA will continue to work to fix those ills."[33]

While health plans recognized the benefit of increasing numbers of enrollees, America's Health Insurance Plans' President and CEO, Karen Ignagni, expressed concerned about cost:

> The law expands coverage to millions of Americans,

> a goal health plans have long supported, but major provisions, such as the premium tax, will have the unintended consequences of raising costs and disrupting coverage unless they are addressed.[34]

With Medicaid's expansion comes greater responsibility on the part of the state. California faces the unenviable task of establishing health insurance exchanges to accommodate an unknown number of beneficiaries seeking coverage in 2014. Health care service plans that wish to participate in California's exchange must "fairly and affirmatively offer, market, and sell in the Exchange at least one product within each of the five levels of coverage" required by the ACA.[35] Adherence to the federal requirements will be no easy task. Last March, the Federal Government issued its final rule on the implementation of health insurance exchanges, and every state would be wise to carefully analyze all 166 pages of codified health care reform.[36] Though the Federal Government will certainly promulgate additional regulations, California's window for getting its insurance exchange operational closes on December 31, 2013, because the ACA directs the Secretary of the Department of Health and Human Services to establish and operate an exchange within States that do not have an operational exchange by January 1, 2014.[37]

Uncertainty remains as to what constitutes the "essential health benefits package" referenced by the Court in connection with its discussion of the Medicaid expansion, particularly for the purpose of satisfying an individual's obligations under the individual mandate.[38] While federal guidance will be ongoing throughout the balance of 2012 and into 2013, California's legislature may need to make some important independent decisions on California's road to reform, and the state has little time to endure the partisan delays inherent in much of the state's fiscal planning. While budget timeliness seems to be a fluid concept in California politics, the State has little control over the deadlines and requirements under the ACA.[39]

Additionally, California differs from other states in many respects. The Stanford Center on Longevity reports: "California may be the sixth youngest state right now. But it has an outsized population of Baby Boomers." The Center predicts doubling of California's elderly population over the next 20 years, meaning that the state's population will be slightly older, and consequently less healthy, than the nation as a whole.[40] Anthony Wright, Executive Director of Health Access, a non-profit coalition that advocates for consumers, points out that "Californians are more likely to be uninsured, less likely to get coverage at their job, less likely to be able to afford coverage on their own, and more likely to be denied for pre-existing conditions."[41] California's large population, its experience with models of integrated care delivery, and its two separate insurance regulators (the Department of Insurance and the Department of Managed Health Care), make implementation of the ACA in California especially difficult.

Still, implementation of some of the core tenets of the ACA has already taken place. In point of fact, many such tenets would be difficult to excise from health care regardless of the Court's decision. As with the rest of the nation, in California health insurance will remain available for dependents until the age of 26,[42] the prohibition of using preexisting conditions as a basis for excluding health care coverage will continue,[43] issuers of health insurance will continue to be required to make meaningful and reasonable disclosures detailing the benefits and premiums relating to coverage,[44] health plans will not be permitted to limit lifetime or annual benefits (a concept to be gradually phased in between now and 2014),[45] and certain measures of preventive health services will continue to apply under both group and individual health insurance coverage.[46]

Tax credits are still available for qualifying small businesses with no more than 25 full-time employees for up to 35% of the employer's contribution toward an insurance premium, and as of 2014 this will apply for participation in California's health insurance exchange.[47] Small businesses can still take advantage of federal grants when they offer workplace wellness programs, and all businesses are eligible for federal assistance in establishing employer-based wellness programs.[48] For the 27 approved accountable care organizations currently participating in the Medicare shared savings program,[49] including two in California, this means that their sizeable investment of time and money in becoming participants in that program will not have been in vain.

While health care reform may have survived its encounter with the Supreme Court, notwithstanding the above its future is anything but certain. Though it is probable that many of the programs referenced in this article will endure whatever iterations of health care reform the future holds, the true legacy of the ACA faces one more daunting challenge in November. Whether or not the ACA will escape partisan politics unscathed remains to be seen and concluding words of the Chief Justice aptly set the stage for what is to come: "[T]he Court does not express any opinion on the wisdom of the ACA. Under the Constitution, that judgment is reserved to the people."[50] By the ballot their voice will soon be heard. ■

Endnotes

1 All references to the ACA include the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-48, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (2010) (codified as amended in scattered sections of U.S.C.).

2 *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

3 The individual mandate creates an obligation on the part of most Americans to maintain "minimum essential coverage" beginning in 2014. *See* 26 U.S.C. § 5000A (2010).

4 *Nat'l Fed'n of Indep. Bus.,* 132 S. Ct. at 2607. Specifically, the Court's holding restricts the ways in which the Federal Government can apply 42 U.S.C. § 1396c (2006) to such states.

5 U.S. CONST., art. I, § 8, cl. 1.

6 *Id.* at art. I, § 8, cl. 18.

7 *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2591.

8 *Id.* at 2573.

9 *Id.* at 2592.

10 *Id.*

11 *Id.* at 2593 (quoting U.S. CONST., art. I, § 8, cl. 1). The Court also addressed challenges to justiciability, and in particular whether the Anti-Injunction Act (26 U.S.C. § 7421(a) (2006)) prevented a ruling on the merits of the case. The Court held that the ACA did not require the penalty provisions to be treated as a tax for violations of the individual mandate, and as such the Anti-Injunction Act did not apply. *Id.* at 2594-95. In their dissenting opinion, Justices Scalia, Kennedy, Thomas and Alito disputed that Congressional taxing authority should control, but nonetheless took issue with the Government's position that "the very same textual indications that show this is *not* a tax under the Anti-Injunction Act show that it *is* a tax under the Constitution. That carries verbal wizardry too far, deep into the forbidden land of the sophists." *Id.* at 2656 (Scalia, Kennedy, Thomas and Alito, JJ., dissenting).

12 *Id.* at 2600 ("Once we recognize that Congress may regulate a particular decision under the Commerce Clause, the Federal Government can bring its full weight to bear. Congress may simply command individuals to do as it directs. An individual who disobeys may be subjected to criminal sanctions.").

13 *Id.* The Court also noted that the ACA waives any criminal penalties in the event a taxpayer fails to comply with the penalty imposed by the individual mandate. *See* 26 U.S.C. § 5000A(g)(2)(A) (2010).

14 *The California Health Care Landscape*, Henry J. Kaiser Family Found., (December 2011), available at http://www.kff.org/medicaid/8268.cfm.

15 The individual mandate exempts prisoners and undocumented aliens from compliance, *see* 26 U.S.C. § 5000A(d), and vitiates any penalty for individuals with income below a certain threshold. *See* 26 U.S.C. § 5000A(e).

16 "Minimal essential coverage" includes coverage under Medicare, Medicaid or other federally funded health care programs, employer-sponsored plans, health insurance through the soon-to-be established health insurance exchanges, "grandfathered" plans, and certain approved high risk pools established under the ACA. 26 U.S.C. § 5000A(f)(1).

17 Under the ACA, businesses with more than 50 full-time employees must offer health insurance that satisfies the minimum essential coverage requirements or pay an annual penalty in the amount of $2,000 for each employee (reduced by 30 employees solely for the purpose of calculating the penalty). 26 U.S.C. § 4980H (2010).

18 *See* Assemb. 1602, 2009-2010 Reg. Sess. (Cal. 2002); *see also* CAL. GOV'T CODE § 100500 (West Supp. 2012); CAL. HEALTH & SAFETY CODE § 1366.6 (West Supp. 2012).

19 Victoria Colliver, *Health Care Exchange Will Offer Policies*, SF Gate, S. F. CHRON., (June 29, 2012) at 2, *available at* http://www.sfgate.com/health/article/Health-care-exchange-will-offer-policies-3675063.php.

20 The expansion includes covering "*all* individuals under the age of 65 with incomes below 133 percent of the federal poverty line" and establishing health insurance programs for new Medicaid beneficiaries that satisfy the threshold requirements under the individual mandate. *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2601; *see also* 42 U.S.C. § 1396a(k)(1) (2012).

21 *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2606 (quoting *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1, 25 (1981)).

22 *Id.* at 2607.

23 *Id.* at 2608. In essence, the Court held that the ACA lacked the constitutional authority to obligate state acquiescence in response to Congressional edict. Rather, "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." *Id.*

24 California's version of Medicaid is "Medi-Cal."

25 42 U.S.C. § 1396d(y) (2011).

26 Justices Scalia, Kennedy, Thomas and Alito noted the

following in their dissenting opinion: "Congress never dreamed that any State would refuse to go along with the expansion of Medicaid. Congress well understood that refusal was not a practical option." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2665 (Scalia, Kennedy, Thomas and Alito, JJ, dissenting).

27 *See generally* Renee Y. Hsia, M.D., *Factors Associated with Closures of Emergency Departments in the United States*, 305 (19) JAMA 1978 (May 18, 2011), *available at* http://jama.jamanetwork.com/Issue.aspx?journalid=67&issueID=23449&direction=P.

28 Pub. L. 99-272, 100 Stat. 164 (1986).

29 42 U.S.C. § 13955dd (2011). Also under EMTALA, any hospital "that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation." Section 1395dd(d)(1)(A).

30 C. Duane Dauner, President of the Cal. Hosp. Ass'n, *California Hospitals Pleased by Supreme Court Decision Upholding Access to Coverage Under ACA*, Cal. Hosp. Ass'n, (June 28, 2012), *available at* http://www.calhospital.org/media-statement/california-hospitals-pleased-supreme-court-decision-upholding-access-coverage-under.

31 *California Medical Association Responds to United States Supreme Court Ruling*, Cal. Med. Ass'n, (June 28, 2012), *available at* http://www.cmanet.org/news/press-detail/?article=california-medical-association-responds-to0

32 *Id.*

33 *Id.*

34 *AHIP Statement on Supreme Court Ruling*, AHIP, (June 28, 2012), *available at* http://www.ahip.org/News/Press-Room/2012/AHIP-Statement-on-Supreme-Court-Ruling.aspx

35 Cal. Health & Safety Code § 1366.6(b) (West Supp. 2012).

36 *See* 77 Fed. Reg. 18310 (Mar. 27, 2012) (to be codified at 45 C.F.R. Parts 155, 156 and 157).

37 *Id.* at 18311.

38 *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2580. Essential health benefits must include at least the following health care services: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventative and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. *See* 42 U.S.C. § 18022(b)(1) (2010).

39 In her dissenting opinion, Justice Ginsburg discussed the challenges states may face in coordinating benefits that conform to threshold requirements under the ACA. "[T]he minimum coverage provision, along with other provisions of the [ACA], addresses the very sort of interstate problem that made the commerce power essential in our federal system . . . . The crisis created by the large number of U.S. residents who lack health insurance is one of national dimension that States are 'separately incompetent' to handle." *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2628 (Ginsburg, J., dissenting).

40 *California's Aging Population: Not Forever Young;* Stanford Ctr. on Longevity, *available at* http://longevity.stanford.edu/blog/2012/06/californias-aging-population-not-forever-young/ (last visited Aug. 3, 2012).

41 Rachel Myrow, *Californians Have a Big Stake in the Health Care Decision,* KQED News, (June 28, 2012) *available at* http://www.kqed.org/news/story/2012/06/28/99522/californians_have_a_big_stake_in_the_health_care_decision?category=bay+area.

42 42 U.S.C. § 300gg-14(a) (2010).

43 *Id.* at § 300gg-3.

44 *Id.* at § 300gg-9.

45 *Id.* at § 300gg-11.

46 *Id.* at § 300gg-13.

47 26 U.S.C. § 45R (2010).

48 42 U.S.C. § 280l (2010).

49 *See* 42 U.S.C. § 1395jjj (2010).

50 *Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2608.

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