be capped, as would increases in future federal contributions. Medicaid for the working poor would be canceled. The proposal also calls for resurrecting Medicaid "health opportunity accounts" (which resemble health savings accounts), despite the fact that the 2005 demonstration project meant to test them was implemented only by South Carolina, which succeeded in signing up only two adults and three children.[3]

States would probably welcome greater flexibility for Medicaid programs but not decreased federal funding, which, unlike current funding, will not increase in economic downturns. Many current Medicaid recipients would be dropped from coverage (although they would most likely be eligible for premium tax credits), and those who remained would most likely face higher cost sharing.

The Republican proposal contains many long-standing Republican health care reform projects — more health savings accounts, association health plans for small businesses, interstate insurance sales, and malpractice reform. The proposal's estimate of the cost of "excessive tort litigation," at $589 billion, is more than 40 times the 0.5% of health care costs that the Congressional Budget Office (CBO) estimates could be saved by malpractice reform, but the proposal does focus on providing compensation to victims and not just liability protections for providers.[4]

The most controversial element of the proposal is its cap on the currently unlimited exclusion from an employee's taxes of the cost of employer-sponsored coverage. The proposal would cap the tax exclusion at 65% of the cost of an average health plan. The employer-sponsored coverage exclusion is currently the largest tax expenditure in the federal budget, and economists have long argued that it distorts the market for health insurance coverage and is more beneficial for higher-income than lower-income taxpayers.

Capping the exclusion would result in a reduction in employer coverage and a substantial tax increase for individuals who retained such coverage. The CBO estimates, for example, that capping the exclusion at 50% of average health plan cost would mean that 6 million Americans would no longer have job-related coverage (comparable to projected employer-coverage losses under the ACA) and an average annual tax increase of about $500 per person by 2019.[5]

Our health care system is unfathomably complex. Any reform will inevitably disrupt current arrangements and create winners and losers, as we are seeing with the ACA. The Republican proposal will give an advantage to some Americans and will put others at a disadvantage. In my opinion, Senators Hatch, Coburn, and Burr are to be commended, however, for moving beyond simply demanding repeal and putting out a proposal, the effects of which can now be debated.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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1. The Patient Choice, Affordability, Responsibility, and Empowerment Act: a legislative proposal. January 27, 2014 (http://www.hatch.senate.gov/public/_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf).
2. Government Accountability Office. Private health insurance: the range of base premiums in the individual market by state in January 2013. July 23, 2013 (http://www.gao.gov/products/GAO-13-712R).
3. *Idem.* Medicaid: health opportunity accounts demonstration program. December 16, 2011 (http://www.gao.gov/products/GAO-12-221R).
4. Congressional Budget Office. Options for reducing the deficit: 2014 to 2023: limit malpractice torts (http://www.cbo.gov/budget-options/2013/44892).
5. *Idem.* Options for reducing the deficit: 2014 to 2023: reduce tax preferences for employment-based health insurance (http://www.cbo.gov/budget-options/2013/44903).

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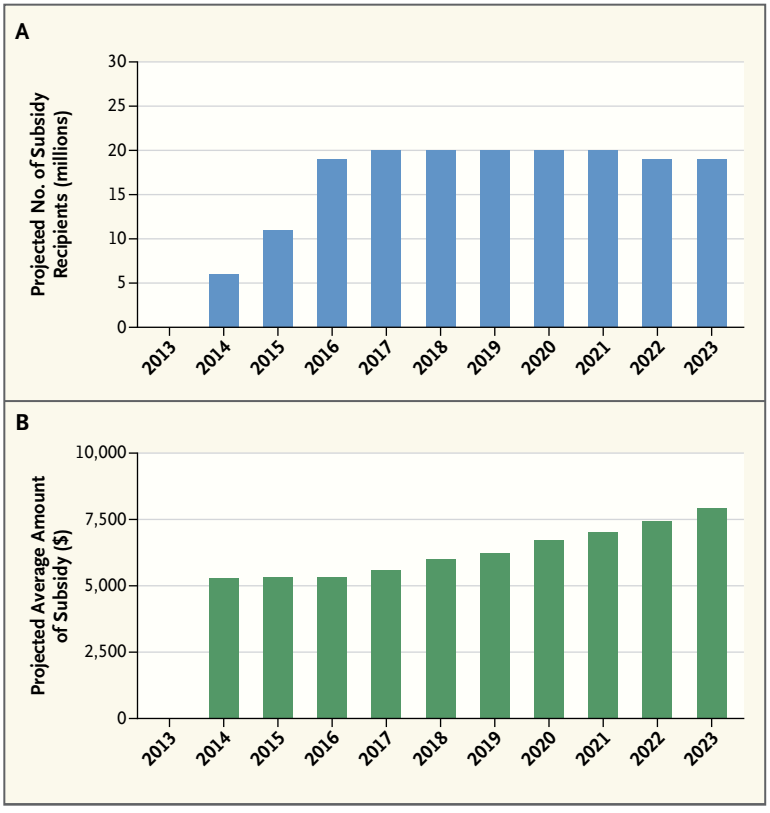
A Legal Victory for Insurance Exchanges

Abbe R. Gluck, J.D.

Health care reform won a big victory in court on January 15, when a federal judge in Washington, D.C., rejected a challenge to the new health insurance marketplaces, or exchanges, created under the Affordable Care Act (ACA). Had this challenge succeeded, it could have crippled the ACA by denying its generous tax subsidies to the more than 12.5 million Americans expected to use this financial assistance to buy their health insurance through a federally run exchange. The ex-



Projected Number of Americans Receiving Subsidies through Health Insurance Exchanges (Panel A) and Projected Average Amount of Subsidies (Panel B).

Data are for both state-run and federally run exchanges, and are from the Congressional Budget Office.

changes' technical difficulties have received much attention, but this legal challenge is arguably more important, because it goes to the heart of one of the exchanges' primary functions — to make insurance more affordable.

Although the government won the case, *Halbig v. Sebelius*,[1] the fight is not over. The ruling has already been appealed. The Washington, D.C., federal Court of Appeals — viewed as second in power only to the U.S. Supreme Court — is scheduled to hear the case at the end of March. Cases raising identical claims are proceeding through courts in Indiana, Oklahoma, and Virginia. The ACA's legal politics have always been unpredictable, and if any of these courts rejects the subsidies, another major ACA case will probably reach the Supreme Court this year. It is critical to understand what is at stake.

The ACA provides large subsidies to people buying insurance on the exchanges; the vast majority of people seeking insurance this way are expected to be eligible for such assistance. The subsidies are offered on a sliding scale based on income, but aid is available to any individual with an annual income between $11,490 and $45,960 and any family with an annual income between $23,550 and $94,200 (lower-income Americans were intended to be covered by the ACA's Medicaid expansion, which became optional for the states after the Supreme Court's 2012 ruling). For 2014, the Congressional Budget Office (CBO) estimates that 6 million people will receive subsidies, and the average subsidy will be $5,290 per person; by 2023, the CBO estimates, 19 million people will receive subsidies (see graphs).[2] This financial assistance is key to the ACA's goal of giving as many Americans as possible access to health care: the requirement that everyone have insurance is tied to the subsidies, which make insurance more affordable.

The legal challenge is directed at the ACA's division of labor between the federal government and the states concerning the operation of the exchanges. This question of state–federal balance was a key issue in congressional debates when the statute was being drafted. The ACA's architects in the House of Representatives wished to give the federal government full control over the exchanges, but Senate ACA supporters insisted that — out of respect for states' rights — the states be given the right of first refusal to operate the exchanges themselves. Ultimately, the Senate's preferences carried the day, and it was anticipated that most states would seize the opportunity and run the exchanges.

But the politics of health care reform are volatile. As a result of the divide over the ACA, 34 states have decided not to run their own exchanges after all. Consequently, as the ACA requires, the federal government has stepped in to operate the exchanges in those states.

The legal challengers have seized on this unexpected federal presence and some sloppy language in the ACA to argue that

the subsidies should be available only when the states themselves run the exchanges. If successful, the challenge — initiated by some of the same lawyers involved in the ACA challenge that reached the Supreme Court in 2012 — would severely impede the statute's goals. In just the first 3 months of enrollment, 1.2 million people have signed up for insurance through federally run exchanges, 80% of them receiving subsidies.[3]

The problem for the government is that the ACA is not a cleanly drafted statute but rather the victim of a highly complex legislative process. The section at issue in this case is one of many instances of less-than-ideal drafting. The statute calls for the subsidies to be calculated on the basis of the costs of the plans enrolled "through an Exchange established by the State under section 1311" of the ACA.[4] The challengers argue that this text excludes individuals enrolled through federally operated exchanges from receiving assistance.

Although that argument might be superficially appealing, the D.C. court was correct to reject it. As the court recognized, this provision cannot be read in isolation. The Supreme Court has long applied a rule that statutes are to be interpreted as a whole and in context, to provide the best indication of Congress's intent. Here, the court concluded that many other provisions make clear that Congress intended for the subsidies to be available on state and federal exchanges alike. For instance, the ACA requires both state-run and federally run exchanges to report information about the subsidies their consumers receive[5] — which makes no sense if federal exchanges' customers aren't eligible. The statute also provides that, if a state opts out, the federal government must operate "such Exchange," language that implies that federally run exchanges step into the shoes of state-run exchanges and operate exactly as they do. The court also looked to other indications of congressional intent, including the fact that the formal budget estimates relied on during the drafting process never assumed that the subsidies would apply only to state-run exchanges.

Finally, the court rejected as unsupported by the ACA's history the argument that Congress viewed the subsidies as a "carrot" to induce the states to run the exchanges (and so had no need to provide them on the federal exchanges). Although today there is great "red state" resistance to the exchanges, when the ACA was drafted, congressional advocates for states' rights clamored to let the states run them, and no one assumed that they wouldn't. The fact that Congress failed to foresee today's political environment doesn't change what it originally intended. The Internal Revenue Service (IRS) confronted similar arguments when enacting regulations to implement the statute and concluded that Congress intended the subsidies to apply to the federal exchanges too. *Halbig v. Sebelius* was a formal challenge to the IRS regulation, and the court found that the ACA was consistent with the IRS's view.

Ultimately, the case is as much about the divisive politics of health care reform as about the difficulties of implementing massive federal laws. This challenge to the ACA's tax subsidies for Americans who buy health insurance on a federally run exchange is part of a broad strategy to topple the law at any cost.

Ultimately, the case is as much about the divisive politics of health care reform as about the difficulties of implementing massive federal laws. This challenge is part of a broad strategy to topple the law at any cost. Other legal cases are en route to the Supreme Court, including the challenge to the regulation involving the coverage of contraception without patient copayments, and some of these cases do raise unresolved legal questions. But the subsidy challenge is more fundamental — 73% of the Americans who are eligible for subsidies live in states with federally run exchanges — even though it stands on much weaker legal ground than some other challenges that have been brought.

The case also raises questions about where such battles over the ACA should be fought, if they should continue being fought at

all. The ACA has survived not only a Supreme Court challenge and this round of litigation but also more than 40 attempts by the House to repeal it, a government shutdown over it, and state efforts to undermine it by refusing to expand Medicaid and resisting implementation. Whatever one's position on the ACA, this case pits a technical argument against what Congress clearly intended. The D.C. Court recognized that, but even a weak case on a topic as politically salient as health care reform diverts government resources and distracts from the important work of implementation. This is really a political fight, not a legal one. It belongs in Congress, not the courts.

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1. Halbig v. Sebelius, Civ. No. 13-0623 (Jan. 25, 2014).
2. CBO's May 2013 estimate of the effects of the Affordable Care Act on health insurance coverage (http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf).
3. Health insurance marketplace: January enrollment report (http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf).
4. 26 U.S.C. § 36B(b)(2)(A).
5. 26 U.S.C. § 38B(f)(3).

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