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Supreme Court Narrowly Upholds Health Reform Law but Limits Congress' Authority Over States

Ruling Lessens Uncertainty, but Many Companies Will Face Increased Regulation and Costs

Today the Supreme Court issued a divided ruling on the core provisions of the Patient Protection and Affordable Care Act. The Court upheld the so-called individual mandate,¹ finding that although the mandate violated the Commerce clause of the Constitution, the mandate was a constitutional exercise of Congress' taxing power. While this ruling enabled the Court to leave the Act's significant health insurance reform measures in place, a majority of the Justices also found that the Act's Medicaid program expansion violates Congress' spending authority by predicating federal Medicaid funding — including funding for existing programs — on a state's acceptance of the terms of the expansion. The court found that the remedy for this violation was to preclude Congress from placing current Medicaid funding in jeopardy for states that decline to expand their Medicaid programs, rather than to invalidate the expansion altogether.

Top-Line Summary

- The Supreme Court, by a 5-4 majority, upheld the Patient Protection and Affordable Care Act's individual mandate requirement, refused to invalidate the Act's Medicaid expansion, and concluded that the case was ripe for decision despite a challenge under the Anti-Injunction Act. The decision leaves intact the remaining provisions of the sweeping law.
- The Court also upheld the Act's Medicaid program expansion but found that Congress could not cut off a state's entire Medicaid funding (not just the incremental funds provided in the Act) if the state chose not to implement the expansion.
- The Court's decision means the many provisions that already have taken effect will remain intact and paves the way for implementation of some of the most sweeping reforms that take effect in 2014 and beyond (including the state health exchanges, employer coverage requirements and the individual mandate).

The Court's ruling means that the many provisions of the Act that already have taken effect — including the ban on insurers denying coverage for pre-existing conditions and lifetime limits, certain industry tax levies, and toughening of health care fraud and

¹ The so-called "individual mandate," formally known as the "minimum coverage requirement," requires most Americans to maintain "minimum essential" health insurance coverage. 26 U.S.C. § 5000A. Under the individual mandate, individuals who are not exempt from the requirement and do not receive insurance through their employers are required to purchase insurance from a private insurer. *Id.* Beginning in 2014, individuals who do not comply with the mandate are required to make a "shared responsibility payment" — or pay a penalty — to the federal government. *Id.* § 5000A(b)(1). This penalty will be paid to the Internal Revenue Service with an individual's income tax and "assessed and collected in the same manner" as tax penalties. *Id.* § 5000A(g)(1).

abuse laws — will remain in effect. None of those provisions were directly challenged in the cases considered by the Court, but would have been at issue if the Court had struck down a portion of the Act and concluded that the Act was not severable. The ruling also paves the way for future implementation of the law's many provisions that come into force beginning in 2013 such as the creation of state health exchanges, the so-called Sunshine Act concerning payments by drug and device companies to physicians and teaching hospitals, various Medicare reimbursement methodology changes, and future levies on employers and individuals.

For the business community, the ruling is a mixed bag. While it lessens the uncertainty that hung over the entire health care industry in anticipation of the Court's ruling, the decision to uphold the Act means increased regulatory requirements and costs for employers generally and for specific sectors within the health care industry. In the short term, the decision is likely a boost for health plans with significant exposure to Medicaid as well as hospitals and health care providers, if the various states choose to expand their Medicaid programs as provided for in the Act and thereby dramatically expand the number of Americans on Medicaid. The ruling also is likely a net negative for other sectors, including device makers that face a new excise tax and drug makers that face a similar sector tax and an expedited approval pathway for generic biologics.

The Act's ultimate impact will depend in large part on whether and how many states opt to expand their Medicaid programs given the blunted penalty under the Supreme Court's ruling. If states choose not to expand their program, and many Americans choose to pay the penalty rather than purchase health insurance, the population of uninsured Americans will not drop by the 30 million figure previously projected. In turn, hospitals may not see a drop in the number of uninsured Americans seeking services through emergency rooms and drug and device companies may not see an increase in product use to offset the new excise taxes.

Procedural Background

In the cases at issue in the Supreme Court's opinion, the Eleventh Circuit found the individual mandate unconstitutional on the merits but upheld the expansion of Medicaid. A number of other federal Courts of Appeals, also considered the ACA, with varying results. Only the D.C. and Sixth Circuits considered the merits of constitutional challenges to the ACA but, unlike the Eleventh Circuit, upheld the individual mandate. Other Circuits dismissed challenges on procedural grounds: the Fourth Circuit dismissed a challenge to the individual mandate by individual plaintiffs based upon the Anti-Injunction Act and another by the State of Virginia for lack of standing; the Third, Eighth and Ninth Circuits also dismissed cases for lack of standing. Additional ACA challenges pending in the Third, Fifth and Sixth Circuits were stayed pending the Supreme Court's review.

Summary: Federal Circuit Court Decisions

Circuit	Standing	Individual Mandate	Medicaid Expansion	Anti-Injunction Act
DC		Upheld		
Third	No standing			
Fourth	No standing			Action barred
Sixth		Upheld		
Eighth	No standing			
Ninth	No standing			
Eleventh		Struck down	Upheld	

Summary of Decision

The Supreme Court's decision directly considered two main provisions of the ACA: the individual mandate and the Medicaid expansion. While the Court ultimately concluded that all but the penalty provisions of the Medicaid expansion are constitutional, Chief Justice Roberts' opinion is built on varying majorities for different aspects of the decision.

- Five justices rejected the principal arguments advanced by the government — that the individual mandate represented a valid exercise of Congress' Commerce Clause power, or alternatively its power under the Necessary and Proper Clause. Chief Justice Roberts concluded that the Commerce Clause did not encompass the power to create commercial activity — that is, to require people to enter the health insurance marketplace — but only the power to regulate existing commercial activity.
- The individual mandate was nevertheless upheld because a different five-justice majority accepted the government's alternative argument that the shared responsibility payment of the individual mandate was properly construed as a tax within Congress's power to tax and spend for the general welfare, notwithstanding its description in the Act as a penalty.
- Despite this conclusion, the Court also rejected the argument accepted by the Fourth Circuit and advanced before the Court by an *amicus curiae* that the Anti-Injunction Act precluded the Court from ruling on the merits of the mandate. On this point, the Court found that Congress' description of the shared responsibility payment as a penalty rather than a tax, combined with the substance of the penalty, demonstrated that it was not subject to the Anti-Injunction Act.
- With respect to the Medicaid expansion, a 7-2 majority found that Congress overstepped its Spending Clause power when it authorized the penalizing of states that did not accept the Medicaid expansion by withholding all Medicaid funding, as opposed to only new funding related to the expansion. That majority recognized that Congress may condition the receipt of federal funding on compliance with federal requirements, but concluded that the penalty provided by the Act was too draconian to leave states with a meaningful choice regarding expansion.
- The Medicaid expansion itself was nevertheless upheld because a five-justice majority concluded the Medicaid Act's severability provision permitted the penalty to be severed from the remainder of the expansion.
- Four justices found the law unconstitutional as a whole because both the individual mandate and the Medicaid expansion were unconstitutional, and were so intertwined with the remainder of the Act that they could not be severed from it.

Timeline for Implementation: Existing and Future Provisions

Implementation to Date

While the individual mandate and Medicaid expansion have not yet been implemented, many other provisions of the Act have taken effect, either by operation of law or through rulemaking or other regulatory action. Examples of provisions that have taken effect or for which final regulations have been issued include:

- prohibiting individual and group health plans from placing lifetime limits on coverage, rescinding coverage except in cases of fraud and denying children coverage based on pre-existing medical conditions;
- increasing the Medicaid drug rebate percentage for brand-name drugs to 23.1 percent and generic drugs to 13 percent;
- requiring health plans to provide rebates to consumers if the share of the premium spent on clinical services and quality is less than 85 percent for large plans and 80 percent for individual and small group plans;
- establishing a Medicare hospital value-based purchasing program that pays hospitals based on performance against quality measures, and requiring plans to be developed to implement value-based purchasing programs for other provider types;
- reducing rebates paid to Medicare Advantage plans and providing bonus payments to high-quality plans;
- gradually reducing Medicare payments that would otherwise be made to hospitals to account for excess (preventable) hospital readmissions; and
- establishing rules governing the formation and operation of Accountable Care Organizations.

In light of the Court's ruling, many additional provisions of the Act, including the signature individual mandate and voluntary Medicaid expansion, will now proceed to take effect as follows:

On or After January 1, 2013

- The amount of contributions to a flexible spending account for medical expenses will be limited to \$2,500 per year, increased annually by the cost of living adjustment.
- Employers who receive Medicare Part D retiree drug subsidy payments will not be able to deduct those subsidies.
- An excise tax of 2.3 percent will be imposed on the sale of any taxable medical device.
- The Sunshine Act will be implemented, requiring disclosures by drug, device and medical supply manufacturers of payments to teaching hospitals and physicians.

On or After January 1, 2014

- Funding for the Children's Health Insurance Program (CHIP) will be extended.
- State-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges will be created. These exchanges will be administered by a governmental agency or nonprofit organization and allow individuals and small businesses (up to 100 employees) to purchase qualified coverage.
- A fee of \$2,000 per full-time employee, excluding the first 30 employees, will be assessed on employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee, excluding the first 30 employees.

- The Independent Payment Advisory Board will submit its first annual report of legislative proposals to reduce the per capita rate of growth in Medicare spending (in the event that spending growth exceeds a target growth rate).

On or After January 1, 2016

- States will be permitted to form health care choice compacts that allow insurers to sell policies in any state participating in the compact.
- An excise tax will be imposed on insurers of employer-sponsored health plans with aggregate expenses that exceed \$10,200 for individual coverage and \$27,500 for family coverage.

What's at Stake for U.S. Business: A Sector-by-Sector Analysis

Employers: Businesses with more than 50 employees will be required by January 1, 2014, to provide minimum coverage to all employees or pay a penalty for each employee who does not receive such coverage. The decision to uphold the law also maintains an employer tax deduction for Medicare Part D retiree drug subsidy payments. Finally, by January 1, 2014, employers should have access to state-run health insurance exchanges, which are intended to provide employers and individuals with cheaper, easier access to insurance. A corresponding provision of the Act allows states to enter into compacts and insurers to offer policies across state lines.

Health Insurers: Before the Court's decision, insurers argued passionately that the only way to both expand coverage and keep premiums affordable was to increase the size of the risk pool to include relatively younger and healthier individuals who would otherwise forego purchasing health insurance. The Court's opinion did just this — upholding the individual mandate while keeping in tact corresponding insurance reforms.

Nevertheless, the Court's ruling results in some continued uncertainty for the insurance industry. Most estimates suggest that, as enacted, the Act would have resulted in approximately 30 million newly insured, premium-paying individuals. The Court's actual ruling, however, recognizes that a substantial number of individuals — projected at four million people per year — may choose to pay the shared responsibility payment penalty rather than obtain frequently more expensive health insurance. If this projection holds, the premium expansions for the insurance industry may not be as large as initially expected. In addition, insurance plans with large footprints in the Medicaid managed care sector face particular uncertainty over future enrollments because it is more likely that certain states will opt not to expand their Medicaid programs in light of the minimized penalty following the Court's opinion.

In any event, the Court's ruling has immediate practical implications for the insurance industry, allowing it to capitalize on the already substantial investments companies have made in preparing for the implementation of the Act's various insurance reforms and the operation of insurance exchanges. Certainty regarding the future of health care reform also may continue to foster the increased M&A activity in the health insurance and health system sectors that has been seen over the past two years.

Hospitals and Institutional Providers: Like insurance companies, institutional providers have devoted substantial effort and resources to preparing to comply with the Act's requirements. Investments that will now be realized in this sector include expanded clinical capabilities, upgraded physical facilities and technology, and enhanced quality and performance programs. Indeed, prior to the Court's opinion, many institutional health care providers argued in favor of upholding the Act

because the projected expansion of coverage to 30 million additional Americans would result in additional revenue for the sector. While the Act includes a number of trade-offs, such as lower reimbursement rates and tougher regulatory requirements, as a whole the industry considered these outweighed by the significant increase in the volume of insured individuals.

Nevertheless, institutional providers continue to face some uncertainty following the Court's opinion because the number of additional Americans that will ultimately be covered by insurance remains to be seen. If large numbers of individuals remain uninsured, either by paying the penalty or because their states opt not to expand Medicaid programs, those individuals' care will continue to impose a burden on emergency rooms.

Drug and Device Manufacturers: The Court's opinion leaves in tact the various provisions of the Act that most directly impact drug and device manufacturers. For drug manufacturers, these include the industry-wide tax, increased Medicaid rebates, provisions to lower and eventually eliminate the Medicare Part D coverage gap (the "donut hole"), the FDA's enhanced authority to approve generic biologics, the expanded definition of 340B entities (which receive favorable pricing from manufacturers), and the Sunshine Act requirement to publicly disclose payments to physicians and institutional providers. For device manufacturers, the Act will result in the 2.3 percent excise tax on all medical devices, Sunshine Act reporting requirements, and various Medicare payment reform mechanisms that will have an important, if indirect, impact on medical device companies.

Many of these reforms will impact drug and device industry profits, through lower reimbursement rates and/or rebates and new sector taxes. As enacted, these impacts were projected to be offset, at least in part, by the expected increase in the use of drugs and devices by the anticipated 30 million newly insured Americans. As with other health care industry sectors, the ultimate impact for drug and device manufacturers will depend upon the number of individuals finally enrolled through a combination of the individual mandate and states that opt to accept the Medicaid expansion.