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The Supreme Court's Ruling on Health Care Reform:

How Does it Impact Our Clients?

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Introduction

On June 28, 2012, the Supreme Court issued its decision in a trio of cases which challenged the constitutionality of certain provisions in the *Affordable Care Act*. Ultimately, a majority of the justices concluded that the Act's "individual mandate" was not authorized by the Commerce Clause. At the same time, though, a different majority of the justices concluded that the provision was within Congress' power to "lay and collect taxes." Art. I, §8, cl. 1. The *Affordable Care Act* therefore has survived its primary constitutional challenges.

In its decision, the Court was careful to withhold comment on the wisdom of the means Congress selected to pursue its goal of increasing the number of Americans covered by health insurance. In fact, each of the justices joined in an opinion which professed in some way that such policy questions were not for the Court to decide.[1] To be sure, the public remains divided in its support for the legislation, and the national election in November 2012 is likely to spark further debate about whether to expand, contract or otherwise substantively change the *Affordable Care Act*. In the meantime, the *Affordable Care Act* still promises to have a profound impact on health insurers, employers and virtually every American citizen.

An understanding of the *Affordable Care Act*'s main provisions and the key changes for which they call therefore is essential to the advice we can provide to our clients.

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[1] See, e.g., Roberts, C.J., p. 44 ["Because the Constitutions permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."]; Ginsburg, J., p. 12 ["Whatever one thinks of the policy decision Congress made, it was Congress' prerogative to make it."]; Scalia, J., [". . . severing other provisions from the Individual Mandate and Medicaid Expansion necessarily would impose significant risks and real uncertainties . . . If those risks and uncertainties are to be imposed, it must not be by the Judiciary."].

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What Was At Stake?

The *Patient Protection and Affordable Care Act* (Pub.L. 111-148) became law on March 30, 2010, when President Barack Obama signed the *Health Care and Education Reconciliation Act of 2010* (Pub.L. 111-152, 124 Stat. 1029). At the time, the *Affordable Care Act* was described as one of the most sweeping and far-reaching national reform acts since the *Civil Rights Act of 1964*. Indeed, the two pieces of legislation used more than 900 pages of text to (among other things) call for numerous insurance reforms, create state-run health benefit exchanges, change the Medicare and Medicaid programs, establish standards for new care environments and revise the tax laws in numerous ways.

By design, those changes were not imposed *enmasse*. Instead, the *Affordable Care Act* directed that certain changes become effective immediately and that the implementation of others be deferred until specified dates in the future. By the time the Supreme Court issued its decision, then, only some of the *Affordable Care Act's* many provisions had been put in place.

Many of the reforms which already are in effect involve the terms of on which health insurance coverage may be offered. Among others, they include:

· Dependents Eligible Until Age 26: Health plans must allow parents to keep their children (under age 26) covered by their family coverage unless the child has job-based coverage of their own.

· No Pre-Existing Condition Exclusions for Children: Health plans cannot deny coverage or limit benefits for a child (under age 19) because the child has a "pre-existing condition."

· Free Preventive Care: Health plans and policies must cover certain preventive services without copayments, co-insurance or deductibles.

· No Lifetime Limits: Health plans and policies may not provide for l*ifetime* limits on essential benefits.

· Restrictions on Annual Limits: The annual limits for which health plans and policies provide with respect to covered health benefits are limited (and will be phased out in 2014).

Other reforms already in effect address the practices of the insurers who issue health insurance coverage. For example:

· Rescissions Limited to Fraud: Insurers are prohibited from rescinding coverage – for individuals or groups – except in cases involving fraud or an intentional misrepresentation of material facts.

· Appeals for Adverse Claim Decisions: Health plans and insurers must allow for both internal appeals of adverse claim decisions and an independent external review.

· Premium Increases Must be Justified: Health insurers must justify to a rate review board any premium increase of 10% or more.

· Medical Loss Ratios/Rebates: Health insurers must spend at least a minimum percentage of every premium dollar on the costs of health care and improving quality. Insurers which fail to do so must rebate of the portion of premium dollars not spent for those purposes.

Still more of the reforms already in effect are of particular interest to employers. They include two sets of provisions that can help employers offset the cost of providing health insurance coverage:

· Small Business Tax Credit: Employers with fewer than 25 employees may qualify for a tax credit of up to 35% (up to 25% for non-profits) to offset the cost providing health insurance. This credit will increase in 2014 to 50% (35% for non-profits).

· Subsidies to Cover Early Retirees: An Early Retirement Reinsurance Program provides reinsurance payments for health benefit claims of retirees (age 55 and older) who are not yet eligible for Medicare, and their eligible dependents. The amount of the reimbursement to the employer or union is 80 percent of medical claims costs for the health benefits of an individual between $15,000 and $90,000.

Other provisions were designed to make certain forms of coverage immediately available to the uninsured. Still more were meant to create the framework for additional reforms which were scheduled to become effective at a later time.

By many accounts, several of the earliest provisions to become effective were immediately popular with the American public. Indeed, even while the constitutionality of the *Affordable Care Act* remained in doubt, several insurers announced plans to retain certain features (e.g., dependents eligible to age 26 and rescissions limited to fraud) – regardless of how the Supreme Court ruled. What hung in the balance, though, was not limited to the potential repeal of the reforms which already had been implemented. Rather, it included several additional reforms which had not yet become effective but promised to change the health care system, health insurance industry, employer obligations and millions of American lives in significant ways.

Chief among those was the "individual mandate," a set of provisions which (with some exceptions) requires that all individuals obtain and maintain "minimal essential coverage" by January 2014. Beginning in 2014, anyone who does not have minimum essential coverage in place will be required to make a "shared responsibility payment" as part of their federal income tax return.

As outlined in Congressional testimony (and later explained in the Court's written decision), Congress reasoned that the individual mandate was made necessary by a pair of insurance reforms which also will become effective in 2014. One – known as "guaranteed issue" -- prohibits health insurers from denying coverage to people for any reason, including their health status. The other – known as "community rating" -- prohibits health insurers from charging people more because of their health status and gender. Instead, premiums will be allowed to vary only on the basis of geographic area, age (by a 3 to 1 ratio), tobacco use (by a 1.5 to 1 ratio), and the number of family members.

Ostensibly to give consumers greater choices in the health insurance marketplace, the *Affordable Care Act* also provides for government-run "health benefit exchanges" from which

individuals and small employers (up to 100 employees) can purchase insurance. Plans in the exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan. Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the exchanges. Cost-sharing subsidies also will be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.

To make "minimal essential coverage" more available to working Americans, the *Affordable Care Act* also contains a different set of provisions which sometimes has been referred to as the "employer mandate." Technically, those provisions do *not* require that employers offer health insurance coverage to their employees. Rather, they provide that large employers (50 or more full-time employees) will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer "minimum essential coverage." Large employers that do offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or opt out of coverage. However, they also will be required to pay a $3,000 fee for each employee who opts out of the employer's plan and has an annual income below 400% of the federal poverty level.[2]

To make coverage available to Americans who have neither private nor employer-sponsored health insurance coverage and who do not have the means to obtain coverage through the exchanges, the *Affordable Care Act* also calls for an expansion of Medicaid to include all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009). Initially, the federal government will fully fund the cost of covering those who become newly eligible for Medicaid. Beginning in 2017, though, the states which administer coverage to those newly eligible participants will be required to fund some portion of the associated costs.

The constitutional issues on which the Supreme Court most recently ruled therefore involved much more than an intellectual riddle about the limits of Congress' regulatory powers. As a practical matter, it also involved the fate of a complex and inter-related statutory scheme for which insurers, employers and consumers all have been making preparations. As Justice Scalia noted in his dissent:

> "The Federal Government, the States, and private parties ought to know at once whether the entire legislation fails."

Scalia, J., p. 55. Through the Court's decision, we now know that the *Affordable Care Act* has survived constitutional challenge *in toto*.

[2] Employers that offer coverage also will be required to provide a voucher to employees with incomes below 400% of the poverty level if the employee's share of the premium cost is between 8% and 9.8% of the employee's income. Employees cause that free choice voucher to purchase insurance through an exchange, and employers that offer a free choice voucher will not be subject to the penalties described above.

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What Is the Impact of the Supreme Court's Decision?

Supreme Court observers have taken note of the unexpected coalition that seemingly was formed when four liberal justices (Ginsburg, J., Sotomayor, J., Breyer, J. and Kagan, J.) joined in substantial portions of Chief Justice Roberts' opinion. Many had expected Justice Kennedy – who joined with Justices Scalia, Thomas and Alito – to be the "swing vote." Some also question why those justices' dissenting opinion appears to refer to Chief Justice Roberts as a dissenter. Scalia, J., p. 14. From a practical perspective, though, the impact of this particular decision must be measured by its terms and ***not*** by any sense of political intrigue.

In that regard, constitutional scholars may find interest in the Court's treatment of several states' claim that the expansion of Medicaid under a scheme which threatened all federal funding for existing Medicaid programs was unconstitutionally "coercive." Indeed, seven[3] of the 9 justices either authored or joined in opinions which concluded that such a circumstance was "surely beyond" whatever line marks the outermost point at which "persuasion gives way to coercion." Roberts, C.J., p. 55; See also, Scalia, J., p. 38 ["Whether federal spending legislation crosses the line from enticement to coercion is often difficult to determine. . . . In this case, however, there can be no doubt."].[4]

Constitutional scholars also may have interest in the Court's analysis of Congress' powers under the Commerce Clause. Writing for the Court, Chief Justice Roberts first explained that "[t]he power to regulate commerce presupposes the existence of commercial activity to be regulated." Roberts, C.J., p. 18. He also observed that:

> "The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity."

Roberts, C.J., p. 27. In the Chief Justice's view, then, the individual mandate could not be justified under the Commerce Clause because it "does not regulate existing commercial activity." *Id.*; See also, Roberts, C.J., p. 20.

Four other justices[5] used similar reasoning to reach the same conclusion. In their words, "one does not regulate commerce that does not exist by compelling its existence." Scalia, J., p. 4. They also shared the Chief Justice's apparent concern for the limits of Congress' regulatory power if such an unprecedented use of the Commerce Clause were upheld:

> "If Congress can reach out and command even those furthest removed from an interstate market to participate in the market, then the Commerce Clause becomes a font of unlimited power. . . ."

Scalia, J., p. 8; Accord, Roberts, C.J., p. 23 ["Accepting the Government's theory would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal Government."].

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[3] Roberts, C.J., Breyer, J., Kagan, J., Scalia, J., Kennedy, J., Alito, J. and Thomas, J.

[4] By clarifying that the statute allowing Medicaid funds to be withheld was unconstitutional only if ***applied*** in a coercive manner, that portion of the Court's decision does allow for the possibility that some states may decline to participate in the expansion of Medicaid for which the *Affordable Care Act* provides. Roberts, C.J., p. 56.

[5] Scalia, J., Kennedy, J., Thomas, J. and Alito, J.

Insurers (and those who advise them) will be interested in those portions of the decision which consider -- then reject -- the notion that health insurance is sufficiently "unique" to be regulated differently under the Commerce Clause. Roberts, C.J., p. 27; Scalia, J., p. 16; But see, Ginsburg, J., p. 28. Political observers also may take note that, because it upheld the individual mandate only as an exercise of Congress' taxing powers [Roberts, C.J., p. 44], the Court's decision suggests any future mandate for the purchase of other goods and services will necessarily be characterized as a tax.

From a substantive standpoint, though, the Supreme Court's decision did not alter any provision in the *Affordable Care Act*. To the contrary, the changes which the Act now promises to implement are the same changes it promised to make when it was signed into law. The Court's decision therefore serves primarily as a signal that health insurers, employers and the American public will be expected to comply with the *Affordable Care Act* as it continues to be implemented.

What Does This Mean for Health Insurers?

In its decision, the Supreme Court acknowledged that "adverse selection" could cause significant increases in the costs of health insurance if the individual mandate were struck down but the *Affordable Care Act*'s requirements of "guaranteed issue" and "community rating" were allowed to stand. As Chief Justice Roberts explained:

> "The guaranteed-issue and community-rating reforms do not . . . address the issue of health individuals who choose not to purchase insurance to cover potential health care needs. In fact, the reforms sharply exacerbate that problem, by providing an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage. The reforms also threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage. This will lead insurers to significantly increase premiums on everyone."

Roberts, C.J., pp. 16-17. The Congressional testimony had painted a far more desperate picture, suggesting that such a circumstance would cause the financial foundation supporting the health care system to fail, "in effect causing the entire health care regime to 'implode'." See, e.g., *Virginia v. Sebelius*, 728 F.Supp.2d 768 (E.D.Va. 2010).[6] Most health insurers therefore were anxiously awaiting the Supreme Court's decision to evaluate whether it might signal the industry's demise.

[6] Further support for this concern can be found in connection with *The Community Living Assistance Services and Supports (CLASS) Act*, a law which was enacted as part of the *Affordable Care Act* to establish a voluntary, national insurance program for American workers to help pay for long-term care services and supports. On April 22, 2010, an actuary from the Centers for Medicare and Medicaid Services issued a memorandum which identified a "very serious risk" that the program would become unsustainable as a result of adverse selection. On October 14, 2011, Secretary Sebelius therefore transmitted a report and letter to Congress stating that the Department does not see a "viable path" for implementing the *CLASS Act* at this time.

During that time, health insurers nevertheless were required to implement many of the insurance reforms for which the *Affordable Care Act* called: families were allowed to continue coverage for dependents under age 26; coverage for children under age 19 was provided without limitation for pre-existing conditions; preventive care was covered without cost; lifetime limits were eliminated; and annual limits were restricted. Health insurers also modified their practices by, among other things, limiting their rescissions to cases involving fraud and establishing procedures for internal and external appeals that meet the newly prescribed standards.

Health insurers also began implementing procedures related to the "medical loss ratio" prescribed by the *Affordable Care Act*. In essence, the implementing regulations require that health insurers publicly report on how premium dollars are spent. They also establish standard percentages of each premium dollar which must be spent on health claims and/or quality improvement expenses: for insurers in the individual and small group market, the minimum is 80%[7]; for insurers in the large group market, the minimum is 85%.[8]

There are numerous expenses that insurers must pay out of the 15-20% of premium dollars that remain, including: overhead, commissions, underwriting expenses, fraud prevention/detection, employee salaries, compliance costs -- and ***profit***. The implementing regulations also provide that activities primarily designed to "control or contain costs" cannot be categorized as a form of quality improvement. Health insurers therefore need to understand which costs can fairly be attributed to "activities that improve health care" and, in turn, can be considered part of the 80-85% portion of their expenses. They also need to prepare for the possibility of rebating a pro-rata portion of premiums if their medical loss ratio ever is less than the applicable standard percentage. Indeed, any rebates payable for 2011 under the *Affordable Care Act's* medical loss ratio provisions must be paid by August 1, 2012.

In addition to ensuring that any medical loss ratio rebates are timely paid, health insurers who serve as plan administrators of group plans must: (1) comply with the *Affordable Care Act's* requirements for additional women's preventative coverage for plan years beginning on or after August 1, 2012; and (2) issue a summary of benefits and coverage document to plan participants starting on September 23, 2012.

What Does This Mean for Employers?

When the Supreme Court granted *certiorari* in the three cases on which it most recently ruled, it also had an opportunity to consider a fourth case which involved a constitutional challenge to the employer mandate. In that case, the district court had held the employer mandate to be constitutional under the Commerce Clause because it "regulat[es] the terms of the employment contract." *Liberty University,* 753 F. Supp. 2d 611, 636 (W.D.Va. 2010). On appeal, the Fourth Circuit simply concluded that the *Anti-Injunction Act* deprived it of jurisdiction to proceed.

Since the Supreme Court did not act on the petition for *certiorari* which followed, it has not yet considered the constitutionality of the employer mandate. As mentioned previously, though, seven of the 9 justices did author or join in opinions which held that the *Anti-Injunction*

[7] 42 U.S.C. §300gg-18(b)(1)(A)(ii).
[8] 42 U.S.C. §300gg-18(b)(1)(A)(i).

Act did not bar judicial review of the individual mandate.[9] There is, therefore, some possibility that the case now will be remanded to the Fourth Circuit. In turn, there is some possibility that the Supreme Court may soon be asked again to consider a constitutional challenge to the employer mandate.[10]

In the interim, employers must prepare for the employer mandate which is scheduled to become effective on January 1, 2014. They also must comply with the related implementing regulations.

To identify their obligations, employers first must consider whether they have 50 or more "full-time employees." Doing so will require that employers evaluate the significance of "full-time equivalent employees," how to account for independent contractors to whom employee functions have been outsourced, and whether the common ownership of businesses requires that their respective employees be aggregated.

Large employers also must verify that any health plan they offer to employees provides "minimum essential coverage." At the same time, they will need to consider that (beginning in 2018) the *Affordable Care Act* will impose an annual excise tax on so-called "Cadillac plans" which have premiums (not including those for vision and dental) that exceed $10,200 for individuals or $27,500 for a family.

Employers with fewer than 100 employees will be eligible to shop for plans in the health benefit exchanges. However, employers with 50 or more full-time employees might also compare the cost of providing "minimum essential coverage" to the total cost of all "assessment payments" that will be imposed if they choose not to. In some cases, such employers might conclude that making assessment payments costs them less than providing minimum essential coverage.

Employers with fewer than 50 employees are exempt from such requirements and do not have to pay an assessment if their employees get tax credits through a health benefit exchange. They will, however, need to consider carefully the financial impact of a decision to hire a "50th employee."

Small employers who provide health insurance already are eligible for a small business tax credit of up to 35% (up to 25% for non-profits) if they have no more than 25 employees and pay average annual wages of less than $50,000. Starting in 2014, the small business tax credit goes up to 50% (up to 35% for non-profits) for qualifying businesses. Accordingly, small employers also will need to consider carefully the financial impact of a decision to hire a "26th employee."

Employers who currently offer health coverage through self-funded plans also will need to anticipate the impact of the *Affordable Care Act*'s restrictions on annual limits and elimination

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[9] See footnote 3, *supra*, and related text.

[10] Unlike the individual mandate, the employer mandate specifically uses the word "tax." 26 U.S.C. §4980H(b)(2). In light of the Supreme Court's most recent decision, then, there is some possibility that the employer mandate would be found to be a constitutional exercise of Congress' taxing power.

of lifetime limits. Doing so may prompt employers who sponsor self-funded plans to consider purchasing stop-loss coverage.[11]

What Does This Mean for States?

In furtherance of the goal of achieving near-universal health coverage, the *Affordable Care Act* assigned two tasks to the states. The first was to create and/or administer health benefit exchanges. The second was to expand the Medicaid programs they already administer to include persons whose annual income is not more than 133% of the federal poverty level.

Anticipating the creation of health benefit exchanges, the *Affordable Care Act* also created a new Pre-Existing Condition Insurance Plan (PCIP) program which was designed to make health insurance available to Americans without over coverage because of a pre-existing condition. The PCIP program is administered by either the state or the federal government. As of April 30, 2012, twenty-three states and the District of Columbia had elected to have their PCIP program administered by the federal government, while the remaining twenty-seven states had chosen to run their own programs. By design, though, the PCIP program is temporary. Indeed, it is scheduled to terminate in 2014, when the health benefit exchanges will become effective. 42 C.F.R. § 152.45.

To that end, the *Affordable Care Act* provides for funding to assist the states in establishing health benefit exchanges. It also directs the U.S. Department of Health and Human Services to establish an exchange (directly or through agreement with a not-for-profit entity) in any state that fails to establish its own. As of the date of the Supreme Court's decision, forty-nine states[12] and the District of Columbia had applied for and received up to $1 million in Exchange Planning Grants. However, only thirty-two states and the District of Columbia had applied for and received Level 1 Establishment Grants,[13] and just two states[14] had applied for and received Level 2 Establishment Grants.[15]

Substantial questions about the remaining states' ability to establish health benefit exchanges by January 1, 2014 therefore exist. In those states which cannot do so, the U.S. Department of Health and Human Services is charged with creating an exchange. Whether and how a federally-created exchange might differ from one a state might create for itself is an important question which cannot yet be answered.

In light of the Supreme Court's decision, the fate of the *Affordable Care Act*'s expansion of Medicaid also is uncertain. As Chief Justice Roberts explained:

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[11] On May 1, 2012, the three federal agencies charged with implementing the *Affordable Care Act* – the Internal Revenue Service, the Centers for Medicare & Medicaid Services, and the Employee Benefits Security Administration –issued a request for information which asks 13 questions about health plan sponsors' current and planned use of stop-loss insurance.
[12] Alaska did not apply for an Exchange Planning Grant.
[13] Level 1 Establishment Grants provide up to one year of funding to states that have made some progress under their Exchange Planning Grant.
[14] Rhode Island and Washington.
[15] Level 2 Establishment Grants provide funding through December 31, 2014 to states that are further along in their efforts to establish a health benefit exchange.

> "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."

Roberts, C.J., p. 57. Given that twenty-six states joined in the lawsuit which challenged the expansion of Medicaid as unconstitutionally coercive, some 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." Roberts, C.J., pp. 57-58. Other states, though, may sign up, "finding the idea of expanding Medicaid coverage attractive, particularly given the level of funding the Act offers at the outset." Roberts, C.J., p. 58.

Just as many states now must scramble to finalize their preparations for health benefit exchanges, then, each must carefully consider whether to participate in an expansion of Medicaid. Doing so may benefit a particular segment of their citizenry, but will come at some increased cost. Choosing not to do so may avoid those costs, but cut against the *Affordable Care Act's* stated goals by further impairing the ability of some low-income citizens to obtain health care coverage.

What Does This Mean for Consumers?

Arguably, consumers have benefited the most from those of the *Affordable Care Act*'s reforms which already are effective. Ironically, though, they may also have benefited the least from the Supreme Court's pronouncement that the *Affordable Care Act* is constitutional.

First, the Supreme Court's decision specifically upheld that part of the Act which authorizes the Internal Revenue Service to assess and collect a monetary sum for non-compliance with the individual mandate. Beginning in 2014, then, every American who is not exempt will be required to either obtain and maintain "minimum essential coverage" or make a "shared responsibility payment."

For those who already have coverage through individual or group health insurance, that development may be inconsequential: in many cases, they need only maintain some form of the coverage they already have in place. For those who do not already have coverage through those sources, the *Affordable Care Act* attempts (through the employer mandate) to make more employer-sponsored group coverage available. It also attempts (through the exchanges) to create a new marketplace from which individuals and small businesses can obtain minimum essential coverage on affordable terms.

However, the Supreme Court also has now ruled that the Constitution prohibits the federal government from withdrawing a state's funding for existing Medicaid programs if it chooses not to participate in the expansions for which the *Affordable Care Act* calls. In so doing, the Supreme Court allowed for the possibility that some states will choose not to expand their Medicaid programs to include persons who make 133% of the federal poverty level ($30,657 for a family of four in 2012).

To be sure, the Act does provide for tax credits which are designed to help low-income Americans pay for health coverage through the exchanges. If, however, a family of four which makes just $30,000 a year does not have the disposable income to pay for health coverage,

they will nonetheless be forced to make a "shared responsibility payment." In 2014, that payment will amount to the greater of $95 or 1% of household income. In 2015, it will amount to the greater of $325 or 2% of household income. Beginning in 2016, it will amount to $695 or 2.5% of household income. A family of four which makes only $30,000 per year in 2016 therefore could be left without health insurance coverage and, at the same time, be required to pay $750 for that consequence.

While low-income Americans may be unable to avoid that circumstance, others may simply weigh the costs of obtaining minimum essential coverage against the cost of their shared responsibility payment. If the costs of coverage prove to be too high, they might then elect to forego purchasing health insurance until (and unless) they need it. In that event, they can rely on those portions of the *Affordable Care Act* which, in Chief Justice Roberts' words, create "an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage." Roberts, C.J., p. 16.

Conclusion

In many ways, the Supreme Court's ruling on the *Affordable Care Act*'s constitutionality was as noteworthy as passage of the Act itself. For practical purposes, though, it really answered just one question: will the *Affordable Care Act* continue to be implemented without change.

The Supreme Court's answer to that question was "yes." However, political winds constantly blow and frequently change. Indeed, there is ongoing dialogue about the policy choices embodied by the *Affordable Care Act.* There also are substantial questions about how to comply with its terms, the costs associated with doing so, and the impact that doing so actually will have on how Americans receive and pay for their health care. At the same time, another national election is just a few months away.

Stated differently, the future might bring important and substantive changes to the *Affordable Care Act* and/or its implementing regulations. For now, though, health insurers, employers and the American public in general must prepare themselves for the significant reforms set forth in a comprehensive piece of legislation which the Supreme Court has held to be constitutional.

About the Author

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