# WISCONSIN LEGISLATIVE COUNCIL
# INFORMATION MEMORANDUM

## U.S. Supreme Court Decision on the Federal Affordable Care Act:

## *National Federation of Independent Business v. Sebelius*

On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius, 567 U.S.* ___, Slip Op., Nos. 11-393, 11-398, and 11-400 *(2012)*. This case addressed four federal legal issues arising under the Affordable Care Act (ACA) [the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act (P.L. 111-152)]: the applicability of the federal Anti-Injunction Act; the constitutionality of the individual mandate; the severability of the individual mandate from the remaining provisions of the Act; and the constitutionality of the Medicaid expansion. By a 5-4 majority, the Court held that the Anti-Injunction Act does not apply and that the individual mandate is constitutional. Having found the individual mandate constitutional, the Court did not address the severability issue. By a 7-2 majority, the Court held that the Medicaid expansion was unconstitutionally coercive and should not be mandatory upon the states.

This Information Memorandum describes relevant major provisions of the ACA and discusses the Supreme Court's decision and its implications for Wisconsin.

## ***ACA***

The ACA contains several major changes to the U.S. health care system as it affects individuals, employers, insurers, and the Medicaid program. This part of the memorandum describes the following major provisions of the ACA: the requirement that all persons have health insurance (the "individual mandate"); health insurance exchanges; insurance market reforms; the system of tax credits and subsidies; and the expansion of the Medicaid program.

### *INDIVIDUAL MANDATE*

The ACA requires most Americans to have in place minimum essential health insurance coverage. This requirement is commonly referred to as the "individual mandate." Employer-provided insurance or insurance from public programs satisfies the mandate. For those without access to insurance through employers or public programs, the ACA contemplates that insurance may be purchased through a health insurance exchange.

Those who fail to obtain coverage will be assessed a "shared responsibility payment" which will vary based on a person's household income. The assessment is phased in over a three-year period from 2014 to 2016, with cost-of-living adjustments after 2016.

### *HEALTH INSURANCE EXCHANGES*

The ACA requires the establishment of health insurance exchanges in order to expand access to health insurance. The ACA allows states to establish their own exchanges or to combine with other states to form regional exchanges. A state may choose to create a combined exchange for both the individuals and small businesses, or to create separate exchanges for these two groups. By January 1, 2013, a state that wants to operate its own exchange must demonstrate that it will have an operable exchange by January 1, 2014. The Secretary of Health and Human Services (HHS) is responsible for establishing and operating exchanges for states that choose not to establish an exchange or that the Secretary determines will not have an exchange operable by January 1, 2014. There is also a hybrid option, where a state and the federal government may cooperate in operating a state's exchange.

The ACA requires that either a governmental agency or a nonprofit entity established by a state run the exchange. The exchange must do all of the following:

- Implement procedures for certification, recertification, and decertification of qualified health plans.
- Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.
- Maintain an Internet website containing comparative information on qualified health plans.
- Assign ratings to each qualified health plan offered through the exchange on the basis of relative quality and price, in accordance with criteria as defined by the Secretary.
- Present plan options (platinum, gold, silver, bronze, and a catastrophic plan for young adults) in a standard format.
- Inform individuals of eligibility requirements for the Medicaid program and Children's Health Insurance Program (CHIP) or any applicable state or local program and enrollment in these programs, if an individual is determined eligible through screening by the exchange.
- Provide an economic calculator for consumers to determine the actual cost of coverage after application of any premium tax credit or cost-sharing reduction.
- Grant certification to individuals relating to hardship or other exemptions.
- Establish a "navigator" program to facilitate enrollment and refer consumers' questions and complaints to the appropriate agencies.

### *INSURANCE REFORMS*

The ACA created many reforms to the health insurance market. The major reforms, and their effective dates, are as follows:

As of September 23, 2010:

- Require health plans to provide coverage, without cost-sharing, for certain preventive services.
- Prohibit health plans from imposing pre-existing condition exclusions for children.
- Require all individual and group policies to provide coverage for young adults, up to age 26, on their parents' policies.
- Prohibit health insurers from rescinding policies, except in cases of fraud.
- Prohibit individual and group plans from imposing lifetime limits on the dollar value of coverage.
- Require states to provide an internal and external appeals process for consumers to utilize for resolving certain types of disputes with health plans.

As of January 1, 2011:

- Require health plans to report the proportion of premium dollars spent on clinical activities, quality improvement, and other costs. Require rebates to consumers if the amount spent on clinical and quality improvement activities falls below a certain percentage (referred to as the medical loss ratio).

As of March 23, 2013:

- Require insurers to provide a uniform explanation of coverage to consumers.

As of January 1, 2014 (when health exchanges become operational):

- Require guaranteed issuance of insurance and prohibit pre-existing condition exclusions in all markets.
- Limit rating variations to factors related to age, geography, tobacco use, and family composition.
- Implement four coverage tiers (platinum, gold, silver, and bronze) based on coverage categories and cost-sharing requirements.
- Prohibit annual limits on the dollar value of coverage.

As of January 1, 2018:

- Implement an excise tax on "high cost" insurance plans.

***TAX CREDITS AND SUBSIDIES***

The ACA provides small businesses with certain tax credits for employer-provided insurance, and it provides individuals and families with certain premium credits and cost-sharing subsidies to help manage the cost of insurance.

For tax years 2010 through 2013, small businesses are eligible for a tax credit of up to 35% of an employer contribution of at least 50% toward employee health insurance premiums. An

employer with 10 or fewer employees and paying average annual wages of less than $25,000 is eligible for the full credit, which phases-out as firm size and average wages increase. Tax-exempt small businesses are eligible for tax credits of up to 25% of the employer's contribution toward the employee health insurance premiums.

For tax years 2014 and later, small businesses that purchase coverage through the state's small business exchange are eligible for a tax credit of up to 50% of contributions of at least 50% toward the employee's health insurance premium. The credit will be available for two years. An employer with 10 or fewer employees and paying average annual wages of less than $25,000 is eligible for the full credit, which phases-out as firm size and average wages increase. Tax-exempt small businesses are eligible for tax credits of up to 35% of the employer's contribution toward the employee health insurance premium.

Effective January 1, 2014, the ACA provides refundable and advanceable premium credits to eligible individuals and families with incomes between 133-400% of the federal poverty level (FPL) to purchase insurance through the exchanges. The premium credits will be set on a sliding scale such that the premium contributions are limited from 2% (up to 133% FPL) to 9.5 % (300% - 400% FPL) of income.

In addition, cost-sharing subsidies will be available to persons with incomes between 100% and 400% FPL, which will reduce the cost sharing for out-of-pocket costs such as copayments and deductibles for these persons.

***MEDICAID EXPANSION***

The ACA modified Medicaid (and its smaller companion program, CHIP) to provide broader coverage for low-income individuals and families. Most significantly, beginning on January 1, 2014, this includes implementation of a national eligibility floor of 138% FPL for all non-Medicare eligible individuals under age 65.

### *Federal Funding for State Medicaid Programs*

Federal funding plays an essential role in underwriting Medicaid and CHIP, covering between 50% and 83% of the cost of each state's program. This funding is conditioned on states meeting minimum eligibility levels for certain population groups. Prior to the ACA's enactment, the federal government conditioned funding on states meeting minimum thresholds of:

- 133% FPL for children under age six and pregnant women.
- 100% FPL for children between ages 6 and 18.
- For parents and caretakers of children under age 19, an income level tied to a state's past Aid to Families With Dependent Children (AFDC) threshold.

States are allowed to adopt higher minimum thresholds for these groups and to offer coverage for other groups lacking a federally required minimum. For example, Wisconsin applies higher eligibility standards for children, pregnant women, and parents and caretakers; and Wisconsin offers coverage to childless adults under the BadgerCare+ Core Plan.

### *Expanded Medicaid Eligibility and Funding*

Beginning on January 1, 2014, the ACA establishes a national eligibility floor for Medicaid of 138% FPL ($15,415/individual; $31,809/family of four) for non-Medicare eligible individuals under age 65.[1] This expansion will allow many new people to qualify for Medicaid and was intended to reduce the current variation in eligibility levels across states.

Medicaid costs for newly eligible individuals (i.e., those who were not eligible for Medicaid prior to the implementation of the eligibility floor of 138% FPL) will qualify for higher levels of federal funding than states ordinarily receive for Medicaid. Beginning in 2014, for the newly eligible, states will receive:

- 100% federal funding through 2016.
- 95% federal funding in 2017.
- 94% federal funding in 2018.
- 93% federal funding in 2019.
- 90% federal funding in 2020 and subsequent years.

Beginning in 2014, additional funding will also be available to the so-called expansion states. These states were already providing coverage for individuals who would otherwise be "newly eligible" upon implementation of the eligibility floor of 138% FPL. An expansion state's funding for these individuals will increase by a set amount each year between 2014 and 2018. In year 2019 and subsequent years, federal funding for these individuals will equal that received for newly eligible individuals in other states.

The ACA includes additional provisions related to Medicaid and CHIP. These include a maintenance-of-effort (MOE) requirement applicable to states that had expanded coverage beyond federally mandated minimums prior to the ACA's enactment. The MOE requirement is effective through 2014 for adults and 2019 for children. It prohibits states from adopting eligibility standards that are more restrictive than the standards in place as of the date of the ACA's enactment. Other related ACA provisions include expanded coverage for foster care children, continuation of CHIP, some new coverage requirements, and numerous administrative changes.

---

[1] As written, the eligibility floor established under the ACA is 133% FPL; however, the calculation of "modified adjusted gross income" under the ACA includes a standard 5% income disregard. This effectively creates a new threshold of 138% FPL.

### *Comparison of Federal and Wisconsin Requirements*

The chart below illustrates Medicaid eligibility thresholds in effect under Wisconsin law, as compared to federally mandated minimums, prior to the ACA's enactment. The national eligibility floor to be implemented under the ACA in 2014 is shown at the right.

| Population Group | WI (pre-ACA) | Federal (pre-ACA) | ACA |
|---|---|---|---|
| Children under 19 (BadgerCare+) | No income limit* | Under 6: 133% FPL<br>6–18: 100% FPL | 138% FPL<br>(as of 2019) |
| Pregnant women (BadgerCare+) | 300% FPL* | 133% FPL | 138% FPL<br>(as of 2014) |
| Parents/caretakers of children under 19 (BadgerCare+) | 200% FPL* | Tied to past AFDC | 138% FPL<br>(as of 2014) |
| Childless adults (BadgerCare+ Core Plan) | 200% FPL** | ----- | 138% FPL<br>(as of 2014) |

* At certain income levels, monthly premiums may begin to apply.

** Benefits provided under BadgerCare+ Core Plan are more limited than offered under traditional MA, and enrollment in BadgerCare+ Core Plan is currently capped.

## ***LOWER COURT DECISIONS***

The U. S. Supreme Court case had its origins in several different proceedings in U.S. Courts of Appeals.

### *ELEVENTH CIRCUIT*

In *State of Florida, et al, vs. U.S. Department of Health and Human Services*, 648 F. 3d 1235 (2011), 26 states and the National Federation of Independent Business brought suit against the U.S., asserting that the individual mandate of the ACA was unconstitutional. The U.S. Court of Appeals for the Eleventh Circuit found that the individual mandate was unauthorized by both the taxing power and the power to regulate commerce, and was therefore unconstitutional. However, the court severed this provision from the remainder of the Act, leaving those other provisions intact.

The court also upheld the Medicaid expansion, finding it to be a valid exercise of Congress's powers under the spending clause, and that the threatened loss of all federal Medicaid funding was not coercive and therefore not a violation of the Tenth Amendment of the U.S. Constitution.

***SIXTH CIRCUIT***

In *Thomas More Law Center vs. Obama*, 651 F. 3d 529 (2011), the Thomas More Law Center, a public interest law firm, and four individuals challenged the individual mandate. The Sixth Circuit Court of Appeals found the individual mandate to be constitutional under the Commerce Clause.

***D.C. CIRCUIT***

In *Seven-Sky vs. Holder*, 661 F. 3d 1 (2011), four individuals challenged the individual mandate. Like the Sixth Circuit, the U.S. Court of Appeals for the District of Columbia circuit found the individual mandate to be constitutional under the Commerce Clause.

***FOURTH CIRCUIT***

In *Liberty University v. Geithner*, 671 F. 3d 391 (2011), Liberty University and certain individuals brought this suit to enjoin the individual mandate. The U.S. Court of Appeals for the Fourth Circuit, found that the Anti-Injunction Act prevented it from reaching the merits of the question. Because the penalty could be considered a tax, the Anti-Injunction Act prevents plaintiffs from challenging the individual mandate until after they had paid the penalty.

***SUPREME COURT DECISION***

The U.S. Supreme Court granted certiorari to review the judgment of the Eleventh Circuit Court of Appeals with respect to both the individual mandate and the Medicaid expansion. The Court appointed *amicus curiae* to defend the position that the individual mandate could be severed from the remainder of the ACA, and also to advance the position that the Anti-Injunction Act deprived the Supreme Court of jurisdiction to hear challenges to the individual mandate, since no party supported those positions.

***MAJORITY OPINION***

The Supreme Court's majority opinion, authored by **Chief Justice Roberts**, held as follows:

***Anti-Injunction Act (Held: 5-4, Anti Injunction Act Does Not Apply)***

The U.S. Supreme Court found that the Anti-Injunction Act, which prohibits a taxpayer from bringing suit to prevent the assessment or collection of any tax before the tax is actually assessed and paid, did not apply to the case. This holding was based on the Court's reading of the language of the ACA, which described the shared responsibility payment not as a tax, but as a penalty. The Court stated that: "The Anti-Injunction Act and the Affordable Care Act ... 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." [Slip Op., Roberts, C.J., p. 13.] The Court found that the ACA's directive that the penalty be assessed and collected in the same manner as taxes was not dispositive. More important was the statutory language characterizing the payment as a penalty, particularly given that the ACA is replete with references to taxes (tax credits and subsidies, for example). [*Id.* at 12.] This demonstrated that

Congress clearly knew how to distinguish between a penalty and tax, and that it characterized the payment as a penalty for specific reasons.

### *Individual Mandate (Held: 5-4, Individual Mandate is Constitutional)*

The Court found that the individual mandate was constitutional under Congress's taxing power. First, however, the Court addressed the constitutionality of the mandate under the Commerce Clause and the Necessary and Proper Clause, and determined that it could not be upheld under either of those provisions.

The Court, while acknowledging Congress's broad authority to regulate commerce under the Commerce Clause, observed that Congress had never attempted to use that power to "compel individuals not engaged in commerce to purchase an unwanted product." [*Id.* at 18.] The Court stated that: "[l]egislative novelty is not necessarily fatal; there is a first time for everything" [*Id.*]; however, the Court held that: "[t]he 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.'" [*Id.* at 27.]

The Court also held that the individual mandate could not be sustained under the Necessary and Proper Clause of the U.S. Constitution. The government argued that Congress had such a power because the mandate is an "'integral part of a comprehensive scheme of economic regulation' – the guaranteed-issue and community-rating reforms." [*Id.* at 27-28, quoting brief for United States.] The Court said that Congress could not rely on the Necessary and Proper Clause to reach beyond the natural limit of the Commerce Clause authority, and "draw within its regulatory scope those who would otherwise be outside of it." [*Id.* at 30.] The Court concluded by saying "[j]ust as the individual mandate cannot be sustained as a law regulating the substantial effects of the failure to purchase health insurance, neither can it be up held as a 'necessary and proper' component of the insurance reforms." [*Id.*]

The Court went on to analyze the constitutionality of the individual mandate under Congress's taxing power, stating that "it is well established that if a statute has two possible meanings, one of which violates the Constitution, courts should adopt the meaning that does not do so." [*Id.* at 31.] The Court agreed with the government's premise that the mandate should be read "not as ordering individuals to buy insurance, but rather as imposing a tax on those who do not buy that product" [*Id.*], even though Congress chose to label the shared responsibility payment for not purchasing insurance as a "penalty" rather than a "tax." The Court cited precedent which held that "exactions not labeled taxes nonetheless were authorized by Congress's power to tax." [*Id.* at 34.] Having found that the taxing power enabled Congress to impose a "tax" on not obtaining health insurance, the Court analyzed the structure of the payment and found it to comply with other Constitutional requirements relating to taxation.

### *Severability*

Having found the individual mandate constitutional, it was unnecessary for the Court to address the issue of whether the individual mandate could be severed from the parts of the law that were found to be constitutional.

### *Medicaid Expansion (Held: 7-2, Medicaid Expansion is Limited in Scope)*

The Court, turning next to the issue of the Medicaid expansion, held that the Medicaid expansion exceeded Congress's constitutional authority but could be preserved with a more limited scope. In enacting the ACA, Congress had added the Medicaid expansion as a condition of the states' federal funding for the entire Medicaid program. Congress's power to grant federal funds is generally authorized by the spending clause of the U.S. Constitution, which provides the power "to pay the Debts and provide for the ... general Welfare of the United States." [Art. I, s. 8, cl. 1; Slip Op., Roberts, C.J., p. 46.] The Court also recognized that Congress may attach conditions to federal funds to "ensure the funds are used by the States to 'provide for the ... general Welfare' in the manner that Congress intended." [Slip Op., p. 46.] However, the Court noted that federal funding for Medicaid constitutes over 10% of most states' total revenue and that a state risks losing this funding in its entirety unless it implements the Medicaid expansion. According to the Court, given the importance of this funding, and given the magnitude of the changes contained in the Medicaid expansion, Congress was coercing states into accepting a major new policy by making it a condition of the funding for the entire Medicaid program.

The solution offered by the Court, in order to preserve the constitutionality of the Medicaid expansion, was to prohibit the use of existing Medicaid funding as leverage for the Medicaid expansion. That is, the Court held that the provision in federal statute authorizing the Secretary of HHS to cut off funds for non-compliance with Medicaid was unconstitutional as applied to the Medicaid expansion. The result is that each state can choose whether or not to participate in the Medicaid expansion. If a state accepts new expansion funds, Congress may condition such funds on the implementation of the Medicaid expansion. However, a state that does not accept new expansion funds and does not implement the Medicaid expansion cannot, on that basis, be denied federal funding for the state's remaining (i.e., existing) Medicaid program.

#### *CONCURRENCE AND DISSENT*

Accompanying the Supreme Court's decision was a separate opinion, concurring in part and dissenting in part, by **Justice Ginsburg** joined by Justice **Sotomayor**, with **Justices Breyer** and **Kagan** joining in part. In the main opinion, Justice Ginsburg had joined with the majority to uphold the individual mandate as an exercise of Congress's taxing power. However, Justice Ginsburg argued that the mandate also should be upheld under the Commerce Clause, noting that the large number of U.S. residents without insurance leads to cost shifting within the national health insurance industry, and Congress has "the power to regulate economic activities 'that substantially affect interstate commerce.'" [Slip Op., Ginsburg, J., pp. 6 and 15.]

Additionally, in the dissenting portion of her opinion, Justice Ginsburg, joined by Justice Sotomayor, defends the Medicaid expansion, stating it should have been left intact. In Justice Ginsburg's view, the ACA's modification of the Medicaid Act was not coercive because it could have been accomplished by repealing and reenacting the Medicaid Act as a whole. [*Id.* at 38.] However, given the majority's conclusion to the contrary, Justice Ginsburg agreed with the majority that existing Medicaid funding cannot be withheld from a state that does not implement the Medicaid expansion. [*Id.* at 40.]

### *DISSENT*

Also accompanying the Supreme Court's decision was a joint dissent from **Justices Scalia, Kennedy, Thomas, and Alito**. The dissenters disapproved of the majority's treatment of the mandate as a tax, arguing instead that it is a penalty and that the distinction is meaningful. In treating the mandate as a tax, the majority did not just interpret the statute but rewrote it, according to the dissenters. [Slip Op., Scalia, Kennedy, Thomas and Alito, J.J., at 24.] The dissenters also faulted the individual mandate because it violated the principle of limited federal power. [*Id*. at 9-13.] Likewise, Congress's attempt to compel adoption of the Medicaid expansion violated the appropriate balance between federal and state governments, they argued. [*Id*. at 37.] As a result, the dissenters stated they would invalidate the provisions of the ACA containing both the individual mandate and the Medicaid expansion. Because these are essential components of the legislation, the dissenters would have gone on to invalidate the ACA in its entirety.

## ***IMPLICATIONS FOR WISCONSIN***

### *HEALTH INSURANCE EXCHANGE*

As a result of the Court's holding that the individual mandate is constitutional, most Americans will be required to have health insurance in place by January 1, 2014. Those without insurance from another source, such as through their employer or a public program, will be required to purchase insurance through a health insurance exchange or pay the shared responsibility payment.

The federal HHS has established a deadline of November 16, 2012, for states to submit their proposals to operate their own exchanges, so that HHS is able to meet the exchange certification deadline of January 1, 2013. Wisconsin has conducted preliminary exchange planning activities under both Governor Doyle and Governor Walker. However, these activities were halted in December 2011 pending the outcome of the U. S. Supreme Court case. Now that the case has been decided, the state will determine whether to implement its own health insurance exchange, alone or in a consortium with other states; allow the federal government to operate the exchange for Wisconsin; or enter into a hybrid arrangement with the federal government.

### *MEDICAID EXPANSION*

As a result of the Court's holding on the Medicaid expansion, the new eligibility floor of 138% FPL created under the Medicaid expansion may be regarded as optional for the states. Prior to the next budget cycle, Wisconsin must decide whether to implement changes in its Medicaid program, which may allow it to qualify for new expansion funds.

Some questions that may impact Wisconsin's options with respect to Medicaid expansion were not expressly addressed by the Supreme Court's opinion, such as whether a partial expansion will be allowed, and what other Medicaid- or CHIP-related provisions, if any, may be regarded as optional for the state because they are included within the Medicaid expansion.

The Secretary of HHS is expected to provide guidance regarding HHS's view of the scope of the Medicaid expansion. However, it will ultimately be up to each state to determine how to proceed.

This memorandum is not a policy statement of the Joint Legislative Council or its staff.

This memorandum was prepared by Laura Rose, Deputy Director, and Brian Larson, Staff Attorney, on July 6, 2012.

---

**WISCONSIN LEGISLATIVE COUNCIL**
One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
Telephone: (608) 266-1304 • Fax: (608) 266-3830
Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc