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Wonders about the Affordable Care Act

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Introduction

"Wonder" is a wonderful word. "Wonder" as a noun, among other things, means the "emotion which is excited by . . . something new, unusual, strange, great, extraordinary, or not well understood [or] inexplicable." *Webster's Twentieth-Century Dictionary of the English Language* p. 1932 (Unabridged 1937).

The Affordable Care Act ("ACA") (Patient Protection and Affordable Care Act Pub. L. 111-148 (Mar. 23, 2010), as amended) has certainly invoked wonder—it's largely "new" with most of its substantive health insurance market reforms taking effect for 2014; it's "unusual" as the first enacted comprehensive federal health

reform since passage of Medicare and Medicaid in 1965; it's "strange" or "great" or "extraordinary" depending on your politics, your religious views, your revenue streams, your health, your health insurance, or your prior inability to afford—or even get—health insurance; and to many, it's "not well understood," and to more than a few, "inexplicable."

"Wonder" is also a verb that, among other things, means "[t]o be curious about [and] to wish to know." *Webster's Dictionary*, *supra*, p. 1932. Here are some ACA wonders to wonder about.

ACA Wonders

1. Wonder what happens if *King v. Burwell* kills premium subsidies?

ACA's "American Health Benefit Exchanges"

The ACA seeks to make health insurance available to individuals and small groups by, among other things, providing guaranteed issue and renewal and eliminating pre-existing condition exclusions; the ACA seeks to make health insurance affordable by, among other things, providing premium subsidies and cost-sharing reductions to eligible individuals and families. *See* Public Health Service Act ("PHSA") §§ 2701-05, added by ACA §§ 1201(2)(A), (4), and ACA §§ 1401, 1402. The premium subsidies are available to eligible individuals and families enrolled in qualified health plans "through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act." Internal Revenue Code ("IRC") § 36B(b)(2), as added by ACA § 1401(a). Those premium subsidies are available for each month during which an eligible individual or family is covered by a qualified health plan in which the individual or family enrolled "through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act." IRC § 36B(c)(2).

The "Exchange" with a capital "E," which IRC § 36B references back to ACA § 1311, is a statutorily defined term that means the "American Health Benefit Exchange" that ACA § 1311(b) directs each State "shall . . . establish." Specifically, ACA § 1311(b) says:

> "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an 'Exchange') . . . ."

The referenced "this title" means ACA Title I, which implements ACA's health insurance market reforms and includes IRC § 36B as added by ACA § 1401(a). So as a matter of the plain statutory language, each appearance of "Exchange" with a capital "E" in ACA Title I stands for the "American Health Benefit Exchange" that "[e]ach State shall . . . establish" under ACA § 1311.

Congress tempered the "shall" directive to States by granting "flexibility" in ACA § 1321 that allows each State to elect whether to establish an "Exchange." Congress told the Department of Health and Human Services ("DHHS") that, if a State elects not to establish an "Exchange" or fails to show sufficient progress by January 1, 2013 toward having an "Exchange operational by January 1, 2014," then DHHS must "establish and operate *such* Exchange within the State." ACA § 1321(c)(1) (emphasis added).

Grammatically, "*such* Exchange" can only mean that, in each State that did not establish the "Exchange" mandated by ACA § 1311, DHHS is establishing and operating exactly that "Exchange"—that is, the "Exchange" that "[e]ach State shall . . . establish" under ACA § 1311. In other words, grammatically, any "Exchange" established and operated by DHHS *is* the "Exchange established by the State under section 1311" of the ACA. That is the construction of the ACA adopted by the Internal Revenue Service and DHHS in implementing premium subsidies under IRC § 36B. *See* 77 *Fed. Reg.* 30,377 (May 23, 2012).

The legal dispute

Not so fast, say the plaintiffs in *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 83 U.S.L.W. 3286 (U.S. Nov. 7, 2014, No. 14-114), *Halbig v. Burwell*, 758 F.3d 390 (D.C. Cir. 2014), *vacated* (Sept. 4, 2014), *stayed* (Nov. 13, 2014), *State of Oklahoma ex rel. Pruitt v. Burwell*, 2014 U.S. Dist. LEXIS 139501 (E.D. Okla. 2014), *cert. denied*, No. 14-586 (U.S. Jan. 26, 2015), and *Indiana v. IRS*, 2014 U.S. Dist. LEXIS 111068 (Aug. 12, 2014). Bringing the theories and arguments of Cato Institute Economist Michael Cannon and Case Western Reserve Law School Professor Jonathan Adler to court, *see* J. Adler & M. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 Health Matrix 119 (Spring 2013), these plaintiffs argue that the "plain language" of the ACA limits premium subsidies only to individuals and families residing in States that have established their own "Exchange." Sixteen States and the District of Columbia has done that, but 34 States have not, and two—Oregon and Nevada—have turned to the federally-operated Exchange for 2015 to replace their technologically failed State efforts.

What the plaintiffs showcase is that, plainly read, Congress adding "established by the State under section 1311" to "Exchange" in IRC § 36B means that premium subsidies are only available through an "Exchange" that is *different* than the "Exchange" that appears everywhere else in ACA Title I. This notwithstanding that, by Congressional definition, the "Exchange" that DHHS must establish and operate is the *same* "Exchange" defined as the "American Health Benefit Exchange" that "[e]ach State shall . . . establish" under ACA Section 1311.

We leave to the Supreme Court to parse out which, if either, of the "plain language" arguments should prevail, or whether Congress left the matter sufficiently muddled that the *Chevron* doctrine controls, requiring deference to

the IRS's interpretation as reflected in the implementing rule it issued. *See Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837 (1984). What we look at, instead, are the ramifications of the Supreme Court nullifying premium subsidies in the 34 States in which DHHS has established and operates the "Exchange."

Ramifications of the Supreme Court Killing Premium Subsidies

What's all this fuss about? For ACA's political opponents, the fuss is the promise of major damage to the ACA they want destroyed. For more than 8 million people eligible for affordable health insurance through premium subsidies in the 34 States with the federally-operated Exchange, the fuss is the threat to their continued ability to afford, hence, keep that coverage. *See* L. Blumberg, M. Buettgens, J. Halahan, *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell: 8.2 Million More Uninsured and 35% Higher Premium*, Urban Institute & Robert Wood Johnson Fdn. (Jan. 2015); E. Saltzman, C. Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces*, Rand Corp. (Jan. 2015).

For health care providers in those 34 States, the fuss is loss of patients with health insurance coverage to pay for care, meaning lost revenue and increased uncompensated emergency room and other care. For the tax-paying public of those 34 States, the fuss is the use of their federal tax dollars to pay premium subsidies for residents of California, New York and other States that have State-operated Exchanges, without the taxpayers of those 34 States getting any federal tax dollars (including their own) for premium subsidies in return.

But the table stakes are even higher than all those fusses; loss of premium subsidies in the States with the federally-operated Exchange could start the demise of their individual health insurance markets. Here's why.

All *King* can do to the ACA is kill the premium subsidies in States that don't have a State-operated Exchange. All other ACA health insurance market reforms will remain in full force and legal effect in those States. That includes guaranteed issue and renewal, no pre-existing condition exclusions, and a single risk pool for individual market coverage sold inside and outside the Exchange. *See* PHSA §§ 2701-04, added by ACA §§ 1201(2)(A), (4), and ACA § 1312(c)(1).

So during annual open enrollment under the ACA *anyone and everyone* can get health insurance for themselves and their families, no matter how sick, just by paying the premium of the individual market qualified health plan selected. And most people will face a tax penalty under the ACA's "individual mandate" if they fail to buy an individual market policy and have no employer-sponsored or other "minimum essential coverage." *See* IRC § 5000A(b)(1), as added by ACA § 1501(b).

Therein lies the rub behind the attacks on premium subsidies in *King* and its companion cases. Individuals and families are excused from the "individual mandate" if it will cost more than 8 percent of their household income to pay "the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), *reduced by the amount of credit allowable under section 36B*," that is, reduced by the amount of available premium subsidy. IRC § 5000A(e)(1) (emphasis added).

There will be *no* premium subsidy in 34 States if the Supreme Court kills premium subsidies in deciding *King*. That means many people in those States will find individual market coverage "unaffordable" because they'll have no premium subsidy to offset coverage cost, excusing those people from the "individual mandate." With no tax penalty to spur purchase of coverage because it's not "affordable," the individual market risk pools of those States will deteriorate as the healthy excused from the "individual mandate" by income delay purchasing coverage while the sick flock to buy what coverage they can afford without premium subsidies. Enter classic "adverse selection" infecting the individual markets of these 34 States.

That sicker, hence, risker and costlier, risk pool will drive up individual market premiums—from 35% to over 43% according to current analyses. *See* Urban Institute, *supra*, and Rand Corp., *supra*. That will drive more healthy people out of the individual market risk pool, which will drive more premium increases, which will make individual market coverage unaffordable for more people in those 34 States. In other words, the result of killing premium subsidies is ever more unaffordable health insurance, not just for those currently eligible for premium subsidies, but also for people currently able to afford coverage without premium subsidies who won't be able to afford the ever higher premiums caused by the deteriorating individual market risk pool. Thus begins the "death spiral" for the individual markets in those 34 States.

Enter the wisdom of Oscar Wilde, who quipped, "The only thing worse than not getting what you want is getting it." A current Kaiser Health News poll found "most people think Congress or states should act to restore health insurance subsidies if the Supreme Court decides . . . they are not permitted in states where the federal government is running" the Exchange. J. Rovner, *If Supreme Court Rules Against Insurance Subsidies, Most Want Them Restored*, Kaiser Health News (Jan. 28, 2015). If the Supreme Court kills premium subsidies, the Kaiser Health News poll found that "64 percent said Congress should restore them, and 59 percent said states should create their own exchanges." *Id*.

So what's a Republican in Congress and the States to do—swallow disdain for the ACA and bend to the public will for premium subsidies to make health coverage affordable, or resist and hope that loss of subsidies and individual market chaos in the States with the federally-operated Exchange will support

public scorn for the ACA rather than political backlash for championing a cause that takes affordable health insurance away from those who now have it? This dilemma is acknowledged by Leavitt Partners, a consulting firm named for and headed by the former Republican governor of Utah and DHHS Secretary during the Second Bush Administration, which observes:

> "Republicans in the Senate and House of Representatives find themselves in a precarious situation in the scenario of a victory for King. On one hand, the ACA is stripped of a powerful provision to extend health care to millions of Americans who enrolled in the federal marketplaces, not to mention the attendant effect on Medicaid expansion in some states. On the other, Republicans have tied their own hands by their outspoken antagonism against the law and could be seen as taking health care away from millions by not providing an amendment that continues the insurance subsidies increasingly viewed as an entitlement." A. Borelon, I. Bennion, J. Uhl, D. Schuyler, *The Stage Is Set: Predicting State and Federal Reactions to King v. Burwell* p. 2, Leavitt Partners (Jan. 2015).

That question is of enough apparent concern that Congressional Republicans are caucusing to develop "a legislative plan of action in case the Supreme Court strikes a major blow against ObamaCare and rules subsidies provided to people on the federal exchange are illegal." A. Bolton, *Senate GOP Plots Plan B for ObamaCare*, The Hill (Jan. 27, 2015). States also have an apparent "Plan B"—establish and operate a "federally-supported" state-operated Exchange to replace the federally-operated Exchange. This "Plan B" would require either State legislative or gubernatorial action to establish a legal entity to be the State's Exchange, which would then contract with DHHS to provide the "back-office" technology of "Healthcare.gov." *See* 45 C.F.R. § 155.105(c); DHHS, Center for Consumer Information & Insurance Oversight, *Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchange*, p. 19 § 1.1.

That "Plan B" is how the State of Idaho established its State-operated Exchange before this year substituting its own back-office infrastructure to replace "Healthcare.gov," and how New Mexico, Nevada and Oregon are operating during 2015. *See* DHHS, *ASPE Issue Brief: Health Insurance Marketplace 2015 Open Enrollment Period: December Enrollment Report*, Appendix Table B1 p. 18, nn. 9, 12, 13 (Dec. 30, 2014); Highroad, *Supported State-Based Marketplace May Gain Traction* (Oct. 15, 2014), available at http://www.highroads.com/newsroom/supported-state-based-marketplace-model-may-gain-traction//. One can wonder, should Congress or States bend to public pressure to restore premium subsidies if the Supreme Court kills them, whether *King* and its companions end up as much ado about nothing.

2. Wonder what it means that health care is going retail?

Market-Based Health Care

Here's an idea—let's create health insurance exchanges in each State to have competitive marketplaces for consumers to shop for health insurance that they can afford and that suits their needs. Acknowledging that adverse selection can destroy the economic viability of those competitive marketplaces, let's institute an "individual mandate" that penalizes those who fail to purchase affordable, available health insurance because of the damage they cause to the risk pool and thereby the cost of health care coverage for those who do buy coverage.

That kind of market-based concept with "individual mandate" was advanced in 1989 by the Heritage Foundation conservative think tank. *See* S. Butler, E. Haislmaier, eds., *A National Health System for America*, Chapter 2, The Heritage Fdn. (1989). That kind of market-based concept with "individual mandate" underlay RomneyCare in Massachusetts, the State-based health reform engineered by Republican Governor and 2012 Republican presidential candidate Mitt Romney that all but eliminated the uninsured in the Bay State. That kind of market-based concept with "individual mandate" backbones ObamaCare—the ACA establishes health insurance exchanges in every State to create competitive marketplaces where individuals can shop for and—thanks to premium subsidies and cost-sharing reductions—buy affordable health insurance coverage to satisfy their "individual mandate" and individual needs.

The market-based structure of ACA exchanges is loosing a megatrend in health care—Retail Consumerism. The CEO of Anthem, one of the nation's largest publicly-traded health insurers, has pronounced that "[w]e're dealing with a consumer-oriented industry," one in which *consumers—not employers*—"will make healthcare decisions." Modern Healthcare (Aug. 12, 2014). Health industry strategists are admonishing health industry incumbents that "[t]here's a new boss in U.S. healthcare; the consumer," resulting in "[t]he healthcare market . . . being upended [with] the consumer . . . in the driver's seat." Strategy&, *The Birth of the Healthcare Consumer* (2014).

What has the ACA done to loose this megatrend? Consider the following:

- ACA's exchanges create retail markets in every State for individuals and families to shop for qualified health plans, and ACA premium subsidies and cost-sharing reductions make those plans affordable to those individuals and families.

- Small employers, not being subject to the ACA's "employer mandate," have the option—and the economic logic—to exit the health benefits business and direct their employees to ACA exchanges to shop for whatever individual market qualified health plans each employee may

want, with the potential for the employees to have premium subsidies and cost-sharing reductions to offset the coverage cost.

- ACA's "Small Business Health Options Program" or "SHOP" exchanges are intended to offer small employers that elect to stay in the health benefits business a defined contribution option that permits them to set their contribution amount and designate a variety of small group qualified health plans from which their employees may choose using the employer's defined contribution to help pay the coverage cost.

- Private exchanges are fast emerging to offer all employers—small and large—a defined contribution option for their employees to use in selecting among the group health plans available on the private exchange.

Add to these ACA market transformation effects that Medicare is already trending to retail with the growth of Medicare Advantage plans sold at retail to Medicare beneficiaries as alternatives to traditional Government-run Medicare Parts A and B, and the use of private market insurers to sell Medicare prescription drug plans at retail to Medicare beneficiaries. The size of these Medicare retail markets are about 16 million enrolled in Medicare Advantage plans and nearly 23.4 million enrolled in private Medicare Part D prescription drug plans. *See* DHHS, Centers for Medicare & Medicaid Services, *Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report—Monthly Summary Report (as of January 2015)*, at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report-Items/Contract-Summary-2015-01.html?DLPage=1&DLSort=1&DLSortDir=descending.

Competitive Disruption versus Abundant Opportunity

The retail consumerism megatrend portends competitive disruption for incumbent health insurers and providers:

> "As the health sector's center of gravity shifts toward customers, savvy new players are moving fast to capitalize on the change. These new entrants are poised to shake up the industry, drawing billions of dollars in revenue from traditional healthcare organizations while building lucrative new markets in the burgeoning New Health Economy." PWC Health Research Institute, *Healthcare's New Entrants: Who Will Be the Industry's Amazon.com?* (Apr. 2014).

Health care will no longer be about "patients"—the inputs on which health care providers work to generate revenue—or "lives"—the sources of premium revenue and benefits expense for health insurers. Health care will be about "consumers"—customers whose custom health care providers and health insurers must earn with

quality, affordable, convenient and efficient products and services. Providers and insurers need to learn to treat people like—well—*people*.

If health industry incumbents fail to recognize, retool and respond to the retail consumerism megatrend, there are plenty of consumer-sophisticated retailers and innovative entrepreneurs that will. Indeed, they already are:

> "New entrants, from retailers to technology companies, are arriving with disruption on their minds as the effects of the Affordable Care Act (ACA) continue to ripple through the [healthcare] sector." PWC Health Research Institute, *Top Health Industry Issues of 2015: Outlines of a Market Emerge* (Dec. 2014).

These new entrants are "attuned to the needs and desires of empowered consumers," and recognize that "consumers are willing to abandon traditional care venues"—like doctor offices and hospital settings—"for more affordable and convenient alternatives." PWC Health Research Institute (Apr. 2014), *supra*. They "[s]tart with the consumer and work backwards," knowing that "[c]onsumers will abandon companies unable to deliver care on their terms." *Id*. That is why, as one recent survey found, more consumers "trust large retailers like Walmart or Target to manage their health [than trust] providers and insurers." Strategy&, *supra*. Such widespread consumer dissatisfaction with the current dysfunctional health care delivery system is what "creates openings" for Walmart, Target, Amazon, Google and more to "disrupt the [healthcare] landscape." *Id*.

When markets are ripe for competitive disruption, they are also abundant with opportunity. That "[a]bundant opportunity" is what is "attracting new players from far afield, from Fortune 50 retailers to telecom companies to fledging start-ups backed by venture capital," all "moving fast with fresh ideas about how to satisfy consumers' appetites for better health and more convenient, affordable, high-quality care." PWC Health Research Institute (Apr. 2014), *supra*.

Competitive disruption and abundant opportunity are being played out on ACA exchanges. Health insurers quickly learned that consumers pick price over provider. Because of ACA constraints on benefit design for qualified health plans, health insurers turned to "narrow networks" and other forms of "high-performing" provider arrangements to keep medical costs, and thereby premiums, low. Those kinds of strategies allowed a small Minnesota health insurer—PreferredOne—to gain 60% of the State's individual market in 2014 by offering the lowest cost qualified health plan based on its narrow network of just 13 hospitals. *See* R. Abelson, *More Insured, but the Choices Are Narrowing*, New York Times (May 12, 2014). In Oregon, Moda Health garnered 76% of the State's individual market enrollment by offering "lower premiums, attributed at least in part to [its] narrow network offerings." S. Corlette, K. Lucia, S. Ahn, *Implementation of the Affordable Care Act: Cross-Cutting Issues—Six State Study on Network Adequacy*, Urban Institute & Robert Wood Johnson Fdn. (Sept. 2014).

The "Narrow Network" Phenomenon

It wasn't that consumers lacked choice in provider network size. Broad preferred provider organization or "PPO" network health plans were available to 90% of the consumers shopping on ACA exchanges. Indeed, "narrow network" plans made up less than 50% of the qualified health plan available to consumers on ACA exchanges. So consumers had ample opportunity to vote with their pocketbooks by paying the extra 13% to 17% in premium for a broad PPO network plan over a "narrow network" plan. *See* N. Bauman, E. Coe, J. Ogden, A. Parikh, *Hospital Network: Updated National View of Configurations on the Exchanges,* McKinsey & Co. (June 2014). They picked "narrow network" plans to save money over broad choice of doctors and hospitals.

Those consumer choices make sense—if you're a consumer—though they may chagrin incumbent providers being forced to compete on price, quality, convenience and efficiency for health plan inclusion. It makes sense because the only providers that matter to a consumer are those doctors, hospitals and pharmacies *that particular consumer* trusts and wants to see. It's irrelevant to *that particular consumer* what other doctors, hospitals and pharmacies are in-network.

That's why co-branded health plans that showcase a particular provider name are emerging to attract consumers on ACA exchanges. Examples include "Medica with Mayo Clinic" in Southeastern Minnesota, "AmeriHealth Cooper Advantage" in New Jersey, and Land of Lincoln Health with various Chicago-area hospitals named as associated with the insurer's particular qualified health plan offerings.

Playing Straight with Consumers

But wait, *because* what's important to the consumer when buying a qualified health plan is the accuracy of whether a particular doctor or hospital or pharmacy that consumer favors and wants to "buy" is in-network, retail health care mandates accurate plan network provider directories *at the point of sale.* Incumbent health insurers have had a problem with that task. The result is no less than 8 pending class action lawsuits against various health insurers for allegedly providing false or misleading information about whether particular physicians or hospitals are within the network of the insurers' particular qualified health plans. *See Simon v. Blue Cross Blue Shield of Kansas City*, No. 1416-CV12765, Cmplt. Filed May 29, 2014 (Mo. Cir. Ct., Jackson Cty.); *Harrington v. Blue Shield of California*, No. 14-539283, Cmplt. Filed May 14, 2014 (Cal. Super. Ct., S.F. Cty.); *Cowart v. Blue Cross of California*, No. BC549428, Cmplt. Filed June 20, 2014 (Cal Super. Ct., L.A. Cty.); *Felser v. Blue Cross of California*, No. BC550739, Cmplt. Filed July 8, 2014 (Cal. Super Ct., L.A. Cty.); *Weiss v. Blue Shield of California*, No. BC559077, Cmplt. Filed July 9, 2014 (Cal. Super. Ct., L.A. Cty.); *Daum v. California Physicians Service*, No. 37-2014-00023350, Cmplt. Filed July 14, 2014 (Cal. Super. Ct., S.D. Cty.); *Brown v. Blue Cross of California*, No. BC554949, Cmplt. Filed Aug. 19, 2014 (Cal. Super. Ct., L.A. Cty.); *McCarthy v. Blue Shield of California*, No. BC558549, Cmplt. Filed Sept.

23, 2014 (Cal. Super. Ct., L.A. Cty.); *Davidson v. Cigna Health & Life Insurance Co.*, No. BC558566, Cmplt. Filed Sept. 24, 2014 (Cal. Super. Ct., L.A. Cty.).

Providers, too, need to reform a seemingly cavalier attitude toward ensuring their "patients"—really, there customers—are seen by in-network providers unless their customers are *told and agree* otherwise. The "fly-by" physician phenomenon—an out-of-network doctor, unknown to the consumer, allowed to "assist" a consumer's in-network physician by arrangement of that physician or an in-network hospital, or allowed to provide emergency room services by an in-network hospital without telling the consumer about the potential negative financial effects—will become a thing of the past, probably in reaction to litigation or maybe legislation in the present. *See* E. Rosenthal, *After Surgery, Surprise $117,000 Medical Bill from Doctor He Didn't Know*, New York Times (Sept. 20, 2014); E. Rosenthal, *Providers Hit Patients with More Separate Fees*, New York Times (Oct. 25, 2014); C. Feibel, *Network Blues: Big Bills Surprise Some E.R. Patients*, Kaiser Health News (Nov. 11. 2014). In the consumer-centered retail health care marketplace, those physicians, hospitals and other providers that want to succeed will be as attuned to their customers' financial health as to their customers' physical health and ensure that only in-network providers are allowed to serve their customers unless the customers are informed and agree otherwise.

The notion that hospitals may continue to charge their customers hidden "facility fees" for providing the exact same laboratory or imaging or outpatient surgery services as free-standing community options that don't charge those fees won't stand long before the "educated" consumer. That will be especially true for the increasing number of consumers in health plans with large cost-sharing components; because "facility fees" will come directly from the consumers' pockets. In the consumer-centered retail health care marketplace, physicians who want to succeed will protect their customers' financial, as well as physical, well-being by knowing the cost-effective providers and facilities to which their customers can be referred.

At bottom, consumer fraud in health care is still consumer fraud, and as FTC Commissioner Brill warned in a recent speech, "Businesses [and health care providers and insurers *are* businesses] must . . . not charge consumers for something they have not agreed to buy." FTC Comm'r Brill, *What's Past Is Prologue: FTC's Competition and Consumer Protection Priorities*, ABA Fall Forum Keynote Address (Nov. 6, 2014).

The wonder of the retail consumerism megatrend loosed by ACA exchanges is whether a health care system will evolve to where health industry competition for the consumers' custom becomes the driver of price, quality, convenience, information and focus, all to the betterment of consumer welfare. The other wonder is whether a Supreme Court decision in *King* that kills premium subsidies in States with federally-operated exchanges can defeat the retail consumerism megatrend and the promise of a health care system that works for people.

3. Wonder whether *Hobby Lobby v. Burwell* will start the demise of employer-sponsored health benefits?

Federal Tax Welfare that Favors Employer-Sponsored Health Benefits

Health care financing in the United States, even after the ACA, is predominantly based on employer-sponsored health benefits for employees and their families. A key economic driver of employer-sponsored health benefits is the federal tax code—employers' contributions to health benefits are a form of employee compensation excluded from payroll tax and the employees' taxable income.

That tax exclusion creates the largest single federal tax expenditure, costing American taxpayers about $250 billion in annual lost federal tax revenue. *See* Congressional Budget Office ("CBO"), *Options for Reducing the Deficit: 2014 to 2023* pp. 243-44 (Nov. 2013). And few federal tax breaks are as regressive as this one. The richer the employee provided employer-sponsored health benefits, the larger the dollar value of the employee's tax benefit. *See id.* at 245. It's a tax break benefiting most those who financially need it least, with little benefit for the working poor and self-employed and none at all for the unemployed or those employed by employers that don't offer health benefits. The ACA "Cadillac Tax," scheduled to take effect in 2018, is intended to temper the tax break for employer-sponsored health benefits by imposing a 40% excise tax on "excess benefits" included in employer-sponsored health benefits. *See* IRC § 4980I, as added by ACA § 9001.

How We Got to Employer-Sponsored Health Benefits

Tax-favored employer-sponsored health benefits became embedded in the U.S. health care system as a byproduct of wartime needs during World War II. In September 1942, the National War Labor Board froze wages to implement the Stabilization Act of 1942. This intensified the challenges of employers to attract enough "Rosie the Riveters" to sustain war-time production. Employers turned to "fringe benefits," which the Board exempted from the wage freeze.

The Internal Revenue Service for its part determined that health benefits as a "fringe benefit" were not taxable as employee income. The National Labor Relations Board furthered employer-sponsored health benefits by ruling in 1949 that unions could include "fringe benefits," including health benefits, in the collective bargaining process. By 1974, employer-sponsored health benefits were sufficiently popular and ubiquitous that Congress enacted the Employee Retirement Income Security Act or "ERISA," which, among many things, exempts employer-sponsored health benefits from State regulation of the "business of insurance."

In many parameters, employer-sponsored health benefits work well—they're cheaper for health insurers and third-party administrators to administer and more predictable for health insurers and self-funded employers to underwrite, especially

for large employers; they allow for professional benefits management through human resource departments and benefits consultants; and they serve to attract and retain talent. In many other parameters, employer-sponsored health benefits fall short—they hinder employee mobility, whether to change jobs or change locations; they limit employee choice to coverage selected by employers; they diminish employee sensitivity to and knowledge of health care cost and quality. In a word, employer-sponsored health benefits are "paternalistic"—the process substitutes employer "paternalism" for employee "responsibility" and "choice."

Other problems with employer-sponsored health benefits are they're not available to the unemployed, the self-employed and those employed by employers that don't offer health benefits. As health inflation has outstripped growth in Gross Domestic Product and become an ever-increasing cost-burden on employers, more and more employers have shifted more and more of the cost of health benefits to employees or, especially for small employers, dropped health benefits altogether.

Why ACA and Hobby Lobby Can Spur the Move Away from Employer-Sponsored Health Benefits

The ACA adds key tools that make alternatives to employer-sponsored health benefits viable for everyone. The ACA's individual market exchanges, with premium subsidies and cost-sharing reductions, guarantee availability of affordable health insurance coverage to any individual and family who wants to buy it, as either an alternative to employer-sponsored health benefits or because employer-sponsored health benefits are not affordable or available to them. As the Congressional Budget Office observes:

> "The Affordable Care Act made several changes to health insurance markets that, together, will substantially reduce the traditional problems in individual markets . . ., thus weakening the rationale for subsidizing employment-based insurance[, including that] new insurance exchanges will enable individuals and families to buy insurance if they lack other sources of coverage that are deemed affordable." CBO, *supra*, p. 245.

Put succinctly, thanks to the ACA, no one need depend *only* on employer "paternalism" to obtain affordable health insurance.

Now comes *Hobby Lobby*. The plaintiffs, three closely-held corporations owned and operated by religious families, challenged on the basis of faith the ACA obligation that employer-sponsored health benefits include women's contraceptives as "preventive services" available without cost-sharing. The case, as characterized by the Supreme Court, required a decision "whether the Religious Freedom Restoration Act of 1993 (RFRA), 107 Stat. 1488, 42 U.S.C. § 2000bb *et seq.*, permits the United States Department of Health and Human Services (HHS) to demand that three closely held corporations provide health

insurance coverage for methods of contraception that violate the sincerely held religious beliefs of the companies' owners." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. ____; 134 S. Ct. 2751; No. 13-354, Majority Slip Op. 1 (June 30, 2014).

The Supreme Court, 5 to 4, held that RFRA does not permit HHS to impose that obligation. The majority instructed that "the owners of [these] companies" did not "forfeit[] all RFRA protection when they decided to organize their businesses as corporations rather than sole proprietorships or general partnerships," explaining that "RFRA makes it perfectly clear that Congress did not discriminate . . . against men and women who wish to run their businesses as for-profit corporations in the manner required by their religious beliefs." *Id*. at 2.

It may seem strange that the legal fiction that State law allows to exist as a "corporation" has religious beliefs—one could strain hard and never find a corporation occupying church pews. It may seem unfair that business owners can obtain State-sanctioned protection from personal liability through forming a corporation and have the corporation exercise its owners' personal religious freedom. But these are essentially what the Supreme Court majority concluded Congress intended by enacting RFRA.

Perhaps more strange and unfair—and more to the point of employer "paternalism"—is that the Supreme Court majority permits owners of closely-held corporations to use those corporations to impose the owners' religious beliefs on the corporations' employees. As explained by Justice Ginsburg, dissenting:

> "[Under the Majority's view], RFRA demands accommodation of a for-profit corporation's religious beliefs no matter the impact that accommodation may have on third parties who do not share the corporation's owners' religious faith—in these cases, thousands of women employed by [the plaintiff corporations] or dependents of persons those corporations employ. . . . The exemption sought by [the plaintiff corporations thus] would override significant interests of the corporations' employees and covered dependents. It would deny legions of women who do not hold their employers' beliefs access to contraceptives that the ACA would otherwise secure." *Id*., Ginsburg Dissent Slip Op. 2, 8.

Not so, retorted the majority; the Government may "assume the cost of providing the four contraceptives at issue to any women who are unable to obtain them under their health insurance policies due to their employers' religious objections." *Id.*, Majority Slip Op. 41. This "accommodation" would, of course, shift responsibility for and cost of providing these contraceptive "preventive services" to taxpayers without regard for *their* religious beliefs.

Alternatively, according to the majority, the Government could extend closely-held for-profit corporations the same "work around" allowed not-for-profit religious organizations—require the administrators or insurers of the group health

plans sponsored by these organizations to "'[p]rovide separate payments for any contraceptive services required to be covered' without imposing 'any cost-sharing requirements . . . on the eligible organizations, the group health plan, or the plan participants or beneficiaries.'" *Id.* at 43. That work around just shifts responsibility for and cost of providing contraceptive "preventive services" to plan administrators and health insurers, which as businesses, will seek to pass those costs back to the organizations that hire them to administer or insure the group health plans or try to spread those costs over their other products and services, all without regard for the religious beliefs of the owners of those plan administrators and health insurers or of others who may be forced to indirectly pay for the work around.

Wouldn't a better solution to this conundrum be to allow individuals to select the kind of health coverage they want and need for themselves and their families, including choosing coverage that conforms to their individual religious beliefs about contraceptives among other things? Wouldn't that end employer "paternalism" and prevent *any* employer from imposing its owners' religious beliefs on employees? Wouldn't this approach best conform to basic national and Constitutional values of religious freedom for *all* people, rather than depriving employees of their free exercise in favor of the religious beliefs of business owners?

Perhaps *Hobby Lobby* may generate a groundswell of opposition to employer-sponsored health benefits as employees come to resent that corporate owners get to impose their religious views to deprive employees of benefits to which they would otherwise be entitled if they worked for someone else. Perhaps that groundswell would find support in the positive effects on federal deficit reduction and tax fairness of eliminating the tax subsidy of employer-sponsored health benefits. Perhaps these factors may create sufficient pressure to prompt Congress to bring tax and religious neutrality to health benefits by leveling the playing field between individual market coverage and employer-sponsored health benefits.

That option is made practicable by the ACA exchanges, with premium subsidies and cost-sharing reductions, which give all employees an alternative to employer "paternalism" to obtain affordable health coverage that fits their personal needs, wants and religious faith. To get there, the current bar against employees qualifying for premium subsidies and cost-sharing reductions on ACA exchanges when they have access to affordable employer-sponsored "minimum essential coverage" needs to be removed.

We can wonder whether the ACA and *Hobby Lobby* will open the door to tax neutrality and religious neutrality in the availability of health coverage—unless of course the Supreme Court slams the door by killing premium subsidies in *King*.