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An Autumn Docket Heavy On Health Policy

A spate of health policy litigation featured a challenge to the individual mandate and the entire ACA.

BY TIMOTHY STOLTZFUS JOST

As 2018 turned from summer to fall, most of the Affordable Care Act (ACA) and health care reform action was in the courts—and what a lot of action there was.

A Challenge To The Individual Mandate And With It The Entire ACA

On September 5 Texas federal district court judge Reed O'Connor heard oral arguments in *Texas v. Azar*, the case filed in February by twenty Republican state attorneys general and governors. The plaintiffs note that the individual mandate was held unconstitutional by the Supreme Court in 2012 as a legal requirement but upheld as a tax. They argue that because the tax associated with the mandate was reduced to $0 in 2019 by the 2017 tax bill, the mandate will become entirely unconstitutional; furthermore, as the entire ACA is dependent on the mandate, the entire ACA must be invalidated.

In June the Department of Justice had, in a surprise move, agreed with the plaintiffs that the mandate is unconstitutional but argued that only the ACA's guaranteed issue and community rating provisions, as well as its ban on preexisting condition exclusion clauses, must be invalidated. Attorneys general from California and a number of other Democratic states are defending the entire ACA.

Oral arguments lasted three hours. Judge O'Connor seemed inclined to accept the plaintiffs' arguments and seemed only to question how much of the ACA he should invalidate. The Department of Justice appeared to be having second thoughts, however, about invalidating the ACA's consumer protections and pleaded with the court not to enjoin the law before the close of open enrollment in December, contending that doing so could "cause chaos in the insurance markets." A ruling is expected shortly.

On September 13 the Maryland Attorney General filed a lawsuit in the Maryland federal district court attempting to offset a possible ruling against the ACA in the *Texas* case. Maryland asks the court to declare that the ACA's individual responsibility provision is constitutional or, failing that, to hold it severable from the rest of the ACA. The complaint notes the refusal of the Department of Justice to fully defend the ACA in the *Texas* case and the serious harm that would be done to Maryland if the ACA were invalidated.

Also in response to the *Texas* case, a group of Republican senators introduced legislation that would reenact most of two ACA provisions prohibiting insurers from denying coverage or varying premiums based on health status. It would not, however, reinstate provisions prohibiting insurers from varying premiums based on other characteristics (such as sex or age) or from excluding coverage for preexisting conditions.

Lawsuits Over The Association Health Plan And Short-Term Coverage Rules

On August 23 twelve Democratic state attorneys general (AGs), led by New York and Massachusetts, moved for summary judgment in a lawsuit challenging the Donald Trump administration's association health plan (AHP) rule. The AGs contend that the ACA provides clear rules for differentiating between large employers, small employers, and individuals for purposes of insurance market regulation as well as rules for aggregating groups of employees. The AHP regulation, they argue, impermissibly aggregates individuals and small groups into large groups to reduce consumer protections.

The AGs further contend that the AHP rule abandons the longstanding Department of Labor understanding of what constitutes an "employer," which Congress relied on in adopting the ACA. The AHP rule is also contradicted by the rulemaking record: Virtually all health care stakeholders opposed the rule. And finally, the AGs note, the rule uses the term "employer" inconsistently, treating associations as single large employers for regulatory purposes but not for applying the ACA's employer mandate or other rules.

In September organizations representing insurers, psychiatrists, and patients filed a federal lawsuit asking that the Trump administration's short-term limited-duration plan rule be declared invalid. The complaint alleges that the rule's definitions of *short-term* as any period less than a year and of *limited-duration* as up to thirty-six months violate the ACA. It further alleges that the rule violates the Administrative Procedure Act because it is arbitrary and capricious and not supported by reasoned explanation or adequate notice. The plaintiffs have asked the court to block the rule while it considers their claims.

Continuing Litigation Over Reimbursement For Cost-Sharing Reductions

On September 4 Judge Elaine Kaplan of the federal Court of Claims entered summary judgment in favor of the Montana Health CO-OP (Consumer Operated and Oriented Plan) in its lawsuit against the United States to collect reimbursement for reducing 2017 cost sharing for low-income enrollees. The saga of cost-shar-

ing reduction payments is well known to readers of this column, but a quick recap: The ACA requires insurers to reduce cost sharing for enrollees with incomes below 250 percent of the federal poverty level who purchase silver plans. The federal government was supposed to reimburse insurers for these reductions. The House of Representatives sued the Barack Obama administration, however, claiming that no money had been appropriated to cover the cost-sharing reductions and won at the district court level. The Obama administration appealed, but in October 2017 the Trump administration decided that the payments were illegal and terminated them.

Although most insurers raised their 2018 silver-plan premiums to cover their increased costs going forward, their rates for the final months of 2017 were locked in. The Montana CO-OP sued, claiming that the federal government owed it reimbursement for those months. Judge Kaplan ruled that, in fact, the ACA promised reimbursement and that the failure of Congress to appropriate funds does not block the insurers from recovering for 2017. A number of other insurers have also sued, and if the judges agree in those cases, the United States may be facing substantial obligations.

Finally, in September two federal district courts in Minnesota and Wisconsin held that the ACA's nondiscrimination provision (section 1557) prohibits discrimination against transgender individuals in the coverage of health services. The Minnesota judge concluded that an earlier nationwide injunction (by Texas judge O'Connor) blocking the protections offered transgender individuals under the Obama administration's 1557 regulation was irrelevant, since the Minnesota decision was based on the statute itself, not the regulation. The Wisconsin judge, also basing his decision on the statute, simply ignored the 1557 regulation.

The Marketplace And Enrollment

Outside the courts, on August 23 the Government Accountability Office (GAO) released a report reviewing the effect of Trump administration actions on the 2018 open enrollment period. The GAO noted that the administration's decision to stop reimbursing health insurers for reducing cost sharing, and subsequent state regulatory actions requiring insurers to load the extra cost they incurred onto silver-plan premiums, resulted in higher premium tax credits for subsidized enrollees and more affordable bronze and gold plans in many markets. However, it also resulted in higher premiums for nonsubsidized enrollees.

The GAO criticized the administration for its approach to evaluating performance in the navigator program. It noted problems identified by stakeholders caused by the administration's dramatic cuts in outreach and education funding. It recommended that the administration set goals for open enrollment to facilitate evaluation, as the previous administration had done.

In spite of the GAO's admonition, the Department of Health and Human Services (HHS) announced on September 12 that it was dramatically cutting and reallocating 2018 navigator funding grants—to be used in assisting consumers shopping for 2019 coverage—for the thirty-four states that use the federal Marketplace. Only $10 million is being awarded for navigator funding in 2018, compared to $36.1 million in 2017 and $63 million in 2016. Only 40 navigator programs received funding, down from 104 in 2016. There will be no navigators in three states, as well as in large parts of other states, including cities like Cleveland, Dallas, and San Antonio and all of Michigan outside Detroit.

The administration contends that navigators have become less important because public awareness of the Marketplace has grown, and brokers sign up enrollees more efficiently than navigators do. There is strong evidence, however, that low-income consumers still have limited knowledge of Marketplace alternatives and need help with enrollment and that brokers do not serve the same low-income, uninsured clients as do navigators. Marketplace enrollment by new enrollees and by consumers with incomes between 100 and 200 percent of poverty dropped significantly between 2017 and 2018.

In September HHS issued a new guidance providing that individuals can claim hardship exemptions from the individual responsibility requirement on their 2018 tax returns, without having to first obtain a hardship exemption certification from the Marketplace. This guidance covers the new hardship exemptions HHS has offered for 2018, including for individuals who live in an area with only one insurer, with no insurers who do not cover abortions, or with other "personal circumstances that create a hardship in obtaining health insurance coverage under a [qualified health plan]."

Rounding out summer developments, on August 27 Illinois became the first and only state to take advantage of the flexibility CMS has offered states to change their essential health benefits benchmark plans for 2020. Illinois is changing its plan to improve opioid addiction services and expand covered mental health and substance use disorder services.

Coverage Trends

On September 12, 2018, the Census Bureau released its 2017 report, *Health Insurance Coverage in the United States*. In 2017, 28.5 million people (8.8 percent of the US population) were uninsured. While this was not a statistically significant change from 2016, it marks the first time since 2010 that the estimate of the number of people without health insurance has risen rather than fallen. Of those with insurance, 67.2 percent had private coverage (including 56 percent with employer coverage), while 37.7 percent had government coverage, mainly through Medicare and Medicaid.

Coverage rates remained essentially unchanged for virtually every age, economic, demographic, and racial/ethnic group, meaning historical disparities continue. Uninsurance rates continue to be significantly higher in states that have not expanded Medicaid than in states that have. It remains to be seen whether the number of uninsured people will increase further in response to administration actions and other developments after 2017. ■

Timothy Stoltzfus Jost (jostt@wlu.edu) is an emeritus professor at the Washington and Lee University School of Law and a contributing editor at *Health Affairs*. [*Published online October 9, 2018.*] Readers can find more detail and updates on health reform at Health Affairs Blog (http://healthaffairs.org/blog).