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Ongoing Challenges to Health Care Reform: What Happens Next?

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The U.S. Supreme Court's decision in *NFIB v. Sebelius*[1] upholding the Affordable Care Act (ACA), and the re-election of President Obama, eliminated the most potent threats to the new law. But some threats survived. Although not as menacing, these residual challenges still could hamper implementation of the Act and affect almost all the participants in the health care market—from patients and health care providers to insurers and pharmaceutical companies.

Despite the government's victory in the Supreme Court, the lawsuits challenging the ACA continue. One pending litigation targets the premium tax credits available to individuals who buy health insurance policies through state insurance exchanges. The ACA provides for exchanges that function as markets for health insurance and contemplates that each state will have one. The federal government, however, cannot compel states to establish such exchanges. Therefore, the Act requires the federal government to set up one when a state does not. So far, less than half the states intend to create an exchange. The rest have declined or are undecided.

[1] 132 S. Ct. 2566 (2012)

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The purpose of the exchanges is to reduce the cost of insurance for individual and small group purchasers by giving them the same leverage large employers have in buying group policies. Because many individual purchasers still could not afford these costs, the Act extends federal premium tax credits to those earning less than 400 percent of the federal poverty level.

In a quirk of legislative drafting, however, the ACA indicates that the tax credits are available to those ''enrolled in [a qualified health plan] through an Exchange *established by the State*.'' Based on other ACA provisions, as well as the central purpose of the Act—universal insurance coverage—the IRS issued a regulation making tax credits available to low income purchasers regardless of who sets up their state's exchange.[2] Oklahoma, which is not creating an exchange, has disputed the IRS's interpretation and has sued to bar the tax credits within its boundaries.[3]

To maintain a lawsuit in Federal Court, a party must have standing to sue. Oklahoma therefore must show that the IRS's reading of the Act will cause the state some concrete injury. Aside from ideological gratification—which is insufficient to establish standing—Oklahoma has no discernible interest in denying 382,000 of its residents an estimated $1.5 billion in federal tax relief. It is therefore unlikely that Oklahoma can get past this hurdle.

Even if it did, the IRS probably would win. Under established Supreme Court precedent, courts must give substantial deference to the IRS's interpretation of a statute it administers. Moreover, Oklahoma's construction of the law would seriously undercut its effectiveness. Citizens of states that have declined to set up an exchange would still be subject to the mandate to obtain insurance, but would not receive the subsidies that make it affordable. The prospect of undermining the Act may be a principal reason the state has urged this interpretation of the statute, but it is also the reason the interpretation is implausible.

Were Oklahoma nonetheless to succeed in its suit, the consequences would reach beyond the individuals denied subsidies. Fewer people would obtain health insurance, to the detriment of insurance companies that are counting on increased sales to offset higher risks and costs arising from the requirement to cover all customers regardless of their pre-existing illnesses. In addition, a greater number of uninsured individuals who cannot pay for medical care would increase the burden on the hospitals that are legally obligated to treat them.

Another pending legal challenge tries to capitalize on the Supreme Court's validation of the individual mandate as an exercise of the taxing power. The plaintiff in this challenge argues that the Origination Clause of the Constitution requires tax measures to originate in the House of Representatives, while this mandate originated in the Senate.[4] The Clause, however, expressly allows the Senate to propose or concur in amendments to revenue bills. The Court held long ago that the same type of procedure the Senate used here—amending a House revenue bill by substituting the text of the ACA—satisfies the Origination Clause. This legislative practice is common, and a reversal of the Court's longstanding view would affect far more than the ACA. Such a reversal is improbable.

Of the several other left-over lawsuits, the most serious are the challenges to the ACA's requirement that employer-sponsored health insurance cover contraception.[5] This issue, however, is largely self-contained, and the outcome of the cases will not likely affect the rest of the Act.

Medicaid Expansion Dispute

The principal legal challenges to the Act are thus manageable. The political challenges are more formidable, but still surmountable. The most significant dispute relates to the expansion of Medicaid.

Currently, states accepting federal Medicaid funds have some flexibility in setting the maximum income that certain beneficiaries can earn to be eligible for the program. For example, as of January 2012, the median state eligibility cap was 37 percent of the federal poverty level for unemployed parents of dependent children, and ranged as low as 24 percent. Moreover, many states do not cover single adults at all. The ACA sets a new nationwide eligibility standard that makes Medicaid available to people earning up to 133 percent of the poverty level, with the federal government covering almost all the increased costs. The expansion anchors a three-pronged effort to achieve universal coverage. For individuals who earn between 100 percent and 400 percent of the poverty level, the Act subsidizes the purchase of insurance. For those above 400 percent, Congress expected that most would obtain insurance as they do now, and that the individual mandate would induce the rest to obtain coverage.

In the *NFIB* case, the states challenged the requirement in the ACA that they participate in the expansion of Medicaid, in order to continue receiving federal Medicaid funding. The Supreme Court ruled that the federal government could not make the states' current Medicaid funds contingent on participation in the expansion, but could require states to comply with the ACA's con-

[2] Dep't of the Treasury, Internal Revenue Service, Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,378 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1 & 206), *available at* http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf.

[3] *Oklahoma v. Sebelius,* Case No. CIV-11-030-RAW (E.D. Okla. Sept. 19, 2012).

[4] *Sissel v. U.S. Dep't of Health & Human Serv.,* Case. No. 1:10-cv-01263 (D.D.C. Oct. 11, 2012).

[5] *See, e.g., Nebraska v. U.S. Dep't of Health & Human Serv.,* 2012 WL 2913402 (D. Neb. Jul. 17, 2012) (dismissing complaint); *O'Brien v. U.S. Dep't of Health & Human Serv.,* 2012 WL 4481208 (E.D. Mo. Sept. 28, 2012) (dismissing complaint); *Legatus v. Sebelius,* 2012 WL 5359630 (E.D. Mich. Oct. 31, 2012) (granting preliminary injunction).

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ditions in order to obtain the new federal funding offered by the Act.

In other words, state participation in the Medicaid expansion had to be voluntary. So far, though, ambiguity reigns, it appears that nine or so states will not participate, and more could join their ranks. In addition, some states have urged the Administration to allow partial opt-outs and approve Medicaid expansions less extensive than required under the ACA. Thus far, the Administration has refused.

Anticipating near universal insurance coverage under the ACA, Congress cut DSH payments. States opting out of the Medicaid expansion thus will leave their hospitals holding the uncompensated care bag for those in the coverage gap.

Because Congress assumed that Medicaid would cover individuals earning less than 100 percent of the poverty level, the ACA did not make them eligible for subsidies. Therefore, in states that fully or partially opt out of the Medicaid expansion, many single individuals, as well as parents who earn more than the state Medicaid income cap but less than 100 percent of the poverty level, will fall into a coverage gap. Although people with incomes that low will almost certainly be exempt from the ACA's penalty for not having insurance, the point is that *most of them will not have insurance* or, for that matter, the means to obtain it. Many, no doubt, will still require catastrophically expensive medical care. They just will not be able to pay for it. Hospitals—required by law to provide those patients at least with emergency care—will, as noted, foot the bill, passing on some but not all the cost to others in the health care market.

To some degree, that is the situation now: hospitals provide uncompensated care to millions of the uninsured. But there is one important difference. Recognizing the burden hospitals bear in treating the uninsured without compensation, the federal government currently provides Disproportionate Share Hospital (DSH) payments to defray part of the cost for hospitals treating the indigent. That support, however, is perishable. Anticipating near universal insurance coverage under the ACA, Congress cut DSH payments. States opting out of the Medicaid expansion thus will leave their hospitals holding the uncompensated care bag for those in the coverage gap.

Hospitals and patients will not be the only ones affected by state opt-outs from the Medicaid expansion. The Medicaid programs in the opt-out states will necessarily be smaller than contemplated under the Act. Smaller programs will likely purchase fewer prescription drugs than expected. The pharmaceutical industry, which did not oppose the ACA, may have anticipated that this increased demand would offset the estimated $80 billion the ACA cost it. Moreover, refusals to expand Medicaid will extinguish significant opportunities for Medicaid managed care companies. And the citizens of the opt-out states will see their federal tax dollars used to finance the expansion of Medicaid in other states. Given these potential impacts, the reticent states may not sit out for long.

Political Challenge: State Exchanges

A second political challenge to the Act involves the state insurance exchanges discussed above. It is unclear how many states will refuse to establish an exchange, but if the number is large, the burden on the federal government to set them up will be substantial. The effort may require additional funding, which Congress will likely be unwilling to grant. That could degrade the effectiveness of the exchanges, which are critical to the goal of universal coverage.

With federal control of state exchanges, moreover, will come enlargement of federal regulatory authority over the participating insurers. Regulation of health insurance has in large part fallen to the states, and many insurers operate separate units in each state where they do business. Under the ACA, exchanges will perform many regulatory functions. In states with federally-run exchanges, health insurers will face more federal regulation. If a substantial number of states cede authority over the exchanges to the federal government, this development could lead over the longer term to more integrated federal regulation of the health insurance industry.

Indeed, one conservative economist has warned that widespread rejection of exchanges would lead to a ''Washington takeover of healthcare,'' and ''give single-payer advocates a foothold across many states.''

Thus, while the refusal of some states to establish exchanges or to participate in the Medicaid expansion could dampen the effectiveness of the Act, it may ultimately be self-defeating for those states. The Affordable Care Act envisions a joint venture between the federal government and the states—essentially an exercise in cooperative federalism. Cooperative federalism without state cooperation, however, will not enhance state sovereignty. It will, instead, either increase federal authority or decrease state benefits.

In the 1960s, Medicare and Medicaid encountered initial opposition. The history of those programs suggests that over time, the currently reluctant states will recognize their self-interest, and resistance to the ACA will subside. But that result is not inevitable. Participants in the health care market have a stake in promoting the success of the Act, but should also be planning for all contingencies.