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February 22, 2018

By Hand Delivery

The Honorable Alex M. Azar
Secretary, U.S. Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: *Legal Analysis of Idaho's Authority to Approve State-Based Individual Insurance Plans*

Dear Secretary Azar:

I am outside counsel to Blue Cross of Idaho Health Service, Inc. ("Blue Cross of Idaho") and write on its behalf respectfully to relay our view that the new "State-based plan" initiative pursued by the State of Idaho for its individual insurance market comports with the Affordable Care Act ("ACA") and other governing legal principles and, therefore, is entirely legal. As you may know, Blue Cross of Idaho has submitted, for State approval, plans that it believes meet the requirements of Idaho's initiative, though the State has not yet approved those offerings; Blue Cross of Idaho, therefore, has a strong interest in the success of Idaho's initiative, the benefits of which have been emphasized in a recent letter to you from Idaho Governor Butch Otter. As you may also know, however, some national press reports – though not local ones from Idaho – have unabashedly asserted that the Idaho initiative is unlawful. To the same effect, you have received letters from a group of Democratic Congresspersons and Senators and from certain industry organizations focused on patients (such as the American Cancer Society, American Diabetes Association, etc.) impugning the legality of Idaho's approach. We seek, with this letter, to show that the opposite is true: the case for the legality of Idaho's initiative is superior to the superficial, categorical statements from opponents that it is unlawful.

A. Factual Background

The legal issues cannot properly be addressed without some brief factual background regarding the current state of the Idaho individual insurance market and the nature of Idaho's initiative. The individual insurance market in Idaho is not healthy currently, a clear contrast to pre-ACA times when Idaho had one of the Nation's best-functioning individual insurance markets. Since the advent of the Exchange in 2014, premium prices on the Exchange have increased more than 70%, nearly 30% last year alone, and all options on the Exchange are well

more than \$1,000 per month (with some more than \$2,000 per month). The number of covered lives in the individual market (collectively through the Exchange and off-Exchange) has decreased since 2014. Indeed, there are now in Idaho roughly 250,000 persons with no health insurance. The number of uninsureds *increased* by 66,000 from 2015 to 2016 (a year for which Idaho collected statistics). Carriers have collectively lost massive amounts of money in the individual market since 2014 – roughly \$47 million in 2015, \$178 million in 2015, and \$69 million in 2016. Not surprisingly, given those losses, the number of carriers on the Exchange has decreased since 2014, with very few options in all counties and just Blue Cross of Idaho and one of the precarious ACA CO-OPs remaining in many counties.

Responding to the serious situation in Idaho, the State fashioned State-based plans. They are known as “State-based plans” because the new products would comply with all applicable State-law requirements, but not necessarily all ACA requirements; previously, Idaho had not incorporated by statute or rule (unlike other States may have done) ACA requirements as part of its State-law mandates. These products might be up to 50% cheaper than Exchange coverage; yet, they are significantly richer in benefits than so-called “grandmothered” plans that States and the federal government alike currently allow, and certainly far more expansive in their benefits than short-duration plans (which, as now proposed, might be issued for just short of twelve months) or faith-based plans, both currently permitted by States and the federal government. Idaho’s Governor and Insurance Director have emphasized that the goal of allowing the offering of State-based plans is to bring into the individual market an affordable option for those individuals currently on the insurance sidelines. That group comprises mostly middle-class individuals, too prosperous to qualify for ACA premium subsidies, but not rich enough to afford the current coverage available on the individual market. These are largely healthy lives *not* in the Exchange, because of the price of Exchange coverage, and soon not subject to any tax penalty for non-compliance with the individual mandate (in light of the recent tax legislation).

In addition to seeking to bring into the insurance market the increasing numbers of middle-class persons outside of it, Idaho also has carefully structured State-based plans in order to complement and, in fact, bolster the Exchange. In this respect, critics of Idaho’s approach have overlooked two critical and indispensable features of State-based plans. First, Idaho has directed that only issuers offering Exchange coverage may offer State-based plans. The obvious point is to seek to increase (or at least not further decrease) the number of carriers, and thus competition, on the Exchange by offering them an opportunity to provide an additional product in the market. Second, Idaho has instructed that State-based plans and Exchange coverage must be part of a common risk pool. That requirement ensures that the healthy lives now entering the insurance market will help stabilize and potentially reduce the premiums for Exchange coverage by improving the risk pool. In light of these features, it is head-scratching, and frankly ignorant, that the patient-industry letter to you states: “Idaho’s action – if it is permitted to stand – would seriously injure Idaho patients and consumers and significantly destabilize Idaho’s entire health insurance market.” Letter from American Cancer Society Action Network, *et al.*, to Hon. Alex Azar at 2 (Feb 14, 2018). Quite to the contrary, and actually *in keeping* with what one would think is the patient industry’s goal of delivering insurance coverage to more people, Idaho’s action – because it links State-based plans to carrier participation on the Exchange and demands

a common risk pool that includes the potentially incoming healthy lives – is a significant positive step toward both increasing the number of insureds and improving the viability of the Exchange. Put another way, the alternative to Idaho’s initiative is not that those individuals now boxed out of coverage will join the individual market, for they are priced-out now and are increasingly leaving it; rather, the alternative is a continuing downward spiral in the individual market’s stability as fewer, sicker individuals continue to buy insurance and more and more healthier individuals choose to go uninsured, which in industry parlance is referred to as a market “death spiral.” Also of note, by having the effect of helping to lower any future increases in Exchange premium rates (due to improving the risk pool and potentially enhancing carrier participation and thus competition on the Exchange), the Idaho initiative would have a positive effect on the federal Treasury through premium subsidies being lower than otherwise.

B. Legal Analysis

The legal case for State-based plans can be divided into four parts: (1) support within the Public Health Service Act (“PHSA”) and the ACA itself; (2) other legal considerations, including constitutional ones, reinforcing that State-based plans are legal; (3) the weakness of any preemption arguments; and (4) federal non-enforcement for Idaho’s State-based plans. I review each of these matters in turn.

1. PHSA and ACA Support for Idaho’s Initiative on State-Based Plans

State-based plans are legal because Congress left to the States the power to enforce the ACA in the first instance, including some leeway to relax ACA requirements in appropriate circumstances. The PHSA’s enforcement scheme, as amended by the ACA, respects the States’ traditional and primary role as the regulator of State health-insurance markets, even after enactment of the ACA. Specifically, in its key enforcement provision, the PHSA, with the ACA’s amendment, provides that the States “*may* require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the [market-reform] requirements of [the ACA].” 42 U.S.C. § 300gg-22(a)(1) (emphasis added). The statute then provides that, where a State does elect to take on the ACA enforcement role, its authority is inviolate, unless the U.S. Department of Health and Human Services (“HHS”) determines that the State fails “to *substantially* enforce” the ACA’s provisions. *Id.* § 300gg-22(a)(2) (emphasis added). More fully, the latter subsection states: “In the case of a determination by the Secretary [of HHS] that a State has failed to *substantially* enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) . . .” *Id.* The same section thereafter lays out HHS’s enforcement obligations where a State fails to substantially enforce the ACA. As relevant here, Congress there said that the federal government may take on that enforcement role “only” if HHS finds that a State falls below the substantial-enforcement standard. *Id.* § 300gg-22(b)(1)(A).

This enforcement provision is most reasonably read as affording the States discretion to relax some ACA provisions’ application, where they view it as necessary. That is, by using the

terminology “substantially enforce,” Congress implicitly left leeway for a State to decide sometimes not to enforce. The word “substantial” means “being largely but not wholly that which is specified” (“Substantial,” *Merriam-Webster’s Collegiate Dictionary* (11th ed. 2003)); and in one case in a different context where it was necessary to define “substantially,” the Supreme Court said it means “in the main” and rejected the notion that the word means “to a high degree.” *Pierce v. Underwood*, 487 U.S. 552, 565 (1988) (internal quotation marks and citation omitted) (interpreting “substantially justified” in the Equal Access to Justice Act). Stated in terms of the PHSA’s and ACA’s assignment of enforcement authority to the States (where the State accepts the assignment), Congress empowered the States, then, to enforce the ACA in large measure or in the main, but did not contemplate them enforcing it to a high degree or completely or rigidly. Moreover, the fact that the initial delegation to the States is placed in permissive terms – *i.e.*, they “may” enforce the statute – only further emphasizes that Congress did not seek to hamstring the States. They “may” enforce the statute, and, if they enforce it for the most part (*i.e.*, in the main), that is the end of the matter; no HHS determination of failure “to substantially enforce” should then occur, under the very text of the PHSA, as amended by the ACA.

Indeed, to view the States as having no discretion to decide when to enforce, and when not to enforce, would be to read the term “substantially” out of the statute. If Congress had anticipated a State applying and enforcing the ACA in all instances and for all individual-market products when it elects to be the ACA’s enforcer, then Congress would have called for the triggering of federal enforcement whenever HHS finds that the State simply fails “to enforce” the ACA or fails “to completely enforce” the ACA. Having used the words it did – “substantially enforce” – Congress defined a flexible enforcement realm for the States who elect the enforcement role. The specific language used, in fact, signals Congressional recognition of a realm of State flexibility long acknowledged by the courts, which have ascribed to executive-branch officials who are tasked with enforcing laws broad discretion on decisions of when and how to enforce. *See Heckler v. Chaney*, 470 U.S. 821, 831, 834 (1985). State flexibility is also congruous with well-recognized notions of federalism. *See Ariz. State Legis. v. Ariz. Indep. Redistricting Comm’n*, 135 S. Ct. 2652, 2673 (2015) (“Deference to state lawmaking allows local policies more sensitive to the diverse needs of a heterogeneous society, permits innovation and experimentation, enables greater citizen involvement in democratic processes, and makes government more responsive by putting the States in competition for a mobile citizenry.”). One court described the ACA’s enforcement scheme – with its delegation of power to the States and prohibition against federal interference with a State’s authority absent the State’s failure to substantially enforce the ACA’s provisions – as a “regime of cooperative federalism.” *W. Va. v. United States HHS*, 145 F. Supp. 3d 94, 97 (D.D.C. 2015), *aff’d*, 827 F.3d 81 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1614 (2017) (internal quotation marks omitted). Interpreting the ACA as instituting some State flexibility in enforcement to account for local vagaries best comports with a cooperative State-federal approach.

Furthermore, HHS already has read the ACA exactly to give the States (and even the federal government) discretion to allow some non-compliance with the statute in appropriate instances. A chief example is grandmothers plans. They plainly are non-compliant with many ACA provisions and are not anywhere specifically authorized in the ACA (unlike grandfathered

plans). Nonetheless, in order to keep a promise President Obama made to the public when signing the ACA (*i.e.*, that “if you like your health plan, you can keep it”), HHS issued guidance in 2013 (that continues to be renewed) encouraging *the States* to allow grandmothered plans. *See* Letter from CMS to State Ins. Comm’rs at 3 (Nov. 14, 2013). Idaho and many other States have, consistent with the HHS recommendation, authorized grandmothered plans. The fact that HHS left it to the States, who are the first-line enforcers under the ACA, to approve grandmothered plans, and then found no problems with State enforcement once they did approve them, helps prove that States have latitude to allow some non-compliance with the ACA, as the statutory language “substantially enforce” facially connotes. *See W. Va. v. United States HHS*, 145 F. Supp. 3d at 108 (noting that HHS’s encouragement of grandmothered plans “neither require[d] nor [forbade] any action on the part of the States”; rather, “the State [was] asked to make a voluntary choice whether or not to enforce the ACA’s market requirements, with the certain consequence that the decision not to enforce will enable non-compliant plans to be sold within the State’s borders”) (internal quotation marks and citation omitted; brackets in original).

The question, then, is whether, in light of the Idaho Department of Insurance’s directives regarding State-based plans, the State is “substantially” enforcing the ACA; if so, then Idaho has exercised its powers in accordance with the authorization provided in the PHSA-ACA enforcement provision (namely, § 300gg-22). Idaho here satisfies that standard. State-based plans are compliant with many ACA standards, although not all, and Idaho otherwise requires compliance with *all* ACA standards in the individual market if the plan is on the Exchange or not approved as a State-based plan (other than grandmothered plans, short-duration plans, or faith-based options). The majority of coverage in the State in the individual market, therefore, will – even after the offering of State-based plans – remain compliant with the ACA. Additionally, the State has identified State-based plans as necessary in order to shore up the Exchange. By increasing the individual-market risk pool with healthy lives that are currently uninsured, and with the risk pool for State-based plans tied to the Exchange plans’ risk pool, the State’s approach promises to keep Exchange rates lower than they otherwise would be. Further, Idaho’s requirement that issuers of State-based plans also offer an ACA-compliant plan on the Exchange helps ensure insurer participation on the Exchange, which otherwise is waning. Under these circumstances, where the majority of individual coverage in the State remains ACA-compliant and where State-based plans are designed to (and do) facilitate, rather than hinder, Exchange coverage, Idaho properly is seen as “substantially” enforcing the ACA provisions overall.

Nor does the PHSA-ACA enforcement provision require a product-specific analysis of whether the State is substantially enforcing an ACA provision. Instead, the provision asks whether the State “has failed to substantially enforce a provision (or provisions) in this part *with respect to health insurance issuers in the State.*” 42 U.S.C. § 300gg-22(a)(2) (emphasis added). That language indicates HHS’s determination – so as to take the draconian measure of divesting a State of enforcement authority – centers on whether a State has failed substantially to enforce a particular market requirement with respect to the industry generally or, possibly, for a particular issuer in the totality of that issuer’s insured business. *Cf. id.* § 300gg-22(b)(2)(A) (suggesting that, in the event HHS takes over the enforcement role, enforcement is at an issuer level, not product-specific level). In this instance, even when considering each market reform individually, Idaho is substantially enforcing the ACA provision *at an industry level* when it requires all

issuers of Exchange products, state-regulated group insurance, and remaining individual-market products, other than State-based plans, to be ACA-compliant. And it cannot be said that Idaho is not substantially enforcing a market provision with respect to *a particular issuer*, when Idaho requires adherence to all ACA provisions in the insurance products that the issuer sells other than State-based plans.

In sum, the PHSA-ACA enforcement scheme itself, in the terms Congress used, denotes that States have room to exercise some discretion in determining the extent to which to enforce the ACA, without jeopardizing their choice to substantially enforce the ACA for the States' individual markets. Here, with the ties between State-based plans and Exchange coverage and Idaho's overarching demand that other plans (*i.e.*, non-State-based plans) comply with applicable ACA requirements, Idaho continues to "substantially enforce" the ACA in its individual market. Accordingly, it has done all that the ACA mandates from a State.

2. Additional Legal Principles Supplying Support for Idaho's Initiative on State-Based Plans

In addition to the PHSA-ACA enforcement provision evincing, on its face, that the States have power to relax ACA standards to some extent (so long as they continue to "substantially" enforce the ACA), other legal considerations – one concerning administrative discretion and the other being a constitutional issue – help establish the legality of Idaho's State-based plans. These considerations on their own provide a separate legal basis for Idaho's initiative; at a minimum, they reinforce the correctness of a reading of the PHSA-ACA enforcement provision that enshrines State flexibility to relax ACA requirements in necessary instances.

a. Rule Favoring Administrative Discretion to Deviate from Statutory Terms to Further Congress's Goals

As noted already, the Supreme Court, in the *Heckler* case, recognized that executive branch officials tasked with enforcing a law generally enjoy broad discretion as to when and how to enforce a statute. *See Heckler*, 470 U.S. at 831 ("an agency's decision not to prosecute or enforce, whether through civil or criminal process, is a decision generally committed to an agency's absolute discretion"). In fact, it was the *Heckler*-type of discretion that animated HHS's conclusion that States could authorize non-ACA-compliant grandfathered plans. *See* Greg Sargent, *The Plum Line*, "White House defends legality of Obamacare fix" (Nov. 14, 2013) (available at <https://perma.cc/KBZ5-Z8YB>). Since Congress wished for States in the first instance to elect to enforce the ACA, and they are in the best position to know which priorities should be most pursued in their locale, they should be ascribed the same administrative enforcement discretion as any other enforcer of federal law. *See id.* at 831 ("agency decision not to enforce often involves a complicated balancing of a number of factors which are peculiarly within its expertise"). State enforcers should have that discretion even if the PHSA and ACA had no indication of express incorporation of such discretion; nonetheless, the case for State enforcement flexibility is far stronger here, where the PHSA-ACA enforcement provision *already* recognizes a level of State discretion (as States are to "substantially" enforce the ACA, not absolutely enforce it).

Even more closely analogous to this situation, courts have recognized that administrators have discretion to suspend enforcement of a statute in part or altogether when there are unforeseen circumstances. As some D.C. Circuit decisions have put it, an administrator can deviate from a statute under “unanticipated circumstances,” if the administrator has reason to believe that strict enforcement of the statute “is frustrating the policies he is obligated to serve.” *Pa. v. Lynn*, 501 F.2d 848, 857 (D.C. Cir. 1974); accord *W. Coal Traffic League v. Surface Transp. Bd.*, 216 F.3d 1168, 1174-75 (D.C. Cir. 2000). Importantly, “[t]here was no indication on the face of the statutes [involved in those cases] that the Secretary could suspend operation of the programs” (*W. Coal Traffic League*, 216 F.3d at 1174 (citing *Lynn*, 501 F.2d at 854)) in the event the administrator believed the statutes were failing to “effectuate[] the policies to which Congress was committed.” *Lynn*, 501 F.2d at 857. Still, “[w]hen Congress establishes a new program, however novel or untested, it does not normally express itself on th[at] question.” *Id.* An administrator’s discretion to deviate from the statute is warranted, among other instances, when the state of affairs in the regulated industry deteriorates from the time Congress enacted the relevant statute. See *W. Coal Traffic League*, 216 F.3d at 1175 (finding that “[t]he present state of the railroad industry [is an] . . . ‘unanticipated circumstance[.]’”) (quoting *Lynn*, 501 F.2d at 857).

This principle – *i.e.*, that regulators can decline to enforce statutory terms where enforcement would defeat Congressional goals – has particular salience in the ACA context, given the Supreme Court’s admonition already that application of the strict wording of the ACA can lead to untoward results and might necessarily need to be avoided. As Chief Justice Roberts wrote for the Court in *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015): “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.”

Here, Idaho has concluded that application of the ACA to the letter for all products in the individual market has had the perverse consequence of subverting, rather than furthering, Congress’s goal of covering the uninsured and that – after five years of experience with its Exchange and the deteriorating conditions in its individual health insurance market (both for consumers and carriers) – special measures must be taken both to allow the ACA to achieve its goals and to save the Exchange. These are exactly the sorts of circumstances that allow for “reasonable” measures by an administrator to allow some non-compliance with the ACA in order to achieve its overarching goals and to avoid the statute – through rigid enforcement – destroying itself. *Lynn*, 501 F.2d at 862. Again, because the States are Congress’s enforcer of choice in the first instance under the enforcement scheme Congress devised, they should have – just as much as federal regulators – the ability to lift statutory requirements to deal with unanticipated circumstances.

b. Constitutional Necessity to Deviate from a Statute’s Strict Terms

State flexibility to relax ACA standards also follows from a constitutional consideration: the need to enforce the ACA in a manner that avoids unconstitutional confiscation of insurer property. As two commentators at the time of the ACA’s initial implementation suggested might eventually become the case, the ACA’s market reforms are nearing the point that, as applied,

they become unconstitutional under the Due Process and Takings Clauses of the Fifth Amendment to the U.S. Constitution and, therefore, are unenforceable absent some relaxation of them. See Richard A. Epstein & Paula M. Stannard, “Constitutional Ratemaking and the Affordable Care Act: A New Source of Vulnerability,” 38 Am. J. of L. & Med. 243 (2012). The set-up for the argument comes, again, from *King v. Burwell*. The Supreme Court there held that premium subsidies are available to qualifying insureds on both State Exchanges and federally-facilitated Exchanges. In that case, the Court emphasized that the ACA has three “closely intertwined” parts (that is, parts intended “to work *together* to expand insurance coverage”): (1) various market-reform measures applicable to insurers; (2) a mandate that all individuals purchase health insurance at pain of a penalty; and (3) subsidies to reduce consumer out-of-pocket expenses. 135 S. Ct. at 2487, 2493 (emphasis added). “Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement. And the coverage requirement would not work without the tax credits.” *Id.* at 2487. Because the effectiveness of each relies on the others, the absence of any of the three elements “could well push a State’s individual insurance market into a death spiral.” *Id.* at 2493.

At this juncture, two of the three parts of the equation are unworkable. The individual mandate has proven to be an ineffective means for expansion of the volume of insureds necessary to ensure a reasonable risk pool to support the market reforms, and tax penalties associated with it have been repealed effective January 1, 2019. Moreover, Congress never correctly funded some of the subsidy programs (such as cost-sharing reduction subsidies), leaving the current Administration with the obligation, consistent with governing Congressional appropriations legal principles, to halt payment of those subsidies. The result is that rigid enforcement of the market reforms (the one ACA pillar left standing) risks further deteriorating financial conditions for insurers in the individual market and the overall implosion of State individual insurance markets (the “death spiral”), since the mechanisms for subsidizing the costs sustained by insurers to comply – namely, expanded insurance pools resulting from the individual mandate, with subsidy support for insureds joining the pool – are increasingly absent.

The situation takes on constitutional dimension because of a line of cases holding that regulators, such as utility boards, *must* ensure to a regulated entity a rate of return “sufficient to assure confidence in the financial integrity of the enterprise, so as to maintain its credit and to attract capital”; otherwise, the regulators violate the Due Process and Takings Clauses. *Fed. Power Comm’n v. Hope Natural Gas Co.*, 320 U.S. 591, 603 (1944); *accord Mich. Bell Tel. Co. v. Engler*, 257 F.3d 587, 593(6th Cir. 2001); *Jersey Cent. Power & Light Co. v. FERC*, 810 F.2d 1168, 1179 (D.C. Cir. 1987) (en banc) (Bork, J.). In this vein, the Ninth Circuit has struck down insurance rates for insufficiency in guaranteeing a reasonable rate of return. See *Guar. Nat’l Ins. Co. v. Gates*, 916 F.2d 508, 513 (9th Cir. 1990).

Idaho’s State-based plan initiative seeks to ameliorate the harsh effects the ACA currently is having in Idaho. The hobbled ACA has left insurers facing repeated losses in the individual market, when the increasing uncertainty under the ACA necessitates an even higher rate of return (to attract capital) than previously. In this situation, uncompromising enforcement of the ACA market reforms (in light of the other, not severable “broken” parts of the ACA)

threatens an unconstitutional “confiscation” of insurer property by way of unjustifiably low rates of return. *Id.* To avoid this result, Idaho is directing approval of State-based plans that will potentially increase subscribership for insurers and provide related financial benefits for insurers. The Ninth Circuit particularly has chided regulators that they must adopt some sort of “rate adjustment mechanism . . . permit[ting] relief from confiscatory rates” in order to save a statute from unconstitutionality, if the statute’s regulatory requirements otherwise result in less than just and reasonable return rates for the regulated entities. *Id.* Ultimately, then, the Constitution provides an independent basis for Idaho (as the first-line enforcer of the ACA in Idaho’s individual market) to adopt “adjustment[s]” to the ACA regime to avoid taking insurer property through regulatory requirements. *Id.* And the constitutional considerations also, once more, add to the arguments for interpreting the ACA itself to permit State flexibility (under the obligation simply “to *substantially* enforce” the ACA’s provisions), since statutory constructions that avoid constitutional problems are always favored. See *Skilling v. United States*, 561 U.S. 358, 405-06 (2010).

3. The Preemption Arguments Are Unpersuasive

When critics have contended that Idaho supposedly is flouting federal law by allowing State-based plans, they appear to be invoking preemption doctrine. Preemption is the concept whereby federal law overrides contrary state law, a principle stated in the Constitution’s Supremacy Clause. See U.S. Const. art. VI (the federal Constitution and federal laws and treaties “shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding”). Preemption exists expressly when Congress has stated in a federal statutory provision the extent of supersession of State law; the ACA contains an express preemption provision stating that ACA standards “shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of [an ACA] requirement.” 42 U.S.C. § 300gg-23(a)(1). Preemption also exists impliedly when “‘compliance with both federal and state regulations is a physical impossibility,’ *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-143 (1963), or when state law ‘stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.’ *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941).” *Fidelity Fed. Sav. & Loan Ass’n v. de la Cuesta*, 458 U.S. 141, 153 (1982). Either way, the strong presumption is against preemption of State measures, especially in areas of traditional regulation, including healthcare and insurance. See *generally Wyeth v. Levine*, 555 U.S. 555, 565 (2009).

As a threshold matter, preemption here is tempered from the start because of Congress’s recognition of discretion in the States to enforce the ACA, so that they are required only to “substantially” enforce the ACA. That statutory directive in the PHSA-ACA enforcement provision acts as a type of “savings” clause overriding typical preemption – *i.e.*, that a State may, without consequence, “substantially” rather than totally enforce the ACA necessarily implies that the State may elect to enforce certain State laws in preference to certain ACA requirements. It

follows, as a matter of logic, that any State law the State chooses to enforce in preference to an ACA requirement cannot be preempted by the ACA, in deference to the authority recognized in the enforcement provision. Congress too seems to have anticipated the coexistence of the State's authority to apply some State laws and general preemption standards, as it cross-referenced the ACA's preemption provision just before noting that the States need only "substantially" enforce the ACA. *See* 42 U.S.C. § 300gg-22(a)(1) ("Subject to section 2723," which is the ACA's preemption provision allowing for the application of State laws that do not prevent the application of federal standards, the States "may" enforce the ACA's standards).

Aside from the notion that preemption should not apply in full force here, Idaho's actions do not frustrate the accomplishment of the ACA scheme because Idaho has structured its approach in a manner designed to bolster the Exchanges where ACA-compliant coverage reigns, through the combined risk pool and the requirement that insurers offering State-based plans also offer Exchange coverage. As to the idea that compliance with State and federal law is impossible, or that (to use the ACA's preemption provision's terms) State law "prevents" the application of ACA standards, Idaho's initiative passes muster under either test. In reality, nothing Idaho is doing with respect to State-based plans is precluding satisfaction of the ACA's standards with respect to the targeted market. The ACA *itself* has made the application of its standards to the currently uninsured population impossible, as the economic reality of the cost of ACA-compliant coverage results in Idahoans of modest means (but too rich to qualify for federal premium subsidies) being unable to purchase insurance. The State has here, laudably, sought to fill the void where the ACA has misfired and prevented its own application, and Idaho has done so in a manner that furthers the ACA's overarching objective of facilitating affordable coverage.

Preemption should not have any greater appeal under a theory that supposedly large numbers of healthy individuals will leave the Exchange in order to purchase State-based coverage, so as to harm an Exchange plan's risk profile and increase the Exchange plan's price. The draining of healthy risks is not possible, because those purchasing State-based coverage are expected to be the vast uninsured population in Idaho, not those currently on the Exchange; and this is a reasonable expectation, as the majority of individuals on Idaho's Exchange obtain subsidized coverage, no subsidies would be available for State-based plans, and it would therefore usually be more expensive for most current Exchange-covered individuals to switch to a State-based plan (despite the overall lower price-point of the State-based plan). In addition, State-based plans could not negatively affect the Exchange plans' risk pool, so as to raise Exchange-plan prices, since the pools are to be combined under the Idaho Department of Insurance's guidance.

Finally, even if there were a preemption problem, HHS's acquiescence to Idaho's initiative would fix that. HHS's action concerning grandmothers' plans again provides a useful precedent. There, HHS encouraged States to allow grandmothers' plans that do not comply with the ACA. When States then did so, no one contended the States were preempted from acting, probably because federal authorities had taken the same view of the necessity of grandmothers' plans as the States.

4. Federal Non-Enforcement with Respect to State-Based Plans

Though State-based plans are, as explained, legal even without HHS sanction, and certainly we believe there is no basis for HHS to make any determination that Idaho is failing to substantially enforce ACA provisions, it would, of course, solidify the legal position of State-based plans if HHS informally indicated that it believes Idaho's initiative is unobjectionable from a federal perspective. In fact, an informal statement of federal non-enforcement in this situation is the result most in sync with HHS's stance in prior situations, where it has authorized limited offerings that otherwise are short of ACA requirements. Federal agencies must not act "inconsistently" and should "treat similar cases similarly." *Green Country Mobilephone, Inc. v. FCC*, 765 F.2d 235, 237 (D.C. Cir. 1985).

HHS has already made numerous exceptions to the ACA's requirements. Again to reference grandmothers plans, after the Obama Administration encouraged States to approve grandmothers plans that are non-compliant with the ACA, many States have approved them for the last five years. Likewise, just after the ACA's enactment, the Obama Administration granted informal waivers for a lengthy period to numerous insurers, employers, and unions to continue offering "mini-med plans," many of which did not satisfy the ACA's benefit requirements. And just this week, HHS announced proposed rules to permit short-duration plans non-compliant with the ACA for just less than twelve-month periods. *See Proposed Rule on Short-Term, Limited-Duration Insurance*, 83 Fed. Reg. 7437 (Feb. 21, 2018). While the latter are not technically governed by the ACA, the authorization of them may, at least in the short-term, provide an alternative choice to ACA-compliant coverage.

If anything, State-based plans are *more worthy* of HHS's approval than these other exceptions already permitted or proposed. State-based plans have the effect of bolstering the Exchange, whereas grandmothers plans and the other federally-sanctioned products arguably *harm* the Exchange because they divert individuals from Exchange products, with no possible benefits to the Exchange (*i.e.*, the risk pools for these other products are separate, and an issuer of those products need not participate on the Exchange). Federal approval of Idaho's initiative also would follow from President Trump's Executive Order 13813 issued just after his inauguration instructing federal regulators affirmatively to pursue various measures to increase options for affordable coverage.

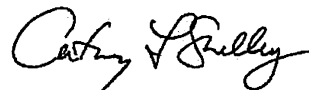
It is worth noting that an informal statement of federal non-enforcement with respect to State-based plans is not subject to judicial review. In situations involving enforcement schemes where a State is the primary enforcer (but even had less leeway than under the PHSA-ACA enforcement provision), subject only to a federal determination of failure to enforce, the courts have found to be unreviewable, as an application of federal agency discretion, federal decisions not to exercise the authority to intervene to upset the State's enforcement priorities. *See Nat'l Wildlife Fed'n v. U.S. EPA*, 980 F.2d 765, 771, 774 (D.C. Cir. 1992).

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Secretary Alex M. Azar
February 22, 2018
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Secretary Azar, I am pleased to have provided this analysis on behalf of Blue Cross of Idaho, and thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Anthony F. Shelley". The signature is written in a cursive style with a large initial "A" and a long, sweeping underline.

Anthony F. Shelley