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A Guide to the Supreme Court’s Affordable Care Act Decision

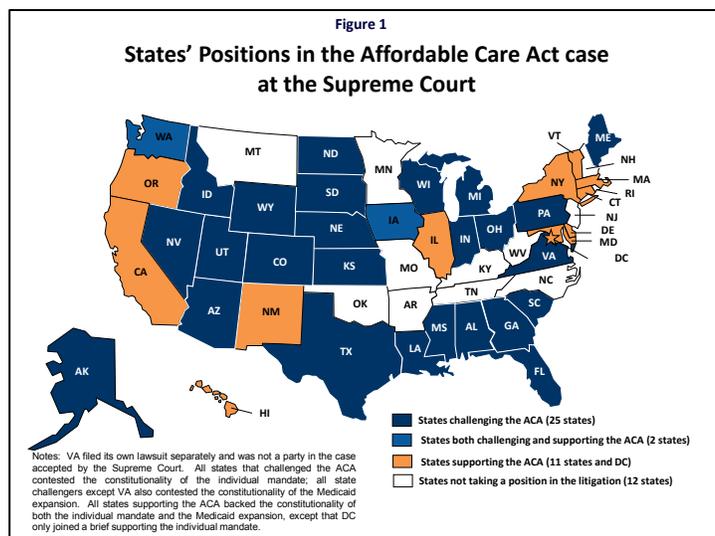
On the last day of the 2011-2012 Term, the United States Supreme Court issued its long-anticipated opinion about the Affordable Care Act (ACA). In a case known as *National Federation of Independent Business v. Sebelius*,¹ the Court agreed to consider the constitutionality of two major provisions of the ACA: the individual mandate and the Medicaid expansion. A majority of the Court upheld the individual mandate. And, while the Court found the Medicaid expansion unconstitutionally coercive of states, because states did not have adequate notice to voluntarily consent and the Secretary could potentially withhold all of a state’s existing federal Medicaid funds for non-compliance, a majority of the Court found that this issue was appropriately remedied by circumscribing the Secretary’s enforcement authority, thus leaving the Medicaid expansion intact in the ACA. This policy brief describes the Court’s decision and looks ahead to the implementation of health reform now that the constitutionality of the ACA has been resolved.

Background

The Case Accepted by the Supreme Court

On March 23, 2010, the day that President Obama signed the ACA, the state of Florida filed a lawsuit in federal district court challenging the constitutionality of the individual mandate and the Medicaid expansion.² Florida was joined by 25 other states: Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming.³ Another group of plaintiffs, including the National Federation of Independent Businesses (NFIB) and some individual plaintiffs who do not currently have health insurance, also filed a lawsuit in Florida. Both cases were considered together by the Supreme Court.

Thirteen states, including California, Connecticut, Delaware, Hawaii, Illinois, Iowa, Maryland, Massachusetts, New Mexico, New York, Oregon, Vermont, and Washington filed *amicus* (“friend of the court”) briefs in the Supreme Court supporting the individual mandate and the Medicaid expansion; the District of Columbia also supported the individual mandate. Two states, Iowa and Washington, were on both sides of the case, as their governors and attorneys general took opposite positions. The states’ positions in the case at the Supreme Court are illustrated in Figure 1.



The Individual Mandate

The minimum essential coverage provision of the ACA, known as the individual mandate, requires most people to maintain a minimum level of health insurance coverage for themselves and their tax dependents in each month beginning in 2014. The individual mandate can be satisfied by obtaining coverage through employer-sponsored insurance, an individual insurance plan including those to be offered through the new health insurance exchanges, a grandfathered health plan, government-sponsored coverage such as Medicare or Medicaid, or similar federally recognized coverage. People exempt from the individual mandate include undocumented immigrants, religious objectors, and people who are incarcerated. Almost 9 in 10 non-elderly people would either satisfy the mandate automatically because they already are insured or be exempt from it.⁴

To increase access to affordable health insurance, the ACA provides for the creation of health insurance exchanges that will offer qualified health plans, as well as advance payment of premium tax credits to people with incomes between 100% and 400% of the federal poverty level (FPL), between \$23,050 and \$92,200 per year for a family of four in 2012. The amount of the premium tax credit varies based upon income: for example, a person with income between 100% and 133% FPL is responsible for paying premiums up to 2% of her income (adjusted for family size) toward her premium and is eligible for a tax credit for the remaining amount. The tax credit is based on the premium for the second lowest cost silver plan in the exchange, and a person enrolling in a plan that costs more than the second lowest cost silver plan must pay the entire difference in premiums. Legal immigrants with incomes below 100% FPL who are ineligible for Medicaid based upon their immigration status also are eligible for premium tax credits. The ACA also provides cost-sharing assistance to people with incomes between 100% and 250% FPL, between \$23,050 and \$57,625 per year for a family of four in 2012.

If a person does not satisfy the individual mandate, she will owe a financial penalty, known as the shared responsibility payment. The financial penalty will be a percentage of household income, subject to a floor and capped at the price of the forgone insurance coverage, assessed and collected by the IRS and reported on federal income tax returns. The penalty is the greater of \$95 or 1% of income in 2014, \$325 or 2% of income in 2015, and \$695 or 2.5% of income in 2016, up to a maximum amount equal to the national average premium for bronze level health plans in the exchanges for the respective year. After 2016, the penalty dollar amounts are subject to an annual cost-of-living adjustment. Certain individuals are exempt from the financial penalty, including people for whom annual insurance premiums would exceed 8% of their household adjusted gross income, members of American Indian tribes, people who receive financial hardship waivers, people with incomes below the tax filing threshold,⁵ and people who lacked insurance for less than three months during a given year.

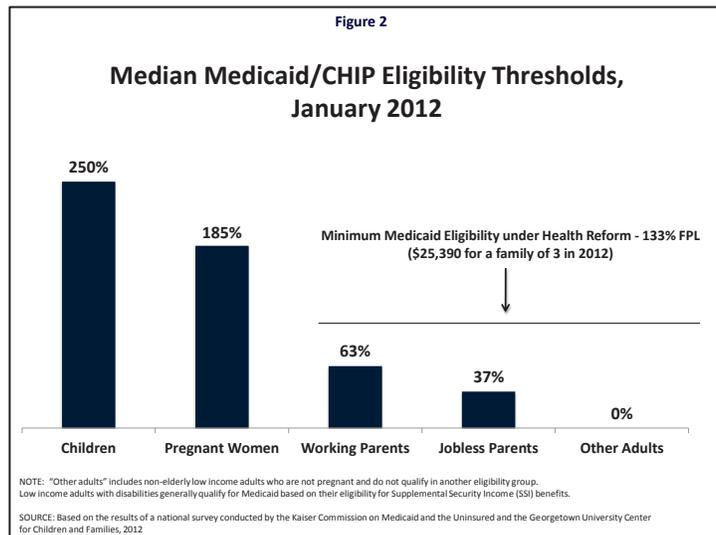
The Medicaid Expansion

The ACA also increases access to affordable health insurance by expanding eligibility for Medicaid benefits. The Medicaid program provides health insurance coverage to people with low incomes and is funded jointly by the federal and state governments. The program is voluntary for states: states are not

required to participate, but all states currently do. If a state chooses to participate in the Medicaid program, there are a number of options that it can elect, but it must follow certain federal rules.⁶

One of the federal requirements (i.e., conditions that Congress has placed on the states' receipt of federal Medicaid funds) concerns the groups of people who must be covered by a state's Medicaid program. The original statute established mandatory coverage groups which have been expanded by Congress several times since the program's 1965 enactment. Prior to the ACA, federal law mandated coverage for the following principal eligibility groups: pregnant women and children under age 6 with family incomes at or below 133% FPL, children ages 6 through 18 with family incomes at or below 100% FPL, parents and caretaker relatives who meet the financial eligibility requirements for the former AFDC (cash assistance) program, and elderly and disabled people who qualify for Supplemental Security Income benefits based on low income and resources. Federal law prior to the ACA excluded non-disabled, non-pregnant adults without dependent children from Medicaid, unless states obtained waivers to cover them.

The ACA expands the Medicaid program's mandatory coverage groups by requiring that participating states cover nearly all people under age 65 with household incomes at or below 133% FPL (\$14,856 per year for an individual and \$30,657 per year for a family of four in 2012) beginning in January, 2014.⁷ While some states have opted or obtained waiver authority to expand coverage to adults beyond the pre-ACA required income thresholds, many states currently do not cover adults without dependent children at all and cover parents only at much lower income levels than the ACA's Medicaid expansion minimum, as illustrated in Figure 2.⁸



To fund this expansion of Medicaid coverage, the ACA provides that the federal government will cover 100% of the states' costs of the coverage expansion in 2014 through 2016, gradually decreasing to 90% in 2020 and thereafter.⁹ The ACA also provides that the benefit package for the newly eligible Medicaid population must include the ten categories of "essential health benefits" specified elsewhere in the ACA.¹⁰ According to the Congressional Budget Office, the ACA's Medicaid expansion would cover an estimated 17 million uninsured, low-income Americans.¹¹

The Supreme Court's Decision

The Supreme Court agreed to decide the constitutionality of two of the ACA's major provisions, the individual mandate and the Medicaid expansion. The Court also agreed to consider two additional issues related to the individual mandate. If the Court found that the individual mandate was

unconstitutional, it would decide whether the mandate is severable, allowing the rest of the ACA to remain in effect or whether, instead, all or part of the entire law must be invalidated along with the individual mandate. In addition, the Court considered whether this is the appropriate time for courts to rule on the ACA’s constitutionality based on whether the Anti-Injunction Act prevents courts from deciding lawsuits about the ACA until taxpayers actually incur the financial penalty for failure to comply with the individual mandate.¹² Figure 3 summarizes the vote tallies on the major aspects of the Court’s decision.

Figure 3

Vote Breakdown of the Court’s Decision

Outcome	For	Against
Court has jurisdiction to decide case now	9	0
Mandate is a constitutional exercise of Congress’ power to tax	5	4
Medicaid expansion violates Congress’ spending clause power as unconstitutionally coercive of states because all existing Medicaid funds at risk and states not given adequate notice to voluntarily consent	7	2
Remedy is to limit HHS Secretary’s power to withhold existing federal Medicaid funds for state non-compliance with Medicaid expansion	5	4

SOURCE: Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. ____ (2012).

The Individual Mandate is a Constitutional Exercise of Congress’ Power to Tax

A majority of the Court, including Chief Justice Roberts joined by Justices Breyer, Kagan, Ginsburg and Sotomayor, held that the individual mandate is a constitutional exercise of Congress’ power to levy taxes.¹³ Article I, Section 8 of the U.S. Constitution in pertinent part provides that “Congress shall have Power. . . to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defense and general Welfare of the United States.” The Court’s decision on this point was somewhat unexpected, as none of the lower federal courts that considered the question had found that the individual mandate was constitutional under Congress’ taxing power, although the federal government did assert this argument.

The majority on the taxing power issue observed that the shared responsibility payment that is triggered by the failure to comply with the individual mandate “looks like a tax” even though Congress did not label it as such: its collection is administered by the IRS, it is reported on and paid when filing federal tax returns, it does not apply to people who are not required to file tax returns because their income is too low, and it is calculated based on factors such as the amount of taxable income, number of dependents, and tax filing status. In addition, the shared responsibility payment “produces at least some revenue for the Government” (the Court noted that the Congressional Budget Office estimates that the shared responsibility payment will raise \$4 billion per year by 2017), which the Court observed is the “essential feature of any tax.”¹⁴

The majority went on to rely on three factors to support the constitutionality of the mandate as a tax: first, “for most Americans the amount due will be far less than the price of insurance, and, by statute it can never be more.” Second, the mandate does not turn on whether a person intentionally fails to purchase insurance. And, finally, the ACA prohibits the IRS from collecting the shared responsibility payment through punitive means such as criminal prosecution.¹⁵ The Court found that these factors support the conclusion that failure to comply with the individual mandate is not an unlawful act, and the

shared responsibility payment is not a penalty to punish an unlawful act. Even though the shared responsibility payment does seek to influence individual behavior, by encouraging people to buy insurance, it functions as a tax because it “leaves an individual with a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice.”¹⁶ The majority noted that many taxes also operate as incentives to influence behavior, and this does not change their nature as taxes.¹⁷

Consequently, the individual mandate survives as a constitutional exercise of Congress’ taxing power, although the remaining four justices, Justices Scalia, Kennedy, Thomas and Alito, disagreed. The dissent found that the shared responsibility payment is imposed for violating a law (i.e., the individual mandate to obtain insurance). The dissent therefore concludes that the shared responsibility payment constitutes a penalty and cannot be upheld under the taxing power.¹⁸

Because a majority of the Court found that the individual mandate is constitutional under the taxing power, the question of whether the mandate would be severable from the rest of the ACA did not have to be decided. However, the four dissenters -- who did not find any constitutional basis to support the individual mandate -- would have held that the individual mandate was not severable and thereby invalidated the entire ACA.¹⁹

The Medicaid Expansion Is Unconstitutionally Coercive of States Because States Lacked Adequate Notice to Voluntarily Consent and the Secretary Could Withhold All Existing Medicaid Funds; the Appropriate Remedy is to Circumscribe the Secretary’s Enforcement Authority

The most complex part of the Court’s decision concerns the Medicaid expansion. The Court considered whether the Medicaid expansion is a constitutional exercise of Congress’ Spending Clause power. The Court has long recognized that Congress may attach conditions on the receipt of federal funds that it disburses under its spending power. Such conditions have allowed Congress to achieve certain policy objectives that it could not attain by legislating directly through its enumerated powers and that can be viewed as extending into areas traditionally encompassed by the states’ police power to regulate to protect the public’s health, safety and welfare.²⁰ In two prior cases, one in 1937, and the other in 1987,²¹ the Court noted as an aside (known as “dicta”) that there could possibly be a future case in which a financial inducement offered by Congress could pass the point at which permissible pressure on states to legislate according to Congress’ policy objectives crosses the line and becomes unconstitutional coercion. However, until the Court reviewed the Medicaid expansion, no court had ever applied a theory of coercion to invalidate a condition on federal funding.

The Court ultimately held that the Medicaid expansion is unconstitutionally coercive of states because states did not have adequate notice to voluntarily consent, and the Secretary could withhold all existing Medicaid funds for state non-compliance. The Court remedied the constitutional violation by circumscribing the Secretary’s enforcement authority. First, a group of three justices, including Chief Justice Roberts joined by Justices Breyer and Kagan, found that the Medicaid expansion is a “gun to the head” because the “threatened loss of over 10 percent of a State’s overall budget. . . is economic dragooning that leaves the States with no real option but to acquiesce.”²² The Roberts plurality makes clear that Congress remains free to offer federal funds to states and to require that accepting states

comply with conditions on their use.²³ This group found however that Congress may not make all of a state's existing Medicaid funds contingent upon the state's compliance with the ACA Medicaid expansion.²⁴

The Roberts plurality fashions a remedy for the "coercion" it finds in the Medicaid expansion by looking to the Medicaid Act provision that governs the Health and Human Services Secretary's authority to enforce state compliance with federal Medicaid rules. Section 1396c of the Medicaid Act, which has been part of the law since its original enactment in 1965, allows the Secretary to withhold all or a part of a non-compliant state's federal Medicaid matching funds. The Secretary's power under § 1396c, which can be imposed only after notice and the opportunity for a hearing and is subject to judicial review, is rarely invoked, and the Secretary has never withheld a state's entire federal Medicaid allotment. The Roberts group concludes that restraining the Secretary from withholding a state's existing Medicaid funding for failure to comply with the Medicaid expansion "fully remedies the constitutional violation."²⁵

Another group of four justices, Justices Scalia, Kennedy, Thomas, and Alito, found that the Medicaid expansion is unconstitutionally coercive of the states. This group went on to find that the Medicaid expansion is not severable from the rest of the law, and therefore, in their view, the only appropriate remedy was to invalidate the entire ACA.²⁶

The remaining two justices, Justice Ginsburg joined by Justice Sotomayor, found that the Medicaid expansion is constitutional. However, theirs were only the two votes for this conclusion, and without their votes there was no majority view about the appropriate remedy, given the differing views of the group of three and the group of four described above. Consequently, Justices Ginsburg and Sotomayor joined the three votes in the Roberts group to yield a five justice majority in support of the conclusion that the Secretary's enforcement authority should be circumscribed by prohibiting her from withholding all existing federal Medicaid funds for a state's non-compliance with the Medicaid expansion.²⁷

The Court's decision is the first time that Spending Clause legislation has been invalidated as unconstitutionally coercive of states. And, the Court does not set out a test to be applied to future coercion challenges; instead, the Roberts plurality simply observes that "wherever the line may be, this statute is surely beyond it."²⁸ However, the Court's decision leaves the Medicaid expansion provision of the ACA intact and instead restricts the Secretary's enforcement authority.²⁹ The Court's decision leaves all other provisions of the ACA intact as well. As a result, all other changes to the Medicaid program contained in the ACA, such as the increase in primary care provider payments, the new options to expand home and community-based services, the gradual reductions in disproportionate share hospital payments, and the requirement that states maintain the eligibility standards in place as of March 23, 2010, until the Secretary certifies exchange readiness, continue to have full force and effect.

Looking Ahead

The Supreme Court's decision confirms the constitutionality of the individual mandate. The fact that the Court upheld the mandate under Congress' taxing power rather than the commerce or necessary and proper powers changes nothing about the language of the ACA or how the individual mandate will function. The mandate will go into effect in 2014 as Congress intended according to the terms of the

ACA. To date, many states have initiated planning activities and have been awarded federal grants to design the state-based health insurance exchanges that will serve as the marketplaces for people to purchase qualified health plans and gain access to premium tax credits and cost-sharing reductions. However, 12 states halted exchange planning while awaiting the Supreme Court's decision on the constitutionality of the ACA, and another five states indicated that, while they would continue exchange planning, they would not pursue state exchange legislation until after the Court's decision. Now that the Court has upheld the individual mandate, states that have delayed exchange planning have only a few months left to meet the November, 2012 deadline to submit a blueprint for approval to either run their own exchange or participate in a federal-state partnership exchange. If states do not establish their own exchanges, the default is a federal exchange or a federal-state partnership model.³⁰

The Supreme Court's decision on the Medicaid expansion does not change or invalidate the language in the ACA about the new eligibility group – it still exists in the law as a new mandatory coverage group beginning in 2014. However, the practical effect of the Court's decision makes the Medicaid expansion optional for states because, if states do not comply with the Medicaid expansion, the Secretary may withhold only ACA Medicaid expansion funds; she may not withhold all or a part of a non-compliant state's federal funds for the rest of the Medicaid program. In addition, the Court's decision did not disturb other Medicaid-related provisions of the ACA. And, the Court's decision leaves intact the existing Medicaid statute and the Secretary's long-standing authority to withhold all or a portion of a state's federal Medicaid funds for non-compliance with existing federal program rules.³¹

Still, many unanswered questions remain in the wake of the Court's decision. Some of these include:

- Given that the ACA provides 100% federal funds for the Medicaid expansion in 2014 through 2016, declining to 90% by 2020 and thereafter, will states decline the significant federal funding available to comply with the Medicaid expansion?
- Given that, under the terms of the ACA, most individuals with incomes under 100% FPL are ineligible for subsidies to purchase coverage in the exchanges, what if any coverage options will be available to the Medicaid expansion population in states that do not comply with the Medicaid expansion, and how and where will the costs of their health care be absorbed?
- What guidance on ACA implementation will CMS provide in light of the Court's decision?

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Endnotes

¹ 567 U.S. ____ (2012). The case was heard together with *Florida v. Department of Health and Human Services*.

² The plaintiffs sued the three main federal government agencies charged with implementing and administering the ACA: the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor.

³ Separately, Virginia filed its own lawsuit challenging the ACA's individual mandate but not the Medicaid expansion. The Supreme Court did not agree to hear Virginia's case.

⁴ Kaiser Family Foundation, Health Reform Source, Notes on Health Insurance and Reform, *The Individual Mandate: How Sweeping?* (March 21, 2012) (citing CBO projection that about 80% of the 272 million non-elderly people in 2014 would be insured even in the absence of the ACA and would therefore fulfill the mandate's requirement, and Kaiser simulation by Jonathan Gruber of MIT estimating that about 40% of those who would be uninsured in the absence of the ACA would be exempt from the mandate), available at <http://healthreform.kff.org/notes-on-health-insurance-and-reform.aspx?source=QL&page=1>.

⁵ The 2011 tax filing thresholds are \$9,500 gross annual income for a single person under age 65, \$12,200 gross annual income for a head of household under age 65, and \$19,000 gross annual income for both spouses under age 65 if married filing jointly. For other tax statuses, see IRS Publication 501, *Exemptions, Standard Deduction, and Filing Information* (2011), available at http://www.irs.gov/publications/p501/ar01.html#en_US_2011_publink1000259853.

⁶ For more information about the Medicaid program's required and optional elements, see Kaiser Commission on Medicaid and the Uninsured, *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues* (April 2011), available at <http://www.kff.org/medicaid/8174.cfm>.

⁷ Social Security Act § 1902(a)(10)(A)(i)(VIII), codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

⁸ See also Kaiser Commission on Medicaid and the Uninsured and Georgetown University Center for Children and Families, *Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012* (Jan. 2012), available at <http://www.kff.org/medicaid/8272.cfm>.

⁹ For states that were covering childless adults at their existing federal matching rates prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that by 2019, federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and prospectively. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (May 2010), available at <http://www.kff.org/healthreform/8076.cfm>.

¹⁰ CMS's final rule on benchmark benefits indicates that states can opt to provide newly eligible Medicaid beneficiaries with benchmark benefits packages that are the same as the state's traditional full state plan benefits package, provided that the ten categories of essential health benefits required by the ACA are covered. Certain people, however, are exempt from mandatory enrollment in benchmark coverage and must receive the Medicaid state plan benefits package. See Kaiser Family Foundation, *Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries* (Aug. 2010), available at <http://www.kff.org/healthreform/8092.cfm>; see also 42 C.F.R. § 440.330(d); CMS, *Frequently Asked Questions on Essential Health Benefits Bulletin*, available at <http://ccio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.

¹¹ Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (March 2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

¹² As a preliminary matter, the Court was unanimous on one point: all nine justices held that the Court had jurisdiction to hear the case now. Roberts, C.J., Slip Opin. at 15. The potential hurdle to hearing the case now was presented by the Anti-Injunction Act (AIA), which is a federal law that bars lawsuits that seek to restrain the assessment or collection of a

tax. The AIA in pertinent part provides that, subject to certain exceptions, “no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person.” 26 U.S.C. § 7421(a). Instead, individuals who want to challenge the imposition of federal taxes in the courts must first pay the tax and then seek to have the tax refunded or raise arguments about the invalidity of the tax as a defense in an IRS enforcement action. The AIA applies only to taxes and not to other sanctions contained in the federal tax code, such as non-tax penalties.

The Court concluded that the shared responsibility payment for failure to comply with the individual mandate does not meet the legal definition of a “tax” under the AIA, and therefore the lawsuit could proceed. If the Court had determined that the AIA did apply, courts would not have jurisdiction to hear challenges to this part of the ACA until after the tax has been assessed, which would be sometime in 2015, after 2014 tax returns are due.

On the surface, this part of the Court’s opinion – that the shared responsibility payment is not a tax for AIA purposes -- does not seem consistent with the majority’s conclusion that the mandate is constitutional as a tax. The majority explains this discrepancy by noting that, while the Court deferred to Congress’ characterization of the shared responsibility payment as a “penalty” for purposes of the AIA, whether Congress chose to label the payment as a tax does not control for purposes of determining whether the payment is constitutional under the taxing power. Roberts, C.J., Slip Opin. at 33.

¹³ In order to survive, the Court only needed to find one constitutional basis to support the individual mandate, and a majority did so by upholding the mandate under Congress’ taxing power. However, the Court also addressed the constitutionality of the individual mandate under the other two powers asserted by the federal government, the Commerce Clause and the Necessary and Proper Clause. On these points, a different majority emerged: Chief Justice Roberts along with Justices Scalia, Kennedy, Thomas and Alito held that the individual mandate is unconstitutional under the Commerce and Necessary and Proper Clauses.

Article I, Section 8 of the U.S. Constitution in pertinent part provides that “Congress shall have Power. . . to regulate Commerce with foreign Nations, and among the several States, and with Indian Tribes.” The Court’s decisions prior to the ACA established that Congress can regulate any economic activity that Congress rationally concludes is in the stream of or substantially affects interstate commerce. The lower courts that upheld the mandate relied on the Commerce Clause. However, the Supreme Court majority on the Congress’ Commerce Clause power as it relates to the individual mandate endorsed the argument that Congress was seeking to compel individuals to enter the insurance market and held that this exceeds Congress’ power to regulate commercial activity. Roberts, C.J., Slip Opin. at 26; Joint Dissent, Slip Opin. at 13.

The same majority also rejected the argument that the individual mandate was constitutional under the Necessary and Proper Clause. Article I, Section 8 of the U.S. Constitution in pertinent part provides that “Congress shall have Power. . . to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.” The federal government argued that the individual mandate was valid under the Necessary and Proper Clause because it is required to effectively execute the private insurance market regulations in the ACA including the guaranteed-issue provision, which prevents insurers from denying coverage to people for any reason including pre-existing conditions, and the community rating provision, which allows health plans to vary premiums based only on age, geographic area, tobacco use, and number of family members, thereby prohibiting plans from charging higher premiums based on health status or gender. The majority on this point, however, found that the individual mandate was not a “proper” exercise of executing Congress’ powers because there was no underlying valid regulation of commerce. Roberts, C.J., Slip Opin. at 30; Joint Dissent, Slip Opin. at 9.

The remaining four justices, Justices Ginsburg, Sotomayor, Breyer and Kagan, concluded that the individual mandate is constitutional under both the Commerce and Necessary and Proper Clauses. This group found that Congress had a

rational basis for concluding that the uninsured as a class substantially affect interstate commerce and the individual mandate is reasonably connected to Congress' goal of ensuring that the health care market functions effectively. Ginsburg, J., Slip Opin. at 16.

¹⁴ Roberts, C.J., Slip Opin. at 33.

¹⁵ Roberts, C.J., Slip Opin. at 35-36.

¹⁶ Roberts, C.J., Slip Opin. at 44.

¹⁷ Roberts, C.J., Slip Opin. at 36.

¹⁸ Joint Dissent, Slip Opin. at 19-20.

¹⁹ Joint Dissent, Slip Opin. at 64.

²⁰ Under the Constitution, the federal government has certain specific powers, and when Congress acts within its powers, its laws are supreme. All powers that are not specifically enumerated in the Constitution as belonging to the federal government are reserved for the states, pursuant to the 10th Amendment.

²¹ *Steward Machine Co. v. Davis*, 301 U.S. 548 (1937); *South Dakota v. Dole*, 483 U.S. 203 (1987).

²² Roberts, C.J., Slip Opin. at 51.

²³ Roberts, C.J., Slip Opin. at 55.

²⁴ Roberts, C.J., Slip Opin. at 50.

²⁵ Roberts, C.J., Slip Opin. at 56.

²⁶ Joint Dissent, Slip Opin. at 38, 64.

²⁷ Ginsburg, J., Slip Opin. at 40-41, 60-61.

²⁸ Roberts, C.J., Slip Opin. at 55; *see also* Ginsburg, J., Slip Opin. at 58.

²⁹ Ginsburg, J., Slip Opin. at 60-61.

³⁰ For more information about the status of state exchange planning efforts, *see* Kaiser Commission on Medicaid and the Uninsured, *Quick Take, Timing Matters: States Waiting for a Supreme Court Decision to Plan an Exchange* (May 2012), available at http://www.kff.org/healthreform/quicktake_SCOTUS_exchanges.cfm.

³¹ Roberts, C.J., Slip Opin. at 56.

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