Newest Lively Experiment: Bringing Universal Health Care to Rhode Island

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The goal of universal health care in the U.S. has been discussed for more than a century, during which time it has become an international norm. In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA)[1] in pursuit of that goal; however, the actual program it established will not be universal or uniform. Instead, each state will serve as a "laboratory of democracy, "[2] placing its own stamp on the ACA ranging from full support to determined opposition. Rhode Island has chosen to support the ACA, and has gotten off to a fast start through its successful introduction of the HealthSource RI exchange.

This article describes how the ACA has become an ongoing experiment in federalism, shaped principally by strategies some states have adopted to oppose the program. It then describes the opportunities Rhode Island has to make its health care program more affordable for both citizens and the State, and the way it can produce savings for other significant governmental obligations.

I. The Federalist Structure of the Affordable Care Act

As enacted by Congress, the ACA creates a path to universal health care combining private insurance and public assistance through insurance market reforms, federal subsidies and an individual mandate.

A. Insurance Market Reforms

Prior to the enactment of the ACA, many Americans could not obtain affordable insurance (or any insurance at all) because of restrictive underwriting practices by insurance companies. The ACA eliminated a number of these barriers through, among other things, the following national mandates:

• All individuals have the right to purchase any insurance policy, regardless of previous illness or current medical condition, [3]

• Insurers can differentiate rates only on the basis of age and smoking status, with cap on the variation of rates within these groups, [4]

• All insurance policies will include a set of federally-mandated "essential health benefits, " supplemented by state mandates.[5]

• Insurers will rate all insurance plans in four categories, Bronze, Silver, Gold and Platinum, based on the amount of expected medical costs is covered in each policy, [6]

• Consumers will have access to a single outlet (or exchange), where they will have a choice of medical insurance policies that provide a wide range of available options including at least one each of Bronze, Silver, Gold and Platinum, [7] The exchanges will provide information about the scope of coverage, available subsidies, the cost of plans and an opportunity to enroll in the plans.[8]

B. Subsidies and Supports

The ACA as enacted contained the following two key subsidies to extend affordable federal health insurance to all Americans:

• For Americans near the poverty line, the ACA, as enacted by Congress, required state programs to provide Medicaid coverage to adults with incomes up to 133 percent of the federal poverty level, whereas many states now cover adults with children only if their income is considerably lower, and do not cover childless adults at all.[9]

• For Americans who do not qualify for free care, but whose incomes are up to 400% of the federal poverty threshold, the ACA provides a sliding scale of subsidies based on the cost of insurance and the individual's ability to pay.[10]

C. Mandated Coverage

The ACA requires all people who meet income criteria purchase a health insurance policy with specified minimum levels of coverage, [11] Taxpayers who can afford insurance but choose not to purchase pay a tax penalty, [12]

The individual mandate is critical to the viability of the ACA. When states have tried to regulate the private insurance market without requiring people to join, it can collapse under the principle of adverse selection. For example, New Jersey tried to regulate the direct purchase insurance market in 1993 by guaranteeing access to all and requiring community rating, but without imposing a mandate, [13] Only those most in need of insurance joined, causing insurers to pay out recoveries in excess of premiums collected. Premiums rose by 155% from 1996-2000 for standard plans and by 48% for less

expensive health maintenance organization plans. Enrollment declined by 41%, causing a death spiral of increasing premiums and declining enrollments, [14] Massachusetts faced the same issue when it instituted its health care program in 2006. During the first year, the enrolling population was especially old and prone to illness. Massachusetts imposed an individual mandate, which caused the risk pool to become more diverse and protected insurance rates from precipitous increases, [15]

II. Fragmenting the Vision: The Supreme Court Decision and State-Level Resistance

The ACA faced intense resistance in Congress, passing over the opposition of every Republican Party member of the House of Representatives [16] and the United States Senate, [17] Since its passage, the ACA's national program has been fragmented, first by the Supreme Court and then by resistance from individual states.

A. The Supreme Court Case

Once the President signed the ACA into law, 26 states filed or joined lawsuits to challenge its constitutionality.[18] In 2012, the Supreme Court's decision, *National Federation of Independent Business v. Sebelius*, [19] reviewed challenges to two essential components of the program, namely the individual mandate and the Medicaid expansion. Without undertaking a complete analysis of the decision, [20] two key features of the holding limited the ACA's national scope.

The Supreme Court upheld the ACA's individual mandate on the basis of Congressional power to tax, rather than as regulation under the Commerce Clause, [21] This decision to uphold the mandate was critical to AC A's survival, although its narrow view of Commerce Clause authority could doom future Congressional initiatives.

The Supreme Court also struck down the ACA's provision requiring states to expand Medicaid coverage to new classes to retain funding for existing Medicaid programs. According to the Court majority, Congress had authority under the Spending Clause to offer states the option of participating in new Medicaid programs; however, Congress could not coerce states into agreeing to pay for new programs (in this case expanding Medicaid) by removing federal funding for existing programs for states that chose not to expand.

The Supreme Court's Medicaid ruling opens a serious potential gap in the ACA's coverage. The ACA's private insurance subsidies will make health insurance affordable only for Americans with incomes at or above 133% of the federal poverty threshold. For non-disabled Americans with incomes at or below this threshold, existing Medicaid provides coverage principally only for the children and pregnant women, leaving adults in poverty without access to affordable health insurance, [22] As a result, the decision left in each state's hands the prerogative to opt out of universal coverage for a significant population.

B. Individual States' Shaping of the ACA

Since the Supreme Court decision, many of the 26 states that challenged the law in court have carried out passive and active resistance to its implementation within their borders. Other states have modified its application to suit their priorities, and Vermont seeks to surpass the ACA's goals by enacting a single payer system.

1. Passive Resistance: Health Care Exchanges

As of July, 2013, sixteen states and the District of Columbia accepted federal grants to operate state-level insurance exchanges, [23] Eight other states are operating exchanges with varying levels of federal involvement, while 26 states - many of which filed lawsuits against the ACA - elected to have the federal government assume responsibility for the exchange, [24] For the most part, the state-run exchanges have met or exceeded participation and enrollment targets set by the federal government, [25] In contrast, the federal exchanges have encountered technical problems reducing enrollments to a trickle, [26] As a result, this decision has contributed to the delay of introduction of the ACA in many states.

2. Active Resistance, Part 1: Refusing Medicaid Expansion

As of August, 2013, 22 states agreed to the complete ACA expansion of Medicaid, and four others agreed to a partial expansion, [27] Four states have not made a decision, while 20 states have rejected Medicaid expansion entirely, many from the states that sued to block the ACA and/or refused to establish state-level exchanges, [28]

3. Active Resistance, Part 2: Legislation and Litigation to Undermine the ACA

After the Supreme Court decision, legislators in Ohio and Missouri introduced similar bills entitled the Health Care Freedom Act 2.0 which seek to suspend the license of any insurance company accepting insurance subsidies for residents who cannot afford private insurance, claiming this follows from a loophole in the ACA's language, [29] In another case now on appeal after being dismissed, litigants claim the ACA is invalid because the Supreme Court described it as tax legislation, and, as such, should have originated in the House of Representatives, not the United States Senate, [30]

4. Shaping ACA Coverage Within a State

The ACA allows states to pass laws banning abortion coverage in any exchange established in the state, [31] As of November, 2013, 23 states have enacted

such laws.[32] Many other states have mandated coverage exceeding those in the ACA's minimum benefits package. The Secretary of Health and Human Services has issued regulations defining each state's combination of the federal baseline and state-level state mandates, [33] These mandates have created a diverse range of extra benefits by state depending on each state's policy.[34]

5. Advancing Beyond the ACA to Single Payer

While other states maintain that the ACA went too far, Vermont took the opposite position. In 2011, the Vermont Legislature enacted a public option program to take effect in 2017, effectively providing government-maintained insurance for all.[35]

III. Challenges and Opportunities for Rhode Island

Through its implementation of the ACA, Rhode Island faces the challenges of funding the program when Federal subsidies run out and ensuring young healthy adults will enroll, as well as the opportunity to apply federal subsidies to public employee health benefit obligations.

A. The Funding Challenge

Healthsource RI has enjoyed a "smashing success" in gaining Medicaid and private insurance enrollments during its first month of operation, [36] At the same time, the operators estimate its annual cost of operating the exchange to going forward at $26 million after Federal subsidies expire in 2014. [37] The State is considering a tax on everyone's health insurance premiums to pay this cost, a controversial option. [38]

B. The Enrollment Challenge

This summer, the Rhode Island Center for Freedom and Prosperity published two reports suggesting the ACA's goal of universal coverage will fail because many citizens will find it cheaper to pay the tax penalty than to purchase insurance, [39] For example, the reports estimate that once the 2016 penalties take effect, a 24-year old earning $40, 215 can save $1, 111 by paying the penalty rather than purchasing insurance coverage. The reports estimate thousands of Rhode Islanders, such as young invincibles, or healthy people under the age of 35, will pay the penalty rather than purchase insurance, thereby compromising the risk pool, driving up insurance rates and increasing the risk of adverse selection, [40]

The reports understate this risk, because they are based on the penalty levels set for 2016, when the ACA is fully implemented.[41] In fact, the ACA's penalties will be significantly lower for 2014 and 2015 as the Act is phased in. In the case of the 24-year old earning $40, 115, the 2014 penalty will be $285, the 2015 penalty will be $570 and the 2016 penalty will be $760.[42]

C. Using a State Mandate to Address the Funding and Enrollment Issues

Fortunately for Rhode Island, the Massachusetts experience suggests the individual mandate stick can increase coverage dramatically when combined with the carrot of subsidies. In a 2010 paper, three researchers estimated the population of uninsured Bay State young adults, aged 19-26, declined from 21.1% to 8.2% over the program's first two years in 2006-08.[43]Over the same two years, the Massachusetts Department of Revenue collected $18 million and $16.4 million in penalties from taxpayers who did not comply with the health insurance mandate, [44] In this way, Massachusetts used its tax policy to strengthen the insurance risk pool and to collect revenues to finance the program. For example, a 24 -year old earning $40, 115 in Massachusetts in 2014 would have the choice of either purchasing insurance or paying a state tax penalty of $1, 008, significantly higher than the ACA penalty of $285. [45]

When Massachusetts introduced its mandate, opponents filed a court challenge on numerous constitutional grounds, [46] The Superior Court dismissed the case, upholding the statute as a valid exercise of the state's police power which the appellate court affirmed in a 2010 decision.[47] The Court's ruling provides an additional basis (taxation power) on which to justify a state mandate. Were a litigant to argue that the ACA preempts a state mandate, that challenge likely will fail, because the ACA's preemption clause is especially deferential, stating, "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title, "[48] Also, there are many examples of the federal and state governments operating parallel taxation programs, such as for income and gasoline.

If enacted, a state mandate could be simple to implement, adding a few lines to the Rhode Island income tax return to pick up the corresponding information from the federal return. Over the next two years, Rhode Island could just require State taxpayers to pay a State penalty equal to the difference between the 2016 full price federal penalty and the 2014 phase-in. Alternatively, Rhode Island could follow the lead of Massachusetts, which has a separate schedule of penalties more generous to lower-income taxpayers and tougher on higher-income ones. Rhode Island can minimize interstate flight concerns by keeping its penalty at or below the Massachusetts level. While other states plot ways to undermine the ACA, Rhode Island can join Massachusetts in becoming a national leader.

D. The OPEB Opportunity

While there has been much recent discussion in Rhode Island about unfunded public employee pension liabilities, there are equally significant issues concerning retiree health benefits, known as other post-employment

benefits (OPEB). As of 2012, the State estimated its unfunded OPEB liability to be $916.8 million.[49] In 2010, Rhode Island's cities and towns collectively had an OPEB liability of $3.56 billion, of which $27 million was funded for a ratio of 0.8%.[50] This represents a larger problem than the combined pension liabilities of these cities and towns, totaling $3.51 billion, of which $1.41 billion was funded for ratio of 40.3%. [51]

In this context, the ACA's health care subsidies could substantially reduce the state and local government's cost. For example, in November, 2013, the Healthsource RI exchange offered a Rhode Island couple, each aged 55 with a combined income of $60, 000, the opportunity to purchase a health insurance plan with a base cost of $787.60 per month supported by a tax credit of $548.75, making a net cost of $238.85. [52] The tax credit amount varies with a retiree's income; however, the example demonstrates how a retiree with a mid-level pension may qualify for a federal tax credit of more than two-thirds the cost of insurance. In this way, the ACA can provide federal subsidies to help state and municipal governments to cover the majority of the OPEB deficit.

While this opportunity holds promise, public employers will have to account for the vested rights of retirees. In 2012, the City of Providence directed retirees to coordinate health benefits with Medicare as a condition of receiving City health care benefits. The retirees sued, and the Superior Court entered a preliminary injunction blocking the program, [53] The City and retirees resolved that case by agreement, and now retirees eligible for Medicare receive federal benefits first before making a claim from the City's program. The Providence Medicare settlement demonstrates how public employers and retirees can work together to access federal subsidies that support health benefits programs while holding retirees virtually harmless.

IV. Conclusion

Affordable health care is a national problem, and the Affordable Care Act was originally designed to present a national solution. However, between the legislative process and the Supreme Court review, the ACA has created areas for wide variation among the states, and some states are continuing to challenge the program's existence within their borders.

Rhode Island chose to adopt the ACA's goal of universal health care. Given that decision, Rhode Island should maximize its ability to implement and pay for the program through a state-level mandate, and its cities and towns should work with retirees to access federal subsidies for health insurance.

Notes:

[1] Pub.L.No. 111-148(2010).

[2] See *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311, 52 S.Ct. 371, 386-87 (1932) (Brandeis, dissenting).

[3] 42U.S.C. §300gg.

[4] *Id.*

[5] 42 U.S.C. § 18022(d). For example, Rhode Island mandates pediatric preventive care. R.I. Gen. Laws § 27-38.1-2.

[6] *Id.*

[7] 42 U.S.C. § 18022(d).

[8] 42 U.S.C. § 18031.

[9] See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[10] 42 U.S.C. § 18071.

[11] 26 U.S.C. §5000A.

[12] *Id*.

[13] Direct purchase insurance refers to policies issued directly to individuals, in contrast to group plans available through the workplace.

[14] See Tanden, Nina and Spiro, Topher, The Case For The Individual Mandate In Health Care Reform pp. 3-4 (Center for American Progress, 2012).

[15] *Id*., p. 7 (citing Amitabh Chandra, Jonathan Gruber and Robin McKnight, The Importance of the Individual Mandate - Evidence from Massachusetts, The New England Journal Of Medicine 364(4): 293-95(2011)).

[16] U.S. House of Representatives, Final Vote Results For Roll Call No. 165 (H.R. 3590, March 21, 2010), see *http://clerk.house.gov/evs/2010/rolll65.xml*.

[17] United States Senate, Voting Record for H.R. 3590 (December 24, 2009), see *http://www.senate.gov/* legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=lll&session=l&vote=00396#top.

[18] See *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566, 2580 (2012).

[19] 132 S.Ct. 2566 (2012).

[20] See, e.g., Karlan, Pamela S., The Supreme Court Foreword: Democracy and Disdain, 126 Harv. L. Rev. 1 (2013).

[21] See Opinion of the Court, *National Federation of Independent Business v. Sebelius*, n. 10, supra, 126 S.Ct. at 2566, 2584-2601.

[22] 42 U.S.C. §§ 1396 et seq.

[23] The Commonwealth Fund, "State Action to Establish Health Insurance Marketplaces, " viewable at *http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx*. These states are: California, Colorado, Connecticut, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont and Washington.

[24] *Id*.

[25] See New York Times, Enrollment in the State Health Exchanges (Nov. 12, 2013) at *http://www.nytimes.com/interactive/20*13/10/04/us/opening-week-of-health-exchanges.html?ref=us.

[26] See New York Times, Problems with Health Care Portal Also Stymie Medicaid Enrollment (November 11, 2013) at *http://www.nytimes.eom/2013/l*1/12/us/problems-with-federal-health-portal-also-stymie-medicaid-enrollment.html?ref=us.

[27] See Commonwealth Fund, Medicaid Expansion Map, viewable at *http://www.commonwealthfund.org/*Maps-and-Data/Medicaid-Expansion-Map.aspx?omnicid=20.

[28] *Id*.

[29] See 2013 Ohio Bill House Bill 91 at the LegiScan website at this address: *http://legiscan.com/OH/bill/*HB91 and Missouri 2013 Senate Bill 473, viewable at the LegiScan website at *http://legiscan.com/MO/*bill/SB473/2013. See Cato Institute, Ohio, Missouri Introduce Health Care Freedom Act 2.0 at the Cato Institute's website, *http://www.cato.org/blog/ohio-missouri-introduce-health-care-freedom-act-20*.

[30] See *Sissel v. Dept. of Health and Human Services, C.A.* 10-1263 (slip op.) (D.D.C. June 28, 2013).

[31] See 42 U.S.C. § 18023(a)(1).

[32] October 25, 2013 Memorandum, Affordable Care Act - Plans That Exclude Abortion Coverage, St. Benedict's Blog, *www.saintbenedicts.com*.

[33] 42 U.S.C. § 18022(d).

[34] See National Conference of State Legislatures, State Health Insurance Mandates and the ACA Essential Health Benefits Provisions, viewable at the NCSL's website at *http://www.ncsl.org/research/*health/state-ins-mandates-and-aca-essential-benefits.aspx.

[35] 18V.S.A. §§9372, 9373.

[36] "Medicaid gets most of new enrollments, " Providence Journal, November 13, 2013, p. A4.

[37] See "Pricey Portal, " Providence Journal, November 10, 2013, p. F6.

[38] *Id.*

[39] See Parnell, Sean, "Will Rhode Islanders Purchase Insurance Under Obamacare?, " Rhode Island Center for Freedom and Prosperity (June 10, 2013), "Left Behind by Health Reform in Rhode Island, " Rhode Island Center for Freedom and Prosperity (August 5, 2013) both posted at *http://www.rifreedom*. org/category/issues/health-care/.

[40] See Parnell, "Will Rhode Islanders Purchase Insurance, " n. 28, supra, p. 2.

[41] The Center's Report projected that the price of a "Bronze" level insurance policy for a 24-year old would be $1, 900.

[42] For a single person, the penalties in 2014 range from $95 to $285, depending on income. They increase to $190 to $570 in 2015. 26 U.S.C. § 5000A(c). When calculating the penalty for a household, adults are assessed the full "flat dollar amount" and children are assessed half of that amount.

[43] See Long, Sharon K., Yemane, Alshadye and Stockley, Karen, "Disentangling the effects of health reform in Massachusetts, " American Economic Review 100(2): 297-302 (2010).

[44] Massachusetts Department of Revenue: Individual Mandate 2008 Preliminary Data Analysis (December, 2009), p. 3, viewable at *http://www.mass.gov/dor/docs/dor/news/pressreleases/2009/2008*-health-care-report.pdf.

[45] See Community Resources Information website *www.massresources.org*. Massachusetts subsidizes insurance policies for residents 26 and younger, and reduces the tax penalty for this group.

[46] See *Fountas v. Commissioner of the Department of Revenue*, Essex Superior Court, No 08-0121-B (2/6/09), aff d, 76 Mass.App.Ct. 1116, 922 N.E.2d 862 (2010).

[47] See n. 35, supra.

[48] See Pub.L.No. 111-148, § 1321(d) (2010).

[49] State of Rhode Island, Comprehensive Annual Financial Report for Fiscal Year Ended June 30, 2012, p. 29.

[50] Office of the Auditor General, Pension and OPEB Plans Administered by Rhode Island Municipalities September 2011 report to Joint Committee on Legislative Services, *http://www.muni-info.ri.gov/*documents/finances/SrudyCommissionPension/lPension

_&_OPEB_Admin_by_RI_Munis_Sept_2011 .pdf.

[51] *Id.*

[52] See HealthSource RI website at *www.healthsourceri.com*.

[53] See Providence Retired Police and *Firefighter's Association v. City of Providence*, C.A. No. PC-11-5853, Decision on Preliminary Injunction (filed January 30, 2012).
