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# Takin' It to the Courts

In their 1976 classic hit, "Takin' It to the Streets," The Doobie Brothers sing about solidarity with the less fortunate: "Take this message to my brother; you will find him everywhere; wherever people live together; tied in poverty's despair." As a last resort in the face of apathy, Michael McDonald's lyrics offer a proposal to "take it to the streets." After 18 months of Trump Administration policy, we are now seeing the result of advocates from all sides of the fight over American health care take their fight to the courts. We at the Center for Health Law & Policy Innovation are big believers in the courts as an effective instrument of last resort to enforce health care rights. Today's *Health Care in Motion* offers an update on three such lawsuits and some significant developments in the last several days.

## Update on Kentucky Medicaid Waiver Litigation

We have written extensively about the lawsuit brought by sixteen Kentucky Medicaid enrollees, fighting back against the approval of work requirements as a condition to remain in the program. It remains the case that this litigation–brought jointly by the National Health Law Program, the Kentucky Equal Justice Center, the Southern Poverty Law Center and private attorneys from Jenner & Block–is critically important, because whatever decision the Court reaches will have a compounded effect on state Medicaid programs across the country. Although the lawsuit focuses on Kentucky, many of the legal issues before the Court are exactly the same as those in the three other states with approved waiver requests and seven more states with pending applications. Suffice it to say that there is plenty at stake in the Kentucky litigation.

On Friday, June 15, the Court heard oral argument on a tangle of pending motions that have the potential decide the case. At the core of Friday's proceedings were **three distinct legal issues**.

**First**, the Trump Administration and its lawyers have defended the lawsuit on procedural grounds, arguing that it is not the role of the Court to second-guess its discretionary decisions, like the approval of state work requirements in Medicaid. The Plaintiffs well-reasoned response painted this defense as an overreach, pointing out that if the government's belief were true, it would allow state governments to enact absurd changes to the program. As the judge himself queried, the federal government certainly would face severe skepticism if it used this same process to allow Kentucky to cut off eligibility for blind enrollees. Although guessing at the result of a judicial opinion based on what happens during court argument is a fool's errand, it is safe to say that the judge was skeptical of affording the government the level of unbridled discretion it seeks.

**Second**, the parties showed a deep disagreement about the fundamental purpose of the Medicaid program. The legal authority underlying Kentucky's new work rule states that changes must promote the "program objectives" of Medicaid. The parties' differing views on the purpose of Medicaid have thus become central to the lawsuit. The Plaintiffs, for their part, cite to the law to argue that Congress passed Medicaid "to furnish medical assistance" to eligible enrollees. The government's

response is deliberately confusing. First, it argues that Medicaid's purpose is not just to provide health care coverage, but more generally to improve the health of its enrollees. From there, the government cites some academic studies purportedly showing that people who work generally have better health outcomes. Putting these separate statements together, the government says that Kentucky's proposal is consistent with Medicaid's purpose because the requirement of work will *cause* its enrollees to have better health outcomes. As the Plaintiff's advocates have pointed out, the government's logic here is faulty. Playing basketball doesn't cause you to be tall, even if a survey of professional basketball players reveals that most of them exceed average height. The Court must now determine whether the government's preference for work requirements serves the objectives of Medicaid, or whether instead it is a method to slash enrollment in the program drastically and thus promote the budget-cutting goals of those currently in power.

And this brings us to the **third** and most dramatic theme to emerge from Friday's court hearing. The government's argument that work requirements are targeted at improving the health outcomes of Medicaid enrollees is belied by Governor Matt Bevin's express threat to withdraw from Medicaid expansion altogether if he loses in court. This tactic, which one legal observer likened to the height of absurdity, belies the assertion that the work requirements are anything other than pretext to reduce Medicaid spending. And that is the decision that now lies in the Court's hands–will it permit the Trump Administration and like-minded state officials to transform Medicaid away from a health care coverage program and into a far smaller and unrecognizable package of job and training requirements?

The Court is set to rule before the new rules' July 1 effective date.

## Trump Administration: Defend Federal Law? No Thanks!

Health care stakeholders were somewhat alarmed by a recent brief filed by the U.S. Department of Justice (DOJ) in the lawsuit brought by several states' Attorneys General challenging the constitutionality of the Affordable Care Act (ACA). In a rare move, the DOJ announced that it will not defend the validity of a federal law.

In 2012, the Supreme Court declared the individual mandate of the ACA to be constitutional, because the mandate qualifies as a valid exercise of Congress's taxing power. In 2018, as part of the new tax reform law, Congress changed the penalty for non-compliance with the individual mandate to $0, beginning in 2019.

As a result, twenty Republican states, led by Texas, filed a lawsuit alleging that this change invalidated the entirety of the ACA. In particular, they argue that the individual mandate is "inseverable" from the community rating and guaranteed issue provisions, all of which are essential elements of ACA. Together, these provisions prohibit insurers from denying coverage or imposing prohibitive premiums on individuals living with preexisting conditions. In May, the Court allowed 16 Democratic states, led by California, to join the lawsuit and defend the ACA.

On June 7, despite a longstanding bipartisan tradition to defend federal law, the DOJ announced that it will not defend these key provisions. Instead, in its brief the DOJ called on the court to invalidate the community rating and guaranteed issue provisions, siding with the Republican states to assert that these two provisions are unconstitutional without a meaningful individual mandate. In a letter to House Speaker Paul Ryan, Attorney General Jeff Sessions explained, "Outside of these two provisions of the ACA, the Department will continue to argue that [the individual mandate] is severable from remaining provisions of the ACA." Following the Trump administration's announcement, the coalition of Democratic Attorney Generals filed a response the next day.

The DOJ's move reinforces that the Administration's ultimate goal is to continue to chip away at the ACA. If the DOJ's position wins the day, key provisions of the ACA that protect people living with chronic health conditions will no longer have the force of law. About 27% of American adults under age 65 have health conditions that would leave them virtually uninsurable without the ACA's consumer protections. The immediate impact of the lawsuit is likely to be limited to premium hikes. During the pendency of the lawsuit, the ACA protections being challenged will remain in place. However, the additional uncertainty surrounding the ACA, the elimination of individual mandate penalties, and the efforts by the Administration to allow non-ACA compliant coverage can all contribute to significant increases in premiums as younger and healthier people are incentivized to leave the ACA's Marketplaces. Given the flimsy legal theory the DOJ is supporting, it is possible that this is the only goal in mind.

The DOJ argues that the two provisions (i.e., community rating and guaranteed issue) are inseverable from the individual mandate. In other words, if the individual mandate is eliminated, so too must community rating and guaranteed issue protections. On the issue of severability, congressional intent is highly dispositive in the courts. If part of a law is found to violate the Constitution, courts usually limit their ruling to only invalidate that specific portion of the law as opposed to the entire legal scheme. This reinforces separation of power principles–the judicial branch will avoid invalidating as much of the congressional branch's work as possible.

Congress is free to alter any portion of the law as it sees fit, and did just that when it zeroed out the individual mandate penalty. If Congress wished to also repeal the ACA's community rating and guaranteed issue provisions, or any other part of the ACA, it would have done so. However, Congress repealed the individual mandate but intentionally left other parts intact. For the DOJ to ignore congressional intent and argue otherwise is to disregard the executive branch's constitutional duty to take care that the laws be faithfully executed.

In fact, the DOJ's arguments are so far off from normal course that three DOJ attorneys withdrew from the case just hours before the brief was filed, and one of these attorneys later decided to resign over the decision. This mass departure from the case is telling as to the apparent weakness of the DOJ's legal arguments. While the case has a long way yet to go before anything is final, we will keep readers updated as things develop further.

## Marketplace Insurers at Risk

Last, we wanted to provide a brief summary of a court case involving ACA insurers going after the federal government for money they believe they are owed. The ACA itself goes to great lengths to entice health insurance companies to participate in its Marketplaces. Among these incentives was a temporary provision that told such companies the government would institute "risk corridor" adjustments for the first three years of the program. Because the Marketplaces were so new, these adjustments were meant to cushion the blow if insurers ended up paying out more claims than their actuarial predictions assumed, and conversely, to claw back excess revenue from insurers who set their premiums too high.

Problems first developed when risk corridor adjustments became a political football, labeled as "insurer bailouts" in the long build-up to the 2016 election. The ACA itself created no independent source of money to fund these payouts. Because Congress had control over the appropriations necessary to fund risk adjustment payments, and because prevailing electoral winds supported proposals to destroy the ACA, the full amount due under the original formula was not forthcoming. Insurers balked.

Beginning in 2016, the insurers came knocking for their money. Over two dozen lawsuits were filed, seeking upwards of 8 billion dollars. Each of the complaining insurance companies alleged similar grounds–the ACA contained a core promise by the federal government, mitigating their downside risk, drawing them into the Marketplaces and creating an obligation to pay. Politics aside, these insurance companies believed that all of the conditions necessary under the law had been met, and that they were entitled to reimbursement. Leading scholars agreed, and the insurance companies expected the federal court responsible for such disputes to order them to be made whole.

That was, until earlier this month. On June 14, a federal appeals court ruled against the insurer-plaintiffs, holding that they could not recover the risk corridor adjustment payments to which they claimed entitlement. In summary, the court ruled both that subsequent congressional maneuvering had amended the original risk corridor law, and that the original language of the ACA could not be construed as a binding promise to insurers. Criticism abounds. A strong dissent from one of the judges who heard the case makes the fundamental point that public-private partnerships–in the form embodied by the infrastructure of the ACA–will not work if the government cannot be counted on to play fairly and live up to its promises.

The insurers are likely to appeal this ruling, first to a full panel of the same appeals court, and eventually to the U.S. Supreme Court. Such appeals are discretionary, and the vast majority are never even heard. Should it stand, this will be yet another strike against ACA Marketplaces. There may not be any immediate effect on consumers, with insurance companies long ago having accounted for the risk of this result in their rate-setting and premium levels. Nevertheless, this ruling represents a significant victory for the ACA's enemies in Congress and state governments across the country, and may have the effect of further discouraging insurers from providing robust choices to health care consumers in the years to come.

In a time where both the executive and legislative branches of the federal government are under one-party control, advocates will continue to "take it to the courts." Courts can serve as independent decision-makers for a host of important protections, including civil rights, safety net programs and health care protections. While the results are not always favorable to those depending on meaningful access to health care, it remains of paramount importance that we stand ready to utilize this avenue when our most important rights are at stake.

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