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CONTEXT IS KING: ANALYSIS OF THE US SUPREME COURT DECISION IN *KING V. BURWELL*

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INTRODUCTION

The US Supreme Court's decision today in *King v. Burwell* was a resounding victory for the Obama Administration, virtually guaranteeing that the Affordable Care Act (ACA) will survive, at least through the end of the President's second term, if not beyond. The *King* case effectively removed the last major threat to the Administration's ability to solidify its health reform legacy before the President leaves office. While opponents are vowing to continue ACA repeal and replace efforts, at a minimum, today's ruling makes such efforts unlikely to succeed until a new Congress and a new president take office in 2017.

In the meantime, the approximately 6.4 million consumers currently relying on federally-facilitated exchanges in 34 states will continue to have access to federal subsidies collectively worth $1.7 billion per month. While carriers' recent rate filings indicate premiums will rise in varying degrees in the 2016 plan year, insurance markets in the federally-facilitated exchange states can now avoid the "death spirals" predicted by supporters of the law, and cited by the Court as key to interpreting congressional intent. Hospitals and other healthcare providers that have seen reductions in uncompensated care and bad debt due to coverage expansion can also breathe a sigh of relief. The Court's decision ensures that the Administration will continue to focus on coverage expansion, strengthening the insurance market and implementation of delivery system reforms.

The Court's majority flatly rejected the *King* plaintiffs' argument that the plain language of the ACA allows subsidies to be paid only "through an Exchange established by the state"; that is, only on behalf of consumers living in states with state-run exchanges, as opposed to consumers in federally-facilitated exchange states who would have been faced with immediate and dramatic increases in the cost of coverage. The Court dismissed, however, the Administration's contention that it should defer to a federal agency's interpretation of a statute – in this case, the IRS's interpretation of the ACA as allowing tax credits to be paid on behalf of eligible consumers in federally-run exchanges as well as state-based exchanges. Instead, the justices relied on their own interpretation of the underlying law, holding that the question whether tax credits were available to residents in federal exchange states is a question of deep "economic and political significance" central to the statutory scheme. In taking on the task of discerning congressional intent, Justice John Roberts wrote "… had Congress wished to assign that question to an agency, it surely would have done so expressly." Roberts added, "It is especially unlikely that Congress would have delegated this decision to the IRS, which has no expertise in crafting health insurance policy of this sort."

Based on the interlocking nature of the ACA's three core market reforms – guaranteed issue and community rating requirements; the individual coverage mandate; and the affordability program of tax credits for individuals with household incomes between 100 percent and 400 percent of the federal poverty limit – the Court concluded that Congress intended to provide health insurance premium subsidies for consumers equally in each state no matter whether the state or the federal government established the exchange.

Without a doubt, the Court's ruling in favor of the Government in *King* creates more certainty for insurance markets in the federally-facilitated exchange states, and assures providers and suppliers in those states of continued access to a growing number of insured consumers. However, Senate and House Republican leadership remains committed to repealing and replacing the law, despite significant challenges in achieving consensus and getting a package through each chamber, let alone the certainty of a presidential veto. Healthcare reform also will remain a key issue for Republican presidential candidates, as will the role of the next president in filling vacancies on the Supreme Court.

Regardless, the healthcare industry in the US is still undergoing dramatic changes in response to policy and economic pressures to reduce healthcare costs, efforts to enhance quality, efficiency and care coordination, improve cost transparency, reduce chronic disease burden and combat fraud, waste and abuse in public healthcare programs. We expect these issues to remain a key focus of the 114th Congress and a high priority for the Administration. In addition, as carriers, hospitals, health systems and physician groups continue to consolidate and develop new corporate models, we expect careful scrutiny from regulators and policymakers with respect to cost, quality and anticompetitive implications.

SCOTUS RULING HIGHLIGHTS

The Supreme Court granted certiorari in *King* to consider the following question: whether the IRS may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the ACA (or 42 U.S.C. Section 18041).

The Court heard oral argument on the case on March 4, 2015. The Court's decision, released on June 25, 2015, held that 26 U.S.C. Section 36B's tax credits are available to individuals in states that have a federally-facilitated exchange. In so holding, the Court read Section 36B in light of the text, the context and the statutory scheme, and ruled against applying *Chevron* to defer to the IRS to reasonably interpret the health reform law. The following is an overview of the Court's decision, including dissenting opinions, as well as an initial analysis of the implications.

1. Should the Court Defer to the IRS's Reasonable Reading of the Statute?

Chevron – When Courts Defer to Agency Interpretations

When analyzing an agency's interpretation of a statute, a court may defer to an agency's reasonable interpretation under the two-part *Chevron* framework. If the Court finds the statute is ambiguous, it asks whether the agency's interpretation is one permissible reading of the statute. So, *Chevron* tends to favor the Government as it need only show that its interpretation is reasonable.

The Suitability of Agency Deference to the IRS

The *King* plaintiffs raised doubts as to the appropriateness of applying *Chevron* to IRS rulemaking. Specifically, they argued that the Court's prior holdings require Congress to establish tax credits, deductions and exemptions in clear and unambiguous terms. During oral argument, Justice Anthony Kennedy expressed a similar reservation on deferring to the IRS when billions of dollars in healthcare-related tax credits are at stake. Solicitor General Donald Verilli responded that *Chevron* has been applied to big, important questions as well as to small, unexciting questions.

- The Roberts Court ruled that *Chevron* does not apply to this case. In holding the *Chevron* framework inapplicable, the Court found that if Congress had intended to assign the question of tax credits to an agency, especially to an agency with no expertise in health insurance, it would have done so expressly.

2. Should the Court Read the Statute in Isolation or in Conjunction with Statutory Context?

Plain Meaning as Perfection in Isolation or Harmony in Context

Courts interpreting statutes will look to the plain meaning of phrases, often reading the phrases as they sit in context. The starting point is the language of the statute itself, and without a clear expression of legislative intent to the contrary, the plain language is ordinarily to be regarded as conclusive. If a statute is found to be subject to ambiguity or objectively absurd, courts will interpret phrases in light of statutory context. Justice Elena Kagan echoed that principle during oral argument, pointing out that the Court will look at "the whole text, the particular context, the more general context, [and] try to make everything harmonious with everything else." Even so, Justice Antonin Scalia in oral argument observed that statutes are to be read in context only where there are "alternative readings that are reasonable."

Challengers and the Government – Two Sides of the Same Coin?

The parties' contrasting interpretations of the statute were similarly driven by plain meaning and context – although their approach differs in the emphasis placed on each. The challengers' interpretation telescopes on the plain English meaning of "an Exchange established by the State under section 1311 [of the ACA]," which the challenger contends finds support with the statutory context. In contrast, the Government's argument relied heavily on the interlocking market reforms in the ACA and the larger statutory context.

- By a vote of 6 to 3, the Court found the Government's view more persuasive, holding that Section 36B's tax-credit subsidies are available to individuals in states that have a federal exchange.
  - While the majority and minority agreed that the phrase "an Exchange established by the State under [42 U.S.C. § 18031]" was ambiguous, the Roberts majority concluded that it could itself interpret Section 36B and related statutes in light of context and its place in the larger statutory scheme. The majority acknowledged the subsidies were intertwined with other reforms of the ACA.
  - Recognizing that the ACA is the product of "inartful drafting," the Court noted that the statute "does not reflect the type of care and deliberation that one might expect of such significant legislation."

- A scathing dissenting opinion by Justices Scalia, Clarence Thomas and Samuel Alito warned that the majority's opinion undermines the value that courts and legislators place on the meaning of words.
  - The dissenting justices rejected the majority's determination that Congress intended to treat the federal exchanges the same as state exchanges. Congress, they argue, knew how to equate the two different types of exchanges, but choose not to do so in crafting the law.
  - The dissenters acknowledged that statutory interpretation should not be couched in isolation, but warned that context is an interpretative tool, not a license to rewrite. To the dissenting justices, the Court's decision was driven by a strong emphasis on context over the traditional importance of natural language which is contrary to the traditional role of the judiciary.

WHAT HAPPENS NOW?

Administration:

With the Court ruling for the Government, the ACA has survived the last legitimate threat to undo the health reform law, the law will continue to be implemented as it stands and the country can generally expect status quo. We anticipate the Administration will continue to promulgate regulations on various aspects of the law, hoping to codify as much of the law as possible before the end of the President's second term. The Government's victory in *King* is likely to reinforce the Administration's determination to ensure that the ACA continues to take root before a new Administration takes office, not only to solidify the President's legacy, but also making it more difficult for a possible Republican President to work with the next Congress to repeal or significantly amend the law. The Administration will also continue to reinforce many of the law's broad policies centering on coverage expansion and delivery system reform through ongoing ACA guidance, grants and other initiatives.

Over the next 18 months, we expect the Administration to focus on initiatives already underway, such as:

- Encouraging states that have not expanded their Medicaid programs for low-income adults to do so. For example, the Centers for Medicare and Medicaid Services (CMS) is likely to continue demonstrating the flexibility it showed in January of this year, when the agency approved Indiana's amendment of its Section 1115 demonstration. While the Administration may have been troubled by certain aspects of Indiana's program, such as the premium requirements on low-income beneficiaries and temporary re-enrollment ban in the event of payment lapse, it approved the demonstration as an interim step toward expansion.
- Testing and implementing new payment models that reward value, quality and care coordination rather than volume. The US Department of Health and Human Services (HHS) believes it has seen promising results on cost savings with alternative payment models. For example, Secretary Sylvia Mathews Burwell recently announced that existing Accountable Care Organizations (ACOs) programs had generated combined total program savings of $417 million to Medicare to date.
- Continuing to shift Medicare payment systems from volume to value. In January 2015, HHS announced a goal of converting 30 percent of traditional fee-for-service Medicare payments into value providers through alternative payment models by 2016, and 50 percent by 2018.
- Incentivizing preventive and primary care services and reducing hospital readmissions in Medicare.
- Using "big data" to improve cost and quality transparency to promote better care, smarter spending and address fraud, waste and abuse. HHS's recent annual releases of Medicare inpatient and outpatient hospital utilization and payment data, as well as Medicare physician and other supplier utilization and payment data, have been well received by the public, researchers, and the press. The Administration remains committed to using such data to drive reform.
- CMS's Center for Medicare and Medicaid Innovation (CMMI) is likely to start narrowing its focus on the new payment and service delivery models it believes are working well. For example, CMMI recently released a final rule making changes to the Medicare Shared Savings Program (MSSP), to encourage new Accountable Care Organizations to form in rural and underserved areas and MSSP ACOs to transition to arrangements with greater financial risk.
- CMS also will continue to focus on implementation of the merit-based incentive payment system (MIPS), consolidating and strengthening the impact of meaningful use incentives for electronic health records, physician quality reporting system, and value-based modifiers, while continuing the performance measurement and reporting mechanisms that providers have seen over the last few years.
- CMS will continue to stabilize the automated back-end financial system of the HealthCare.gov platform to improve the accuracy and reliability of payments and subsidies to issuers, and verification of consumer eligibility.

- HHS also can be expected to pursue the non-ACA priorities announced by Secretary Burwell during recent budget hearings, such as combating antibiotic-resistant bacteria; improving access to behavioral health and treatment of prescription opioid and heroin use disorders; and combating fraud, waste and abuse in the Medicare and Medicaid programs.
- In addition, the Administration can be expected to propose changes to the regulatory framework necessary to implement its precision medicine initiative, an inter-agency effort to develop treatments, diagnostics and prevention strategies tailored to the genetic characteristics of individual patients, particularly focusing on cancer genomics.

Notwithstanding ongoing opportunities for stakeholder engagement with HHS in delivery, insurance market and payment system reforms, the healthcare industry will need to keep a close watch for new rules, regulations and enforcement actions as the Obama Administration nears the end of its second term. The items remaining on the Administration's agenda may be less sweeping in scope than the decision in the *King* case, but will have significant impact on the business strategies and decisions facing stakeholders in the near term.

State Response:

The landscape of state-based, federally-run and partnership exchanges could continue to shift, despite the fact that *King* preserves the flow of subsidies to residents of federally-run exchange states. The Obama Administration is likely to continue being as flexible as possible with respect to conditions of approval for any states seeking to establish their own exchanges, although federal grant monies for newly established state-run exchanges are no longer available for such efforts. Before the *King* ruling, CMS acted swiftly and flexibly to facilitate the establishment of additional state-run marketplaces. On June 15, 2015, after only two weeks of consideration, CMS issued conditional approvals for the establishment of state-based exchanges in Pennsylvania and Delaware in 2016. That same day CMS also conditionally approved the establishment of a state-based exchange in Arkansas for small businesses in 2016 and for individual consumers in 2017.

At the same time, the Administration may renew offers to beleaguered state-run exchange states to have them "piggy-back" on the HealthCare.gov platform, as four states – Oregon, Nevada, Hawaii and New Mexico – did when their own systems failed to work. Many states, however, are likely to continue to resist setting up their own exchanges, particularly now that the threat of their residents' losing subsidized coverage has been removed. Between 2010 and July 2013, 21 state legislatures had enacted laws and measures related to opting out, opposing or seeking to challenge broad provisions of health reform, especially related to mandatory provisions of the ACA.

Congressional Response:

Despite assertions from the Administration and leading Democrats that a Court ruling for the government means it's time to "move on," we expect the Republican Congress will continue its work to undermine the law with ongoing repeal and replace proposals. Congressional Republicans were quick to respond to the ruling reaffirming their commitment to ACA repeal. To date, Congress has voted over 50 times to repeal all or parts of the law, stall implementation and block funding that supports the law. Just in the last several weeks, the House voted to repeal both the medical device tax, as well as the Independent Payment Advisory Board (IPAB), a government commission created by the ACA charged with finding savings in the Medicare program. The Court's decision to uphold the subsidies is not expected to diminish congressional enthusiasm for attacking the health reform law, and we anticipate more to come.

While the decision represents a loss for Republicans hoping to overturn the ACA, they have also narrowly avoided what was expected to be a significant challenge to both the 2016 congressional and presidential campaigns. Strategists have been struggling with potential response efforts where any support for extending the subsidies, even temporarily, could have been received by the party faithful as support for the President's health reform law and harmful to GOP campaign prospects. Senate and House Republicans made progress last week in coalescing around a potential legislative response plan if the Court invalidated the subsidies that were carefully crafted to focus on establishing economic stability for subsidy recipients while including a few favorite GOP repeal items to ease the bitter pill for many Republicans of extending any portion of the law. The Senate announced a plan that would focus on creating stability in the short term by extending subsidies (messaged as financial support) likely into 2017 to carry through the election cycle. The plan would also have included repeal of both the employer and individual mandates, in order to garner enough support within the conference to be approved by the chamber. The House plan would have kept the subsidies through 2015, and would allow states to opt out of all ACA requirements in 2016. States opting out would be eligible for block grants to establish their own health programs. States declining the block grant option would still be eligible to receive financial support to help people pay for their health insurance. The House patch would sunset in 2017, allowing for a replacement plan from a new Administration or Congress.

Beyond leadership, many other rank and file members introduced plans to respond to a ruling striking subsidies that we anticipate will receive continued coverage despite the Court ruling rendering them unwarranted. The "Preserving Freedom and Choice in Health Care Act" introduced by Sens. Johnson (R-WI) and Barrasso (R-WY) has the most support to date including notable co-sponsors like Senate Majority Leader Mitch McConnell (R-KY) and Senate Finance Chairman Orrin Hatch (R-UT).

The bill would temporarily extend premium tax credits for existing enrollees of federal exchanges until September 2017, repeals both the individual and employer mandates, and reduces a number of essential health benefit and consumer protection requirements to allow for continuation of coverage.

Sen. Bill Cassidy (R-LA) recently introduced the "Patient Freedom Act" that would allow states to keep ACA marketplaces by establishing a state-based exchange or allowing states to opt out of various provisions of the ACA like the individual and employer mandates and essential health benefits. The bill addresses health coverage through block grants to states and tax credits, in addition to enhanced support for health savings accounts and health insurance portability.

On the House side, similar proposals have been introduced including the Republican Study Committee-backed proposal introduced by Rep. Bill Flores (R-TX) and Rep. Austin Scott (R-GA), the "American Health Care Reform Act." The legislation would fully repeal the ACA and create a standard deduction for health insurance ($7500 for individuals and $20,500 for families). The bill would expand federal support for high risk pools for people with pre-existing conditions and expand health insurance portability across state lines. Rep. Tom Price (R-GA), a physician who is well-respected on health policy issues, has also introduced the "Restoring Equity, Saving Coverage and Undoing Errors (RESTORE) Act" that would address the fallout in states with federally facilitated exchanges to provide refundable tax credits for health insurance coverage, establish individual health pools for individuals and small employers, and repeal the ACA's insurance reforms. State-based exchange states could terminate their exchanges to have these provisions apply. Just last week, Rep. Paul Gosar (R-AZ) introduced the latest *King* response plan with other conservative House Republicans, including Reps. Marsha Blackburn (R-TN), Trent Franks (R-NJ) and John Flemming (R-LA), that would repeal a number of big-ticket ACA provisions and would **not** extend health insurance subsidies. The legislation responds to concerns of the conservative wing of the House GOP conference that opposes any extension of the ACA, which will continue to present a struggle for House leadership in determining the path forward on health policy issues.

The proposals contain many overlapping provisions with common themes of supporting health reform through state flexibility, tax credits, reduced regulatory burden, insurance portability and support for individual tools like health savings accounts. Some of these proposals could see additional consideration this Congress either as stand-alone measures, a compilation of proposals or even peeled off as individual, issue-specific measures. Reconciliation, a procedural maneuver where Congress can approve budget-related items through a fast-track consideration process, remains a viable option as committees of jurisdiction already have reconciliation instructions from the Budget Resolution.

These policy themes will also undoubtedly re-emerge on the campaign trail during the 2016 cycle. The biggest challenge for congressional Republicans, however, will be to build support for a comprehensive health reform replacement plan that would only have a serious chance of approval with a Republican White House.

The bigger question now, with *King v. Burwell* in the rearview mirror and most of the ACA intact, is whether President Obama will be willing to consider legislative proposals to improve the law as the Administration looks to cement his legacy. The medical device tax, for example, has been widely panned by industry stakeholders (manufacturers, providers and patients) as a hindrance to innovation, has bipartisan support in both the House and Senate, and repeal legislation has already been approved by the House. Momentum to address the "Cadillac Tax" that would impose penalties on high-cost health insurance plans is also growing, reviving a debate that proved particularly painful for President Obama and congressional Democrats during the health reform debate. The large employer community, unions and other patient groups are already speaking out against the looming tax, which does not take effect until 2018. Legislation to modify the definition of full-time employee from 30 to 40 hours is high on the Republican list of priorities, but has earned limited Democratic support to date.

Action to address unintended consequences that have emerged through implementation of the law could also see a renewed sense of urgency. For example, children's health and family advocates have been fighting to address the so called "family glitch" that prevents some families from receiving appropriate subsidies through the exchanges. Exchange subsidy eligibility is determined by income as well as access to affordable employer-sponsored health insurance. Affordability is based only on the cost of an individual plan, not family coverage, making family coverage out of reach for many families.

The ACA also included reductions to disproportionate share hospital (DSH) payments to those treating a high number of under- and uninsured patients. Health insurance expansion, the theory went, would lessen the need for these payments over time as more Americans were enrolled in Medicaid, employer-sponsored plans and health insurance exchanges. The Supreme Court determined in 2012 that Medicaid expansion is optional, in *NFIB v Sebelius*, meaning hospitals in non-expansion states continue to treat high numbers of uninsured patients. State budget pressures also continue to stress Medicaid reimbursement rates. Safety net providers continue to rely on DSH funds, and have had some success in pushing them back, yet cuts are still scheduled to take effect in 2018.

Cost is also a weighty concern. Each of these proposals raised considerable funds to pay for health reform, so repeal comes with a hefty price tag. Congress has chosen not to offset certain repeal measures, as was the case in the House-passed version of the medical device tax repeal. The President, however, will be unlikely to support measures that eliminate crucial funding for the health reform law without an offset. Bipartisan support will be critical to advance such measures, but cost will continue to be a powerful obstacle, leaving much of the improvement work to the next Administration.

Beyond ACA repeal and modification legislation, Congress has a number of other health policy items on its agenda to address this session. The House Energy and Commerce Committee has been actively driving the 21st Century Cures initiative, which was favorably reported by the committee last month. The legislation seeks to enhance research, innovation and personalized, modernize clinical trials, as well as streamline the regulatory approval process to bring new therapies to market. The Senate Health, Education, Labor and Pensions (HELP) Committee is working on a companion effort with formal action expected early next year. The House Ways and Means Committee has also moved a number of Medicare Advantage bills that have already been approved by the full chamber.

The Senate Finance Committee has launched a Chronic Care Working Group that Sens. Johnny Isakson (R-GA) and Mark Warner (D-VA) are leading with Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-WY). The group will analyze current law, discuss policy alternatives and present bipartisan legislative proposals to improve care for Medicare beneficiaries with chronic conditions. Just this week, the committee approved a slate of non-controversial health bills, and is working on additional health bills that could be considered this fall.

The appropriations process is also in full swing, with both House and Senate Committees moving Labor-HHS spending bills this week. Both bills contain provisions that would eliminate ACA funding, highlighting ongoing ACA-related battles that will continue throughout the year. Other issues on the congressional health agenda include Medicare and Medicaid reimbursement issues stemming from regulatory activity, fraud and abuse legislation, and cybersecurity measures that will impact all sectors of the economy, including healthcare.

While status quo prevailed, the controversial nature of the ACA and divisive political environment forecast ongoing risk for healthcare providers. The Squire Patton Boggs Healthcare team is available for additional analysis and support as needed.

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