

Supreme Court Upholds Healthcare Reform – Affordable Care Act

Today, June, 28, 2012, the Supreme Court of the United States (SCOTUS) handed down its highly anticipated decision upholding the 2010 healthcare reform act, the Patient Protection and Affordable Care Act (ACA). This opinion addresses two cases and declined to rule on the matter of the individual mandate related to Federal Congressional powers over the states, i.e., the U.S. Constitution's Commerce and Supremacy Clauses, instead relying on a more narrow interpretation of Federal taxing authority. Touted as the one of the most significant SCOTUS decisions of this century, the Court's 5 to 4 ruling to uphold the Law will have repercussions throughout the U.S. healthcare delivery system and U.S. political arena.

BACKGROUND

On March 23, 2010, the ACA (as amended by the Health Care and Education Reconciliation Act) was signed into law. These significant pieces of legislation, collectively known as healthcare reform, may be the most transformative to the healthcare delivery system since the passage of Medicare and Medicaid in the 1960s. The many provisions of the ACA that have already taken affect, as well as the features of the Law remaining to be implemented will lead to significant changes in the U.S. healthcare delivery system to increase patient access to care while restraining healthcare costs and improving quality outcomes. In order to cross-subsidize many of the ACA's provisions for coverage expansion, it also required that individuals either purchase a minimum amount of healthcare insurance or pay a penalty.ⁱ

The "individual mandate" created an uproar among certain States' Attorney Generals, who argued that Congress overstepped its bounds to violate both the Supremacy and Commerce Clauses.ⁱⁱ These states took legal action against the ACA in *Florida v. DHHS*, in which the 26 states who disputed the constitutionality of the ACA's individual mandate provision and the constitutionality of the ACA itself.ⁱⁱⁱ Similarly, the *National Federation of Independent Business* filed a suit challenging the constitutionality of the ACA's Medicaid expansion provisions, which require states to expand their Medicaid coverage to 133 percent of the Federal Poverty Line (FPL), or face losing federal Medicaid funding altogether.^{iv} Circuit court decisions rendered were split 3 to 1 in favor of upholding the individual mandate, giving rise to the need for a unifying decision by SCOTUS.^v Writs of certiorari (the motion filed to argue a case in front of SCOTUS) were filed and approved, to be combined, with one final SCOTUS opinion ruling for both of the underlying cases.

In March of 2012, two years after the passage of the ACA, the Court began hearing oral arguments to consider four key questions related to the ACA: (1) whether the individual mandate is a "tax" or "penalty," thereby addressing the question of the "ripeness" necessary for a constitutional challenge; (2) whether the individual mandate is a violation of the U.S. Constitution's Commerce Clause; (3) whether the individual mandate section is severable from the rest of the law; and, (4) whether the federal requirement that Medicaid coverage be expanded a violation of the U.S. Constitution's Supremacy Clause.^{vi}

ARGUMENTS

Arguments for ripeness:

The fate of the ACA has one threshold question as to the *ripeness* of the arguments presented before SCOTUS. If the individual mandate is determined to be a “*tax*” and not a “*penalty*,” as the ACA presents it, then the *Anti-Injunction Act* must be applied to the ACA provisions currently at bar. The Anti-Injunction Act prohibits constitutional challenges of a “*tax*” before the tax has been implemented. As the individual mandate does not take effect until 2014, states must wait until 2015, when individual mandate *taxes* have actually been assessed and not paid before SCOTUS can address the constitutionality of the individual mandate provisions.^{vii} Under this argument, SCOTUS would be required to defer their ruling until 2015, at which point majority of the provisions of the ACA would have been implemented.

Arguments in support of the ACA:

Those in support of the individual mandate argued that the mandate is justified under the *Commerce Clause* because all U.S. citizens already participate in the healthcare market.^{viii} This statement is supported by the fact that, at 17.9 percent of the U.S. gross domestic product (GDP), healthcare is a substantial portion of the national economy, and federal regulation is a necessity.^{ix} Further, due to the nature of life and health, all U.S. citizens will need to enter the healthcare market at some point in their lives. The unpredictability of this demand for services and the associated costs creates uncertainty in the healthcare market, and in response, insurers and providers shift the cost of unpaid medical care for uninsured patients to those who are insured.^x Thus, even if an individual does not seek medical care, i.e., is not “*active*” in the healthcare market, the uncertainty caused by their lack of insurance still influences how the market works.^{xi} The government argued that this necessitates federal regulation as interstate commerce, validating the individual mandate requirement.^{xii}

Regarding the severability clause, the government argued that severability clauses are not required. Judges often infer severability even if the language is not present in the legislation.^{xiii}

Regarding the Medicaid expansion, the government argued that it is within its constitutional powers to attach conditions to federal funding, and as such, Congress has expanded mandatory coverage for Medicaid numerous times since its inception. In a practical sense, the states do not have a valid argument regarding the financial impossibility of expanding coverage, as the federal government is funding most of the expansion itself.^{xiv}

Arguments against the ACA:

Those against the individual mandate argued that, although Congress has the power to regulate interstate commerce and to enact laws in order to carry out that power, the mandate is an *unconstitutional overreach* by the federal government.^{xv} Opponents of the individual mandate argue that requiring individuals to purchase *minimum health insurance coverage* equates to forcing them to participate in interstate commerce, rather than voluntarily participating and being regulated by the government.^{xvi} This argument is supported by the fact that the government has never been able to force an individual into the commerce market, and that allowing it would eliminate the purpose of the Commerce Clause to limit the powers of Congress.^{xvii}

Regarding the severability issue, opponents of the mandate noted that the ACA conspicuously lacked a severability clause, which is present in most legislation. Therefore, if the individual mandate was stricken, the entire ACA would have had to be overturned as well.^{xviii}

Regarding Medicaid expansion, opponents argued that the ACA’s provisions are coercive, requiring coverage of a substantial new patient population in order to receive any federal Medicaid funding. Given the current financial limitations of many States, they have become dependent upon Federal funding and would, essentially, have no choice to refuse the ACA’s expansion option. Refusal to cover the mandated expanded population would result in a State being unable to cover *any* of its Medicaid patients.^{xix}

EFFECT OF THE RULING

In upholding the individual mandate provision, the entire ACA remains intact and will be implemented as enacted until it is completely rolled-out in 2014. Individuals are still required to have a government-approved health plan or face a “*taxing*” penalty.

There is little change to stakeholders in both the public and commercial sectors. Hospitals will still have less bad-debt risk from unpaid hospital bills because of the vast increase of insured patients, as well as reduced Medicare reimbursement rates, and medical device manufacturers will see increased tax assessments.^{xx}

CONCLUSION

Notwithstanding today's SCOTUS ruling on the constitutionality of the ACA and/or several of its provisions the move toward national risk pools may be inevitable to accommodate future demands. Given the background of the delivery of healthcare services in other societies, some type of national health insurance may likely be the ultimate conclusion to many of the current issues within the U.S. healthcare industry. In that vein, the ACA may well be viewed as just an inevitable necessary first step on the path to a National Single Payor Insurance model.

The future drivers of healthcare delivery are the same as those occurring today: exponential growth of Medicare enrollees; increasing complexity and associated costs of technology; the personalization of medicine; and, the fiscal burnout due to slow economic growth, high unemployment, and record Federal deficit and debt. The first baby boomers enrolled in Medicare in 2010. As the rest of the cohort follows, the impact on the Medicare program will be significant, with an estimated 92.8 million people enrolled in Medicare by 2050. The increased demand for healthcare services caused by this demographic time-bomb will likely strain, not only budgets, but the already limited physician supply. Today, Medicare spending accounts for 15% of the federal budget and is expected to grow at an average annual rate per capita of 3.5% between 2010 and 2019. This situation is further complicated as initiatives to limit healthcare spending need to be accomplished within significant political pressure not to damaging the present level of patient care or placing undue financial burdens on the elderly. On its current trajectory, the Medicare program may well become unsustainable, making the Medicare policy debate a main driver of healthcare reform.

Despite current legislative efforts to manage and control the rising cost of healthcare, continued technological advancements will likely force costs upwards. Correlations between the cost of medical services and the quality improvements resulting from technology advancements may further exacerbate health disparities based on income and class, which runs contrary to the current aims of healthcare reform. In addition to cost, technology will also drive the approach and possibilities available during the provision of care and services as the personalization of medicine (e.g., genomics) continues to develop.

Several of the many initiatives set into motion under the healthcare reform legislation, will no doubt continue to move forward the ideals set forth within healthcare reform's triple aim (i.e., access, quality, and cost). As the healthcare industry moves forward, policy makers and healthcare administrators should keep in mind that simply lowering the cost of healthcare does not necessarily increase access, nor do increases in quality necessarily require parallel increases in cost.

How the healthcare industry will address future challenges is still uncertain, however, the question as to whether the ACA is a logical step toward Enthoven's^{xxi} concept of managed competition is a dynamic and volatile topic, involving the economic concerns of almost every stakeholder, each with constituencies, advocacy groups, and lobbyists. Each of these stakeholders currently operates under a pretense of commercial competitive markets at a time when a majority of those markets are dominated by a single payor, and the consolidation of hospitals and physician providers continues at a rapid pace.

Ultimately, the economic survival of all U.S. healthcare delivery (and perhaps the U.S. economy in general) may need to be framed within a universal and centralized risk pool and some version of a single payor system. This transformation will demand the further codification of treatment protocols, derived from evidence-based medicine, as well as the heretofore-illusory quality metrics expectable to both providers and payors as the basis for value-based reimbursement. The ensuing disruption of healthcare delivery from the current free market model to universal coverage, by any measure a dramatic change to the healthcare delivery system, will not happen overnight, no matter how dire the economic and social situation. However, change will inevitably come, since any economic system that remains static dies.

Substantive change in U.S. healthcare delivery will be, by necessity, an iterative process, likely with several phases of political bloodletting and heated debate. Regardless of your viewpoint on its merits, today's SCOTUS decision on the ACA, represents a relevant step forward in the debate and the process, toward creating value-based

reimbursement synergies between high quality and beneficial outcomes in pursuit of lower overall costs. However, the provisions of the ACA are not likely to be the light at the end of the tunnel, as more changes related to the ACA's implementation will be required. While the path forward is not yet apparent, our current national trajectory of cost and outcomes is unsustainable. Finding the solution it is not a matter of a lack of money or a paucity of ideas, but rather the public and political will for change. Whether one views it as a blessing or a curse, it is undeniable that, "*we live in interesting times.*"

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- i "Patient Protection and Affordable Care Act" Pub. L. 111-148 (March 23, 2010).
 - ii "Showdown gets a head start" By Rich Daly and Jessica Zigmond, *Modern Healthcare*, March 26, 2012.
 - iii "Florida, et al., v. Department of Health and Human Services, et al." Writ of Certiorari, Motion No. 11-400, November 14, 2011.
 - iv "National Federation of Independent Business, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al." Writ of Certiorari, Motion No. 11-393, November 14, 2011.
 - v "A Guide to the Supreme Court's Review of the 2010 Health Care Reform Law" Kaiser Family Foundation, *Focus on Health Reform*, January 2012.
 - vi "Supreme Court Review of the Health Care Reform Law" By Gregory D. Curfman, Brendan S. Abel and Renee M. Landers, *New England Journal of Medicine*, March 15, 2012.
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 - viii "U.S. Department of Health and Human Services, et al v. Florida, et al.", Supreme Court cause 11-400, Petitioner's Oral Argument, March 27, 2012, Accessed at <http://www.scotusblog.com/case-files/cases/u-s-department-of-health-and-human-services-v-florida> (accessed 6/22/12).
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 - x "U.S. Department of Health and Human Services, et al v. Florida, et al." Supreme Court cause 11-400, March 27, 2012.
 - xi *Ibid.*
 - xii *Ibid.*
 - xiii "National Federation of Independent Business, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al." Supreme Court cause 11-393, and "Florida, et al. v. Department of Health and Human Services, et al." Supreme Court cause 11-400, March 28, 2012.
 - xiv *Ibid.*
 - xv Article I, Section 8, U.S. Constitution.
 - xvi "National Federation of Independent Business, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al." Supreme Court cause 11-393, and "Florida, et al. v. Department of Health and Human Services, et al." Supreme Court cause 11-400, March 28, 2012.
 - xvii *Ibid.*
 - xviii "National Federation of Independent Business, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al." Supreme Court cause 11-393, and "Florida, et al. v. Department of Health and Human Services, et al.", Supreme Court cause 11-400, Petitioner's Oral Argument, March 28, 2012, Accessed at <http://www.scotusblog.com/case-files/cases/national-federation-of-independent-business-v-sebelius> (accessed 6/22/12).
 - xix "National Federation of Independent Business, et al., v. Kathleen Sebelius, Secretary of Health and Human Services, et al.", Supreme Court cause 11-393, and "Florida, et al. v. Department of Health and Human Services, et al.", Supreme Court cause 11-400, Petitioner's Oral Argument, March 28, 2012, Accessed at <http://www.scotusblog.com/case-files/cases/national-federation-of-independent-business-v-sebelius> (accessed 6/22/12).
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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS (HCC)**, a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: *“The U.S. Healthcare Certificate of Need Sourcebook”* [2005 - Beard Books], *“An Exciting Insight into the Healthcare Industry and Medical Practice Valuation”* [2002 – AICPA], and *“A Guide to Consulting Services for Emerging Healthcare Organizations”* [1999 John Wiley and Sons].

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious *“Shannon Pratt Award in Business Valuation”* conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.



Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the Senior Vice President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia, and is a Fellow of the American College of Healthcare Executives. He has co-authored *“Research and Financial Benchmarking in the Healthcare Industry”* (STP Financial Management) and *“Healthcare Industry Research and its Application in Financial Consulting”* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.



Anne P. Sharamitaro, Esq., is the Vice President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the *Journal of Health Law*, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America and the National Association of Certified Valuation Analysts and co-authored chapters in *“Healthcare Organizations: Financial Management Strategies,”* published in 2008.