PREGNANCY AND CHILDBIRTH

A healthy 23-year-old woman is pregnant for the first time.

Ms. Perez receives her antenatal care at a public primary care center. As a publicly insured patient, she does not pay for her antenatal care, which includes laboratory tests and two ultrasounds. Clinical protocols indicate which vitamin supplements a pregnant woman should receive and some educational activities she and her partner may attend. Antenatal care is delivered by midwives, though high-risk patients are referred to an obstetrician at a specialized clinic.

Almost all deliveries in Chile are assisted by health care professionals, and clinical outcomes of obstetrical care are similar in the public and private systems. The odds are about 50–50 that Ms. Perez will be assisted by a midwife. An obstetrician would be called for a high-risk pregnancy or complicated delivery or if a cesarean section is required, but Ms. Perez is less likely to have a cesarean delivery in the public system (40% of deliveries) than she would be in a private hospital (70%), where all deliveries involve an obstetrician.

Ms. Perez chose to use the FONASA vouchers program and go to a private hospital, where deliveries are clinically better supported, with ready access to specialists who might be needed. At the private hospital, she was able to rest for 2 days in a private room.

When the baby was 10 days old, Ms. Perez attended her first well-child visit with a nurse at the primary care center and scheduled an appointment with a doctor for the 1-month visit. Well-child visits, educational activities, immunizations, supplements, and even powdered milk for older children are provided free at public primary care centers. However, many children are taken to private clinical centers for care by a physician instead of a nurse, and some families can afford to pay for additional vaccines, including rotavirus, hepatitis A, and varicella zoster.

for care, which in turn has affected the quality of care and timely access to services, at least in the large public services. Chile is also contending with substantial inequality between high-income participants in the private system and the large majority covered by social insurance and tax-funded public health services.

With the courts and both public and private sectors acknowledging the need for reform, presidential advisory commissions have been convened to develop a consensus plan. The most recent commission recommended returning to a single-payer public insurance system somewhat similar to the Canadian system (and the recently abandoned Vermont plan). A minority report, however, proposed introducing a broader minimum health plan, at a single price, into the private system, with a compensation fund for reducing risk-selection behavior (which could also eventually be open to FONASA). The debate is ongoing.

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The House and the ACA — A Lawsuit over Cost-Sharing Reductions

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The Affordable Care Act (ACA) has twice survived a near-death experience at the hands of the judiciary. In 2012, the Supreme Court in *National Federation of Independent Business v. Sebelius* narrowly upheld the ACA's individual mandate as a valid exercise of Congress's taxing power. But it also held that Congress could not compel the states to expand Medicaid to cover working-age

adults, which left millions of Americans uninsured. In its June 2015 decision in *King v. Burwell*, the Court decisively rejected a claim that the federal marketplaces lack authority under the ACA to issue the premium tax credits that make health insurance affordable to lower-income Americans.

Yet another attack on the ACA is making its way through the courts. Frustrated that dozens of votes to repeal the ACA have gone nowhere, the House of Representatives voted along party lines in 2014 to file a lawsuit challenging the administration's implementation of two provisions of the law.

As the case now stands, the judge will decide in the spring whether the administration can reimburse insurers for reducing cost sharing. If she decides against the administration, her decision will certainly be appealed, perhaps ultimately to the Supreme Court.

First, the House claimed that the decision of the Obama administration to delay the employer mandate violated the ACA. Second, it claimed that the administration was illegally reimbursing insurers for reducing cost sharing for enrollees under the ACA's cost-sharing reduction program, asserting that Congress had not specifically appropriated funds for the program.

Cost-sharing reductions are available under the ACA to marketplace plan enrollees with household incomes not exceeding 250% of the federal poverty level. Cost-sharing reductions reduce the total amount that enrollees may be required to spend out of pocket annually and also increase the actuarial value of enrollees' plans — that is, the proportion of total medical costs that insurers must cover under those plans for a standard population. For very-low-income enrollees the reductions are dramatic, lowering out-of-pocket limits by two thirds and increasing the actuarial value of standard plans from 70% to 94% for enrollees with household incomes below 150% of the federal poverty level. The ACA provides that the Department of Health and Human Services "shall make periodic and timely payments to the issuer equal to the value of the reductions" that insurers offer to low-income enrollees under the program.

Approximately 5.6 million Americans, or 56% of marketplace enrollees, are receiving cost-sharing reductions, according to the Centers for Medicare and Medicaid Services. Many more could be eligible. Whereas the premium tax credits upheld in *King v. Burwell* make health insurance affordable, the cost-sharing reductions make health care itself affordable.

The House argues that it has not explicitly appropriated funding for the cost-sharing reductions and that the Constitution prohibits the expenditure of public funds without an explicit appropriation. The administration, however, relies on Chief Justice John Roberts's admonition in *King* that "A fair reading of legislation demands a fair understanding of the legislative plan."[1] The ACA links the cost-sharing reduction payments, through an integrated legislative plan, to the premium tax credits, for which Congress has indisputably provided a permanent appropriation. Thus, the administration contends, no additional annual appropriation is needed.

Although the technical legal issue in *House v. Burwell* is whether funding for the cost-sharing reductions has been properly appropriated, the really significant issue in the case is whether the House can bring the lawsuit at all. This is not the first time that members of Congress have sued an administration for actions they considered to be illegal. Time and again, the federal courts have rejected lawsuits brought by disgruntled members of Congress, holding that the federal courts have no business getting involved in disputes between the legislative and executive branches over the interpretation of statutes.

The Constitution limits the jurisdiction of the federal courts to "cases" and "controversies." The courts have long understood these limits to mean that they cannot hear complaints unless the plaintiff has been personally injured by the challenged action and the court has the power to assuage that injury. The Supreme Court has held that members of Congress are not personally injured by an improper interpretation of a law and thus have no standing to sue to force the executive to adopt their interpretation of the law. The federal courts do not exist to exercise "some amorphous general supervision of the operations of government," as

noted in the leading Supreme Court case rejecting congressional standing.[2] Moreover, serious questions arise about the separation of powers if Congress can embroil the courts in its disputes with an administration, as recognized by a Supreme Court case just this term in an Arizona redistricting case. Congress has ample weapons of its own to force its will on the executive branch, such as oversight hearings and appropriations riders.

Immediately after the lawsuit was filed, the administration asked the court to dismiss it for lack of jurisdiction. On September 9, 2015, Judge Rosemary Collyer of the U.S. District Court for the District of Columbia refused to dismiss the House's challenge to cost-sharing reductions.[3] Although Collyer dismissed the challenge to the employer-mandate delay, holding that she had no jurisdiction over this garden-variety disagreement over the interpretation of a law, she held that the House was in fact injured if the administration was spending money without an appropriation, given Congress's constitutional authority over appropriations. Of course, the administration argues that there is in fact an appropriation for the cost-sharing reductions, which means that this dispute is also simply about interpretation of the law. Collyer identified several legal theories under which Congress could proceed with its lawsuit and held that separation-of-powers considerations did not preclude her hearing the case.

An audio interview with Timothy Jost is available at NEJM.org

Given the importance of the constitutional issues raised by the case and the fact that Collyer admitted that her decision was unprecedented, the government asked her to allow an interlocutory appeal to the U.S. Court of Appeals for the District of Columbia Circuit to decide the constitutional jurisdictional question before she examined the merits of the case. On October 19, 2015, Collyer denied their request, holding that the case would proceed more quickly if she decided the merits first.[4] Her decision, however, raises the possibility — indeed the likelihood, given existing precedents — that the Court of Appeals may later find that Collyer herself violated the Constitution by deciding a case that the Constitution prohibits her from hearing.

As the case now stands, Collyer will decide sometime next spring whether the administration can reimburse insurers for reducing cost sharing. If she decides against the administration, her decision will certainly be appealed, perhaps ultimately to the Supreme Court.

The ACA requires insurers to reduce cost sharing for eligible enrollees regardless of whether the insurers are reimbursed by the government for the cost-sharing reductions. The cost-sharing reductions, however, will cost $5 billion this year and $136 billion over the next 10 years.[5] If insurers are not reimbursed, they will either have to cease covering marketplace enrollees or dramatically increase premiums across the individual market. Given these stakes, the mere fact that the case remains pending is likely to cause further anxiety among insurers. Of course, Congress can always specifically appropriate money to cover the program. But battles between Congress and the administration over the ACA appropriation have become increasingly acrimonious, and if a Republican is elected President in 2016, specific appropriations to cover the cost-sharing reductions may not even be requested. If the ultimate result is that the cost-sharing reductions themselves are ended, millions of low-income Americans will no longer be able to afford health care, and health care providers will see their uncompensated care burden, which has been substantially reduced under the ACA, balloon once again.

Heretofore, the federal courts have concluded that the Constitution largely prohibits them from interjecting themselves into the disputes that ceaselessly occur between Congress and the executive branch. Despite the lack of support in precedent, Judge Collyer has chosen to enter this fray. Unfortunately, her decision, though likely to be ultimately reversed on appeal, will continue in the interim to cause uncertainty for insurers, consumers, and providers.

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2. Raines v. Byrd, 521 U.S. 811, 829 (1997), quoting U.S. v. Richardson, 418 U.S. 166, 192 (1974).
3. House v. Burwell, Sept. 9, 2015 (https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2014cv1967-41).
4. House v. Burwell, October 19, 2015 (http://pdfserver.amlaw.com/nlj/10-19-15%20motion%20denying%20interloc%20appeal.pdf).
5. Insurance coverage provisions of the Affordable Care Act — CBO's March 2015 baseline (https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf).

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