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THE FRAGILITY OF THE AFFORDABLE CARE ACT’S UNIVERSAL COVERAGE STRATEGY

Elizabeth Weeks Leonard*

I. INTRODUCTION

THIS Article examines the very fragile nature of the Patient Protection and Affordable Care Act’s (“ACA”) approach to near-universal health insurance coverage, as accentuated by a variety of implementation hurdles and challenges. The ACA’s vision for expanding insurance coverage was to build on the country’s existing patchwork of market-based health insurance delivery for most, combined with government insurance for select segments of the population. But that patchwork strategy is only as strong as the threads that tie it together. Over the past five years since the ACA was enacted, the threads have unraveled in several critical spots.

The United States has deliberately and repeatedly declined to establish a comprehensive national health-care system. The ACA, while dramatic in scope and aim, demonstrates our unwillingness to embrace that sort of centralized, single-payer approach. When the bills that would become the ACA were being debated in Congress, any such single-payer proposal would have been a political non-starter. As this author has explained elsewhere, such a move would require tectonic shifts in public attitudes toward subsidization and rationing. Even relatively modest suggestions to allow a government health plan to be offered in the same market with commercial health plans—the “public option”—were quickly nixed by lawmakers.

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Accordingly, we remain committed to a non-system of health insurance delivery. The ACA is a monumental achievement in reforming a number of major distortions of the existing health insurance market and closing gaps in the existing public insurance programs. Nevertheless, what this Article hopes to elucidate is just how delicate the ACA’s balancing act is; it does so by drawing together a number of discrete events in the post-enactment period. Perhaps after realizing how tenuously the whole arrangement is held together, we may be willing, in the future, to entertain more comprehensive reform and establishment of a true health care system.

II. BACKGROUND

With that introduction, consider the foundation of existing insurance coverage on which the ACA attempts to build: In 2009, before the ACA was enacted, close to half of the U.S. population was covered by an employer-sponsored health plan. Public health insurance programs, predominately Medicare and Medicaid, covered nearly one-third of the population. A very small portion, just 5%, purchased individual or small group coverage through the private market. The remaining 18% of the population were uninsured.5

Without disrupting anyone’s existing coverage (recall President Obama’s famous “you can keep your health plan” promise6), the ACA sought to build on the existing pieces of the pie to cover the uninsured wedge. First, public health insurance coverage was expanded through changes to Medicaid eligibility. Second, the ACA sought to reform the individual and small group health insurance market by creating new regulated “exchange” marketplaces and restricting a wide range of traditional commercial insurance underwriting and ratemaking practices. Third, employer-sponsored coverage was bolstered, if not significantly expanded, through a combination of subsidies, mandates, and penalties. Each of those three components of the ACA’s coverage strategy has suffered considerable erosions since the Act was passed.

If successful, the ACA promised to reduce the number of uninsured Americans from 57 million to 23 million.7 The Centers for Medicare and Medicaid Services’s (“CMS”) chief actuary estimated that roughly half (18 million) of the 34 million newly insured would gain coverage through Medicaid expansion. Another 16 million were expected to receive coverage under the newly created health insurance exchanges. Employer-sponsored health insurance

5. Rachel Garfield et al., Henry J. Kaiser Family Found., The Uninsured at the Starting Line: Findings from the 2013 Kaiser Survey of Low-Income Americans and the ACA, at i (2014), available at https://kaiserfamilyfoundation.files.wordpress.com/2014/02/8552-the-uninsured-at-the-starting-line7.pdf (regarding 18% uninsured rate); id. at 5 (regarding 5% non-group insurance purchasers).

6. See Elizabeth Weeks Leonard, Can You Really Keep Your Health Plan? The Limits of Grandfathering under the Affordable Care Act, 36 J. Corp. L. 753, 754 n.2 (internal citations omitted).

was expected to remain the largest source of coverage in the United States, with an estimated 13 million employees and families becoming insured through that means. At the same time, 14 million people currently receiving employer-sponsored coverage would be shifted to Medicaid or plans offered through the exchanges, resulting in a net decrease of 1 million people in the employer slice of the pie.

III. THE ACA’S UNIVERSAL COVERAGE STRATEGY

This Part describes the various ingredients of the ACA’s universal coverage strategy and the major erosions that each has experienced. As will be revealed, the components of the strategy are interdependent; erosion of one may cascade onto another. The discussion begins with expansion of the government slice of the pie, primarily through Medicaid. Next, various reforms intended to expand coverage through the individual and small group market are described. The Part concludes with the ACA’s strategies to maintain, if not expand, the current level of employer-sponsored health insurance coverage.

A. Government Slice

The ACA, as enacted, significantly re-envisioned the role of Medicaid in providing coverage for low-income individuals and families. A surprising U.S. Supreme Court decision, however, diluted that vision, allowing states to opt out of the ACA’s expansion of Medicaid. By design, the ACA gradually eliminates another government health-care program, the Children’s Health Insurance Program (“CHIP”), on the expectation that the low- and middle-income CHIP beneficiaries would obtain coverage on the exchanges. Due to a drafting glitch, however, that expectation may not be realized. The combined effect of these developments undermines the ACA’s expansion of coverage through government programs.

1. Medicaid Expansion

The ACA included unambiguous and significant expansion of public health insurance coverage through Medicaid. By statute, the ACA does away with categorical eligibility for Medicaid, which was historically limited to the “deserving” poor, namely, the elderly, the disabled, pregnant women, children, caretakers of eligible children, and the medically indigent. Instead, the ACA implemented an across-the-board income test for Medicaid eligibility: Congress

8. Id. at 6-8.
deemed anyone with income below 133% of the federal poverty level\textsuperscript{11} as “deserving” of public health insurance. As Professor Huberfeld’s article in this symposium explains,\textsuperscript{12} Medicaid expansion operates as a significant step toward a single-payor health-care system. The Medicaid element of the ACA’s near-universal coverage strategy was expected to account for approximately 18 million of the newly insured.\textsuperscript{13}

Medicaid has always operated as a federal-state partnership, with the federal government offering states matching funds for voluntarily implementing state programs compliant with federal requirements.\textsuperscript{14} Due to the anti-commandeering limit on federal spending power, Congress cannot simply require states to implement federal programs or policies.\textsuperscript{15} All 50 states, however, voluntarily have participated in the Medicaid program since at least the 1980s.\textsuperscript{16} Pre-ACA, the federal match ranged from 50% to 83%, depending on the state’s relative poverty level.\textsuperscript{17} The ACA offered much more generous federal funding for states agreeing to expand coverage, beginning with three years of full (100%) federal funding, trending down to perpetual 90% federal funding.\textsuperscript{18}

Despite the universal acceptance of Medicaid conditional funding by the 50 states and previously unquestioned constitutionality of the program, 26 states (including my own, Georgia) challenged Congress’s exercise of its spending power to incentivize state participation in federal program implementation.\textsuperscript{19} The Medicaid expansion challenge was a tagalong to the higher-profile lawsuit over

\begin{itemize}
\item \textsuperscript{12} Nicole Huberfeld & Jessica L. Roberts, \textit{An Empirical Perspective on Medicaid as Social Insurance}, 46 U. TOL. L. REV. 545 (2015).
\item \textsuperscript{13} See Foster, \textit{supra} note 7, at 6.
\item \textsuperscript{14} See 42 U.S.C. § 1396b(a) (2014) (listing the percentage of state spending that the federal government will match, depending on the type of expenditure); Harris v. McRae, 448 U.S. 297, 308 (1980) (describing the “cooperative federalism” approach enacted in order “to provide federal financial assistance for all legitimate state expenditures under an approved Medicaid plan”); Elizabeth Weeks Leonard, \textit{Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform}, 39 HOFSTRA L. REV. 111, 134-35 (2011) [hereinafter Leonard, \textit{Rhetorical Federalism}].
\item \textsuperscript{15} See South Dakota v. Dole, 483 U.S. 203, 207-08, 211 (1987).
\item \textsuperscript{16} See Nicole Huberfeld, \textit{Federalizing Medicaid}, 14 U. PA. J. CONST. L. 431, 445 n.69 (2011) (“Arizona and Alaska were holdouts, with Arizona joining Medicaid in 1982 and Alaska joining in 1972.”).
\item \textsuperscript{17} Federal Medicaid Assistance Percentage ("FMAP") calculations are published in the Federal Register each year. \textit{See, e.g.}, ALISON MITCHELL & EVELYNE P. BAUMRUCKER, MEDICAID’S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP), FY2014, at 2 (Jan. 30, 2013), available at https://www.fas.org/sgp/crs/misc/R42941.pdf.
\end{itemize}
the constitutionality of the ACA’s individual mandate. Although both arguments seemed dubious when first asserted, several lower courts accepted the suggestion that the individual mandate might exceed congressional power to regulate interstate commerce. No lower court, however, had struck down Medicaid expansion as exceeding congressional spending power. Both the Florida District Court and Eleventh Circuit, while holding the individual mandate unconstitutional, upheld Medicaid expansion as within congressional power.

But the Supreme Court, to great surprise, in NFIB v. Sebelius, for the first time struck down a congressional enactment as exceeding the spending power. The Court reasoned that the ACA’s Medicaid expansion was coercive of states, giving them no real option but to expand, on pain of losing not only “new” federal funding for the expansion population but also all existing (pre-ACA) federal funding for Medicaid. The “remedy” that the Court (or more precisely, Justice Ginsburg) devised for this unconstitutionality was that states had to be given the option to continue participating in “old” Medicaid, with no loss of funding, or to extend eligibility to new beneficiaries, as specified under the ACA. In effect, the Court deemed the statutory mandate to expand coverage as merely an option.

At last count, 28 states and the District of Columbia had accepted the Court’s invitation and agreed to expand Medicaid coverage to all individuals below 133% of federal poverty level. Before the ACA, states could receive federal dollars to cover additional beneficiaries besides those required under federal Medicaid law. Most states declined to do so, or offered coverage of non-mandatory beneficiaries up to a much lower income level. The impact of states’ elections not to expand coverage after the ACA will leave nearly four million of the expected newly insured individuals uninsured. As just one

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22. Huberfeld et al., supra note 18, at 31-32.
24. Huberfeld et al., supra note 18, at 36-39.
25. Id. at 39-40.
26. Id.

Although states certainly retain discretion to establish their own programs to cover these excluded populations, that seems an unlikely outcome. Most states declining to expand Medicaid under the ACA cited the increased costs, even with the promise of very generous federal funding. Accordingly, we would not expect states to dramatically expand social welfare programs entirely on their own dollars.

2. \textit{CHIP’s “Family Glitch”}

The ACA also has implications for the Children’s Health Insurance Program, another cooperative federal-state health insurance program. This program remains vulnerable to de-authorization and has spin-off effects on other elements of the universal coverage strategy. CHIP covers children in families that earn too much to qualify for Medicaid.\footnote{Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level, HENRY J. KAISER FAMILY FOUND., http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-at-application-as-of-april-1-2014/ (last updated Jan. 1, 2015).} States’ upper income limits range from 200% to 300% of federal poverty level.\footnote{Medicaid Eligibility for Adults as of January 1, 2014, at 1 fig.1 (2013), available at http://kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/.} In some states, CHIP also covers
parents and pregnant women. Like Medicaid, CHIP is voluntary, and, like Medicaid, all states participate. CHIP has a shorter history and has been more politically vulnerable over time, with repeated struggles for reauthorization and differences of political opinion about extending government health insurance to middle-income children and families.

The culmination of that tension is that the ACA, rather than expanding or maintaining CHIP, funds the program only through September 2015. The assumption is that middle-income families previously eligible for CHIP instead would be eligible for subsidized coverage on the exchanges. But that expectation is undermined for working families by the ACA’s “family glitch.” Federal tax subsidies are available to help individuals and families purchase private insurance on the new exchanges but only if they are offered “unaffordable” coverage at work. By regulation, the Internal Revenue Service (“IRS”) defined “unaffordable” by reference to an individual, employer-sponsored health insurance plan that costs more than 9.5% of household income.

The IRS’s unaffordability definition does not refer the cost of a family plan. The family glitch, therefore, occurs when one (or both) parent’s employer offers affordable individual coverage, but family coverage either is not offered or is unaffordable. The individual employee(s) might be covered, but the rest of the


family would not be and also would be ineligible for subsidies on the exchanges because the unaffordability trigger would not have been tripped. The IRS responded to the problem by exempting families impacted by the glitch from enforcement of the individual mandate. Nevertheless, those families remain uninsured, including close to half a million children. Overall, if CHIP is allowed to sunset, and those children are shifted to the exchanges, and the unaffordability definition stays in place, 1.9 million children potentially could be without coverage. To remove the glitch, the administration would need to redefine "unaffordability" by reference to a family plan. That interpretation is seemingly in keeping with congressional intent although not supported by the plain language of the statute.

That tension between congressional intent and statutory text would likely invite a new round of litigation challenging ACA implementation.

The interplay of CHIP reauthorization and availability of federal assistance to purchase private insurance again reveals the precarious nature of the ACA's universal coverage strategy. Just as the successful judicial challenge to Medicaid expansion had a dramatic negative impact on coverage expectations due to states' decisions to opt out, the "family glitch" may similarly erode the statutory scheme. As the next Part describes, expansions of coverage through the private market to help individuals, families, and small groups purchase their own coverage also faces affronts.

B. Private Market Slice

A number of the ACA's most publicized and most popular provisions aim at expanding the very small slice of the pie that represents coverage in the small group and individual market. By prohibiting insurers from refusing to cover individuals with preexisting conditions and requiring them to set premiums without regard to most health-status factors, the ACA aims to bring many people who previously could not obtain or afford insurance into the market.

46. White, supra note 40.
47. See, e.g., King v, Burwell, 135 S. Ct. 2480 (2015) (considering statutory interpretation challenge to availability of premium assistance tax credits under the ACA).
49. 42 U.S.C. § 300gg-300gg(4) (2014) (allowing limited rate discrimination based on tobacco use, age, workplace wellness program participation, geography, and individual versus family coverage).
Those requirements, however, present a significant adverse selection problem because individuals could wait until they become sick to purchase coverage, thereby reducing the quantum of low-risk individuals paying premiums into the pool to balance out the cost of providing care to high-risk individuals. Accordingly, the ACA requires most individuals to obtain minimum essential coverage or pay a tax penalty for failing to do so. For purposes of discussion below, one of the most important exemptions from the mandate to obtain health insurance is based on unaffordability; that is, if the lowest price coverage costs more than 8% of one’s income, then one is not required to have health insurance.

For middle- and lower-income individuals who are not eligible for government health-care programs or are not offered employer-sponsored health insurance, the ACA offers financial assistance to purchase private coverage. Federal financial assistance takes two forms: First, individuals and families with income between 100% and 400% of federal poverty level are eligible for sliding-scale premium assistance tax subsidies. That assistance reaches distinctly middle-income individuals, earning up to $46,680 annually, and families, earning up to $95,400 for a family of four. The amount of federal assistance varies based on income and insurance premiums in the applicant’s state. Individuals and families who qualify for other assistance, including government health-care programs, or who are offered affordable, minimum essential coverage from an employer-based plan, are not eligible for premium assistance tax credits.

Second, individuals and families with slightly lower incomes, between 100% and 250% of the federal poverty level, may also qualify for cost-sharing reduction payments. These payments help reduce out-of-pocket costs, such as deductibles, copayments, and coinsurance, for eligible individuals. As enacted, individuals and families below 100% of the federal poverty level would be eligible for public coverage through Medicaid expansion. Above 400% of the federal poverty level, purchasers are subject to full market prices, but with various other controls and adjustments to coverage, premiums, and cost-sharing.

52. 26 U.S.C. § 5000A(b)(1), (3) (2014). See also 26 U.S.C. § 5000A(e) (2014) (listing penalty as $695/individual or 2.5% of income (above the tax filing threshold) at full implementation, but only $95/individual in the first year).
57. 42 U.S.C. § 18071 (2014). Section 18071(b)(1) specifies that the credit is available for eligible individuals who enroll in qualified silver-level plans.
58. See supra Part III.A.1.
1. Individual Mandate Challenge

The first attack on the private market reforms was the previously mentioned constitutional challenge to the individual mandate. A federal requirement to purchase a commercial product struck many as the government overreaching into their private lives. Individual rights, such as liberty, privacy, and property, however, are not threatened in any constitutionally protected way by the individual mandate.

Therefore, the challenge was framed as a structural one, asserting again that Congress had exceeded the scope of its enumerated powers, as against states' reserved powers.

Although the Supreme Court ultimately upheld the individual mandate as a valid exercise of congressional taxing power, the case resulted in a lengthy plurality opinion "holding" (but with enough votes to make it count) that the mandate violates the commerce power.

If the individual mandate challenge had been successful, it would have undermined expansion of the sliver of pie representing individual and small group coverage. Insurers would be left to cover anyone who applied, no matter how sick, at the same premium rates as anyone else in the market. Under that arrangement, insurers simply could not continue to offer affordable insurance and remain solvent. The employer piece of the pie would also have been compromised inasmuch as employees, no longer facing potential sanctions for failing to have insurance, might not pressure their employers to offer insurance to the same degree that they would with the mandate in place.

Fortunately, the legal challenge was averted, but implementation of the requirement was not without hurdles. The technological shortcomings of the Healthcare.gov website, through which online applications for government health-care programs and government subsidies were to be channeled, were legion. In addition, defying President Obama's promise, a number of insurers

60. Leonard, Rhetoric Hits the Road, supra note 48, at 811 n.203.
64. Sebelius, 132 S. Ct. at 2573 (construing individual mandate penalty as constitutional tax).
sent cancellation notices of pre-ACA plans to insureds, apparently demonstrating that, in fact, you cannot keep your health plan. In response to those fiascos, the administration effectively extended the deadline for compliance with the individual mandate through 2016 by allowing most anyone to self-certify plan cancellation and thereby obtain a hardship exemption from the mandate penalty. If conservative pundits are correct, the administration’s accommodation for plan cancellations could effectively gut the ACA’s hard-fought, signature reform and the overall universal coverage strategy.

2. **Premium Assistance Tax Subsidies Challenge**

An additional significant threat to the ACA’s near-universal coverage is the potential unavailability of federal subsidies for close to half of the otherwise eligible population. In addition to Medicaid, the ACA includes several other opportunities for states to engage in “cooperative federalism,” assisting with implementation of federal policy. One of those options allows states to establish their own exchanges or regulated marketplaces for individual and small group insurance. Like Medicaid, the ACA sets federal requirements with which

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participating states must comply. But rather than conditional funding, the ACA's approach to exchange implementation operates on conditional preemption. In other words, if states elect not to establish their own exchanges, the federal government will do so for them. Some federal funding, in the form of exchange establishment grants, is also available to states.

Under the ACA's statutory design, the exchanges are the gateway to access federal financial assistance to purchase private health insurance on the exchanges. IRS rulemaking specified that premium assistance tax credits would be available in both states that operated their own exchanges and states in which the federal fallback operated. Implemented nationwide, it was estimated that 17 million people would qualify for federal tax credits in 2014, out of the 29 million potential nationwide market for exchanges. The rule seemed a noncontroversial application of the statutory design and language. Nevertheless, the same people who brought the seemingly far-fetched commerce clause challenge to the individual mandate also raised the novel suggestion that federal premium assistance tax credits are available only in states that establish their own exchanges, not in states where the federal government does so for them. That suggested interpretation might have been less dramatic if, as Congress likely expected, most states opted to establish their own exchanges. As it turned out, a clear majority of states—more than opted out of Medicaid expansion—opted not to establish their own exchanges, leaving the task to the federal government. That means, if the argument succeeds, that residents in states with federally facilitated exchanges will be ineligible for federal financial assistance to purchase insurance, leaving another gaping hole in the ACA's near-universal coverage strategy.

72. 42 U.S.C. § 18041(c)(1) (2014) (providing that if a state refuses or is unable to set up an Exchange, the federal government, through the Secretary of Health and Human Services ("HHS"), "shall ... establish and operate such Exchange within the State").
73. Leonard, Rhetoric Hits the Road, supra note 48, at 798.
The Supreme Court’s decision in *NFIB v. Sebelius* was dubbed the “June Surprise.” Two summers later, the D.C. Circuit and Fourth Circuit brought us the “July Surprise,” in the form of same-day, conflicting opinions in *Halbig v. Burwell* and *King v. Burwell*. A three-judge panel of the D.C. Circuit accepted the challengers’ argument and declared, based on textualist and contextualist reading of the ACA, that federal premium assistance tax subsidies are available only in states with state-operated exchanges. The Fourth Circuit held the opposite, recognizing Congress’s overarching design to expand coverage and finding no support for an interpretation of the statute that resulted in a two-tiered exchange approach. The D.C. Circuit reasoned that Congress intended to make subsidies available only in state-operated exchanges as an incentive to states to opt into participation, while the Fourth Circuit found no support for the suggestion that Congress intended a two-tiered system of exchanges.

Within a few months, the full D.C. Circuit Court vacated the panel’s decision and granted en banc review in the *Halbig* case. Meanwhile, another federal district court in Oklahoma issued an opinion in *Oklahoma ex rel. Pruitt v. Burwell*, following the D.C. Circuit’s panel decision. A fourth case on the same issue, *Indiana v. Internal Revenue Service*, was still pending. Perhaps emboldened by the November 2014 mid-term elections giving Republicans control of both the House and the Senate, the Court granted review even though, on the present posture of the cases, there is no circuit split. Whether the Court will now take the opportunity it passed up in *NFIB v. Sebelius* to pull the rug out from under the ACA’s private market reforms remains to be seen.


81. *Halbig*, 758 F.3d at 394.

82. *King*, 759 F.3d at 376.

83. *Halbig*, 758 F.3d at 408.

84. *King*, 759 F.3d at 377.


3. Potential King Fallout

If the Court reverses the Fourth Circuit decision, holding similarly to the D.C. Circuit panel and Oklahoma District Court that federal premiums assistance tax credits are not available in states with federally facilitated exchanges ("FFEs"), the results would be devastating. If residents of more than half of the states would be ineligible for federal assistance. Of the 12 million people expected to apply for private insurance coverage through federally facilitated exchanges, more than half, 7.3 million, were expected to qualify for federal subsidies. The unavailability of federal subsidies would represent a loss of $36 billion in subsidies nationwide.

In addition to depriving so many individuals of federal subsidies, a Supreme Court decision reversing King would have a cascade effect on multiple other parts of the law. First, without federal financial assistance, private insurance coverage would become unaffordable for many more people than expected. That would mean more people would be exempt from the individual mandate. As described previously, the more people who are not brought into the risk pools created by the exchanges, the more vulnerable the private insurance marketplace would be to the "death spiral" of adverse selection and resultant premium rate inflation.

Second, combining the unavailability of premium assistance for middle-income individuals and families with states’ elections not to expand Medicaid for low-income individuals and families, the gap in the ACA’s near-universal coverage strategy becomes even more gaping. There is strong alignment between states that opted out of both Medicaid expansion and exchange implementation. Accordingly, in at least 22 states, individuals between 100% and 400% of federal poverty level will be denied both government health insurance through Medicaid as well as government assistance to purchase private insurance through the exchanges. Another 12 states opted to expand Medicaid


93. Id.

94. See sources cited supra note 63 and accompanying text.


but not to establish their own exchanges, meaning that the very poor would have coverage but middle-income, often working poor, individuals and families would not. One state, Idaho, made the opposite election—refusing to expand Medicaid but establishing its own exchange, meaning the opposite—very low-income adults would be denied public assistance through Medicaid but middle-income individuals and families would receive federal subsidies to purchase private insurance. A clear minority of states, 16 plus the District of Columbia, have proceeded as Congress arguably intended, making both Medicaid expansion and premium assistance tax subsidies available to their residents.

Third, Supreme Court reversal in King could impact states’ Medicaid eligibility levels, whether they opted to expand or not. According to the D.C. Circuit panel’s reasoning in Halbig, states are required to maintain pre-ACA eligibility levels until a “state exchange” is established. The Halbig court interpreted “state exchange” to refer only to exchanges in states that declined FFE implementation. Accordingly, that reasoning would seem to require that that states with FFEs would never be allowed to amend their Medicaid eligibility because they would never establish a “state exchange.”

More precisely, the ACA contains a Medicaid “maintenance of effort” (“MOE”) provision that was intended to prevent states from taking advantage of the more generous federal match for the Medicaid expansion population by dropping their current, optional coverage for some portion of the expansion population. For example, pre-ACA, states may have opted not to cover childless adults or to cover only those individuals with very low income levels. Under the Halbig panel decision, by definition, state-operated exchanges will not be established in the 27 FFE states—at least for now. Therefore, those states will not be released from the MOE and will be hamstrung to modify or alter their current Medicaid programs in response to budgetary or other needs over time. The D.C. Circuit panel accepted the plaintiffs’ suggestion that such a result was consistent with congressional design to protect impoverished individuals in states where premium assistance subsidies would be unavailable. Given the extraordinarily limited coverage in most states for those individuals, the assurance of “protection” offers little comfort.

Fourth, Supreme Court reversal of the King decision would also impact the ACA’s strategy to shore up employer-based health insurance coverage because the employer “free-rider” penalties are tied to availability of federal tax subsidies on the exchanges. Accordingly, employers in FFE states will not be subject to

97. Id.
98. Id.
99. Id.
101. Id. at 406.
104. Halbig, 758 F.3d at 406.
penalties for failing to offer affordable or adequate insurance. Under the ACA, there are two ways that applicable large employers may be penalized: the “pay-or-play” penalty or the “free-rider” penalty. The “pay-or-play” penalty applies to large employers that fail to offer minimum essential coverage to substantially all of their employees by January 1, 2014. Even employers that meet the requirement to offer coverage may be subject to “free-rider” penalties if the coverage they offer is unaffordable (defined as costing more than 9.5% of household income), or inadequate (defined as failing to provide at least 60% actuarial value). In either case, the employer penalty is triggered only if at least one employee purchases coverage on the exchanges and qualifies for federal subsidies. The notion is that employers, by failing to offer adequate or affordable coverage, are imposing costs that otherwise will fall on the government and taxpayers.

The first big, high-profile attempt to destabilize the ACA’s individual and small group market reforms was averted by a surprising Supreme Court decision characterizing the individual mandate penalty as a tax, within Congress’s enumerated powers. Whether the highly technical statutory interpretation challenge to the premium assistance tax subsidies will be successful remains to be seen. If the challengers convince the Court that those subsidies should be available only to residents of the minority of states that opted to establish their own health insurance exchanges, the direct and spillover effects on the ACA’s universal coverage strategy will be dramatic.

105. 26 U.S.C. § 4980H(c)(2)(A) (2014) (defining “applicable large employer” as “an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year”).


110. See supra Part III.B.1.
C. Employer-sponsored Slice

As just described, the statutory construction challenge to the premium assistance tax credit provisions of the ACA has a potentially serious impact on employer-based health coverage. By removing the trigger for potential sanctions on employers that provide affordable minimum essential coverage, employers have little additional incentive to offer health insurance to their employees, beyond pre-ACA tax and business incentives to do so. Accordingly, more employers may cease offering coverage and fewer employers may begin offering coverage than predicted.111

The employer-sponsored slice represents almost half of the universal coverage pie.112 Pre-ACA, close to half of all Americans obtained coverage, either as employees or dependents of employees, from employer-sponsored plans. Federal law has never required that employers offer health insurance to their workers, and states are generally barred from imposing such a requirement as a matter of ERISA preemption.113 Historically, employers provide employee health coverage because any amount spent on employee benefits is excluded from taxable income.114 Moreover, it is generally in employers’ interests to maintain a healthy workforce and prevent lost productivity due to illness.115 Although the United States is relatively unique among developed countries in relying so heavily on employer-based insurance, it has become as matter of custom and expectation for many industries and professions.116

The ACA still does not require employers to offer health insurance to their employees, but the law does apply additional nudges. First, the law offers federal tax credits to certain small employers, in a manner similar to the approach toward individuals of making the purchase of commercial insurance through the exchanges more affordable. Employers with fewer than 25 full-time equivalent employees and average wages under $50,000 annually qualify for the subsidies as long as they pay 50% of the cost of employees’ plans purchased through the small business health options program (“SHOP”).117 The credit is available for the first two consecutive years during which the small business offers its

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111. See supra note 8 and accompanying text.
112. See Garfield et al., supra note 5.
113. See generally 29 U.S.C. § 1132(c) (2014); 29 U.S.C. § 1144(a) (2006). See also Retail Indus. Leaders Ass’n v. Fiedler, 475 F.3d 180, 180 (4th Cir. 2007) (striking down Maryland’s “Fair Share Health Care Fund Act,” which had the effect of requiring very large employers to offer health plans to their employees); Standard Oil Co. of Cal. v. Agsalud, 633 F.2d 760, 761 (9th Cir. 1980) (striking down Hawaii’s employer mandate).
114. See Leonard, supra note 6, at 760-61.
115. Id. at 761.
116. Id.
employees coverage through the SHOP. There are other incentives for larger employers, discussed next.

1. Employer Penalties

In addition to carrots, in the form of tax subsidies to assist certain small employers to purchase health plans for their employees, the ACA also includes sticks, in the form of sanctions on certain large employers for failing to offer coverage that meets certain requirements. The employer responsibility provisions are fairly narrowly circumscribed. First, only a very small percentage of employers are subject to the requirements. Second, the penalties are triggered only under particular circumstances. Specifically, only employers with 50 or more full-time equivalent employees face the sanctions, which means that 96% of employers in United States are exempt even from the potential for sanctions on that basis alone. Of the remaining 4% of employers, half (2%) already offer employee health plans that meet the ACA requirements and, thus, would not be sanctioned. Accordingly, a mere 2% of U.S. employers risk the potential sanctions for failing to offer ACA-compliant coverage to their employees.

Second, the employer penalties do not operate as an across-the-board mandate but arise only under precise scenarios. As described above, the ACA includes a pay-or-play penalty, applicable to any large employer that fails to offer health insurance to “substantially all” of its employees, and a “free-rider” penalty applicable to employers who fail to offer coverage meeting the ACA’s standards for affordability and minimum essential coverage. The “free-rider” penalty attaches only if a full-time employee then purchases private insurance on the exchanges and is of low enough income to qualify for federal premium assistance tax subsidies. Moreover, if the Supreme Court in King decides that those subsidies are available only in states with state-operated exchanges, the employer penalty would never be triggered in FFE states, leaving employers of all sizes exempt from any added pressure to extend employee health coverage.

Even aside from King, a Republican proposal that recently passed the federal House of Representatives would redefine “full-time employee” from 30 hours per week, as the ACA presently provides, to 40 hours per week. That amendment would have the effect of exempting even more employers from the

120. See supra notes 105-109 and accompanying text.
penalties and leave even more employees without coverage. The upshot is that the vast majority of employers do not have to do anything different under the ACA than they were doing previously, and for the very few employers that are implicated, the pressure that the ACA applies may be fairly diffuse.

Nevertheless, employers expressed concern about meeting the January 2014 deadline for compliance with the new ACA requirements. Through administrative rulemaking, the effective date for these employer responsibility provisions has twice been delayed. Under IRS regulations, no employer will face sanctions for 2014, despite the statute’s clear reference to that date. Employers with 50-99 full-time equivalent employees are not subject to any sanctions for two years, until 2016. The regulations also effectively stagger implementation of potential “pay-or-play” sanctions for employers with 100 or more employees by defining “substantially all” as 70% of employees for 2015, and 95% of employees for 2016 and thereafter. Also, for 2015, the first 80 employees, rather than first 30, are excluded from the $2,000 per employee per month penalty. Those adjustments to ACA implementation will further dilute the impact of the employer coverage incentives.

At this point, the reader should not be surprised to learn that the IRS rulemaking has also become the subject of legal challenge. John Boehner, the Republican Speaker of the U.S. House of Representatives, on November 21, 2014, filed a lawsuit on behalf of Republican members of the House, against the secretaries of the IRS and the U.S. Department of Health and Human Services (“HHS”) for abuse of executive power in delaying implementation of the employer requirements, contrary to clear statutory language. The case asserts that federal dollars were not properly appropriated to offer premium assistance tax subsidies in any states, including the 14 states with state-operated exchanges. House v. Burwell is pending in the D.C. Circuit Court, the same


court, a panel of which initially accepted Halbig’s strict statutory interpretation against availability of premium assistance tax subsidies FFE states. Considerable questions remain about the procedural and substantive viability of House, but the litigation seems clearly calculated to undermine the overall effectiveness of the ACA’s near-universal coverage strategy. Combined with the already limited reach of the ACA’s employer responsibility provisions, the case further undermines the statutory scheme.

2. Preventive Services Coverage Mandate

Another seemingly narrower attack on the employer responsibility provisions of the ACA focused on the mandate to cover preventive services. But, like the challenges discussed above, that attack has the potential to unravel the fragile web of coverage that the ACA attempted to construct. Under the ACA’s preventive services mandate, all private plans, including individual, small group, large group, and self-insured employer plans, must provide “first dollar” coverage for preventive services, meaning without charging deductibles, copayments, or coinsurance. Acting under authority delegated by the ACA, through administrative guidelines, HHS defined preventive services to include well-woman visits, contraception, and domestic violence screening and counseling. The list of covered contraception included at least four types that certain religious organizations consider abortion because they have the effect of preventing an already fertilized egg from attaching to the uterus and developing. For that reason, a number of employers challenged the contraceptive coverage mandate on religious liberties grounds.

By statute, regulation, and judicial order, application of the ACA’s preventive services mandate to employer-based coverage has been gradually eroded. As a starting point, under the ACA, employers with 50 or fewer employees are not required to cover any preventive care services, including the

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130. See Roberts, supra note 126.
four objectionable forms of contraception. Also, grandfathered plans in existence as of March 23, 2010 that have not significantly changed and thus lost grandfathered status are exempt from the mandate. For the remaining employers subject to the requirement, the mandate took effect January 1, 2012.

But the religious objection brought about exemption of a number of additional employers. By regulations issued in July 2013, religious employers (nonprofit corporations including churches, houses of worship, church auxiliaries, conventions, and religious orders) are exempt from the contraceptive coverage mandate. The same set of rules provided an accommodation for certain non-profit religious organizations (as well as nonprofits that hold themselves out as religious organizations and object on the basis of religion to coverage for some or all of the forms of contraception, e.g., Notre Dame University and Wheaton College). Non-profit religious organizations that self-certify their objection to HHS are still required to provide access to the contraception but do not have to pay any portion of the premiums for that particular benefit. Effectively, insurance companies selling group plans to self-certifying non-profit religious organizations must provide a separate plan to cover that benefit, and none of the benefit may be paid for by the objecting employer.

Despite the above administrative exemption and accommodation, other religious employers continued to object to the contraceptive coverage mandate. In particular, certain for-profit employers challenged the rule as violating the federal Religious Freedom Restoration Act ("RFRA") by requiring them to provide their employees with free access to the forms of contraception that violate their sincere religious beliefs that life begins at conception. Essentially, these employers sought accommodations similar to those already granted to non-profit religious organizations. In a highly anticipated opinion, the Supreme Court, in Burwell v. Hobby Lobby Stores, Inc., held that the contraceptive coverage mandate substantially burdens the plaintiff for-profit corporation’s exercise of religion. Noting the Administration’s regulatory accommodation for non-profit religious employers, the Court concluded that the RFRA’s “least


135. See id. See also Leonard, supra note 6, at 765-69 (discussing difficulty of maintaining grandfathered status).

136. 45 C.F.R. § 147.131(a) (Westlaw current through Mar. 26, 2015).

137. Id. § 147.131(b) (Westlaw current through Mar. 26, 2015).

138. Under a typical employer health plan, the employer pays a substantial share of each employee’s individual or family health insurance plan, and the employee pays the remainder. Under this accommodation, the insurer would only be able to collect the employees’ share of the premiums and would have to arrange coverage for eligible employees, at no cost to the employee or employer. Women’s Preventive Services Coverage and Non-Profit Religious Organizations, CMS.GOV, www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/womens-preven-02012013.html (last visited Aug. 31, 2015).


140. Id. at 2775.
restrictive means" test was not met because a similar accommodation easily could be extended to the *Hobby Lobby* plaintiffs.\(^ {141}\)

But within a week of the Court holding in *Hobby Lobby* that the regulatory accommodation already adopted for non-profit religious organizations would satisfy RFRA with respect to for-profit religious organizations, the Court enjoined that very regulatory accommodation. Specifically, the Court granted an injunction to Wheaton College, a non-profit religious organization, against enforcement of the self-certification option.\(^ {142}\) The highly unusual, unsigned emergency injunction provided that instead of notifying its own third-party insurer under the self-certification method described above, Wheaton College could instead notify the government directly, which would then notify the insurer, of the employer’s objection.\(^ {143}\) Employees would still be guaranteed first-dollar contraceptive coverage, but the employer’s involvement in providing the coverage would be further attenuated.\(^ {144}\) Adding one additional step in the process, thereby further distancing the religious organization from facilitating what it considers abortion, seemed to satisfy the employer’s religious objections. The effect of the Court’s injunction, however, is to open to question the legitimacy of the very accommodation on which the *Hobby Lobby* decision for for-profit religious organizations was based.

In the greater scheme of the law, the Supreme Court’s decision in *Hobby Lobby* is more significant for defining the scope of religious freedom recognized under RFRA (as distinguished from the First Amendment) and extension of individual liberties to corporate entities. But the decision, and related decisions and administrative actions that followed, have implications for the ACA’s universal coverage strategy as well. Adding to the existing statutory exemption for small employers, regulatory exemption for religious employers, and regulatory accommodation for nonprofit religious organizations, the Administration responded to the Court’s decision by extending the regulatory accommodation to closely held for-profit religious organizations.

Meanwhile, Wheaton College and other nonprofit religious employers challenged that very accommodation as burdening their religious beliefs. The Administration accordingly revised that accommodation, allowing employers to place themselves at one additional step removed from the provision of contraception. Regulatory rulemaking is still working out the definition of organizations to which the accommodation would extend. The particulars aside, approximately 90% of all businesses in the United States would fall into the

\(^ {141}\) *Id.* at 2782.


\(^ {143}\) *Id.* at 2807.

category of closely held corporation. Questions remain whether other closely held (or, for that matter, publicly traded or other types of employers) could successful challenge other coverage mandates or other ACA requirements on corporate individual liberty grounds. Those challenges would further erode the ACA’s strategy of extending employer-sponsored health insurance coverage.

IV. CONCLUSION

The foregoing discussion aims to highlight the intricacy as well as the fragility of the ACA’s goal of achieving near-universal health insurance coverage by combining expansion of government health-care programs, reforming the private health insurance market, and adjusting the incentives for employer-sponsored health insurance. That patchwork strategy had significant advantages politically, in terms of getting the massive legislation passed, but also has significant drawbacks in terms of achieving the law’s goals. Each component of the strategy—government, private market, and employer-based insurance—has sustained repeated blows and resulting erosion. As a result, fewer uninsured Americans may stand to benefit from the law than predicted. It is beyond the scope of this brief Article to offer a sweeping, alternative model for coverage expansion. By revealing the drawbacks of the patchwork approach, however, it may embolden lawmakers to embrace a more radical, truly systemic, fix the next time the opportunity arises.
