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The Power to Block the Affordable Care Act: What Are the Limits?

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The Power to Block the Affordable Care Act
What Are the Limits?

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Health care reform remains precarious in the United States, with intense political disagreement about the Affordable Care Act (ACA). Former Governor Romney vows to “repeal and replace” President Obama’s signature domestic achievement. Although repeal would face potentially insurmountable political barriers, a Republican president could selectively enforce the ACA, effectively blocking full implementation. The president has wide discretion in implementing legislation, so understanding the scope of executive powers is important—not only for the ACA but also for a broad range of social welfare legislation.

ACA Waivers

The Republican health care plan states, “On his first day in office, Mitt Romney will issue an executive order . . . to issue Obamacare waivers to all fifty states,” which appears to envisage authorizing states to waive all, or major parts, of the ACA. The Constitution, however, requires the president to “take care that the laws be faithfully executed,” meaning that he lacks the power “to refuse to execute laws passed by Congress with which he disagrees,” unless Congress grants that discretion. Because the ACA provides no such blanket waiver authority, granting states authority to disregard the ACA’s key provisions would likely violate the “take care” clause.

The ACA does envision that certain provisions could be waived, permitting innovative state approaches to better fulfill the act’s mission. The secretaries of the Department of Health and Human Services (DHHS) and the Treasury, for example, could waive provisions—including the individual mandate—if a state can show it would increase coverage and reduce cost without raising the federal deficit. States, however, must specifically request such waivers, which would not become available before 2017. President Obama has sought an ACA amendment to make innovation waivers available by 2014. Similarly, the ACA retains Medicaid waiver authority, which grants DHHS flexibility to permit state alterations to Medicaid. These limited waiver authorities, in principle, are intended to enhance, not undermine, the ACA’s goals of increased access and lower cost.

Federal Health Insurance Exchanges

Executive agencies have considerable discretion to implement ACA provisions that are ambiguous. One area of ambiguity is in the operation of federal health insurance exchanges. The ACA authorizes states to establish their own exchanges, but the federal government is empowered to create them if states decline. Several governors have opposed creating exchanges or taken no steps to create them. The law also offers premium subsidies for people whose household income is below 4 times the federal poverty level if they buy insurance from the exchanges. The ACA directs the Internal Revenue Service (IRS) to grant subsidies as a tax credit. Due to an apparent oversight, the ACA only explicitly offers subsidies in state-operated exchanges, but the IRS has issued regulations to extend subsidies to federal exchanges.

The courts defer to “reasonable” agency interpretations in the face of statutory ambiguity. The courts would likely uphold the Obama administration’s approach given evidence that Congress intended the subsidies to extend to federally operated exchanges. A Romney administration, however, could alter the regulations, refusing to extend subsidies to federal exchanges. Given the ACA’s plain language, the courts could uphold such a Romney rule, unless they concluded that the change was motivated by purely political reasons and therefore arbitrary. Notably, “an agency interpretation . . . which conflicts with the agency’s earlier interpretation is entitled to considerably less deference.”

The Individual Mandate

The individual mandate operates as a tax, with the IRS charged with collecting the funds. A President Romney could instruct the IRS not to make collection of this tax a priority—potentially signaling that individuals will not be penalized for failing to purchase qualifying insurance. He could, for example, effectively fail to collect the tax from individuals with high-deductible insurance—a long-favored Republican option. If this had the effect of nullifying a key ACA pro-
vision, the courts might view it as unconstitutional, but the result is unclear. Notably, when Obama instructed federal law enforcement officials to deprioritize the deportation of nonviolent undocumented immigrants, he relied on the traditional executive discretion to enforce the law. Romney, if elected, could claim a similar level of discretion.

Incomplete Funding of the ACA

Beyond presidential discretion to enforce the law, Congress could fail to fully fund ACA implementation. This approach would not require repealing the ACA so it is more politically palatable. Congressional scope to starve the ACA of funds would be limited in relation to several key provisions. For example, Congress directly funded high-risk pools for individuals with preexisting conditions, health insurance exchanges, the Independent Payment Advisory Board, as well as the Community Health Center Fund and the Prevention and Public Health Trust Fund. To withdraw this funding, Congress would have to act through legislation, which would be difficult in the current political environment.

Congress, however, did not directly fund the expansion of the health workforce (including loan repayment), quality improvement, reduction of health disparities, and certain prevention programs. This discretionary funding is more susceptible to defunding because it can be accomplished through congressional inaction. Thus, even if President Obama is reelected, unless Congress acts affirmatively to fund important parts of the ACA, health care reform will remain incomplete.

Repeal and Replace

The approach most often proposed by opponents of the ACA is “repeal and replace.” Although the details are unclear, this approach would require congressional legislation to alter or eliminate substantial parts of the ACA. The most likely targets would be the individual mandate, federal conditions on Medicaid payments to states, and the Independent Payment Advisory Board. Popular provisions, such as barring preexisting condition exclusions, might be retained, though perhaps in a less vigorous form. If not done carefully, piecemeal replacement could result in a substantially worse product. For example, by keeping preexisting condition coverage while eliminating the mandate, the cost of insurance might soar.

“Repealing and replacing” the ACA is unlikely, requiring Obama to lose the presidency and Republicans to hold the House and 60 Senate seats to prevent a filibuster. An alternative approach, through the budget reconciliation process, cannot be filibustered. However, the budget reconciliation process would face fierce Democratic challenges under the “Byrd Rule,” which requires the Senate parliamentarian to determine whether all aspects of the law have direct—not merely incidental—effects on federal revenue or spending.

The ACA has considerable content beyond cost, such as defined benefits, public health, and higher-quality services. Moreover, the fiscal effect appears positive, with the Congressional Budget Office scoring the ACA as saving $109 billion. Nor could Republicans use reconciliation to advance a social agenda, such as banning abortion funding, because of previous rulings that the budget effect is incidental.

Continuing on the Pathway to Fundamental Reform

Repeal of the ACA or blanket state waivers are unlikely given the political and constitutional landscape. Still, if a President Romney or a Republican-controlled Congress remained determined to do so, there would be ample opportunity to slow or block full ACA implementation. The future of health care reform hinges on the November 6 election. The public has a clear choice—either continue on the pathway toward full health reform or scale back and adopt market-based solutions. What is at stake is a fundamental vision of how to ensure near-universal access to quality care at an affordable cost.

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REFERENCES