MAYO CLINIC

Challenges to the Affordable Care Act After *King v Burwell*

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The plaintiffs in *King v Burwell*, which the Supreme Court decided in June 2015, challenged the availability of federal premium subsidies in federal or federally facilitated health insurance exchanges. The Supreme Court's rejection of the plaintiffs' claims in *King v Burwell* was a momentous event in the legal history of the Patient Protection and Affordable Care Act (ACA). Yet the decision did not mark the end of legal challenges to the ACA's viability. This article identifies legal, social, and political effects of the Court's decision in *King v Burwell* and examines further challenges to the ACA in the wake of the decision.

The ACA's private coverage provisions constitute a 3-legged stool of sorts, each leg of which is necessary to support the entire edifice. The first leg is insurance market reforms that require insurers to issue coverage to all applicants at modified community rates, no matter what the applicant's health status might be. The second leg requires all individuals to have coverage or else pay a tax to the Internal Revenue Service (IRS). The Supreme Court upheld this "individual mandate" as a permissible exercise of Congress's constitutional power to tax and spend in *National Federation of Independent Business v Sebelius*, although some groups continue to challenge it, so far unsuccessfully.

The third leg is premium tax credits. Given the high cost of health insurance coverage, it would be prohibitively expensive for most Americans who otherwise lack coverage to buy it on their own. Although the cost varies substantially from state to state, the average monthly premium for the second-lowest cost silver plan for a 40-year-old nonsmoker is $276,[1] an amount that is more than 10% of the median monthly income for a single, nonfamily householder in 2014.[2] Premium tax credits subsidize the purchase of coverage through ACA-mandated health insurance Exchanges or Marketplaces to Americans earning between 100% and 400% of the federal poverty level ($11,880 to $47,520 for a single individual in 2016). These Exchanges may be created and run by the state or, if a state declines to do so or wants federal assistance, by the federal government.

In 2011, Jonathan Adler, a law professor at Case Western Reserve University, and Michael Cannon, the Cato Institute's director of health policy, started arguing that the ACA "has a major glitch that threatens its basic functioning."[3] This glitch, as they originally called it, made premium tax credits available on state exchanges but not, they claimed, on federal exchanges.

The glitch is quite technical. The part of the law dealing with premium tax credits, section 36B of the Internal Revenue Code, provides in relevant part that taxpayers may claim, as a credit against the income tax that they owe to the federal government, the amount of premium assistance to which they are entitled under the ACA based on their purchase of coverage "through an Exchange established by the State under [section] 1311 of the [ACA]…."[4] Section 1311 of the ACA concerns the establishment and function of Exchanges established and operated by states. Section 36B does not reference section 1321, on the other hand, which concerns exchanges established and operated by the federal government in states that fail to establish one.

After a law is enacted, the relevant federal administrative agency usually develops and issues regulations that explain in detail how to follow the law. In the case of section 36B, the IRS interpreted "Exchange" as used in that section to mean any exchange, whether state, federal, or a state/federal hybrid. Yet, as we saw above, the language of the statute refers to "an Exchange established by the State," rather than by the federal government or another entity.

The IRS's interpretation of the law, Adler and Cannon argued, was incorrect. They

Mayo Clin Proc. ■ May 2016;91(5):554-557 ■ http://dx.doi.org/10.1016/j.mayocp.2016.03.013
www.mayoclinicproceedings.org ■

claimed that the administration must be held to the language that Congress enacted, simply as a matter of principle. But this is not likely the only reason for their claim.

Rather, if their argument were successful, it would eliminate the availability of subsidies on the federal exchanges. This, in turn, would very likely mean the ultimate demise of the private coverage provisions of the ACA, at least in those states with federal or federally facilitated Exchanges, as most people who currently have coverage through them need subsidies to make the coverage affordable.[5]

Yet in *King v Burwell*, the legal challenge that tested Adler and Cannon's theory, the Supreme Court upheld the challenged IRS regulation. In doing so, the Court relied heavily on the fact that many other portions of the ACA seem to assume that subsidies will be available on both state and federal exchanges. Moreover, if the plaintiffs' interpretation of the statute were accepted, it would remove 1 of the 3 legs on which the ACA's private insurance reforms were established and would likely lead to the destruction of relevant health insurance markets in states with a federal Exchange.[6]

Justices Scalia, Thomas, and Alito disagreed. They argued that "[w]ords no longer have meaning if an Exchange that is not established by a State is 'established by the State.'"[6,p2496] To interpret that language otherwise, they argued, effectively amounts to the rewriting of the statute—a gross usurpation of congressional power by the Court. Other sections of the ACA, they point out, clearly distinguish between state and federal Exchanges. Moreover, Congress could plausibly have intended to favor state over federal Exchanges and, accordingly, to offer a carrot to states in the form of subsidies for their residents that would be available only on state-established Exchanges.

It is not likely that those who agree with either side in *King v Burwell* could be convinced that the opposite interpretation is correct. The problem is that *King v Burwell*, at base, concerns drafting errors. No matter how one believes the case should have come out, sections exist in the ACA that support the opposite interpretation. In times past, Congress would likely have corrected these drafting errors by passing technical corrections. This is precisely what the dissenting justices said should have happened. Unfortunately, given the acrimony engendered by the ACA, it is questionable whether the Congress of today could ever be expected to do that.

To be sure, there have, indeed, been some successful amendments to the ACA. Some, however, have been as partisan as the ACA itself. For example, a provision slipped into the Consolidated Appropriations Act of 2014 limits the ACA's risk corridor program, which subsidizes health insurer losses on premiums sold on the Exchanges for the first several years of their sale.[7] The provision prohibits the government from using any funds other than those collected from insurers with better than average risks to pay for the risk corridor program. Because of this provision, most losses from such premiums for 2014 will not be covered owing to insufficient funds. It has been a major factor in the closure of many co-op plans[8] and has helped prompt at least 1 large insurer, UnitedHealth, to reconsider its participation in the Exchanges altogether.[9]

Congress also recently passed the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015 along partisan lines, although President Obama vetoed it. This bill would have eliminated the core features of the Affordable Care Act's coverage provisions.[10] It joins the more than 60 bills the House has passed to repeal the ACA. Its passage is notable not for what it will accomplish legislatively but rather for showing the real possibility that the ACA will be repealed in part or in whole if a Republican is elected President in 2016 with Republican majorities remaining in the Senate and House.

Numerous lawsuits challenging various provisions of the ACA are pending. Most concern religious objections to the requirement that health insurance offered by most employers must cover contraceptives for women. Although important, these cases do not, in themselves, threaten the integrity of the ACA. Among the other challenges to the ACA's coverage provisions, one with major potential substantive import is *US House of Representatives v Burwell*.[11] This suit challenges the administration's funding of ACA subsidies to reduce out-of-pocket costs incurred by certain low-income Americans despite the House's refusal to appropriate funds for that purpose. The Constitution states that "[n]o Money shall be drawn from the Treasury,

but in Consequence of Appropriations made by Law."[12] Some features of the ACA are self-funding, such as the premium subsidies, but others are not. The House alleges that the cost-sharing subsidies are not self-funding but rather are subject to yearly appropriations. Nevertheless, the Treasury has been reimbursing insurers for cost-sharing reductions they have been providing to eligible Americans. Although procedural issues may decide the case in the administration's favor, the House of Representatives may have the better argument if the court reaches the merits of the case.

Why, after all these years, has the ACA remained so contentious? One obvious answer is that the ACA's provisions are not cheap, and the law was never intended to be self-funding. The Congressional Budget Office estimates that the ACA's provisions will cost more than $1.2 trillion dollars during the next decade.[13] Many Americans, especially those who think the ACA should never have been enacted, believe that the ACA requires far too much new spending.

But expense is not the only problem. Rather, not everyone directly benefits from those expenditures. To be sure, millions of previously uninsured Americans now have health coverage. A large percentage of mostly low-income Americans had no consistent, reasonably affordable access to health coverage before the ACA. However, people with higher incomes who need to buy coverage on the Exchange may find that they must spend even more for health insurance than they did before the ACA was enacted. Opting out of coverage, moreover, now carries a tax penalty.

Many who support the ACA, on the other hand, are pleased by the ACA's extension of health coverage to a greater number of Americans and the strengthening of the health care safety net generally. Although most Americans still obtain coverage through employment or family members' employment, those whose jobs are less stable or who earn less than the median income for Americans often have no such option.

Many ACA supporters also agree with the ACA's insurance market reforms. Yet when it comes to paying for these market corrections, even those who otherwise support the ACA can balk.

Polls suggest that most Americans believe that everyone should have health insurance. Yet, Americans do not all agree on the best way to achieve full coverage. A 2015 Harris Poll, for example, found that although a large majority of Americans believe that having a system that ensures that people who get sick can obtain the care they need is a moral issue, a bare majority of respondents also agree that "[i]t should be everybody's personal responsibility to figure out how to get their health insurance, not the government's responsibility."[14]

The divergence suggested in the Harris Poll may have to do with a fundamental disagreement regarding why most Americans believe everyone should have health insurance. Is it a matter of personal responsibility or collective risk sharing? Should people have to prove that they are contributing members of society before they get coverage, or is health coverage more properly viewed as a precondition of being able to meaningfully contribute in the first place? What help, if any, should anyone get in obtaining insurance? Does it matter that most Americans receive substantial financial subsidies from the government in the form of tax exemptions for employer-sponsored coverage and that these have been in place for decades? These are issues that the public and Congress need to address in resolving the rift that the ACA has engendered. Until they do so, the division will likely remain.

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