Even After *King*, the Affordable Care Act Continues to Face Litigation

By Caroline Brown, Philip Peisch and Shruti Barker

In the five years since its enactment, the Affordable Care Act (ACA) has already been the subject of three important Supreme Court decisions, *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012) (hereafter “NFIB”), *Burwell v. Hobby Lobby*, 134 S. Ct. 2751 (2014), and, most recently, *King v. Burwell*, 576 U.S. ___ (2015). Like the NFIB case, *King* threatened the underpinnings of the statute and, had the Court ruled differently, could have resulted in the loss of subsidized insurance for five million Americans in the dozens of states with federally-run health insurance exchanges.

While the Act has survived these foundational challenges, the status of many of the statute’s provisions and implementing regulations remains uncertain. In addition to the legislative effort to dismantle the ACA, the statute continues to be the subject of litigation across the country. This article analyzes the major statutory, regulatory and constitutional challenges still pending before federal courts across the country.

**Religious Challenges**

Several plaintiffs continue to challenge the ACA on religious grounds.

One line of cases challenges the constitutionality of the ACA’s “religious accommodation” exception to the requirement that all health plans cover preventive services—which the Department of Health and Human Services (HHS) has interpreted to include contraception—without cost-sharing. Under the religious accommodation, nonprofit religious organizations that certify an objection to coverage for contraceptive services do not have to pay for such coverage for their employees. However, the issuers of the employer-sponsored plans must still provide the objected-to services for all enrolled beneficiaries. In essence, the exemption shifts the costs of contraceptive coverage from the employer to the insurer. See 45 C.F.R. § 147.131; 29 C.F.R. § 2590.715-2713A.

In its original form, the contraception mandate asked religious organizations to certify their objections directly to their insurers. Several religious organizations refused to do so, on the theory that the filing of the form would make them complicit in the provision of contraceptives by triggering the obligation for the insurer to pay for these services. In June 2014, the Supreme Court issued an order in *Wheaton College v. Burwell*, 134 S. Ct. 2806 (2014), allowing the college to certify its objections by writing a letter directly to HHS, instead of signing a form to its insurer. In light of *Wheaton College*, the Obama administration adopted new regulations allowing religious objectors to certify their objections directly to HHS, which would then instruct the insurers to provide contraceptive coverage to the employees directly.

Religiously affiliated organizations continue to argue that this carve-out does not sufficiently unburden their conscience because the “certification” process still results in third parties providing the contraceptives found to be objectionable. See, e.g., *Little Sisters of the Poor v. Burwell*, 6 F. Supp. 3d 1225 (D. Colo. 2013); *United
Third parties.

RFRA provided no right to challenge the conduct of

*24. The Fifth Circuit followed the D.C. Circuit's rejections.

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obligated to act in ways their religion abhors.''

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from Insurance Commissioners, November 14, 2013, available at:


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federally mandated market requirements.

The ACA’s abortion coverage provision has also been

the subject of litigation. Bracy v. Burwell, No. 3:14-cv-00593 (D. Conn. filed May 1, 2014). Under the ACA,

states may allow abortion coverage in some or all of the

exchange plans offered, but elective abortions cannot

be subsidized using federal tax credits or subsidies. 42

U.S.C. § 18023(b)(2). If an exchange plan includes abor-

tion coverage, the ACA requires the state to collect a

separate fee from each enrollee in the plan, to exclu-

sively pay for abortions. Id.; 45 C.F.R. § 156.280. How-

ever, several state exchanges currently do not offer in-

surance exchanges without abortion coverage, effect-

ively requiring some citizens to purchase a plan that

includes abortion coverage, despite their religious ob-

jections.2 This list included Connecticut until November

2014, when health plans that did not provide elective

abortion coverage were included on the Connecticut ex-

chage. The plaintiffs voluntarily dismissed their case

following this decision. However, this area continues to

be open for new challenges in the four states that still
do not offer exchanges without elective abortion cover-


The constitutionality of this delay had also been chal-

lenged on similar grounds by the Association of American Phy-

icians and Surgeons (AAPS), but the suit was dismissed for

lack of standing. AAPS v. Koskinen, 768 F.3d 640 (7th Cir.

2014).

Since the ACA’s enactment, President Obama has
taken executive action to either delay enforcement of
portions of the ACA, or to otherwise correct mistakes in

the statute. Opponents of the ACA have argued that

these executive actions make the statute more palat-
able, thereby alleviating the political pressure to repeal

the law.

Several suits are pending to enforce the provisions of

the ACA exactly as written. For example, because in

2013 many individual health insurance plans were not

compliant with the ACA’s market requirements, insur-

ance companies began eliminating such plans in the

months prior to January 1, 2014, when the new federal

requirements were to take effect. In order to prevent

Americans from losing their current insurance, the

Obama administration announced an “administrative

fix” to allow insurers to extend their noncompliant

health plans into 2014 to cover existing enrollees. HHS

extended this “administrative fix” to October 1, 2016,

essentially delaying the enforcement of the ACA’s mar-

ket requirements for almost three years. In response,

West Virginia sued HHS, arguing that this fix violates

the enforcement scheme laid out in the ACA, which

gives state governments the first opportunity to enforce

federally mandated market requirements. State of West


West Virginia also argues that the “administrative

fix” was improperly promulgated without public

notice and comment, unlawfully delegated federal ex-

ecutive and legislative powers to the states, and violated

states’ sovereignty by forcing state governments to bear

the political costs of regulating non-compliant indi-

vidual health plans. State of West Virginia v. HHS, No.

14-1287, at 4. This case is currently pending in the Fed-

eral District Court in D.C.

The U.S. House of Representatives brought a similar

suit challenging the Obama Administration’s delayed

implementation of the employer mandate. U.S. House

of Representatives v. Burwell, 14-cv-01967 (D.D.C. filed

Nov. 21, 2014). The ACA provides that the employer

mandate (and the individual mandate) becomes effect-

ive on January 1, 2014. 26 U.S.C. § 4980H. However,

the Obama Administration delayed the effective date

of the employer mandate twice, such that it will not take

effect until 2016. The House of Representatives chal-

lenged this enforcement delay under the Separation of

Powers Clause and the Tenth Amendment, arguing that

the action has legislated changes to the ACA without

approval from Congress. The district court has not yet

issued a decision on this challenge.

The House of Representatives suit also challenges the

Obama Administration’s decision to make “offset pay-

ments” under an ACA provision establishing reduced

**CHALLENGES TO THE OBAMA ADMINISTRATION’S IMPLEMENTATION OF THE ACA**

Since the ACA’s enactment, President Obama has
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1 The Becket Fund for Religious Liberty, HHS Mandate In-

formation Central, available at: http://www.becketfund.org/
hhsinformationcentral/#tab1.

2 GAO Report 14-742R, Health Insurance Exchanges: Cov-

erage of Non-excepted Abortion Services by Qualified Health

cost-sharing for individuals enrolled in exchange plans. This provision requires that health insurers provide lower copays and deductibles to low-income enrollees, which can be offset by the government through direct payments to insurers. 42 U.S.C. § 18071. Although Congress never appropriated funds for these offsets, the Treasury Department made $3 billion in offset payments to insurers in 2014. The U.S. Treasury contends that these offset payments were funded as a part of the mandatory payment program fully appropriated by Congress. Oral arguments on the government’s motion to dismiss were heard on May 23, 2015, but the district court has yet to issue a decision.

In Johnson v. U.S. Office of Personnel Management, 783 F. 3d 655 (7th Cir. 2015), plaintiffs challenged U.S. Office of Personnel Management (OPM) regulations implementing the provision of the ACA that requires members of Congress and their staff to purchase coverage through the Exchange. The “consumer choice” provision of the ACA states that members of Congress and their staff may only receive health plans “created under” the ACA or “offered through an exchange established under” the ACA. 42 U.S.C. § 18032(d)(3)(D). The OPM regulation authorized members and staff to purchase coverage through the DC Small Business Health Options Program (SHOP), with the Federal Employees Health Benefits (FEHB) Program continuing to pay a portion of the premium, rather than requiring them to purchase on the individual exchange with no FEHB contribution. 5 C.F.R. § 890.501(h). Senator Ron Johnson brought suit, arguing that the OPM regulation violates the ACA because the federal government is not a small employer and OPM did not have authority to contribute to premiums on the Exchange. Johnson, 783 F.3d 655. The Seventh Circuit dismissed the suit on April 14th for lack of standing.

Another suit challenges the Centers for Medicare & Medicaid Services’ (CMS) failure to comply with a federal regulation requiring CMS to disclose the rates health insurers propose to charge during the new enrollment period beginning in November 2015, and to allow for public comment. Consumers Council of Missouri v. HHS, No. 14-cv-01682 (E.D. Mo. filed Sept. 30, 2014); 42 C.F.R. § 154.215(h)(4). The Consumers Council of Missouri submitted a Freedom of Information Act (FOIA) request for this information. According to the complaint, ten national consumer organizations, 56 state consumer organization, and eight National Association of Insurance Commissioners’ consumer representatives also petitioned CMS to make rate filings public. Id. at ¶ 8. Despite numerous requests for this information, CMS has refused to make the rate filing information public, and to date has not provided the records requested by any of these individuals and organizations. Id. at ¶ 9. The Consumers Council of Missouri has brought suit against HHS for failing to comply with the Rate Review regulations, and for violation of the Freedom of Information Act. The case is currently pending in the Eastern District of Missouri.

CHALLENGE TO THE INDEPENDENT PAYMENT ADVISORY BOARD

In Coons v. Lew, the Goldwater Institute filed suit challenging, among other things, the constitutionality of the ACA’s creation of the Independent Payment Advisory Board (IPAB). 762 F.3d 891 (9th Cir. 2014). Under the ACA, the IPAB is meant to monitor the growth of Medicare spending and develop and submit recommendations to reduce the spending growth rate. 42 U.S.C. § 1395kkk. The IPAB may not, however, make recommendations to ration healthcare, increase Medicare premiums or co-pay, cut benefits, or restrict eligibility. Id. The IPAB’s recommendations become law unless Congress and the President agree to an alternative proposal, or the Senate garners a three-fifths majority to override the recommendation. Id. If Congress does not act, the IPAB’s proposal goes into effect automatically.

The Ninth Circuit dismissed the suit as unripe, and did not reach the merits of the plaintiff’s challenge under the constitutional anti-delegation doctrine, explaining that the IPAB is statutorily prohibited from recommending a reduction until January 1, 2019. Id. The Supreme Court has since denied certiorari on the case. See Coons, 762 F.3d at 900-01, cert. denied, 135 S. Ct. 1699 (March 30, 2015). However, if the IPAB is ever implemented, this type of challenge could re-emerge.

CHALLENGES TO HEALTH INSURER DECISIONS IN IMPLEMENTING THE ACA

In a final category of cases, the Act has sparked lawsuits that do not directly challenge the ACA itself, but instead challenge decisions taken by health insurers as a result of the market conditions created by the Act. Several recent lawsuits, for example, have been brought by patients and doctors challenging an insurer’s decision to provide only narrow provider networks. In response to the decreasing size of provider networks, the Obama administration has raised the required number of “essential community providers” in provider networks from 20 percent in the 2014 plan year to 30 percent starting in 2015.

CONCLUSION

Although the ACA has already been subjected to five years of extensive litigation, including three major challenges in the Supreme Court, challenges to the statute and its implementing regulations are likely to continue for years to come. That said, after King, the legality of the core provisions of the ACA—i.e., the provisions that extend health care coverage to millions of Americans—have now been addressed by the Supreme Court. Even if some plaintiffs succeed in the pending litigation described above, the employer mandate, the individual mandate, the subsidies for coverage purchased on the exchange, and the optional Medicaid expansion will remain intact.
