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King v. Burwell: What's Next? (Part Two of a Two-Part Series)

Now that the *Supreme Court of the United States* (SCOTUS) has validated the issuance of subsidies on the federally-run health insurance exchanges, the next question for the *Patient Protection and Affordable Care Act* (ACA) is now, quite simply, "*what's next?*" As discussed in the first installment of this two-part series, entitled "*SCOTUS Finds Obamacare Insurance Subsidies Legal*," the *King v. Burwell* decision validated subsidies for millions of Americans who utilize federal exchanges to purchase health insurance. However, more broadly speaking, the decision further entrenched the ACA by validating a key tool in the effort to expand the number of insured persons, strengthening the law's position in the U.S. healthcare industry in the future. While judicial challenges to the ACA are still pending in U.S. lower court systems, e.g., *House v. Burwell*, prominent legal experts believe that *King v. Burwell* served as the last major threat to the foundation of the ACA.[1] Further, the outcome of *King v. Burwell* is likely to influence how lower courts adjudicate future ACA litigation, potentially making these courts less receptive to disputes regarding the language of the statute.[2]

With the subsidy issue resolved, the focus for many industry actors has shifted to ACA implementation issues, particularly the viability of state-based health insurance exchanges and the pending 40% excise tax on high-cost health benefit plans (commonly known as the "*Cadillac*" tax). Implementation issues, coupled with the rulings on the remaining lawsuits challenging the ACA, will likely dominate ACA-related headlines in the near future. This second part of this two-part *Health Capital Topics* series on the *King v. Burwell* decision will address these implementation issues, as well as discuss notable remaining legal challenges to the ACA.

One of the primary issues from the *King v. Burwell* ruling revolves around the future viability and prevalence of state-based health insurance exchanges. Originally, states viewed the operation of their own exchange positively, reasoning that the state would retain greater autonomy and policy flexibility in creation and implementation of the exchange.[3] However, many of the state-based exchanges have been more expensive and difficult to run than anticipated, because of the technological and logistical challenges that emerged during implementation.[4] In the first year of operation, three of the seventeen states had such extensive technological failures that they turned over the majority of their exchange operations to the federal government; an additional two exchanges had so many *information technology* (IT) issues that they had to completely rebuild their programs for the 2015 enrollment period.[5] Even those exchanges that have experienced success have done so at considerable cost to the individual states.[6] During the most recent enrollment period, new enrollees in state-based exchanges increased by 12%, significantly lower than the 61% increase seen in the federal exchanges.[7] Lower than expected growth in enrollment caused budget shortfalls in state-based exchanges, which relied on income from the fees charged to insurers based on total enrollment numbers.[8] Due to the large number of problems that many states have experienced, some states, particularly smaller states that lack the population to draw a sufficient number of enrollees,[9] are considering opting into a federal exchange to save costs while maintaining compliance with the ACA.[10] Further, because of the SCOTUS decision in *King v. Burwell*, there is little motivation for the states currently using a federal exchange to pursue their own state-run exchanges.[11]

In addition to state governments grappling with the decision to run their own health insurance exchange, increasing numbers of opponents are lobbying for the repeal of the "*Cadillac*" tax on high-cost health plans. The "*Cadillac*" tax, which will become effective on January 1, 2018, consists of a 40% excise tax on health insurance plans costing more than $10,200 for individual coverage, or $27,500 for family coverage.[12] This tax rate is applied to the excess amount of coverage over the above-stated limits applicable for individual or family coverage, and is to be paid by the coverage provider, e.g., the health insurance issuer, employer, or health plan administrator.[13] Although this tax does not become effective for over two years, opposition to the tax has coalesced in an effort to repeal the provision. According to an estimate by Joel Kopperud, vice president of government affairs at the Council of Insurance Agents and Brokers, quoted in an article by *Employee Benefits News*, 30% of all employers will be subject to the tax in 2018, with that percentage expected to rise significantly due to tax threshold levels rising slower than desired.[14] Additionally, an estimate published in *Forbes* noted that 62% of companies facing

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potential tax liability under the "*Cadillac*" tax are currently working to alter their coverage provisions to avoid liability.[15] With support from a small but bipartisan group in Congress, repeal discussions could occur in the near future.[16]

Other challenges remaining for the ACA include a variety of lawsuits pending in the lower courts across the U.S. regarding specific ACA provisions. One of the most significant cases awaiting judicial consideration is that of *House v. Burwell*, in which the U.S. House of Representatives has brought suit against the Secretary of the *United States Department of Health and Human Services* (HHS), challenging HHS's payment to private insurers to offset reduced cost-sharing income from enrollees.[17] The cost-sharing reduction payments are designed to make health insurance more affordable for low-income individuals under the 250% poverty line enrolled in a health insurance plan sold through a health insurance exchange, and include a reduction of deductibles, copayments, and coinsurance levels.[18] Currently, HHS provides payment to private insurers to offset the reduction in cost-sharing payments to health insurers.[19] Without those payments from HHS, private insurers would raise premiums across the board to cover the expenses of cost-sharing, since insurers would still be required to offer cost-sharing to qualified beneficiaries.[20]

At contention in the case is whether the federal government or the private insurance companies should bear the burden of these cost-sharing measures. The House of Representatives argues that it did not explicitly appropriate funding for these payments in the ACA, which consequently renders those payments invalid.[21] If the House of Representatives prevails, private insurers will lose the government funding that helps them balance the expenses of cost-sharing, and, as a result, will be forced to increase premiums to cover the expenses.[22] Before this case can be argued before the D.C. Circuit, however, it must first overcome HHS's motion to dismiss for lack of standing.[23] To support this motion, HHS cites *Raines v. Byrd*, a 1997 SCOTUS case wherein the Court found that the Congressional members who brought the suit lacked standing because they failed to assert an individual harm, and instead, alleged their congressional power had been affected.[24] The future of this lawsuit may hinge on the application of this obscure constitutional rule to the ACA challenge brought by the House.

The *King v. Burwell* litigation is now over, but questions remain regarding numerous provisions of the ACA, including state decisions on whether or not to run an exchange, and whether certain provisions, such as the "*Cadillac*" tax, will be revised or repealed. Following these issues remains important for providers, employers, and individuals, as these developments may impact insurance cost and availability in the future.

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17 "United States House of Representatives v. Sylvia Burwell, et al." Case No. 14-cv-01967 (D.D.C. November 21, 2014), Complaint, p. 3.

18 *Ibid*, p. 10; Jost, June 23, 2015.

19 "Key Facts You Need to Know About: Cost-Sharing Reductions" Center on Budget and Policy Priorities, September 25, 2013, http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/ (Accessed 8/11/15).

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24 *Ibid*, p. 6.

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