CHALLENGES AHEAD FOR FEDERAL HEALTH REFORM:
Maine's Implementation of Health Insurance Exchange Requirements and Federal Court Challenges to Validity of the Law

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In the year since the Affordable Care Act ("ACA") became law (on September 23, 2010, public laws 111-148 and 111-152), the Maine Legislature has invested significant time in considering how this state will chose to implement a key provision of the law, the requirement for health insurance exchanges. That debate will continue in the coming year. Meanwhile, on the national stage, 26 lawsuits challenging the validity of the federal reforms, some of which have been joined by state attorneys general, including Maine's, threaten to disrupt the entire complex system by invalidating a key provision, the individual mandate to purchase health insurance. This paper very briefly summarizes these state legislative and federal court challenges to full implementation of the Affordable Care Act in Maine.

I. IMPLEMENTATION OF HEALTH INSURANCE EXCHANGES IN MAINE

One of the key provisions of the Affordable Care Act, § 1311, requires the establishment of American Health Benefit Exchanges, designed to provide structured, accessible marketplaces for individuals and small businesses (through the Small Business Health Options or "SHOP" Exchange) to compare and purchase health benefit plans that meet defined standards for coverage and quality. *See sub-§* 1311(d)(4) of the Act for a list of minimum required functions of an Exchange. By establishing standards for plans participating in the exchanges and by providing subsidies for the purchase of these plans by persons with incomes below 400% of the federal poverty guideline, the Exchange, working in combination with the mandate and subsidy provisions of the ACA, is intended to stimulate the delivery of competitive and affordable health insurance products.

The Exchanges function as a mechanism for consumers to identify and assess the relative value of health insurance plan offerings. They provide a mechanism for calculating and delivering the available subsidy for those who qualify. They are also intended to provide a single point of entry to the health insurance system for those who can and cannot afford to purchase their own health insurance, i.e. to seamlessly interconnect private and Medicaid

coverage for those individuals whose income falls to levels at which private insurance offering essential benefits coverage is unaffordable even with a subsidized premium payment.[1]

Under the ACA, each state may either establish its own Exchange or Exchanges, operate an exchange in conjunction with other states, or opt out of creating an Exchange, in which case the federal government will establish one to serve that state's population. Notwithstanding the ideological opposition to the ACA expressed by the current Administration and the Republican party, which controls the Maine Legislature, both the Legislature and the Governor's Office appear to be on track to develop and implement a state-based Exchange in Maine.

The prior Administration and Legislature had begun outlining the complex task of Exchange implementation through a Steering Committee established by the Governor, working with the pre-existing Advisory Council on Health Systems Development ("ACHSD") and a Joint Select Committee on Health Care Reform ("JSCHCR") established by the Legislature. Reports from those groups were issued shortly before the transfer of power to the new Legislature and Governor. In the spring of this year, the Legislature considered competing partisan proposals for legislation to establish Health Benefit Exchange functions in Maine. The two bills, LD 1497 and LD 1498, were actually similar in significant respects, as both of them were based on recommendations of the National Association of Insurance Commissioners ("NAIC"). The Republican bill, LD 1497, sponsored by Representative McKane, was the simpler of the two, relying primarily on the NAIC provisions. The Democratic bill, sponsored by Senator Treat, added to the NAIC model a number of provisions unanimously recommended by the prior Legislature's JSCHCR.

At the close of the first regular session of the 125th Legislature, both of these competing bills were carried over for further consideration next year. In the meantime, the Legislature established a study committee to make interim recommendations on legislation to carry out the exchange functions envisioned by the ACA. Resolves 2011, chapter 105, "Creating the

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[1] For a more detailed discussion of the functions and role of the Exchange, an excellent summary may be found in Options and Opportunities for Implementing the Affordable Care Act in Maine, the Final Report on health reform prepared by the Advisory Council on Health Systems Development (December 17, 2010). This report, among many resources on Maine implementation of the ACA, may be found on the website of the Advisory Committee on Maine's Health Insurance Exchange, hosted by the Dirigo Health Agency's website at http://www.dirigohealth.maine.gov/Pages/hix_ac.html.

Advisory Committee on Maine's Health Insurance Exchange," sets up a nine-member group appointed by the Governor, to include representatives of health care providers, insurers, brokers, consumers, small and large employers, and the Dirigo Health Board of Trustees. The Governor appointed to fill these roles representatives of two insurance companies (Anthem Blue Cross and Harvard Pilgrim); two health care providers (Intermed and the Maine Hospital Association); two representatives of insurance producers (Joel Allumbaugh and Dan Bernier); Joseph Bruno, the Chair of the Dirigo Health Board; Jamie Bissonette Lewey, Chair of the Maine Indian Tribal State Commission; and David Clough, Maine State Director of the NFIB. The Committee expects to complete its work by September 15, making recommendations for consideration by the Legislature on major decision points with regard to the structure of an exchange. Ultimately, the Legislature can be expected to work through these points during the course of the next session, and there is likely to be considerable further debate involving both the interests represented on the Advisory Committee and other significant participants in Maine health policy and economics, including various representatives of business, public health, and consumer interests, all of whom have observed and commented on the process but have not been represented directly on the Advisory Committee.

Attached to this summary are two significant draft documents prepared by staff to the Advisory Committee – a draft of its recommendations and an accompanying chart entitled "Exchange Integration Decision Points," which details a daunting array of decisions about the establishment of the Exchange, showing, with respect to each, the approach proposed by Representative McKane's bill, the approach proposed by Representative Treat's bill, the recommendations made by the ACHSD and JSCHCR, the legislation developed by the State of Washington, and the still-developing recommendations of the Committee. While these documents are in draft form, they highlight the numerous and challenging questions that must be resolved in the coming year. Among them are:

- Whether to structure the Exchange as a governmental agency or a non-profit entity;
- Whether to form a regional Exchange or use regional or interstate resources for certain Exchange functions;
- Whether to establish a single Exchange for both individuals and small businesses or two separate Exchanges for these groups;

- Whether to merge the individual and small group insurance markets;
- The extent to which employers have control over employee choices within options available in the small business Exchange;
- Whether to expand the small business Exchange to include businesses with up to 100 employees or limit it to 50 until 2016;
- Whether to allow large group employers and health insurance plans into the Exchange in 2017;
- How to deal with the potential for repeal of federal health reform;
- How the Exchange will be governed and how the Board will be composed (including questions of conflict of interest);
- How stakeholders not represented in the Exchange governing body will be represented and consulted as required by federal law;
- Whether the Exchange will function as a selective, "active purchaser" or a more passive, "open marketplace";
- Whether to add Exchange duties beyond those required by federal law;
- The role of "navigators" and their relationship to the insurance industry;
- The role of traditional brokers and agents (producers);
- The extent to which the benefits offered by health plans participating in the Exchange must contain coverage in addition to that defined by federal law as "essential health benefits," and, if so, how the costs of this additional coverage will be addressed; and
- Whether to establish a "basic health program" to deliver health coverage to individuals between 133 and 200% of federal poverty instead of offering these individuals coverage through the Exchange. This last question, in turn, highlights various other issues concerning how to handle "churn" between Medicaid and private plans as incomes rise and fall.

II. THE POTENTIAL FOR INVALIDATION OF THE FEDERAL HEALTH REFORM LAW ON CONSTITUTIONAL GROUNDS

In the year since enactment of the Affordable Care Act, as many as 26 lawsuits have been commenced to challenge the constitutionality of the Federal Health Reform Law on a variety of

grounds.[2] The most notorious of these is the argument that the individual mandate to purchase health insurance is unconstitutional because Congress does not have the power to require individual action as part of its regulatory authority under the commerce clause. One defense against this theory is that the same result could have been accomplished by levying a clearly constitutional tax and then providing a credit to those who bought insurance. However, some of the reviewing courts have reacted negatively to the notion that Congress could indulge its political aversion to new taxes by structuring the reform in terms of mandates, yet still defend its actions as an exercise of its broad taxing power.

Various lawsuits have also challenged other aspects of the law, notably the Independent Payment Advisory Board ("IPAB"), a key cost containment provision designed to limit Medicare expenditure increases, on the ground that the IPAB violates constitutionally required separation of powers between the Executive and Legislative branches; the law's impact on physician-patient confidentiality and on contractual, commercial relationships between physicians and patients, and others.

So far, only two District Courts have overturned all or a part of the law in their rulings, with the most sweeping decision coming from Judge Vinson in Florida, who concluded not only that the individual mandate was unconstitutional but that the *entire law* had to be struck down because the individual mandate was integral to it. Six courts have upheld the constitutionality of the law, nine others have dismissed cases on procedural grounds of one kind or another, and nine cases remain pending at the District Court level as of this writing.[3]

Four of the eight substantive District Court decisions have already been decided on appeal to the applicable Courts of Appeals. Of those four, three have upheld the law, and one, decided on August 12 in *Florida v. United States Department of Health & Human Services,* No. 11-11021, 2011 WL 3519178 (11th Cir. Aug. 12, 2011), determined in a two-to-one ruling that the individual mandate is unconstitutional. This decision by the 11th Circuit Court of Appeals

[2] Bara Vaida and Karl Eisenhower, *Scoreboard: Tracking Health Law Court Challenges*, http://www.kaiserhealthnews.org (September 6, 2011). Most of the material in this section of the summary is drawn from this article.

[3] *Id.*

rejected the more sweeping conclusion of the Florida District Court that the entire Act was unconstitutional, instead holding that only the individual mandate would have to be invalidated.

Although thus far only one U.S. Court of Appeals has invalidated the individual mandate, this is sufficient to set the matter up for consideration by the U.S. Supreme Court. The 11th Circuit Decision creates a clear division of opinion among the Circuits that have considered the matter, with the 3rd, 9th, and 6th Circuits having upheld the law. Of the decisions favorable to the validity of the law, *Thomas More Law Center v. Obama*, No. 10-2388, 2011 WL 2556039 (6th Cir., June 29, 2011), provides the clearest contrast to the 11th Circuit decision. Both of those cases were decided by two-to-one majorities of the respective panels, and thus both produced dissenting opinions, as well. The difference of opinion among the circuits makes it virtually certain that the U.S. Supreme Court will, at an appropriate procedural juncture, accept one or more of these challenges for review in order to resolve the matter definitively.

It is difficult to predict the timing of the Supreme Court's action. Some have speculated that the Supreme Court could take jurisdiction quickly and decide the matter by the middle of 2012, i.e. before the next presidential election. Other scenarios, however, in which additional, full-court hearings are requested and granted at the Appeals Court level, or in which some of the remaining Court of Appeals decisions complicate the issues before the matter is framed for the highest court, would result in a longer delay and the potential that the matter could be decided after November of 2012.

The uncertainty with regard to the question of the individual mandate prompts questions about how health reform would proceed if the individual mandate is ultimately invalidated. The invalidation of that key provision of the law would undoubtedly present both technical and political challenges to the progress of health reform, but there is no reason to believe that it would result in a return to the pre-2010 status quo. First, the health reform law has many significant components that can proceed with or without the individual mandate. These include the expansion of Medicaid coverage to a higher income level and to populations previously not required to receive coverage (such as childless adults who do not qualify on the basis of disability). The provisions that allow for the reform of the insurance marketplace through the elimination of pre-existing condition exclusions, the standardization of coverage packages and

participation in the exchanges, etc., could move forward without the individual mandate provisions. Cost containment efforts such as the IPAB, various payment reforms such as Accountable Care Organizations and bundled payments, and the dissemination of electronic health record technology could also move forward.

The difficulty, however, would be in making these mechanisms work together economically, if substantial portions of the population took the risk of forgoing coverage, thus driving up premiums as only those in relatively immediate need of major health care services purchased coverage. With consumer reforms designed to prevent denial of coverage, but no mandate for everyone to have it, the problem of "adverse selection" would be greatly exacerbated, and the system could quickly become untenable economically. New mechanisms would need to be devised in order to address these economic realities, if the mandate proves unenforceable. Ironically, the most obvious remedies would erode the very consumer protections that provided the first hallmark of reform.[4] To survive, the reformed system might have to devise both imaginative and courageous solutions to adverse selection, potentially less likely than the original law to attract broad healthcare industry support.

[4] *See generally* Stephanie Stapleton, *Back-Up Plans For The Individual Mandate?,* Kaiser Health News, http://www.kaiserhealthnews.org/Stories/2011/September/06/individual-mandate-round-robin.aspx (September 6, 2011).