



Analysis: Challenges and Opportunities for the ACA

Five years after President Obama signed the Patient Protection and Affordable Care Act (ACA) into law and a year and a half after most of its major provisions were implemented, health reform is at a crossroads. The Supreme Court is set to decide *King v. Burwell* this summer and the Court's decision will either upset a core aspect of the ACA in most states or allow health reform to stay the course pending continued work on the part of policymakers at the state and federal levels to improve the law and iron out its implementation.

The plaintiffs in *King* are challenging an Internal Revenue Service (IRS) regulation that makes federal tax subsidies available to middle- and lower-income individuals who purchase health insurance through online insurance exchanges or "marketplaces" set up by the federal government. Plaintiffs contend that the IRS regulation violates the ACA, which says that the subsidies are available for insurance plans purchased on "an Exchange established by the State."

Fourteen states, including Colorado, set up their own online marketplaces under the ACA, two states set up a federally supported marketplace or state-partnership marketplace and 34 states did nothing.¹ For those states that chose not to set up a state marketplace, the ACA authorized the Secretary of the federal Department of Health and Human Services (HHS) to step in and establish marketplaces on the states' behalf. The plaintiffs' position is that the ACA does not make subsidies available for insurance purchased in the states that use a federal marketplace. If the Court rules in the plaintiffs' favor, the millions of people who bought insurance with the help of a subsidy in one of the 34 states that did not set up their own marketplace will lose their subsidies.

Whatever way the Court decides, this crossroads presents an excellent opportunity to assess what health reform has accomplished to date and to consider where it might go in light of the possible outcomes in *King*. This issue brief examines the direct and indirect consequences that may arise in the event of a ruling for the *King* plaintiffs and also what a

¹ Kaiser Family Foundation, *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*, May 2015, available at <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/>.

ruling for the administration might look like. Then, it looks at what work is still needed to improve the ACA if the Court leaves it as is.

A Core Aspect of the ACA Framework at Issue in *King*

The tax subsidies at the center of *King* are an essential piece of a framework designed to address what had become a health care crisis in America. It is well established that “people who lack health insurance live sicker lives. They receive care later, if at all, and skip recommended preventive care.”² Yet, nationwide in 2009, an estimated 47 million Americans were uninsured³ and, in November and December of that year, 14,000 Americans were losing coverage daily.⁴ In Colorado, a Gallup survey showed that 17 percent of Coloradans were uninsured in the year before the ACA was implemented.

Nationwide, high unemployment rates and rising insurance costs for employers meant that fewer and fewer Americans were offered or able to afford employer-sponsored insurance. Furthermore, the alternatives to employer-sponsored insurance were increasingly unaffordable. While evidence at the time suggested that premiums for non-group plans were generally lower than they were for employer-sponsored coverage, individuals with non-group coverage generally paid a higher share of their health care expenses out of pocket.⁵ In 2010, six out of ten individuals who purchased non-group coverage on the individual market reported having difficulty paying for health care and insurance and that was nearly twice as many as the 33 percent of those with employer-sponsored coverage who said it was difficult for them to afford the cost of care and insurance in 2008.⁶ In addition, many individuals, even though willing and able to pay were still denied coverage in most states due to previous illnesses or conditions that insurance companies considered too risky or too expensive to cover.

² Robert Wood Johnson Foundation, What Is the Link Between Having Health Insurance and Getting Adequate Care?, August 2011, available at <http://www.rwjf.org/en/library/research/2011/08/what-is-the-link-between-having-health-insurance-and-getting-ade.html>.

³ The total number of uninsured at the time the ACA passed was estimated to be 47 million. RAND Health, The Affordable Care Act in Depth, <http://www.rand.org/health/key-topics/aca/in-depth.html>.

⁴ James Kvaal, Health Care In Crisis: The Economic Imperative for Health Care Reform, Center for American Progress, February 2009.

⁵ Kaiser Family Foundation, Comparison of Expenditures in Non-group and Employer-Sponsored Insurance: 2004-2007, 2010, available at: <http://kff.org/health-costs/issue-brief/snapshots-comparison-of-expenditures-in-nongroup-and-employer-sponsored-insurance-2004-2007/>.

⁶ Kaiser Family Foundation, Survey of People Who Purchase Their Own Insurance, 2010, available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8077-r.pdf>.

In Colorado, the percentage of people covered by employer-sponsored insurance fell from 63.7 percent in 2009 to 59.0 percent in 2013, and, in 2009, 88.4 percent of uninsured Coloradans ranked the high cost of health insurance as the top reason for being uninsured.⁷ Colorado was ahead of most states in implementing a coverage program (CoverColorado) for people with preexisting conditions but the high cost of participating in the program left many Coloradans without access to coverage and affordable care.

Moreover, the lack of insurance was not only affecting people's health; it was affecting their pocket books. Nationwide, an estimated 1.5 million Americans declared bankruptcy in 2009 and 60 percent of people who went bankrupt did so due to medical bills. Bankruptcies due to medical bills increased from 46 percent in 2001 to 62 percent in 2007 and most of those who filed bankruptcy were middle-class, well-educated homeowners.⁸ As Steffie Woolhandler, M.D., of the Harvard Medical School said at the time, "unless you're a Warren Buffet or Bill Gates, you're one illness away from financial ruin in this country."

In the lead up to passage of the ACA, the single-payer system favored by some on the left and the elimination of employer-based health insurance in favor of an individual market favored by some on the right were both rejected as too radical. It was thought that a shift in either direction would disrupt the health care most people already had. Since health care represented one-sixth of the American economy, the choice was made to implement health reform by building on what was working and fixing what was not, rather than designing an entirely new system.

Thus, for the tens of millions of Americans who did not have health insurance, the ACA's insurance provisions were designed to offer quality, affordable coverage choices. To accomplish that goal, the ACA provides for the creation of new online marketplaces where individuals and small businesses can shop for health insurance. The ACA incentivizes insurance companies to

⁷ Colorado Health Institute, 2013 Colorado Health Access Survey: 20 High-Level Findings, November 2013, available at http://www.coloradohealthinstitute.org/uploads/downloads/CHAS_2013_Chartpack.pdf.

⁸ David U. Himmelstein, M.D., Deborah Thorne, Ph.D., Elizabeth Warren, J.D., Steffie Woolhandler, M.D., M.P.H., Medical Bankruptcy in the United States, 2007: Results of a National Study, *The American Journal of Medicine* (2009). The report stated its results as follows: "Using a conservative definition, 62.1% of all bankruptcies in 2007 were medical; 92% of these medical debtors had medical debts over \$5000, or 10% of pretax family income. The rest met criteria for medical bankruptcy because they had lost significant income due to illness or mortgaged a home to pay medical bills. Most medical debtors were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance. Using identical definitions in 2001 and 2007, the share of bankruptcies attributable to medical problems rose by 49.6%. In logistic regression analysis controlling for demographic factors, the odds that a bankruptcy had a medical cause was 2.38-fold higher in 2007 than in 2001."

participate in the marketplaces by allowing them to compete for millions of new customers. In addition, the ACA requires that every plan offered on the marketplace include a specified set of minimum essential benefits and categorizes them as platinum, gold, silver, or bronze, depending on the extent of consumer cost-sharing. For platinum coverage – the most comprehensive – the consumers, on average, will pay only 10 percent of the cost of covered services as cost-sharing at the point of service. The next three types of coverage – gold, silver, and bronze – feature progressively higher point-of-service cost-sharing corresponding to 20 percent, 30 percent, and 40 percent of the total cost of covered services. Consumers can expect to pay lower premiums up front for these categories of coverage, with bronze plans being the least expensive.

Colorado began discussing the concept of an insurance marketplace long before the ACA passed in 2010. In 2006, concerned with rising healthcare costs and the high number of uninsured Coloradans, Colorado’s Republican governor and Democratic legislature formed a bipartisan Blue Ribbon Commission for Health Care Reform to examine options to make affordable health coverage available to all Colorado residents. In early 2008, the Commission published their recommendations to provide a “roadmap to health reform.” One of the key recommendations was to establish a “connector” where people could shop and compare health insurance options. Building on that history, when the ACA passed in 2010 and required that marketplaces operate in every state by 2014, a bipartisan group of state legislators determined that Colorado should develop its own, unique marketplace rather than rely on the federal exchange. The legislation in Colorado was supported by consumer groups, health care providers, hospitals, brokers, health insurance carriers and business associations.

At the ACA’s core is a “tree-legged stool” approach to expanding health insurance coverage. The three legs of the stool are 1) guaranteed access, which prohibits insurers from denying coverage or raising premiums based on preexisting conditions; 2) the individual mandate, which requires virtually everyone to carry health insurance; and 3) expansion of Medicaid and sliding scale premium tax credits designed to act as subsidies to make insurance affordable for those under 400 percent of the Federal Poverty Level (FPL). Opponents of the law have been highly critical of the individual mandate and many are also critical of the cost of the Medicaid expansion and the tax credits. But it is not feasible to have guaranteed access, which is highly popular, without the other legs of the stool.

While implementation of the law at both the state and federal levels has been rocky, there are early signs that the law is resulting in significant coverage gains. The RAND Corporation has developed a modeling tool that makes it possible to estimate the effect of policy changes in key areas of health reform and an opinion survey that allows it to monitor enrollment trends and track shifts in public opinion. With regard to the insurance provisions

specifically, RAND's tools have shown that the ACA is reducing the number of uninsured;⁹ that the individual mandate is effectively incentivizing people to enroll in coverage;¹⁰ and that the tax subsidies are helping to stabilize individual insurance markets. In Colorado, a Gallup survey showed that the State's uninsured population dropped by six percentage points from 17 percent to 11 percent in the first quarter after the ACA was implemented.

The Court is expected to hand down a decision in *King v. Burwell* in late June and while states like Colorado that set up their own insurance marketplaces will not be directly impacted, it is expected that a decision for the plaintiffs will severely disrupt the coverage gains experienced in most states since the ACA's insurance provisions were implemented a year and a half ago. RAND's model estimates that eliminating the subsidies in the 34 states that use federal marketplaces will reduce enrollment in those states from 13.7 million to 4.1 million – a drop of 9.6 million, or 70 percent.¹¹ Furthermore, the model predicts that 8 million of those would be left uninsured and that the cost of a basic silver plan would rise from \$3,450 to \$5,060 – a price hike of \$1,610, or 47 percent.

There is expected to be such a large impact on enrollments because the ACA provides for guaranteed access. Guaranteed access causes insurance consumer pools to shrink and become more costly, which, in turn, causes premiums to rise unless such provisions are supplemented by an individual mandate that forces healthy people into the market and by subsidies that make insurance affordable. Under the ACA framework, a subsidy shutdown in the affected states would effectively invalidate the individual mandate for millions of individuals. Without a subsidy, many would qualify for an exemption from the individual mandate because insurance would be unaffordable. Healthy policyholders who could not afford insurance would

⁹ According to data from the RAND survey, sizable numbers of previously uninsured people were able to obtain coverage over the first and second enrollment periods. Survey data show that between October 2013 and April 2015, 22.8 million Americans became newly insured, including 4.1 million newly insured Americans who obtained coverage through one of the new insurance marketplaces. The survey shows that the total number of uninsured Americans dropped from 42.7 million to 25.8 million. RAND Health, *The Affordable Care Act in Depth*.

¹⁰ Analysis of the RAND data found that eliminating the individual mandate would cause the number of people enrolled in the individual exchanges to fall by more than 20 percent. RAND Health, *The Affordable Care Act in Depth*.

¹¹ Similar projections from the Robert Wood Johnson Foundation estimate that 8.2 million people will lose health insurance if the plaintiffs in *King* prevail. Matthew Buettgens, John Holahan, Linda J. Blumberg, and Hannah Recht, *Health Care Spending by Those Becoming Uninsured if the Supreme Court Finds for the Plaintiff in King v. Burwell Would Fall by at Least 35 percent*, February 2015, available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000106-Health-Care-Spending-by-Those-Becoming-Uninsured-if-the-Supreme-Court-Finds-for-the-Plaintiff-in-King-v-Burwell-Would-Fall-by-at-Least-35-Percent.pdf>.

likely leave the insurance market, while costlier policyholders with greater healthcare needs would more likely do what was necessary to maintain coverage. The result would be higher cost risk pools, which would drive increases in premiums, which would have the effect of driving more people to leave the market. An article from The Commonwealth Fund provides historical evidence from state-level reform efforts that illustrates those effects. The article states that:

Prior to the ACA's enactment, five-states – Massachusetts, New Jersey, New York, Rhode Island, and Vermont – had provided consumers guaranteed access to individual health insurance but did not enact an individual mandate or sufficient subsidies to make coverage affordable. In every case, the results were escalating prices and shrinking enrollment, as premium increases drove young and healthy people out of the market. As New York implemented its reforms, the percentage of residents under age 65 who were uninsured actually *increased*, from 14 percent to 20 percent, with premiums rising by as much as 40 percent. Massachusetts alone reversed the trend with a second round of reform that supplemented guaranteed access with an individual mandate and broader subsidies, the so-called “three legged stool” that subsequently became the model for the ACA.¹²

Possible Responses to a Ruling for the Plaintiffs in *King*

The insurance market deterioration predicted by RAND would be the direct result if the Court invalidated the subsidies in those 34 states that use federal-run marketplaces and nothing was done in response. And it is looking like a solution will be hard to come by even where motivation on the part of policymakers to do something is high.

Much of the discussion surrounding the *King* case assumes that the affected states can fix the problem by setting up their own marketplaces. The effectiveness of that solution may depend on how the Court treats states like New Mexico, which operates its marketplace but uses the federal platform, Healthcare.gov. If the Court rules that such a marketplace qualifies as an “Exchange established by the State,” then the states affected by a ruling for the *King* plaintiffs may be able to adopt a similar model and use the federal platform to get a state marketplace going and get the subsidies restored much more efficiently than if they had to set up a brand new marketplace from scratch.

¹² Joel Ario, Michael Kolber and Deborah Bachrach, *King v. Burwell: What a Subsidy Shutdown Could Mean for States*, February 2015, available at <http://www.commonwealthfund.org/publications/blog/2015/feb/king-v-burwell-what-shutdown-could-mean-states>.

But it is not certain which way the Court will rule on that issue if it does so at all.¹³ In any event, setting up state marketplaces in 34 states will come with significant logistical, political and financial challenges and there will undoubtedly be holdout states, at least for some time. The Commonwealth Fund estimates that “there may be more than a dozen states willing to let their residents become uninsured again – which would lead to significant inequalities in coverage across the states.”¹⁴ Moreover, the insurance markets in the affected states will experience at least a periodic disruption as the states scramble to get their marketplaces up and running.

Furthermore, even if there is the political will and financial wherewithal in the states to accomplish the monumental task of setting up state-run marketplaces at lightning speed, the post-*King* state marketplaces may face legal barriers as well. As legal commentator Nicholas Bagley argues, there’s a plausible world in which the Supreme Court reads the ACA as restricting subsidies to marketplaces that states built before 2014. Though Bagley reads the 2014 deadline as a deadline for when a state has to launch a marketplace before the federal government steps in, and not as a deadline that precludes further action, the Court may not read it the same way. He points out that “[i]f the Supreme Court rules in the *King* plaintiffs’ favor ... it will have taken a highly literal approach to the ACA – an approach that might give juice to the argument that post-*King* exchanges haven’t been properly established.”¹⁵

Of course, there may also be a fix on the federal level but significant challenges exist there as well. First, a fix will require legislation. In a letter to Republican members of Congress, Secretary Burwell admitted that the administration does not have a contingency plan, noting that, “[w]e know of no administrative actions that could, and therefore we have no plans that would, undo the massive damage to our health care system that would be caused by an adverse decision [in *King*].” Congress could act and Congressional leaders say they have a

¹³ The Court may instead remand the case to a lower court for a decision on that issue or may not comment on the issue at all, leaving it an open question for future federal court challenges.

¹⁴ Joel Ario, Michael Kolber and Deborah Bachrach, *King v. Burwell: What a Subsidy Shutdown Could Mean for States*, February 2015, available at <http://www.commonwealthfund.org/publications/blog/2015/feb/king-v-burwell-what-shutdown-could-mean-states>

¹⁵ Sarah Kliff, *Could the Supreme Court screw up Obamacare even worse than we thought?*, *Vox Policy & Politics*, updated April 2015, available at <http://www.vox.com/2015/4/14/8406473/king-burwell-state-exchanges>.

response plan in the works,¹⁶ but so far, the GOP, which controls both houses of Congress, has been unable to coalesce around a specific and comprehensive alternative to the ACA.

Impact on States with State Marketplaces if the Court Rules for the Plaintiffs in *King*

It also important to think about how the *King* decision might affect the 14 states, like Colorado, that set up their own marketplaces. While those states will not be directly affected by a ruling for the *King* plaintiffs it is very likely, that such a ruling will impact those states indirectly.

For example, if the Court adopts the *King* plaintiffs' interpretation of the ACA, the marketplace program as a whole may find that it becomes the target of future constitutional challenges. It is a basic tenant of federalism that Congress cannot force a state to pass any regulations or legislation. But the ACA as the *King* plaintiffs interpret it may be found to do just that. The issue was first raised by Justice Sonia Sotomayor during oral arguments in the *King* case when she suggested that plaintiffs' interpretation of the disputed provision would make the law unconstitutional because the states would be coerced into setting up their own marketplaces. Because it is well understood that guaranteed access without an individual mandate and subsidies to make insurance affordable will cause state insurance markets to fail, Justice Sotomayor characterized plaintiffs' reading of the statute as coercive because it would require the states to choose between setting up their own marketplaces or sending the insurance markets in their states into a "death spiral."

The point Justice Sotomayor went on to make was that the doctrine of constitutional avoidance should cause the Court to avoid plaintiffs' interpretation if it raises a constitutional issue and if an alternative interpretation is plausible. But the Court could rule that the plaintiffs' interpretation is the only plausible one. In that world, future plaintiffs may try to get into federal court to argue that the whole marketplace program established under the ACA is unconstitutionally coercive to the states and given the politically charged atmosphere surrounding the ACA, it is not unlikely that such litigation attempts would follow.

Additionally, if a decision in favor of the *King* plaintiffs results in Congressional action, that action is likely to affect both federal marketplace and state marketplace states. Congressional leadership has been critical of many of the ACA's provisions and vocal in their position that the law costs too much and is not working. While a plan to replace the ACA is still ill-defined, their rallying cry regarding the ACA has been "repeal and replace" and any

¹⁶ Sarah Ferris, Ryan: GOP will have 'immediate response' for ObamaCare court ruling, *The Hill*, March, 27, 2015, available at <http://thehill.com/policy/healthcare/237262-ryan-gop-will-have-immediate-response-for-obamacare-court-ruling>

replacement may look very different from current law. It is important to note that while a Congressional replacement may look very different, the President has vowed to veto any legislation that seeks to undo key aspects of the ACA, including the guaranteed access provisions, the subsidies, and the individual mandate. However, it is unclear how a decision for the *King* plaintiffs will impact the balance of bargaining power between the administration and Congress.

Impact on Other Provisions of the ACA if the Court Rules for the Plaintiffs in *King*

It is also likely that any replacement legislation will impact more than the coverage provisions of the ACA. Some of those provisions that might be impacted were designed to make health insurance work better because even those who had insurance in 2009 faced loss of coverage as a result of routine changes in life circumstances.

For example, thousands lost coverage when they lost or changed jobs. Many had their coverage terminated or revoked when they got sick because their carriers used flimsy excuses to cancel their coverage – a practice known as rescission. An investigation launched in 2009 by the House Subcommittee on Oversight and Investigations, showed that major health insurers WellPoint Inc., UnitedHealth Group and Assurant Inc. had cancelled the coverage of more than 20,000 people, allowing the companies to avoid paying more than \$300 million in medical claims over a five year period.¹⁷ Testimony revealed that policyholders with breast cancer, lymphoma and more than 1,000 other conditions were targeted for rescission and that employees were praised in performance reviews for terminating the policies of customers with expensive illnesses.¹⁸

In addition, coverage was inadequate even for those who had it and could keep it. In 2009, a Consumer Reports investigation found that “[m]any people who believe they have adequate health insurance actually have coverage so riddled with loopholes, limits, exclusions and gotchas that it wouldn’t come close to covering their expenses if they fall seriously ill.”¹⁹ The report indicated that the lack of consumer protections in most states allowed insurers to sell plans with “affordable” premiums whose skimpy coverage left people who got very sick with the added burden of ruinous medical debt.

¹⁷ Lisa Girion, Blue Cross praised employees who dropped sick policyholders, lawmaker says, *Los Angeles Times*, June 17, 2009, available at <http://articles.latimes.com/2009/jun/17/business/fi-rescind17>.

¹⁸ *Id.*

¹⁹ Hazardous health plans: Coverage gaps can leave you in big trouble, *ConsumerReports.org*, May 2009, available at <http://www.consumerreports.org/cro/2012/05/hazardous-health-plans/index.htm>.

To answer those challenges, the ACA, in addition to providing for guaranteed access, prohibits insurance companies from dropping coverage when individuals get sick, from watering coverage down when it's needed most, and from placing arbitrary caps on the amount of coverage individuals can receive in a given year or lifetime. The ACA also places limits on how much insurance companies can charge for out of pocket expenses and requires insurance companies to cover, at no charge, routine checkups and preventive care. It also requires insurers to spend at least 80 or 85 percent of premium dollars on medical care, with review provisions imposing tighter limits on health insurance rate increases.

Other provisions of the ACA were designed to control health care costs and improve quality by strengthening physician and hospital incentives to improve the quality of care and provide care more efficiently. In 2009, rising costs were both contributing to and exacerbating the inaccessibility of health insurance. Health care spending per person was one and a half times greater in America than in any other country, but Americans weren't any healthier for it. As a result, insurance premiums had gone up three times faster than wages and employers -- especially small business employers -- were addressing the problem by requiring their employees to pay a higher share of health care costs or by dropping their coverage entirely. In addition, the inability of tens of millions to get health insurance meant that hospitals were shifting some of the cost of caring for uninsured patients to insured patients -- about \$1,000 per year was going toward paying somebody else's emergency room expenses.²⁰

Unsustainable growth in health care costs was also putting increasing pressure on taxpayer funded programs like Medicare and Medicaid. U.S. health care spending reached \$2.5 trillion in 2009, a 5.7 percent increase over 2008. And that growth was despite a decline in Gross Domestic Product (GDP) in the same period. As a result, health care spending represented 17.3 of the economy in 2009.²¹ According to a projection from the federal Centers for Medicare & Medicaid Services (CMS), health spending without reform was expected to continue growing from 2009 through 2019 at an average annual rate of 6.1 percent -- 1.7 percentage points faster than projected GDP growth.

To control costs and improve quality of care, the ACA expanded Medicaid to include Americans making up to 133 percent of the federal poverty level (FPL) and provides for new programs and demonstration projects that are designed to identify effective ways to encourage the provision of high-value care in the Medicare and Medicaid program. In addition, the ACA

²⁰ Families USA, Hidden Health Tax: Americans Pay a Premium, May 2009, available at <http://familiesusa.org/product/hidden-health-tax-americans-pay-premium>.

²¹ Chris Fleming, 2009 U.S. Health Spending Estimated At 2.5 Trillion, *Health Affairs Blog*, February 4, 2010, available at <http://healthaffairs.org/blog/2010/02/04/2009-u-s-health-spending-estimated-at-2-5-trillion/>.

supports research regarding patient outcomes and creates a quality-reporting program for Medicare physicians that is designed to empower patients with better information. The delivery system and payment reform provisions of the ACA are already improving the value of care provided in areas that have embraced the reforms and evidence also shows that cuts in Medicare payments under the ACA are reducing Medicare spending growth and beginning to exert a spillover effect on private sector healthcare spending as well.²²

Also, a RAND analysis has found that Medicaid expansion is a boon for those states that chose to expand their Medicaid programs under the ACA in that “it boosts state economies and benefits the poorest residents by expanding their access to coverage and care and reducing their health spending and exposure to catastrophic medical costs.” In addition, a study released by the Colorado Hospital Association last June showed that hospitals in states that expanded Medicaid witnessed a significant decrease in the volume of uninsured patients treated and the amount of charity care provided in the first quarter after the expansion went into effect in 2014²³. Based on data from 465 hospitals in 30 states – 15 that expanded Medicaid and 15 that did not – the report concluded that in states that chose to expand Medicaid, the average charity care cost per hospital decreased from \$2.8 million to \$1.9 million. CHA’s report also showed an even greater change for Colorado hospitals, which saw average charity care cost per hospital drop from \$4.6 million to \$2.9 million. The significant decrease in charity care cost reduces the amount of costs that hospitals shift to insured patients.

The Medicaid expansion may also result in earlier diagnosis of chronic illnesses for poor and minority populations, which can have significant cost savings. A recent study by Quest Diagnostics has shown that, the number of Medicaid enrollees with newly identified diabetes rose by 23 percent in the first six months of 2014 in those states that expanded Medicaid.²⁴ This is compared to the statistically significant 0.4 percent increase in diabetes diagnoses in states that did not expand Medicaid. Diabetes takes its toll if caught late, and may eventually cause heart attacks, blindness, and kidney failure, and leg and foot amputations among those

²² RAND Health, The Affordable Care Act in Depth, <http://www.rand.org/health/key-topics/aca/in-depth.html>.

²³ Colorado Hospital Association, Impact of Medical Expansion on Hospital Volumes, June 2014, available at <http://www.cha.com/Documents/Press-Releases/CHA-Medicaid-Expansion-Study-June-2014.aspx>

²⁴ Quest Diagnostics, Diabetes Diagnoses Surge in States that Expanded Medicaid Under the Affordable Care Act, March 23, 2015, available at <http://newsroom.questdiagnostics.com/2015-03-23-Diabetes-Diagnoses-Surge-in-States-that-Expanded-Medicaid-Under-the-Affordable-Care-Act>.

affected. In addition, the disease accounts for \$176 billion in annual U.S. medical costs and disproportionately affects poor and minority populations.²⁵

The ACA's insurance market regulations and its provisions aimed at reducing cost and improving quality will not be directly affected by a ruling for the plaintiffs in *King*. But a ruling for the plaintiffs may galvanize the political will needed to repeal and replace significant portions of the law as many on the right hold strong ideological objections to the Medicaid expansion and have talked negatively about the law's Medicare reforms.

Bases for a Decision in Favor of the Administration in *King*

There are also a few different scenarios possible if the Court rules in favor of the administration. The Court could rule for the administration on the basis of the *Chevron* case, which stands for the proposition that the Court will defer to a federal agency's interpretation of a law, if it is reasonable. Since the plaintiffs in *King* are challenging an Internal Revenue Service regulation that makes tax subsidies available for insurance purchased on the federal marketplaces, the Court could decide to defer to the agency under the *Chevron* doctrine.

As Justice Kennedy pointed out during oral arguments a ruling on the basis of *Chevron* could mean "that a future administration could change that interpretation." However, as counsel for the administration, Donald Verrilli, Jr., pointed out in reply to Justice Kennedy, "a subsequent administration would need a very strong case under step two of the *Chevron* analysis that [changing the interpretation] was a reasonable judgment in view of the disruptive consequences" that would result.

The Court could also hold for the administration by adopting the administration's primary argument, which is that the disputed statutory language – "Exchange established by the state" –includes the federal marketplaces. That would be the most solid win for the administration and would guarantee that subsidies remain available in all 50 states regardless of any future administration's interpretation of the provision.

Continuing the Work of Health Reform After *King*

Even if the Court's decision leaves the ACA as it has been implemented intact, the work of health reform is not done. Ideological objections to the ACA aside, empirical evidence shows that there are populations that are not benefitting from the reforms. As the RAND analysis points out, "[d]espite the goal of universal health coverage, the ACA leaves substantial numbers of Americans without access to insurance." Even after the ACA goes into full effect, the RAND

analysis estimates that “19 million uninsured Americans will remain ineligible for Medicaid or subsidies, and hence are ‘left behind’ by the ACA.”

Certain vulnerable groups are among those “left behind.” Undocumented immigrants, for example, are categorically prohibited under the ACA from participating in the Medicaid expansion and from receiving premium tax credits for marketplace plans. In Colorado, CHAS data show that Hispanic adults are nearly twice as likely to be without health insurance as the rest of the state’s adult population and that citizenship status is the largest single factor associated with the coverage disparity.²⁶

Certain low-income individuals residing in states that have not expanded Medicaid are also left behind. The ACA, as written, required states participating in Medicaid to expand the program to cover all citizens and lawfully present aliens under 133 percent of the Federal Poverty Level (FPL). The Supreme Court, in *NFIB v. Sebelius*, invalidated that provision, however, ruling that it was an unconstitutional intrusion on the Federal-State relationship, and changed the requirement to a state option. Because the ACA had assumed that all states would expand Medicaid, it made individuals below 100 percent of FPL ineligible for premium tax credits because everyone below that threshold would have been eligible for Medicaid. Thus, low-income individuals in non-expansion states are left without coverage if their income is too low to qualify them for tax credits and they are not eligible for Medicaid under the current state law. Colorado is one of the 29 states that have decided to participate in the Medicaid expansion to date.

Individuals with “affordable offers” from employers are also liable to be left behind due to what has been called the “family glitch.” Under current IRS regulations interpreting the ACA, an individual worker and family members who can enroll in “affordable” job-based health insurance cannot get tax subsidies to lower the cost of marketplace insurance. However, employer-sponsored insurance, for both the employee and his or her family members, is deemed affordable if the cost of self-only coverage--that is, a plan that covers only the individual worker--is less than 9.5 percent of household income.²⁷ Defining eligibility in this way ignores the cost of a family plan, which is frequently much more expensive than self-only coverage. A policy brief from *Health Affairs*, described the common scenario –

In 2013 the average worker contribution for self-only, employer-sponsored coverage was \$999 annually, while the average contribution for family coverage was \$4,565, although there is considerable variation in both single and family

²⁶ http://www.coloradohealthinstitute.org/uploads/postfiles/CHAS/Disparities_brief_2014.pdf

²⁷ This measure is adjusted annually and will increase to 9.56 percent of household income in 2015.

plans. Therefore, the employer-sponsored coverage would be considered affordable for a family of four with a household income of \$33,000 (just over 140 percent of the federal poverty level) [and all members of the family would be disqualified from receiving a subsidy for marketplace coverage], even though buying a plan for the entire family would cost 13.8 percent of their household income, well above the current 9.5 percent threshold.²⁸

As the *Health Affairs* brief points out, “[l]ow-income families are hit hardest by this glitch” because “[w]orkers in the lowest 25 percent wage category contribute a much higher proportion of their income to secure coverage” and “their compensation in general, including employer-provided coverage, is typically less generous.” According to research by the Colorado Center on Law and Policy (CCLP) 3.9 million children and other dependents nationwide will lack access to affordable health insurance through either an employer or the marketplace because of the family glitch.²⁹

In addition to addressing the needs of those left out of the ACA, there is still affordability work to be done for individuals who are able to get subsidized coverage through the marketplaces. A report from *Families USA* that examined 2014 data from the Urban Institute’s Health Reform Monitoring Survey shows that a quarter of adults who bought private, non-group health insurance went without some needed care because they could not afford the cost. The report indicates that “for many Americans with non-group coverage, deductibles and other out-of-pocket costs are prohibitively high and are associated with many of these insured customers forgoing needed health care.”³⁰ What that means, as the survey found, is that millions of people are paying into the insurance system but are largely unable to reap the benefits.

Conclusion

Regardless of how the Court rules in *King v. Burwell*, it is an important time to look critically at the provisions of the ACA to determine what is working and what is not. While significant gains have been made, there is still work to be done. The ruling in *King* will have a significant effect on that work and it is essential that we be ready with a clear understanding of how far health reform has come in this country and where it should go next.

²⁸ http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129

²⁹ Kyle Brown, The “Family Glitch: Excluding Colorado Families from Affordable Health Coverage”

³⁰ <http://familiesusa.org/product/non-group-health-insurance-many-insured-americans-high-out-pocket-costs-forgo-needed-health>. The Commonwealth fund also put out a report on that looked at the same data.