states had not agreed to, nor could have anticipated, such a drastic change in the Medicaid program.

Finally, regarding whether the remaining provisions should survive overruling of one provision, Roberts and the four justices on the Ginsburg opinion voted to sustain the rest of the law, reasoning that Congress would not have wanted the entire statute to fall because of a constitutional problem with the Medicaid provision.

The Court’s decision settles doubt about the ACA’s constitutionality and clears the path for implementation and innovations in care delivery and cost control. Regarding the Medicaid expansion, the decision creates uncertainty. With weakened incentives for participating in the expansion, states may opt out for ideological or financial reasons. In addition, under the ACA, some Medicaid populations are not eligible for federal subsidies to obtain health insurance on the exchanges. As the Court noted, Congress was relying on the Medicaid expansion to help reduce the numbers of uninsured Americans. Without all states participating, the ACA will fall short of its goals.

No Supreme Court decision can resolve political uncertainty about the ACA’s long-term viability. The outcome of the 2012 federal elections may determine the fate of health care reform. State leaders who oppose the ACA may decide to wait and see what the election portends.

Roberts introduced his opinion with a disposition on “both the limits of federal power, and [the Court’s] own limited role in policing these boundaries.” Noting the broad powers that the Constitution grants the federal government for regulating commerce and accomplishing through taxation and spending what it cannot regulate directly, he stated that the Necessary and Proper Clause gives Congress “great latitude in exercising its powers.” Roberts explained this “permissive reading of these powers” as justified by a “general reticence to invalidate the acts of the Nation’s elected leaders.” The Court, he stated, “possesses neither the expertise nor the prerogative to make policy judgments,” but it could not abdicate its responsibility “to enforce the limits on federal power by striking down acts of Congress that transgress those limits.”

Despite this expression of judicial modesty, Roberts’s opinion could supply a rationale for future limitations on Congress’s regulatory ability. Ginsburg’s dissent criticized his “crabbed reading of the Commerce Clause” as evoking “the era in which the Court routinely thwarted Congress's efforts to regulate the national economy in the interest of those who labor to sustain it.” Arguing for judicial deference to reasonable congressional regulatory judgments, she wrote that Roberts’s limited reading “should not have staying power.”

Similarly, by characterizing the Medicaid expansion as a “shift in kind, not merely degree” and outlining possible criteria for invalidating federal spending conditions as unconstitutionally coercive, the Roberts opinion could give states more leverage in resisting federal standards accompanying receipt of federal funds. Ginsburg argues that these judgments fall outside the judiciary’s competency. Only future cases will indicate whether the analysis in the ACA case marks a shift in the Supreme Court’s Commerce Clause and 10th Amendment doctrines or was a rationale specific to this case.

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From Suffolk University Law School, Boston.

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The Road Ahead for the Affordable Care Act

John E. McDonough, Dr.P.H.

The Affordable Care Act (ACA), the U.S. health care reform law enacted in 2010 and upheld as constitutional by the U.S. Supreme Court on June 28, 2012,1 has survived a series of life-threatening obstacles since its congressional consideration began in mid-2009.

The most dramatic threat involved the surprise election of Massachusetts Republican Scott Brown to the U.S. Senate on January 19, 2010, which deprived Democrats of their 60-vote Senate majority and left most observers convinced that continued hopes for comprehensive health care reform were delusional.

Until the oral arguments before the Supreme Court this
March, few analysts believed that the Court’s decision would be another life-threatening episode. But from the dissent issued by Anthony Kennedy, Antonin Scalia, Clarence Thomas, and Samuel Alito, we now know that four of the nine justices wanted to overturn the entire statute. The stakes, in other words, were all or nothing.

The now-completed judicial process was the latest obstacle and not the last. The next mortal challenge comes with the November 6 elections. Although many issues, especially economic ones, will determine the outcomes of the presidential and congressional races, the policy consequences of the election will be most immediately and compellingly felt in connection with health care reform.

In January 2013, if Democrats hold the White House and Senate and regain control of the House, the ACA will be implemented mostly as constructed. If Republicans capture the White House and Senate and retain House control, the ACA will face major deconstruction early in 2013. Republican leaders will attempt to use Congress’s budget-reconciliation authority to enact extensive repeal — and will need only 51 Senate votes, with no filibuster threat. If control of the White House and Congress is divided between the parties, then conflict over the law will persist. Thus, the November elections increasingly feel like a referendum on the ACA.

Though the Court’s ruling will result in some changes, until the elections, implementation continues. The individual responsibility requirement (the individual mandate to obtain insurance coverage), insurance reforms such as the elimination of coverage exclusions for preexisting conditions, the establishment of state health insurance exchanges, and the provision of private health insurance subsidies stand unaltered despite the Court-ordered switch in the basis for constitutional legitimacy from the Commerce Clause to Congress’s taxing authority.

One consequential outcome of the ruling is the continuing benefit, and harm averted, for millions of Americans from ACA provisions that have already been implemented. Those benefiting include more than 6 million young adults enrolled in their parents’ insurance plans, 5.2 million Medicare enrollees who have saved on prescription-drug costs because of the shrinking Part D “doughnut hole,” 600,000 new adult Medicaid enrollees in seven states that have already expanded Medicaid eligibility, 12.8 million consumers who will receive more than $1 billion in insurance-premium rebates, and many others.

Also undisturbed are the ACA’s numerous system reforms, such as accountable care organizations, patient-centered medical homes, the Prevention and Public Health Fund, and the Patient-Centered Outcomes Research Institute. Since the ACA’s passage, health system innovation has surged — a dynamic that would have been undermined by a negative Court ruling.

The biggest change involves Medicaid. The ACA required that Medicaid serve nearly all legal residents with incomes below 138% of the federal poverty level. Now, states won’t risk losing federal funding if they choose not to expand their Medicaid programs. The Court decided that Congress faces limits on its authority to compel states to assume categorically new Medicaid obligations. This decision creates new uncertainties in the dynamic relationship between states and the federal government with regard to social welfare programs. It also creates a new inequity in the health system: by 2014, all Americans will have guaranteed access to affordable health insurance except adults with incomes below the poverty level who were previously ineligible for Medicaid (those with incomes between 100 and 138% of the poverty level will be allowed to obtain coverage through insurance exchanges). After the ruling, some Republican governors announced their intention to take a pass on expanding Medicaid. That reaction isn’t surprising in today’s hyperpoliticized pre-election environment. More telling will be judgments made after the elections. States have strong economic incentives to expand Medicaid, since the federal government will pay 100% of expansion costs between 2014 and 2016. By 2020, the federal share will drop to no less than 90% — much more generous than the 50 to 83% that the federal government contributes for traditional Medicaid and the Children’s Health Insurance Plan.

Although progress toward full implementation of Medicaid expansions will slow because of the ruling, history suggests that the financial incentives will attract states eventually. Although Medicaid was created in 1965, Arizona, for example, didn’t join the program until 1982. Because the most resistant governors lead states with the most uninsured
residents, Medicaid expansion will undoubtedly become the subject of fierce political controversy in those jurisdictions. Physicians, hospitals, and other stakeholders can influence these choices.

Some governors fear that the individual mandate will induce many currently eligible but unenrolled individuals to sign up for Medicaid. States will receive their traditional federal match of 50 to 83% for coverage in these cases, and their increased expenses will stress their budgets further. Disagreement over how many such people will enroll helps to explain the wide divergence in estimates of the costs to states of expanding Medicaid.

Most states must still decide whether to launch their own health insurance exchanges to assist consumers and small businesses in purchasing coverage or to let the federal government do it. States must demonstrate “sufficient” progress by January 2013, or the U.S. Department of Health and Human Services will begin launching its fallback exchange. Progress has been slow: only 14 states and the District of Columbia have authorized the creation of exchanges. If the ACA survives past November, many recalcitrant states will quickly establish exchanges rather than surrender their insurance markets to federal control. Many congressional Democrats preferred a muscular federal exchange; Republicans won’t grant their wish by default.

For now, the Obama administration is continuing to implement the ACA as quickly and thoroughly as possible, working to establish infrastructure, rules, and relationships in one of the most complex and multifaceted statutory implementations ever. Though most issues fly under the public’s radar, the challenges are consequential and conflict-laden. The current implementation queue includes writing definitions and rules for private health insurance markets, clarifying rules for determining required “essential health benefits,” explaining how employer-responsibility provisions will be devised, and much more.

Unappreciated in this chaotic political environment is that the ACA is the first U.S. law to attempt comprehensive reform touching nearly every aspect of our health system. Even President Lyndon Johnson’s achievement in establishing Medicare and Medicaid in 1965 was more narrowly focused. The law addresses far more than coverage, including health system quality and efficiency, prevention and wellness, the health care workforce, fraud and abuse, long-term care, bio-

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From the Department of Health Policy and Management, Harvard School of Public Health, Boston.

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