care Locals were disbanded, and on July 1, 2015, they were replaced by 31 Primary Health Networks. The call for applications to establish these networks emphasized the eligibility of various organizations, including private health insurance funds, as contractors. The successful bids came mainly from consortia of Medicare Locals, some of them including insurers as partners. The networks may yet develop the potential to become purchasers and thereby provide impetus for integrated care, but given the challenge of setting up new entities, that transformation remains aspirational.

The new government has also reversed the agreement that provided additional Commonwealth funding to public hospitals on the basis of efficient cost increases and volume growth. Beginning in July 2017, the Commonwealth's additional contributions will be based only on population growth and inflation. This change presents a major challenge for states, whose public-hospital expenditure is a major budgetary commitment that isn't matched by revenue-raising capability. It will therefore severely limit states' flexibility in funding other programs, such as education and transportation, and in developing innovative health programs that might improve care integration and coordination.

In addition, a new agreement with the retail pharmacy sector suggests that pharmacists will begin playing a greater role in primary care, including chronic-disease management. Although the details haven't been announced, this agreement could represent yet another missed opportunity for improving primary care coordination and may lead to further fragmentation.

An underlying concern is the extent to which the Commonwealth government intends to reduce its share of health care expenditure. In 2014, it attempted to reduce its outlays on Medicare by imposing patient copayments for GP visits — a tactic that was eventually dropped in the face of concerted opposition. But other cost-reduction avenues remain open, and recent announcements have, for example, targeted the cost of pharmaceuticals. Since 2002, the Commonwealth has produced a series of Intergenerational Reports predicting what government expenditures will be over the next 40 years if current policies remain in place. These reports show significant increases in health care spending, but they focus on the Commonwealth budget rather than the entire health sector. If reducing Commonwealth expenditures remains the primary objective for the health portfolio, it could lead to further fragmentation of care and missed opportunities for developing a coherent and efficient health system.

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King v. Burwell — ACA Armageddon Averted

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For the second time in 3 years, U.S. Chief Justice John Roberts wrote a Supreme Court opinion that averted a near-death experience for the Affordable Care Act (ACA). In *National Federation of Independent Business [NFIB] v. Sebelius* (2012), Roberts joined the Court's four liberal justices in upholding the constitutionality of the ACA's individual mandate — its requirement that individuals maintain insurance coverage if it's affordable — with the unexpected rationale that it is valid as a tax, even if not as a regulatory mandate. This year's end-of-term decision, *King v. Burwell*, responded to a statutory rather than a constitutional challenge. Many people were surprised that the Court so quickly took the case, which was based on a small glitch in statutory wording that

appears to make subsidies available only through exchanges "established by the State." Writing for a six-member majority that also includes Justices Anthony Kennedy, Ruth Bader Ginsburg, Sonia Sotomayor, Stephen Breyer, and Elena Kagan, Roberts ruled that the ACA's tax subsidies for insurance premiums are available both in states with their own insurance exchanges and those relying on a federal exchange.

Had the Court ruled the other way, as many legal experts feared, premium subsidies would have been withdrawn from the federally run exchanges that cover more than half the country.[1] That could have been catastrophic, because the ACA's other major provisions remain in full effect, including requirements that insurers accept all subscribers at average community rates, regardless of health status. As the Court recognized, removing premium subsidies would make insurance unaffordable for many people, weakening the individual mandate and leading more people to avoid purchasing insurance unless they were sick. That "adverse selection" behavior would drive up rates, causing more people to drop coverage, which could cause a "death spiral" in insurance markets.

The Court emphasized that Congress obviously did not intend such destructive consequences, so it must have meant for premium subsidies to be available in all states. The Court gave short shrift to the challengers' unfounded argument that Congress meant to withhold subsidies in order to encourage states to adopt their own exchanges. Instead, the Court ruled that Congress's actual intent can be honored because it's possible to read "established by the State" to include federal exchanges operated as a fallback in states without their own exchange. Acknowledging that this is not the "most natural" reading, the Court stressed the need to consider the phrase in the context of the ACA's overall structure and purpose, rather than in isolation. "Our duty, after all, is 'to construe statutes, not isolated provisions.'"

An earlier example of this principle comes from the Court's 2000 decision in *FDA v. Brown and Williamson*, which *King* cites or quotes several times. *Brown and Williamson* held that (before more recent legislation) the Food and Drug Administration (FDA) lacked authority to regulate cigarettes as devices that deliver the drug nicotine. Despite the FDA statute's broad literal definitions of "drug" and "device," the Court concluded that "considering the [statute] as a whole, it is clear that Congress intended to exclude tobacco products from the FDA's jurisdiction."

Using a similar contextual approach in *King*, the Court found many reasons that Congress must have intended premium subsidies to be available through federal exchanges. First, when a state does not establish its own exchange, the ACA requires the federal government to establish "such Exchange," indicating that the fallback exchange holds the same functional position as state exchanges. Second, restricting premium subsidies to only state-based exchanges would create some statutory anomalies related to Congress's obvious expectation that citizens in all states would qualify for subsidies. For instance, ACA requirements that all exchanges provide subsidy calculators and report the amount of subsidies they confer would not make sense if some states were to receive no subsidies, nor would several provisions referring to all exchanges as serving people "qualified" for subsidies.

Through this careful parsing, the Court concluded that it is possible to read "established by the State" to include both state and federal exchanges, when that phrase is read in the context of the ACA's overall design and purpose. This conclusion inspired a caustic and exasperated dissent from Justice Antonin Scalia, peppered with derisive and sometimes mocking comments characterizing various points of reasoning as "quite absurd," "eccentric," "feeble," "interpretive jiggery-pokery," "pure applesauce," and a "dismal failure."

The majority conceded that the challengers made a "strong" argument and that the ACA "contains more than a few examples of inartful drafting." Nevertheless, the Court's closing words are clear and resolute: "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter. ['Established by the State'] can fairly be read consistent with what we see as Congress's plan, and that is the reading we adopt."

The *King* opinion is notable for its decisiveness. Many legal experts expected the Court simply to defer to the interpretation of the ambiguous statute adopted by the Internal Revenue Service (IRS). But the Court took a firmer hand: "This is not a case for the IRS. It is instead our task to determine the correct reading." Administrative deference would have left the door open to a subsequent administration to adopt a contrary interpretation. This decision closes

that door, so only Congress can restrict eligibility for premium subsidies.

The decision also relies on clear-sighted health policy analysis. It opens with a cogent summary of the ACA's "series of interlocking reforms" that others have compared to a three-legged stool[2]: guaranteed issue and community rating of insurance policies, the individual mandate, and premium subsidies. The opinion recites the "long history of failed health insurance reform" by states to show that all three legs are needed for these "closely intertwined" reforms to work, and it notes that the ACA "adopts a version of the three key reforms that made the Massachusetts system successful."

In emphasizing each of the ACA's core elements' support of the others, the opinion contrasts with Roberts' *NFIB* opinion, in which he focused his rhetorical attention on more abstract constitutional federalism principles rather than on Congress's concrete health policy goals. There, rather than embracing the individual mandate's reinforcement of insurance reform goals, Roberts characterized it as a measure that "forces into the insurance risk pool more healthy individuals, whose premiums on average will be higher than their health care expenses" in order "to subsidize the costs of covering the unhealthy individuals the reforms require [insurers] to accept." In *King*, we hear nothing about involuntary cross-subsidies or social redistribution. Instead, Roberts cites solid health policy research by RAND and the Urban Institute to document that disrupting the ACA's scheme "could well push a State's individual insurance market into a death spiral."

Additional court challenges to other ACA provisions are still possible, but *King*'s six-member majority shows little appetite for challenges threatening the Act's core structure. Even Scalia's dissent recognizes that the ACA may one day "attain the enduring status of the Social Security Act." Thus, the decision may usher in a new era of policy maturity, in which efforts to undermine the ACA diminish, as focus shifts to efforts to implement and improve it.

One key question is how states will respond. Some states that refused to create their own exchanges for conservative political reasons could conceivably reconsider, now that rejecting state-based exchanges does not mean declining a core portion of the ACA. Other states that have recently proposed or struggled to maintain their own exchanges so as not to risk losing premium subsidies may now decide it's best to use the federal exchange or to partner with another state's successful exchange. At the federal level, major changes to the ACA are unlikely before the next presidential election. Still, congressional thought preceding *King* about how to respond if the decision went the other way produced ideas that might lay the groundwork for future legislative action, such as scaling back the effect on employers or increasing flexibility for states to adopt alternative approaches. Whatever the course of political and policy debate, *King v. Burwell* removes the largest remaining cloud of judicial uncertainty hanging over the ACA.

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Public Health in the Precision-Medicine Era

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That clinical medicine has contributed enormously to our ability to treat and cure sick people is beyond contention. But whether and to what extent medical care has transformed morbidity and mortality patterns at a population level and what contribution, if any, it has made to the well-being and life expectancy of the least-advantaged people have been matters of contention for more than a century. This debate has taken on renewed importance as the scientific leadership at the National Institutes of Health (NIH), National Academy of Medicine, and U.S.