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No Good Options: Picking Up the Pieces After *King v. Burwell*

Nicholas Bagley & David K. Jones

INTRODUCTION

If the Supreme Court rules against the government in *King v. Burwell*,¹ insurance subsidies available under the Affordable Care Act (ACA) will evaporate in the thirty-four states that have refused to establish their own health-care exchanges.² The pain could be felt within weeks. Without subsidies, an estimated eight or nine million people stand to lose their health coverage.³ Because sicker people will retain coverage at a much higher rate than healthier people, insurance premiums in the individual market will surge by as much as fifty percent.⁴

Policymakers will come under intense pressure to mitigate the fallout from a government loss in *King*. But the Republican-controlled Congress has already ruled out a surgical fix,⁵ and recent reporting suggests that Congress will be hard-pressed to develop an alternative reform proposal that could meet with

1. No. 14-114 (argued Mar. 4, 2015).

2. *State Health Insurance Marketplace Types, 2015*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types> [<http://perma.cc/4D6V-JYXF>].

3. Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums*, ROBERT WOOD JOHNSON FOUND. & URBAN INST. 4 (2015), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf417289 [<http://perma.cc/J8TD-ZCZZ>] (estimating that eliminating subsidies would increase the rolls of the uninsured by 8.2 million); Evan Saltzman & Christine Eibner, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces*, RAND CORP. (2015), http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf [<http://perma.cc/9AS7-RLX4>] (estimating an enrollment decline of 9.6 million).

4. Saltzman & Eibner, *supra* note 3, at 1.

5. Louise Radnofsky, *Republicans To Block Legislative Fix to Health-Care Law*, WALL ST. J., Jan. 29, 2015, <http://www.wsj.com/articles/republicans-to-block-legislative-fix-to-health-care-law-1422575627> [<http://perma.cc/A9AF-4GCA>].

the White House's approval.⁶ Even a temporary extension will meet with fierce resistance from legislators who will see an extension as a tacit concession that the subsidies, in some form, are here to stay.

All eyes will turn to the Obama administration and to the states. Yet public debate about their post-*King* options has been limited. Part of the reason is strategic: the government's supporters fear that discussing fixes might signal to the Supreme Court that eliminating the subsidies would not do much damage. The Obama administration, for example, has declined to tell Congress whether it even has a contingency plan.⁷ And while the ACA's opponents suggest that the *King* aftermath might not be so bad, they have generally declined to endorse specific fallback plans.

In this Essay, we take a hard look at some potential options available both to the administration and to the states to mitigate the fallout of a government defeat in *King*. Some are straightforward and noncontroversial; others will face intense political resistance and press up against legal boundaries. Taken together, we believe these options might enable policymakers to moderate, at least somewhat, the consequences of a government loss in *King*.

Even under the most optimistic scenario, however, millions of people will still lose their health coverage and the market for individual insurance in many states will still collapse. Vague claims that the administration has some sort of "fix" up its sleeve or that the states can snap their fingers and establish exchanges are, in our view, irresponsible. In the long run, of course, all but a few holdout states might establish their own exchanges, and Congress could always intervene down the line. In the near term, however, there are no good options: just halfway measures and ill-fitting patches.

This Essay first examines possible responses from the Obama administration and, in particular, addresses three questions: Could the Internal Revenue Service (IRS) decline to require taxpayers to pay back subsidies, provided through refundable tax credits, which were improperly paid out under the IRS rule? What could the Department of Health and Human Services (HHS) do to make it easier for uncooperative states to transition to state-based exchanges? And does HHS have the legal power to say that states performing certain exchange functions have established an exchange, even if the states have not formally elected to do so?

The Essay then turns to the states, which will confront immediate difficulties if they wish to create their own exchanges. Time is short: the

6. Sahil Kapur, *Republicans Are at a Loss on What To Do If SCOTUS Nixes Obamacare Subsidies*, TALKING POINTS MEMO (Jan. 29, 2015, 6:00 AM), <http://talkingpointsmemo.com/dc/republican-response-king-burwell-obamacare> [<http://perma.cc/LZ9E-WEDU>].

7. *GOP Senator: HHS Chief's Answers 'Contemptuous'*, N.Y. TIMES, Feb. 4, 2015, <http://www.nytimes.com/aponline/2015/02/04/us/politics/ap-us-congress-health-overhaul.html> [<http://perma.cc/6FEJ-QABM>].

enrollment period for 2016 coverage begins on November 1, 2015, a scant four months after the Supreme Court is likely to rule. States trying to create an exchange will have almost no time to do what took other states many years to accomplish. By the time the Court rules, only eight of the thirty-four states with a federally run exchange are likely to have legislatures that are still in session.⁸ Calling a special session in most of the remaining states will be politically impossible. Those states that wish to create an exchange should begin now to plan for a quick transition. In particular, they should train their attention on three core challenges: securing legal authority to operate a state-based exchange; developing the capacity to perform the functions of an exchange; and financing new state-based exchanges.

THE OBAMA ADMINISTRATION

Could the administration decline to claw back tax credits?

If the Court invalidates the IRS rule at issue in *King*, those who purchased coverage through the federally facilitated exchanges will be in a tough spot. Under the ACA, their insurers will already have received “advance payment tax credits” from the IRS on their behalf. At tax time, the IRS is supposed to reconcile those advance payments with the tax credits that the purchaser is entitled to under the ACA.⁹ Since purchasers would not have received any tax credits but for the unlawful IRS rule, they would, in the normal course, have to pay back the amount that was improperly disbursed to their insurers.

The administration has the legal flexibility to avoid that harsh result. Under 26 U.S.C. § 7805(b)(8), the IRS can choose whether to give “retroactive effect” to a court decision or instead to apply that decision only in the future.¹⁰ Pursuant to this authority, the IRS could issue a rule specifying that individuals could properly claim tax credits, based on their annual income, for

8. Nicholas Bagley, David K. Jones & Timothy Stoltzfus Jost, *Predicting the Fallout from King v. Burwell—Exchanges and the ACA*, 372 NEW ENGL. J. MED. 101, 102 (2015).

9. 26 U.S.C. § 36B(f) (2012).

10. 26 U.S.C. § 7805(b)(8) (2012); *see also* Cent. Laborers’ Pension Fund v. Heinz, 541 U.S. 739, 748 n.4 (2004) (“Nothing we hold today requires the IRS to revisit the tax-exempt status in past years of plans that were amended in reliance on [a mistaken IRS manual] . . . The Internal Revenue Code gives the Commissioner discretion to decline to apply decisions of this Court retroactively.”); *Auto. Club of Mich. v. Comm’r*, 353 U.S. 180, 184 (1957) (holding that an earlier version of § 7805(b)(8) “confirmed the authority of the Commissioner to correct any ruling, regulation or Treasury decision retroactively, but empowered him, in his discretion, to limit retroactive application to the extent necessary to avoid inequitable results”); *IBM Corp. v. United States*, 343 F.2d 914, 919 (Ct. Cl. 1965) (“Implicit in the permission to make tax rulings prospective is Congressional authorization not to collect taxes, for the past period, which would otherwise be required by substantive taxing provisions of the internal revenue legislation.”).

the period until the Supreme Court's decision takes effect. (For the 2015 tax year, tax credits would have to be pro-rated.) If the IRS were to issue such a rule, it would not need to claw back tax credits that were disbursed to taxpayers prior to the Court's decision in *King*.

Could the administration make it easier for states to establish exchanges?

Looking forward, the administration might try to clear the way for states with federally facilitated exchanges to transition to state-based exchanges. Although a few of the requirements for creating a state-based exchange are statutory, most are contained in regulations or in an HHS "Blueprint" for establishing a state-based exchange.¹¹ HHS could try to relax some of these requirements.

There is a threshold question, however: does the ACA even permit states to receive tax credits on newly established state exchanges? Tax credits are linked to "an Exchange established by the State under 1311."¹² But the ACA provides, in section 1311, that "[e]ach State shall, *not later than January 1, 2014*, establish an American Health Benefit Exchange."¹³ Does a state exchange established after January 1, 2014, count as an exchange "established under 1311"?

The answer appears to be yes. The 2014 deadline is best understood not as a limitation on state authority, but as the date by which HHS had to create an exchange in any state that failed to establish one. As the Supreme Court has explained, courts do not "construe[] a provision that the Government 'shall' act within a specified time, without more, as a jurisdictional limit precluding action later."¹⁴ And apart from the deadline itself, nothing in the statute suggests that Congress meant to strip states of the power to establish subsidy-eligible exchanges after January 1, 2014. Indeed, such an interpretation would raise serious federalism concerns: the ACA would not only have put states to the difficult choice of whether to establish an exchange or forgo tax credits, but would have also disabled states from ever reconsidering that choice.¹⁵

11. Ctr. for Consumer Info. & Ins. Oversight, *Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Nov. 16, 2012), <https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie-blueprint-11162012.pdf> [<http://perma.cc/W3E9-E396>] [hereinafter *Blueprint*].

12. 26 U.S.C. § 36B(b)(2)(A) (2012).

13. 42 U.S.C. § 18031(b)(1) (2012) (emphasis added); *see also* § 18041(b) (providing that, "not later than January 1, 2014," a state that "elects" to establish an exchange must "adopt and have in effect" certain federal or state standards).

14. *Barnhart v. Peabody Coal Co.*, 537 U.S. 149, 158 (2003).

15. *Cf. Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) (holding that any "condition on the grant of federal moneys" must be imposed "unambiguously").

The courts will instead ask whether the statute contains “less drastic remedies” for failure to hit a deadline.¹⁶ And the ACA does include a less drastic remedy: in any state that failed to establish its own exchange by January 1, 2014, the Secretary of HHS had to step in and establish an exchange on the state’s behalf. The ACA does not purport to further punish the states. Several statutory provisions reinforce the point. Under section 1321(b), for example, a state that elects to establish an exchange must adopt certain federal and state standards “not later than January 1, 2014.”¹⁷ But a state’s refusal to do so just triggers the Secretary’s obligation, under section 1321(c), to act on the state’s behalf.¹⁸ It would be anomalous to construe section 1321, which is titled “[s]tate flexibility in operation and enforcement of Exchanges,” to impose an irreversible, one-time decision on the states.¹⁹

The states thus could transition from federally facilitated exchanges to subsidy-eligible state-based exchanges. HHS, in turn, could take steps to ease that transition. First and foremost, HHS’s transition rule requires a state to have an exchange approved (or conditionally approved) 6.5 months in advance of launching operations.²⁰ To accommodate states that seek to establish exchanges for January 2016, HHS could adopt an interim rule to push back the deadline.²¹

Even with extended deadlines, as we explore below, there may still be inadequate time in many states to establish exchanges. In recognition of these time constraints, HHS could revise its 2016 Blueprint to enable states to launch

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16. *Brock v. Pierce Cnty.*, 476 U.S. 253, 260 (1986) (“We would be most reluctant to conclude that every failure of an agency to observe a procedural requirement voids subsequent agency action, especially when important public rights are at stake. When, as here, there are less drastic remedies available for failure to meet a statutory deadline, courts should not assume that Congress intended the agency to lose its power to act.” (footnote omitted)); *see also* *Nat’l Petrochemical & Refiners Ass’n v. EPA*, 630 F.3d 145, 154-57 (D.C. Cir. 2010) (applying *Brock*); *Linemaster Switch Corp. v. EPA*, 938 F.2d 1299, 1304 (D.C. Cir. 1991) (applying *Brock*).
 17. 42 U.S.C. § 18041(b) (2012).
 18. *Id.* § 18041(c).
 19. *Id.* § 18041; *see also* *Barnhart*, 537 U.S. at 160 (“Congress was presumably aware that we do not readily infer congressional intent to limit an agency’s power to get a mandatory job done merely from a specification to act by a certain time.”).
 20. 42 C.F.R. § 155.106(a)(2) (2012); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,792 (Mar. 11, 2014) (to be codified in scattered sections of 45 C.F.R.) (explaining HHS’s March 2014 reduction of the approval time from one year to 6.5 months in order to “give States more time prior to approval of the Exchange Blueprint to prepare for the transition from an FFE or State Partnership Exchange model to a State Exchange”).
 21. *See* 5 U.S.C. § 553(b)(B) (2012) (authorizing an agency to dispense with notice and comment if the agency “for good cause finds . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest”).

their exchanges mid-year. Nothing in the ACA or its governing regulations appears to preclude HHS from doing so. Although the open-enrollment periods for 2016 have been set, the ACA authorizes HHS to establish special enrollment periods when potential enrollees “meet such exceptional conditions . . . as the Secretary may provide.”²² The invalidation of the IRS’s tax credit rule would surely qualify as an exceptional circumstance, enabling HHS to create special enrollment periods for 2016 during which states could launch their exchanges.²³

Without question, creating special periods and running mid-year enrollment would be extremely messy for insurers, regulators, and consumers. But still other adjustments to the Blueprint could ease the transition to state-based exchanges. Under the Blueprint, for example, state-based exchanges are permitted to rely on “[f]ederal government services” to perform certain functions, including the calculation of the tax credits and cost-sharing subsidies. As we discuss in detail below, the list of functions that state exchanges could contract out to the federal government could be expanded, perhaps dramatically.

Could the administration deem some federally-facilitated exchanges to be state exchanges?

More controversially, the administration might attempt to deem the federally facilitated exchanges in some uncooperative states to be state-based exchanges. As it stands, a state exchange can only be established if HHS receives a declaration letter from the governor confirming the state’s election to establish an exchange.²⁴ But the ACA does not define what it means for a state to “establish” an exchange. Instead, the ACA grants the Secretary of HHS the authority to “issue regulations setting standards . . . with respect to . . . the establishment and operation of Exchanges.”²⁵ It further emphasizes that a “State . . . elect[ion]” to establish an exchange can be taken to occur “at such time and in such manner as the Secretary may prescribe.”²⁶

22. 42 U.S.C. § 1395w-101(b)(3)(C) (2012) (incorporated by reference into the Affordable Care Act through 42 U.S.C. § 18031(c)(6) (2012)).

23. Cf. Ctr. for Consumer Info. & Ins. Oversight, *Special Enrollment Period for Individuals Losing Coverage Through the Pre-Existing Condition Insurance Program (PCIP) on April 30, 2014*, CENTERS FOR MEDICARE & MEDICAID SERVICES (Apr. 24, 2014), <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/PCIP-bulletin-4-24-14.pdf> [<http://perma.cc/3H92-PGG3>] (characterizing as an “exceptional circumstance[]” the loss of coverage arising from the elimination of a high-risk insurance program).

24. *Blueprint*, *supra* note 11, at 6.

25. 42 U.S.C. § 18041(a)(1) (2012).

26. *Id.* § 18041(b).

Given these broad statutory delegations, HHS could revise its regulations and the Blueprint to provide that some states should be understood as having established an exchange, even if they never formally elected to do so. Consider, most notably, the fourteen states that conduct plan management functions for their federally facilitated exchanges. They include the seven “partnership” states (AR, DE, IL, IA, MI, NH, and WV) as well as seven others that did not apply for partnership status (ME, VA, OH, KS, NE, SD, and MT). These states already perform many of the core functions of an exchange. They are primarily responsible for certifying whether health plans meet federal standards for exchange participation; they monitor those health plans to assure their compliance with those standards; they oversee quality reporting requirements; and they collect data from the plans on their rates and benefits.²⁷

Could the regular performance of essential and substantial exchange functions, over time, constitute the establishment of an exchange? As relevant here, the term “establish” means “[t]o make or form; to bring about or into existence.”²⁸ Arguably, that act of creation need not be intentional or formal. In common usage, a consistent practice can be said to constitute the establishment of whatever that practice entails. “Establish” simply connotes making something “stable or firm.”²⁹ Just as habits, routes, and norms can be established over time through a regular course of conduct, so too might states establish exchanges.

By analogy, the courts have resisted the idea that an employee benefit plan is only “established” within the meaning of the Employee Retirement Income Security Act (ERISA) when an employer explicitly elects to establish a plan.³⁰ As one circuit court explained, “[a] formal document designated as ‘the Plan’ is not required to establish that an ERISA plan exists; otherwise, employers could avoid federal regulation merely by failing to memorialize their employee benefit programs in a separate document so designated.”³¹ When it comes to

27. Sarah Dash, Christine Monahan & Kevin W. Lucia, *Health Policy Brief: Health Insurance Exchanges and State Decisions*, HEALTH AFF. (July 18, 2013), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_96.pdf [<http://perma.cc/S87W-AWQX>].

28. BLACK’S LAW DICTIONARY (10th ed. 2014); *see also* MERRIAM-WEBSTER (2015), <http://www.merriam-webster.com/dictionary/establish> [<http://perma.cc/CYZ5-P5Q6>] (defining “establish” as “to bring into existence”). “Establish” can also mean “to put beyond doubt,” *id.*, but that’s not the sense in which the ACA uses the word.

29. OXFORD ENGLISH DICTIONARY (2015), <http://www.oed.com/view/Entry/64530> [<http://perma.cc/DJQ4-4Y9M>] (defining establish in its original sense as meaning “[t]o render stable or firm”).

30. 29 U.S.C. § 1002(1) (2012) (defining “employee welfare benefit plan” to mean, in part, “any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both”).

31. *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 241 (5th Cir. 1990).

the establishment of a plan, “it is the reality of a plan, fund, or program and not the decision to extend certain benefits that is determinative.”³²

So long as the state’s ongoing activities are, by themselves, sufficient to constitute the establishment of an exchange, the federal government’s heavy involvement in exchange operations should be irrelevant. The Supreme Court has held, for example, that a state can still “establish” telephone rates even when the federal government sets strict rules governing that ratemaking.³³ The same should arguably hold true here.

To be clear, “establish” need not be read in this flexible manner. The word is also defined to mean “[t]o fix, settle, institute or ordain permanently, *by enactment or agreement.*”³⁴ When it comes to the creation of an entity with legal personality—like an exchange—this may be the most natural way to understand the word. That’s especially so given that the ACA speaks in terms of a state “elect[ion]” to establish an exchange, and distinguishes between the terms “establish” and “operate”—suggesting that operation, by itself, does not count as establishment.³⁵ Respect for federalism principles may also cut against a capacious understanding of “establish.” Because the states were not on notice that operation of the exchange might be taken to count as establishment, treating that continued operation as establishment would arguably show disrespect to the states’ considered choices.³⁶

Nonetheless, the term “establish” may be sufficiently ambiguous to enable HHS to adopt an interpretation that would capture those states with

32. *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc); *see also* *Grimo v. Blue Cross/Blue Shield of Vt.*, 34 F.3d 148, 151 (2d Cir. 1994) (holding that an ERISA plan “is established if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits” (quoting *Donovan*, 288 F.2d at 1373) (internal quotation marks omitted)); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991) (finding that an employee benefit plan had been established in part because the employer “assume[d] some responsibility for the administration of the program and the payment of benefits”); *Brown v. Ampco–Pittsburgh Corp.*, 876 F.2d 546, 551 (6th Cir. 1989) (finding that the employer had established a plan, even as the company denied it).

33. *AT&T Corp. v. Iowa Utils. Bd.*, 525 U.S. 366, 384 (1999) (“[The carriers’ argument] attributes to that [rate-setting] task a greater degree of autonomy than the phrase ‘establish any rates’ necessarily implies . . . It is the States that will apply those standards and implement that methodology, determining the concrete result in particular circumstances. That is enough to constitute the establishment of rates.”).

34. OXFORD ENGLISH DICTIONARY, *supra* note 29 (emphasis added).

35. 42 U.S.C. § 18041(a)(1)(A), (c).

36. *Cf. Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981). Because a state-based exchange must either be a government agency or a non-profit entity, *see* 42 U.S.C. § 18041(c)(1), HHS would have to designate the state agency that performs plan management functions as the state exchange.

substantial, ongoing exchange-related responsibilities.³⁷ Doing so would require substantial changes to HHS rules. Since full-dress notice-and-comment rulemaking would take too long to forestall the meltdown of state insurance markets, HHS would have to issue an interim final rule that would take effect almost immediately.³⁸ Notice and comment could then occur with the new rules already in place.

We should emphasize, however, that this “deeming” approach has serious limits. Most obviously, HHS would be unable to help the many states that have declined to cooperate with the federally facilitated exchanges. And any effort to treat some federally facilitated exchanges as state-based exchanges is sure to meet with a serious legal challenge from those who think the agency has exceeded its statutory authority. Still, the challenges would take time to play out. In the meantime, the political conversation in the deemed states would shift: the question would be not whether to establish a state-based exchange, but whether to dismantle it.

THE STATES

Although the Obama administration could make it easier for states to establish their own exchanges, the states will nonetheless face daunting challenges in doing so. First, they will have to negotiate the political obstacles to establishing legal authority for the exchanges. In most cases, the necessary authority will have to come through new legislation, although governors and other executive branch leaders could act unilaterally in some cases. Second, states will need to develop the capacity to perform the functions of an exchange. Given the intense time pressures, the central question will be how much states can delegate, and to whom. Third, states will have to figure out how to finance any new exchange—without the federal grants that were once available to help establish state-based exchanges.

Authority

Legislative Option

First and foremost, a state must have the requisite legal authority to establish an exchange. A state law authorizing an exchange would be desirable

37. See *Chevron U.S.A. Inc. v. NRDC, Inc.*, 467 U.S. 837 (1984) (holding that courts should defer to an agency’s reasonable construction of an ambiguous term in a statute it administers).

38. 5 U.S.C. § 553(b)(B) (2012) (permitting an agency to issue a rule without notice and comment “when the agency for good cause finds . . . that notice and public procedure thereon are . . . contrary to the public interest”).

where it is politically feasible. Thirteen of the existing state-based exchanges (plus the District of Columbia) were established pursuant to legislation.³⁹ The legislative route would lend political legitimacy to the new exchanges and could increase buy-in thanks to deeper stakeholder engagement.

There are downsides to seeking legislation, however. For one thing, the legislative calendar imposes restrictions on when states can act. As described earlier, the legislatures of the vast majority of the states without their own exchanges will be out of session by the time the Supreme Court is expected to rule. Even if the decision is released earlier and a few more states are still in session, there will not be much time for significant debate.

States could consider exchange legislation during a special session, though such sessions are rare in most states. In ten of the thirty-four states that lack exchanges, only the governor is authorized to call a special session. Legislative majorities of two-thirds or three-fourths are required in sixteen states. The other eight require straight majorities, majorities of both political parties in both chambers, or agreement between legislative leaders.⁴⁰ These are high thresholds under normal circumstances, never mind on an issue as divisive as the ACA.

Even if the legislative calendar coincided with the timing of the ruling, the legislative process affords opponents many opportunities to block an exchange. Supporters generally need to win support in multiple committees in multiple chambers, whereas opponents succeed by winning at just one of these junctures. Legislative resistance to establishing an exchange could be intense. After all, many of these thirty-four states could not pass exchange legislation in the first place because of their resistance to the ACA.⁴¹

But political opposition to an exchange may not be insurmountable. Republicans in some states have safely supported state control of exchanges by framing control in terms of facilitating market competition, resisting federal control, and supporting private rather than public insurance.⁴² In fact, between September 2010 (when California created the first state-based exchange) and March 2013 (when New Mexico created the last one), twenty-two states held floor votes on twenty-seven bills, and these bills received support from an average of forty-two percent of Republican state legislators.⁴³ Even in ultra-conservative Idaho, fifty-three percent of Republicans voted to retain control of

39. David K. Jones, Katharine W. V. Bradley & Jonathan Oberlander, *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. HEALTH POL. POL'Y & L. 97, 98 (2014).

40. *Special Sessions*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/about-state-legislatures/special-sessions472.aspx> [<http://perma.cc/AM2F-G8WU>].

41. Jones et al., *supra* note 39, at 98.

42. *Id.*

43. *Id.* at 106-07.

its exchange.⁴⁴ The vast majority of those legislators were re-elected in 2014, despite threats from Tea Party challengers.⁴⁵

Moreover, the growing number of Republicans working to expand Medicaid suggests that state-run exchanges can receive bipartisan support when the alternative is a large coverage gap and the loss of large amounts of federal support.⁴⁶ Prior to *King*, Republicans faced very little pressure to support exchanges, since they expected that state residents would get tax credits with or without a state-based exchange. If that expectation proves unfounded, many Republicans might drop their resistance—particularly in those twelve states that chose to expand Medicaid even though they did not create an exchange.⁴⁷

Nonetheless, the intensity of the opposition to the ACA should not be underestimated. All but seven of the uncooperative states are led by Republican governors, and Delaware is the only state with both a Democratic governor and legislature. Many of the Republicans elected in 2014 campaigned on their ardent opposition to Obamacare.⁴⁸ It will be very difficult for them to vote for anything resembling a fix to the law they despise.⁴⁹

Executive Order Option

In those states where it's not possible to secure new legislation, proceeding by executive order may offer a promising alternative. In principle, at least, exchanges could be established quickly, unilaterally, and regardless of whether the legislature is in session. Indeed, three states—Kentucky, New York, and Rhode Island—established their exchanges by executive order.⁵⁰

44. *Id.* at 109 tbl.2.

45. David K. Jones, *Tea Party Fails in Idaho Primary*, AL-JAZEERA AM., May 28, 2014, <http://america.aljazeera.com/opinions/2014/5/idaho-republicanprimaryteapartyotter.html> [http://perma.cc/T28F-TDUR]; see also Election Div., *May 20, 2014 Primary Election Results*, IDAHO SECRETARY ST., http://www.sos.idaho.gov/elect/results/2014/Primary/legislative_totals.html [http://perma.cc/3DWG-S9UT] (listing primary results).

46. See Rebecca Adams, *GOP Governors Seek To Cut Deals on Medicaid Expansion*, CQ ROLL CALL, Jan. 13, 2015, <http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2015/jan/jan-20-2015/gop-governors-seek-to-cut-deals-on-medicare-expansion> [http://perma.cc/KRC2-VMYG].

47. David K. Jones, Phillip M. Singer & John Z. Ayanian, *The Changing Landscape of Medicaid: Practical and Political Considerations for Expansion*, 311 J. AM. MED. SOC'Y 1965, 1965-66 (2014).

48. Anthony Man, *Obamacare Becomes Weapon in Florida Governor's Race*, SUN SENTINEL, Apr. 26, 2014, http://articles.sun-sentinel.com/2014-04-26/news/fl-obamacare-rick-scott-charlie-crist-20140426_1-obamacare-charlie-crist-florida-voters [http://perma.cc/2CFG-RZ63].

49. Bagley et al., *supra* note 8.

50. Jones et al., *supra* note 39.

But it is unclear how many governors have the legal authority to create exchanges. Under HHS's Blueprint, governors must identify a law or regulation authorizing the executive creation of an exchange.⁵¹ Governors may, however, be able to push the point. Although HHS requires the authorizing law to be clear on its face or to have been construed by state legal counsel, the Obama administration is unlikely—especially after *King*—to question a governor's judgment that she has the authority to establish an exchange.

Again, however, there are downsides. Executive orders may lack buy-in from key stakeholders, can provoke legislative backlash or legal challenge, and can easily be undone by subsequent governors. Plus, the option is off the table in at least eight states whose legislatures have forbidden any ACA implementation without legislative involvement.⁵² Arizona is the most recent, passing legislation in April 2015 prohibiting any state personnel or resources being used to “enforce, administer, or cooperate” with the ACA.⁵³

Proceeding via executive order may also limit the type of entity that can operate the exchange. An exchange can either be a “governmental agency or nonprofit entity that is established by a State,” but governors may need additional legislation authorizing them to create non-profit or a quasi-governmental organizations. They could always house an exchange within an existing state agency, including a health or insurance department.⁵⁴ Kentucky has taken this approach, and its exchange has been widely lauded.⁵⁵ But such exchanges would be subject to government hiring and procurement rules, which slows the process down and limits flexibility (though the exchange would not need to create a governance board).⁵⁶

Regulatory Option

A third option may be available for those states that are unable or unwilling to establish exchanges through legislation or executive order. State insurance commissioners with sufficient constitutional and statutory authority could try

51. *Blueprint*, *supra* note 11.

52. Richard Cauchi, *States Laws and Actions Challenging Certain Health Reforms*, NAT'L CONF. ST. LEGISLATURES (Apr. 9, 2015), <http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx> [<http://perma.cc/J8KE-L2LT>].

53. H.R. 2643, 52d Leg., 1st Reg. Sess. (Ariz. 2015).

54. 45 C.F.R. § 155.110(a)(2) (2014).

55. Steven Brill, *How Kentucky Got Obamacare Right*, TIME, July 31, 2014, <http://time.com/3062886/how-kentucky-got-obamacare-right> [<http://perma.cc/KZU4-S2VF>].

56. 45 C.F.R. § 155.110(c) (2014).

to establish an exchange on their own.⁵⁷ Although HHS’s Blueprint currently requires states provide the signature of the governor or a designee, it could be amended to enable insurance commissioners to move ahead without explicit gubernatorial support.

Mississippi’s insurance commissioner already tried this approach in 2013. Although HHS rejected the commissioner’s application, it did not question his authority to establish an exchange. The basis for HHS’s denial, instead, was Governor Phil Bryant’s threat to block any cooperation between the insurance commissioner’s exchange and the state’s Medicaid program.⁵⁸

Insurance commissioners won’t be able to go it alone in every state, but they may be able to press ahead in some. 9 states with federally facilitated exchanges have independently elected insurance commissioners.⁵⁹ Of these, only Montana has a specific prohibition against ACA implementation without legislative action, and only Delaware has a Democratic governor. The seven remaining Republican governors have resisted the ACA and may obstruct any transition to a state-based exchange, much like Governor Bryant did in Mississippi. But some of these governors might allow their insurance commissioners to move forward; they might even welcome this option as providing a way to avoid a coverage gap without having to go on record as supporting the ACA.

Functionality

Legal authority alone will be inadequate. States that wish to establish their own exchanges post-*King* will also have to assure that the exchanges can function properly. The 2015 Blueprint application outlines fourteen functions that a state-based exchange needs to perform. Pulling together a new exchange from scratch would be unmanageable and cost-prohibitive for most states, especially in a compressed timeframe.

But states can contract out much of the work. The ACA gives HHS considerable discretion to allocate exchange responsibilities between the states and the federal government. In particular, the ACA allows state exchanges to contract its functions out to an “eligible entity,” which includes a state

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57. No state health cabinet-level official or Medicaid director is independently elected, making it difficult for them to claim the authority to speak on the state’s behalf when it comes to exchanges.
58. David K. Jones, *Implementing Obamacare: Intergovernmental Battles over the Creation of Health Insurance Exchanges* (2014) (unpublished Ph.D. dissertation, University of Michigan), http://deepblue.lib.umich.edu/bitstream/handle/2027.42/108945/davidkj_1.pdf [<http://perma.cc/ASS7-BSLC>].
59. *Table 1: State Commissioners – 2013*, NAT’L ASS’N OF INS. COMM’RS 2 (2014), http://www.naic.org/documents/members_state_commissioners_elected_appointed.pdf [<http://perma.cc/7F8M-H854>] (Delaware, Georgia, Kansas, Louisiana, Mississippi, Montana, North Carolina, North Dakota, and Oklahoma).

Medicaid agency or state-incorporated entity. As long as a state designates a “governmental agency or nonprofit entity that is established by a State” to be the exchange, the states will have considerable flexibility to outsource exchange functions.

Technology

The most challenging task will likely be acquiring the technology to run a functional exchange. Perhaps the most straightforward option for states would be to work closely with the private contractors that currently run HealthCare.gov. Those contractors are incorporated under state law, even though they work for the federal government.⁶⁰ Creative use of contracting authority, for example, allowed Idaho and New Mexico, each of which established its own exchange, to use HealthCare.gov to run enrollment for the 2014 plan year. (Idaho transitioned to its own website in 2015.)⁶¹ Similarly, Nevada and Oregon are now considered “[f]ederally supported state-based marketplaces” after trying and failing to develop their own technology.⁶² States could also consider following Maryland’s example. After its exchange failed, Maryland overhauled its website using technology imported from the successful Connecticut exchange.⁶³

States that wish to avoid HealthCare.gov may be able to work directly with IT vendors. One company, for example, claims that it can create a new state-based marketplace in 60 days with no need for the state to cover any upfront costs.⁶⁴ It is not yet clear whether private contractors in fact have the capacity to move so expeditiously. Given the difficulties in establishing state-based exchanges and HealthCare.gov, it seems safe to assume that any transition

60. 42 U.S.C. § 18031(f)(3) (2012) (authorizing exchanges to contract with an “eligible entity,” which is defined to include state-incorporated entities like the private contractors that operate HealthCare.gov).

61. Sarah J. Dash & Amy Thomas, *New State-Based Marketplaces Unlikely in 2015, but Technology Challenges Create More Shades of Gray*, THE COMMONWEALTH FUND BLOG (May 1, 2014), <http://www.commonwealthfund.org/publications/blog/2014/may/new-state-based-marketplaces-unlikely-in-2015> [<http://perma.cc/E9BH-ZR78>].

62. *A Look at State ACA Participation and 2015 Individual Health Insurance Rate Filings*, PWC, Feb. 25, 2015, <http://www.pwc.com/us/en/health-industries/health-research-institute/aca-state-exchanges.jhtml> [<http://perma.cc/2M8P-AV9W>].

63. Jenna Johnson & Mary P. Flaherty, *As Md. Rebuilds Its Health Insurance Exchange, Lots of Pressure and Little Room for Missteps*, WASH. POST, May 3, 2014, http://www.washingtonpost.com/local/md-politics/as-md-rebuilds-its-health-insurance-exchange-lots-of-pressure-and-little-room-for-missteps/2014/05/03/4ba5c12c-d214-11e3-937f-d3026234b51c_story.html [<http://perma.cc/3QD3-Y5RS>].

64. See Dan Mangan, *Could These Guys Help Save Obamacare from the Supreme Court?*, CNBC, Apr. 16, 2015, <http://www.cnbc.com/id/102590651> [<http://perma.cc/P728-RCPC>].

requiring coordination between contractors and state governments will be rife with confusion and delays.

The ACA also gives states the option of establishing regional exchanges, which could enable states to work together to develop the needed functionality.⁶⁵ The law and subsequent regulations afford states considerable flexibility in crafting regional exchanges, as long as they meet the same standards as the state-based exchanges.⁶⁶ So far, the states have shown little appetite for creating regional exchanges, perhaps because coordinating across state lines can be challenging. Nonetheless, regional exchanges might be an option for states that are unable or unwilling to proceed on their own.

Alternatively, a state could simply designate a federally facilitated exchange as a state-based exchange, either through legislation or executive order.⁶⁷ This approach would obviate most of the practical difficulties in establishing an exchange, making it an especially attractive option for states that wish to get exchanges up and running immediately. But the approach raises at least two legal questions. First, for a state to establish an exchange, must a state do more than merely deem HealthCare.gov to be state-established? Perhaps not, especially given HHS's wide latitude to define what counts as establishment.⁶⁸ But the ACA does distinguish between the act of "elect[ing]" to create a state-based exchange and actually "establish[ing]" the exchange,⁶⁹ suggesting (albeit weakly) that the act of establishment may require something more than a naked designation.

Second, the ACA requires a state-based exchange to be "a governmental agency or nonprofit entity that is established by the state."⁷⁰ Does the phrase "that is established by the state" apply only to "nonprofit entit[ies]" – that is, the last antecedent?⁷¹ Or does it also apply to "governmental agenc[ies]," too? The statute is ambiguous on this precise point. Although HHS could resolve that ambiguity to allow a federal agency to house state-based exchanges, such a construction of the statutory requirement could come in for legal challenge. States that wish to delegate exchange functions to HealthCare.gov, but which

65. 42 U.S.C. § 18031(f)(1) (2012).

66. 45 C.F.R. § 155.140(a) (2014).

67. Trish Riley et al., *King v. Burwell: State Options*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Mar. 17, 2015), http://www.nashp.org.php5-2.dfw1-1.websitetestlink.com/wp-content/uploads/2015/03/King_v._Burwell_Brief_FINAL.pdf [<http://perma.cc/PJ6M-AZ52>].

68. 42 U.S.C. § 18041(a)(1) (2012) (authorizing HHS to "issue regulations setting standards . . . with respect to . . . the establishment and operation of Exchanges").

69. *See id.* § 18041(a), (b) (requiring each state that "elects" to "apply the requirements" relating to "the establishment and operation of Exchanges" to adhere to federal and state standards).

70. *Id.* § 18031(d)(1).

71. *Barnhart v. Thomas*, 540 U.S. 20, 26-28 (2003) (discussing the "rule of the last antecedent" in statutory interpretation).

hope to put their exchanges on a surer legal footing, may opt, instead, to partner directly with the contractors that run the federal exchanges.

Other Functions

Those states that transition to running their own exchanges will also have to assume plan management functions, such as certifying qualified health plans, monitoring compliance with relevant laws, and collecting data on premiums and benefits. Such oversight is a natural role for states, which historically have taken the lead in regulating health insurance. Indeed, fourteen of the states that refused to establish exchanges do plan management anyway. If the other twenty states likewise took some responsibility over plan management, state-level stakeholders could work with local regulators familiar with and invested in the specific cultural and market conditions of each state. Political conservatives may wish to take the opportunity to craft state-level exchanges that are open to all insurers that meet basic requirements—the so-called “clearinghouse model”—especially now that studies have found that the clearinghouse model is associated with lower premiums than the “active purchaser” model employed on HealthCare.gov and some state exchanges.⁷²

Other aspects of running a state-based exchange will not be as straightforward. For example, states will need to assume responsibilities for consumer and stakeholder engagement, including opening call centers, developing navigator standards, and defining the role of agents and brokers. The federal government already performs some of these functions on behalf of states that rejected establishing an exchange, however, and could continue doing so. In the meantime, HHS could conditionally approve exchanges while states figure out these details.

Financing

Even if states navigate deadlines, provide authority, and achieve necessary functionality, they will have to figure out how to pay for their exchanges. Two elements of the ACA complicate the financing question. First, starting this year, state-based exchanges must be financially self-sustaining. Second, HHS is no longer permitted to award grants to subsidize the construction of state exchanges.⁷³

72. Kelly Krinn, Pinar Karaca-Madic & Lynn A. Blewett, *State-Based Marketplaces Using “Clearinghouse” Plan Management Models Are Associated with Lower Premiums*, 34 HEALTH AFF. (forthcoming 2015), <http://content.healthaffairs.org/content/early/2014/12/12/hlthaff.2014.0627.full.pdf> [<http://perma.cc/J7W6-XSEM>].

73. 42 U.S.C. § 18031(a)(4)(B) (2012).

The absence of grant funding is an especially serious problem. The sixteen states (plus the District of Columbia) that established their own exchanges each received an average of \$250 million in grants (including planning, level 1 and level 2 establishment grants), with California spending more than one billion dollars. Nevada spent the least, receiving *just* \$100 million.⁷⁴ Establishing a state-based exchange need not be so expensive, particularly if a state relies on HealthCare.gov. Many states spent so much because they were trying to function as active purchasers and engage in significant consumer outreach and education.⁷⁵ A state could meet the requirements of the law with a less ambitious approach and a bare-bones staff.

Even so, an exchange will be costly, and some of the money will likely have to come from the state's general treasury. The seven partnership states have the advantage of already receiving an average of \$65 million in exchange planning and establishment grants from the federal government.⁷⁶ Much of this money is already accounted for, however, and will not help with long-term sustainability. States could also direct money they collect in user fees to finance their exchanges. In 2015, for example, HealthCare.gov mainly (but not exclusively) financed its operations through assessments on participating health plans of 3.5% of their premiums.⁷⁷ New state-based exchanges could adopt similar assessments, and much of the money could flow through the exchanges right back to the contractors that had been providing services to the federally facilitated exchange. Appropriating general funds and imposing user fees may require legislative approval, even in states relying on an executive order for authority.

CONCLUSION

A ruling for the plaintiffs in *King v. Burwell* would be enormously disruptive for millions of people and for state insurance markets. There are no good options for either the Obama administration or the states. Together, they can apply some band-aids, but they cannot stop the bleeding. We nonetheless urge policymakers to prepare their contingency plans now, well in advance of a

74. *Total Health Insurance Exchange Grants*, KAISER FAMILY FOUND., <http://kff.org/health-reform/state-indicator/total-exchange-grants> [<http://perma.cc/3GYQ-KAD3>].

75. See, e.g., Chad Terhune, *State's Health Insurance Exchange Gets \$674-Million Federal Grant*, L.A. TIMES, Jan. 18, 2013, <http://articles.latimes.com/2013/jan/18/business/la-fi-health-insurance-grant-20130118> [<http://perma.cc/F8U9-VC96>].

76. *Total Health Insurance Exchange Grants*, *supra* note 74.

77. Sarah J. Dash et al., *State Marketplace Approaches to Financing and Sustainability*, COMMONWEALTH FUND BLOG (Nov. 6, 2014), <http://www.commonwealthfund.org/publications/blog/2014/nov/state-marketplace-approaches-to-financing-and-sustainability> [<http://perma.cc/AK8L-CJR4>].

ruling. Without plans in place, they may find themselves with fewer options still, and even less time to implement them.

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