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Supreme Court Affirms Opportunities and Uncertainties for Health Care Contractors

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By upholding the individual mandate—the heart of the Patient Protection and Affordable Care Act (ACA)[1] requiring most Americans to maintain ''minimum essential'' health insurance coverage—and by preserving Medicaid expansion, albeit at the state's option, the Supreme Court has allowed the Department of Health and Human Services (HHS) and the states to get back to the business of implementing the Act.[2] To be sure, challenges remain for the Administration, but the ACA has survived an important test. As we discuss below, the entities with whom the states will contract to build their insurance exchanges or underwrite Medicaid managed care plans should be cautiously optimistic about the future and yet mindful to secure contractual protections against political reversals.

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I. The Political Backdrop

That optimism requires an understanding of the politics that may delay or ultimately eliminate contracting opportunities afforded by the ACA. If former Massachusetts Governor Romney wins the election in November and the Republicans win control of the U.S. Senate while retaining the majority in the House, the ACA will almost certainly be repealed.[3] Governor Romney has pledged to repeal the ACA on his first day in office. Regardless of the Supreme Court's decision, the upcoming election will determine the future of health care reform and the contract opportunities that follow for the next decade.

The path forward for health care reform also will be shaped by critical fiscal pressures that will force painful decisions in the coming months and years. Regardless

[1] Pub. L. No. 111-148, 124 Stat. 119 (2010).

[2] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, No. 11-393, slip op. (U.S. June 28, 2012). Twenty-six states challenged the constitutionality of the Act, and this case, decided together with *Dep't of Health and Human Servs. v. Fla.* (No. 11-398) and *Fla. v. Dep't of Health and Human Servs.* (No. 11-400), arose from the Eleventh Circuit. The Court held that: the Anti-Injunction Act did not bar the challenge to the Act; the individual mandate was a constitutional exercise of Congress's taxing power; and the Medicaid expansion provision was unconstitutionally coercive of the states but could be remedied without invalidating the entire Act.

[3] House Republicans (and five Democrats) voted 244-185 to repeal the ACA on July 11, 2012. Although the measure never had a chance of passing the Democrat-controlled Senate, the vote foreshadows future votes that may be called after the November elections.

of the outcome of the election in November, the next Congress and president will face what some are calling a fiscal cliff or perfect economic storm. The combined effect of the expiration of the Bush tax cuts, the payroll tax cut, the need to raise the debt ceiling in late 2012 or early 2013, and the possible automatic spending cuts required under the Budget Control Act of 2011 (BCA),[4] including sequestration, will put enormous political pressure on Congress to cut spending. As a result, the upcoming budget negotiations may be the most difficult since the end of World War II.

The cost of health care is the fastest growing part of the federal budget and thus will be under intense scrutiny. Budget experts know that federal spending cannot be effectively controlled without containing the costs of Medicare, Medicaid, Veterans' health care, and other federal health care related outlays. The movement away from fee-for-service reimbursement envisioned in the ACA and toward accountable care organizations (ACOs), managed care, and integrated care with greater reliance on preventive medicine holds promise to contain costs in these programs and offer new partnerships with private entities.

A. Medicaid Jostling

Although Medicaid is generally exempt from the upcoming sequestration cuts, its future will be hotly debated and it will come under intense budget review in the next few years—a review now complicated by the Supreme Court's 7-2 holding that the Constitution does not permit the federal government to coerce or ''dragoon'' states into providing Medicaid coverage to all people with incomes at or below 133 percent of the federal poverty level (FPL) by threatening to take away existing federal funding. Starting in 2014, the Supreme Court has given the states a choice to accept generous federal expansion money or leave the funds in Washington. A number of governors have announced that they will not accept these funds due to state budgetary constraints and their fear that Congress will terminate funding in the future, leaving a huge unfunded burden on the states. When rhetoric settles after the election, many analysts believe these governors will find it difficult to actually turn down federal funds that will pay the cost of medical care that will otherwise be shifted to their voters in the form of higher premiums or taxes to offset uncompensated care. Providers and local business leaders will surely pressure states to accept all the federal money available although some states may have sufficient leverage to negotiate their own less costly terms of expansion.

Much of the new federal funding is likely to go to managed care organizations (MCOs) currently providing Medicaid coverage to approximately 70 percent of program beneficiaries, a number that is only expected to grow.[5] Many governors in both political parties have concluded that managed care is a cost-efficient way to deliver Medicaid without compromising the quality of care. Democrats, who have historically been slow to embrace managed care, are accepting it as an alternative to the traditional fee-for-service reimbursement system and its exploding costs. As reported by *The Wall Street Journal*, WellPoint Inc.'s recent announcement that it would pay $4.46 billion to buy the Medicaid contractor Amerigroup Corp. underscores ''the future of health coverage as a business that increasingly intertwines the roles of government and private companies.''[6]

B. Survival of the Health Insurance Exchanges

Health insurance exchanges have been described as the ''centerpiece'' of the ACA.[7] They are instrumental to the success of health care reform because they are expected to increase consumer access and expand coverage.[8] The intent behind the Act was that small business owners and individuals who purchase their own coverage would benefit from reduced insurance premiums that would accompany enlarged risk pools. Many believe that increased competition between insurance companies, as well as the ease and transparency that come with online insurance markets (which exist in the private market today and are known as ''web-based entities''), should make premiums more affordable.

The development and implementation of these exchanges offer sizeable contracting opportunities to entities with the requisite experience and expertise, as states must have their exchanges in place by the start of 2014 unless this date is extended as some are advocating. Republican victories in the White House and the Senate could take many of these opportunities away. If the Democrats retain control, the opportunities only grow.

C. Fiscal Pressures, Discretionary Spending Caps, and Sequestration

The funding for the ACA will certainly be affected by the current budget stalemate in Washington. To put the challenge in context, national health care spending amounted to 17.6 percent of GDP in 2009, and annual spending is expected to increase from $2.5 trillion in 2009 to $4.7 trillion in 2019.[9] Total expenditures for national health care are projected to reach almost $40 trillion for the decade between 2010 and 2020[10] without factoring in health care reform. Including ACA-related expenditures in the calculation will increase this estimate by 5 percent according to the ACA's strongest critics. Supporters argue that expenditures will actually drop.

The BCA established new budget enforcement mechanisms for reducing the federal deficit, including automatic spending reductions in the form of lower

[4] Pub. L. No. 112-25, 125 Stat. 240 (2011).

[5] Kaiser Commission on Medicaid and the Uninsured, Medicaid and Managed Care: Key Data, Trends, and Issues, (February 2010), *available at* http://www.kff.org/medicaid/upload/8046.pdf.

[6] Anna Wilde Mathews and Jon Kamp, WellPoint's Medicaid Bet, *The Wall Street Journal*, July 9, 2012, available at http://online.wsj.com/article/SB10001424052702303343404577516393834465420.html.

[7] Timothy Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, The Commonwealth Fund, July 2010, *available at* http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.

[8] *Id.*

[9] Affordable Care Act (ACA), § 1501 (a)(2)(B), 42 U.S.C. § 18091(2)(B).

[10] CMS Office of the Actuary, National Health Expenditure Projections 2010–2020 (2010), *available at* https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf.

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caps on discretionary spending and sequestration of appropriated funds, triggered by the failure of the Deficit Reduction Super Committee to develop and pass $1.5 trillion in federal budget cuts. Absent intervening legislation to repeal or amend these procedures, federal agencies, including HHS, are faced with across-the-board cuts at a level set by the Office of Management and Budget (OMB) for all non-defense, non-exempt spending.[11] For FY 2013 this process would involve sequestration of funds. For FY 2014 through FY 2021, it would involve reductions in spending limits, with sequestration coming into play should non-defense spending exceed its limit in any year.

As the law is currently written, much of the ACA spending likely would not be subject to these cuts. Many expenditures are specifically exempted from sequestration or capped by the BCA or the earlier Balanced Budget and Emergency Deficit Control Act (also referred to as ''Gramm-Rudman-Hollings'');[12] for example:

- Veterans health care, Medicaid, and CHIP spending are exempt from sequestration.[13]
- Medicare FY 2013 cuts are capped at 2 percent, as are cuts to Health Resources and Services Administration (HRSA) and the Indian Health Service (IHS) funding.[14]
- Refundable federal income tax credits to individuals purchasing insurance coverage through an exchange could be deemed by OMB as exempt.[15]

The sequestration process still would apply to other programs created or impacted by the ACA and regardless of whether they were funded by direct (*i.e.*, mandatory) or discretionary spending.[16] Mandatory appropriation language (such as the ACA provisions funding the development of insurance exchanges) is not a safe harbor from sequestration; however, for any given fiscal year in which sequestration is triggered, only new budget authority for that year is reduced—*i.e.*, funds that first become available for obligation in that year. Unobligated balances properly carried over from previous fiscal years generally are exempt from sequestration.[17] This exemption covers a number of ACA programs funded by direct appropriations that became available in or before 2012 and remain available in subsequent fiscal years under the terms of the ACA.

The sequestration process is under fire on Capitol Hill primarily due to the cuts to defense spending that are part of the overall reductions in the federal budget.[18] House Budget Committee Chairman Paul Ryan, in fact, has introduced an alternative to sequestration, the Sequester Replacement Reconciliation Act of 2012,[19] which would reverse the defense cuts and replace them with various other cuts to the federal budget, including areas currently exempt from sequestration, such as Medicare, Medicaid, and other programs created by the ACA.[20]

Finally, the president and Congress face another federal debt ceiling increase either late this year or early in 2013. As with the last debt ceiling debate (which resulted in the BCA sequestration triggers), Republicans are expected to demand additional federal spending cuts to offset any debt ceiling increase and to require that these cuts add to, and not replace, cuts already agreed to in the BCA. Thus, even though Medicare and Medicaid survived the first debt ceiling showdown (as noted above), they may not be out of the woods. Prospects for dramatic reforms to both programs as well as sweeping amendments to or repeal of the ACA will increase significantly if control of the Senate or the White House changes hands in November.

D. Threats From the Appropriations Process

Despite the Supreme Court's affirmation of the ACA, the law also faces threats in the yearly congressional appropriations process. House Republicans already have tried to use both the standard appropriations bills and continuing resolutions (CRs) to defund certain ACA programs or to bar HHS from using federal funds to implement the program. Given the current political divide, few expect Congress to pass all or even many of the FY 2013 appropriations bills. Rather, a CR to set FY 2013 spending, subject to the budgetary limits established in the BCA, is the likely outcome. In the end, it seems likely but not certain that the CR will contain sufficient monies to ensure continued implementation of the ACA in FY 2013.[21]

Republican efforts to restrict or eliminate funding for ACA programs and to repeal the entire law will continue. As long as Democrats remain in control of the Senate or the White House, those efforts should be stalemated. But if the Senate changes hands, Republican congressional ambitions will be strengthened, even if Democrats retain sufficient Senate votes to mount a filibuster. Given the Supreme Court's holding that the mandate is a tax, Republicans are certain to use the reconciliation process, which would require only 51 Senate votes to repeal or undermine the ACA.

II. Outlook for Medicaid Contractors

Not many predicted the Supreme Court's decision on Medicaid expansion. Rather than affirm Medicaid ex-

[11] These rules apply to defense spending as well.

[12] *See* Balanced Budget and Emergency Deficit Control Act (''BBEDCA''), 2 U.S.C. § 900.

[13] *See id.* § 905(h).

[14] *See id.* § 906(e).

[15] *See id.* § 905(d).

[16] Discretionary spending is also subject to the general appropriations process, which can approve a funding level smaller than the amount that was requested or authorized in the law or deny funding entirely. Costs to implement the ACA generally that are not funded through direct appropriations generally fall into this discretionary category. A useful list of those projects can be found in a report by the Congressional Research Service titled, *Discretionary Funding in the Patient Protection and Affordable Care Act (ACA)* (Dec. 16, 2011), *available at* http://www.ncsl.org/documents/health/DisFundingACA.pdf.

[17] 2 U.S.C. § 905(e).

[18] The BCA requires approximately 50 percent of the spending reductions to come from defense programs.

[19] H.R. 5652, 112th Cong. (2012).

[20] The proposed ACA cuts include repeals of the grant program for the state health exchanges, funding for the Prevention and Public Health Fund, and funding for the Consumer Operated and Oriented Plan program.

[21] In fact, the Senate has proposed an FY 2013 Labor/HHS appropriations bill that fully funds all of the core ACA programs and provides CMS with additional administrative funding to implement ACA's health care reforms. *See* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2013, S. 3295, 112th Cong. (2012). The increase in administrative funding amounts to approximately $500 million.

pansion as enacted, the Court left intact the federal offer to fund the expansion of Medicaid benefits but refused to let Congress strip a state's current federal funding if it opted out of the expansion. With some states, particularly states with Republican governors, now giving serious consideration to opting out of expansion, MCOs foresee less opportunity to add new Medicaid eligibles to their insured rolls, and hospital systems foresee increases in uncompensated care exacerbated by a loss of disproportionate share hospital (DSH) payments under the ACA. Alternatively, some analysts see the states leveraging the Supreme Court decision to win the right to privatize parts of Medicaid, to expand Medicaid coverage to a smaller population making less than 133 percent of the FPL, or to take federal funding in the form of a block grant without any attached strings. After all, Medicaid has always been a heavily negotiated program between the federal and state governments. Others may simply wait for repeal of the law.

A. What the Supreme Court Held

In a 7-2 ruling in which all but Justices Ginsburg and Sotomayor joined, the Court held that Congress's expansion of Medicaid exceeded its authority under the Spending Clause, and not just by a little bit. Heralded as a landmark ruling by many, it marks the first time the Court has struck down an exercise of the Spending Clause under a theory of legislative coercion.

The ACA, as enacted, required states to expand their Medicaid programs by 2014 to provide coverage to all individuals under the age of 65 with incomes at or below 133 percent of the federal poverty line[22] ($30,656 for a family of four in 2012) or lose all federal funding for their current Medicaid programs. Today, Medicaid law requires states to provide benefits only to ''discrete categories of needy individuals,''[23] and thus expansion was seen by the drafters of the ACA as a means to achieve nearly universal health care coverage. Under the ACA as enacted, if a state were to determine it could not afford to expand its Medicaid coverage, it would have lost all federal funding of its current Medicaid program, not a small loss considering that the federal government is required by law to pay for 50 to 83 percent of program costs, depending on the average per capita income of each state, and Medicaid may account for more than 20 percent of a state's total annual budget.[24]

Writing for Justices Breyer and Kagan, Chief Justice Roberts concluded that ''[t]he threatened loss of over 10 percent of a State's overall budget . . . is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.'' Upping the drama, the Chief Justice added that Congress's offer of new federal funding ''crossed the line distinguishing encouragement from coercion'' and put ''a gun to the head'' of the states. He did not buy the federal government's argument that Congress's original reservation of the right to ''alter'' or ''amend'' the Medicaid program included the ''power to transform it so dramatically,'' possibly adding 17 million more individuals to the Medicaid rolls. Rather, he explained, a state's acceptance of funding must be voluntary, and when ''pressure turns into compulsion . . . legislation runs contrary to our system of federalism.''

Although Justice Roberts acknowledged that there is a line ''where persuasion gives way to coercion,'' he found ''no need to fix a line'' on this occasion as ''this statute is surely beyond it.'' Five justices agreed that this clear constitutional violation could be fully remedied by severing from the Act the Secretary's right to withhold federal funds from a state that opts not to expand its Medicaid program.

B. New Opportunities for Medicaid MCOs

Given that the Court found a way to preserve a state's right to opt out of Medicaid expansion, the question turns to whether the states that fought the legislation will sign up for expansion. Pressure to do so will come from many sides. Hospital systems, provider associations, and MCOs can be expected to make compelling cases for expansion by focusing on the anticipated savings from a reduction in uncompensated care, new corporate investment and corresponding job growth, and an increase in corporate tax revenues. Whether those dollars—and any economic gains associated with a healthier Medicaid population—would be sufficient to offset the increased state expenditures for Medicaid expansion starting in 2017 is the subject of vigorous debate.

Today, the states and the federal government split the costs of Medicaid with the federal government paying 50 percent to 83 percent of those costs. Under Medicaid expansion, the federal government would assume 100 percent of the costs of the newly insured through 2016 before gradually decreasing funding, reaching a floor at 90 percent in 2020.[25] This deal may sound too good to refuse, but some states have forecasted that Medicaid expansion would eventually cripple their state's health systems. A spokesperson for the Pennsylvania Department of Public Welfare stated that expansion would possibly add $2 billion to state expenditures during the first five years of expansion.[26] Even if states intend to opt out of expansion, they are quick to note there will be other significant ACA costs to fund. For example, in 2013 and 2014 the Act will increase reimbursement rates for primary care doctors to the higher Medicare levels.[27] This hike amounts to an average rate increase of about 34 percent, according to the American Academy of Family Physicians.[28] In addition, the new ACA mandated ''essential health benefits'' package comes

[22] ACA, 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

[23] Categories include pregnant women, children, families, the elderly, and disabled individuals who meet requisite income levels. The ACA extends coverage to childless adults.

[24] *See Nat'l Fed'n of Indep. Bus.*, slip op. at 51; *see also Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2011 through September 30, 2012,* 75 Fed. Reg. 69,082 (Nov. 10, 2010), *available at* http://aspe.hhs.gov/health/fmap12.shtml.

[25] Kaiser Family Foundation, *The Health Reform Law's Medicaid Expansion: A Guide to the Supreme Court Arguments,* March, 2012, available at http://www.kff.org/healthreform/upload/8270-2.pdf.

[26] *See* Melissa Daniels, *Medicaid Expansion Would Cost PA $2B*, The Mercury (June 25, 2012, 12:01 AM), http://www.pottsmerc.com/article/20120625/NEWS01/120629702/medicaid-expansion-would-cost-pa—2b&pager=1.

[27] *See* Phil Galewitz, *Court Challenges Could Result in Medicaid Cutbacks Instead of Expansion,* Kaiser Health News (June 20, 2012), http://www.kaiserhealthnews.org/stories/2012/june/20/medicaid-health-law-supreme-court.aspx.

[28] *See id.*

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with a price tag for Medicaid beneficiaries enrolled in the expansion pool. Some states anticipate a substantial rise in Medicaid enrollment among those currently eligible for program benefits simply due to increased community awareness of the program from coverage of the ACA debate (known as the ''woodwork effect''). The new exchanges are expected to help that number grow even more through an improved eligibility determination process.

By the end of the second week following the Supreme Court announcement, Republican governors in eight states [29] had decried the decision and announced their firm resolve to opt out of Medicaid expansion, expressing an unwillingness to pledge state funds to Medicaid programs four and five years in advance. Twelve states, all with Democratic or independent governors, had embraced expansion, while 30 were still on the fence. This latter group included strong critics of the ACA, like Virginia Governor McDonnell, who might not be in a position to foreclose accepting Medicaid expansion and the billions of dollars in federal funding that come with it. Although Medicaid is the fastest-growing budget item for many states, uncompensated care and the anticipated loss of DSH payments will put tremendous financial strain on both providers and taxpayers. Some governors, like Nevada Governor Sandoval, have left open the possibility that they might opt in to Medicaid expansion in 2014 but then withdraw for 2017 when cost-sharing kicks in. Whether the grant of federal funding permits such a pull-out may be secondary to the political challenge those governors may have in pulling back a popular entitlement. Other questions being asked are whether a state can expand Medicaid up to a percentage less than 133 percent of the FPL and still receive federal funding (through exercise of a Section 1115 waiver), and whether the Administration might delay expansion past 2014. The National Governors Association and the National Association of Medicaid Directors have sent letters to HHS asking for clarification about the impact of the Supreme Court decision on states' Medicaid options.[30]

A quirk in the law that may put additional pressure on some states to opt in is that some individuals in the Medicaid expansion population would not be eligible for either Medicaid under current state law or refundable premium tax credits (in addition to cost-sharing subsidies) under the ACA when buying private insurance. Under the IRS Final Rule on Health Insurance Premium Tax Credits,[31] individuals with incomes between 100 percent and 400 percent of the FPL are eligible for tax credits (referred to by some as subsidies) if they do not receive Medicaid. In contrast, individuals with incomes below 100 percent of the FPL who are not eligible for Medicaid (*e.g.*, in Texas employed adult parents only receive Medicaid if their incomes are below 26 percent of the FPL)[32] will not receive tax credits unless they qualify for an advance credit early in the year because their income is projected at that time to be between 100 percent and 400 percent of the FPL. The rub is that the ACA assumed it would give Medicaid eligibility to all Texans below the FPL. Now that Texas has chosen to opt out of expansion, that assumption is no longer valid, and some individuals may find themselves under a mandate to buy insurance but without the means to do so. Of course, if their income is below the tax filing threshold or 100 percent of the FPL, they will not be assessed a tax for failing to meet the mandate. This wrinkle in the law, or ''Medicaid donut hole'' as some are calling it, will need to be examined before states must opt in to expansion. Secretary of HHS Kathleen Sebelius already has issued a letter to state governors indicating the Administration's intention to exercise its authority to establish any additional hardship exemptions that may be needed.[33] The more significant issue is that this population may remain uninsured

III. Contracting for Health Insurance Exchanges

A. State Investments

Under the ACA, states are required to have health insurance exchanges in place by the start of 2014.[34] The Act specifies that funding for the exchanges will be allocated to the states on an annual basis by the secretary of HHS.[35] HHS has been making grants on an ongoing basis, but will not award any grants after Jan. 1, 2015.[36] If a state elects not to establish an exchange or the HHS secretary determines that the state has not made enough progress by Jan. 1, 2013, to have the required exchange operational by the first day of 2014, then the secretary will either directly establish an exchange within the state or will implement one through agreement with a nonprofit.[37]

Given past uncertainty surrounding the future of the ACA, it is not surprising that states have made varying degrees of progress toward meeting the exchange requirement.[38] As of June 18, 2012, 14 states[39] and the District Columbia had established exchanges or taken concrete steps to implement an exchange; 18 were studying their options;[40] 14 had made no significant ac-

[29] Florida, Iowa, Louisiana, Mississippi, Nebraska, South Carolina, Texas, and Wisconsin.

[30] Dan Crippen, Letter to Kathleen Sebelius (July 2, 2012), available at http://op.bna.com/hl.nsf/r?Open=bbrk-8w5qbz; National Association of Medicaid Directors, Letter to Centers for Medicaid and CHIP Services (July 3, 2012), available at http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_submitted_questions_120703.pdf.

[31] 77 Fed. Reg. 30,377 (May 23, 2012) (to be codified at 26 C.F.R. pts. 1 and 602).

[32] Kaiser Commission on Medicaid and the Uninsured, *Where are the States Today: Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults* (March 2010), *available at* http://www.kff.org/medicaid/upload/7993-02.pdf.

[33] Kathleen Sebelius, Letter to State Governors (July 10, 2012).

[34] ACA, § 1311.

[35] *Id.* § 1311(a).

[36] *Id.*

[37] *Id.* § 1321 (c)(1).

[38] Kaiser Family Foundation, *State Action Toward Creating Health Insurance Exchanges, as of June 18, 2012*, statehealthfacts.org (June 18, 2012), http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17.

[39] *Id.* (California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Nevada, New York, Oregon, Rhode Island, Utah, Vermont, Washington, and West Virginia).

[40] *Id.* (Alabama, Arizona, Delaware, Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Pennsylvania, Tennessee, and Virginia).

tivity towards establishing an exchange;[41] three (Louisiana, Maine, and New Hampshire) had decided not to create a state exchange; and Arkansas was planning to implement a partnership exchange.[42] It is significant to note that states representing 42 percent of the U.S. population indicated before the Supreme Court decision that they planned to invest in an exchange regardless of the outcome.[43]

B. Issues Ahead for Exchange Contractors

For current state grantees and contractors, the Supreme Court's decision means that performance under their respective exchange grants and contracts will move full speed ahead. The decision will likely open up numerous additional opportunities with states that delayed work on the design and implementation of health insurance exchanges pending the Supreme Court's decision, notwithstanding the ACA's mandate that these exchanges begin serving the public in 2014. In the wake of the Supreme Court's decision, many of these states will likely rush towards the Nov. 16, 2012 deadline to submit exchange blueprints to HHS, and will undoubtedly rely on contractors to support that effort. In fact, on June 29, 2012, HHS made more funding available to help states continue their work to implement exchanges.[44] HHS also issued further guidance to help states understand the full scope of activities that can be funded under the available grant funding as they work to build exchanges.

Like many other ACA projects, grants to assist states in building and implementing exchanges are funded by appropriations. As discussed above, such projects already have been the subject of efforts to ''defund'' the appropriation that can be expected to continue. Although the BCA exempts from sequestration unobligated balances carried over from prior fiscal years, and this exemption likely protects grants to assist states in creating exchanges, Congress is expected to explore a variety of alternatives to sequestration. As a result, unobligated ACA funds for exchange development may be placed on the table as Congress attempts to right the country's fiscal problems.

There are steps contractors can take to prepare for and mitigate the effects of potential spending reductions before they occur.[45] Of particular importance to contractors working with state grantees under the ACA are the following:

- *Availability of Funds Clauses*: Contracts with state grantees may contain a variety of provisions that limit the state's liability to available funding. Such provisions have been included in many state exchange contracts, for example, and some are far less forgiving than others. Contractors should inventory their contracts to understand how the risk of funding shortfalls has been allocated. Contractors should further ensure that their expenditures do not exceed the funds obligated by the state to the contract, particularly in large IT projects where costs can be front-loaded with substantial software license fees. In the event that expenditures exceed or are close to exceeding available funding, contractors should comply with any notice provisions in their contracts and otherwise document the grantee's knowledge and approval of the expenditure.

- *Termination and Changes Clauses*: If ACA programs are cut or scaled back, termination and changes clauses will likely be the vehicles used to achieve any savings. Again, these clauses vary by contract and by state, and may be substantially different from standard federal clauses. Contractors should be cognizant of the distinction between a ''partial'' termination of the contract for convenience and a deductive change to the contract and the potentially different remedies that may be available for each.

- *Subcontractors, Vendors, and Suppliers*: Contractors should review their agreements with their team members to ensure that their liability under these agreements is co-extensive with the state's liability for a lack of available funding, partial termination, or deductive change.

IV. Conclusion

Supporters of the ACA can celebrate a half-time lead following the Supreme Court decision, but opponents are fully energized to take their case to the people for a final decision in the November elections. Among the contractors on the sidelines, those holding exchange contracts have the most at risk should Republicans regain the White House and the Senate. MCOs have a more certain future as the expansion population represents only a portion of Medicaid beneficiaries, not all states will opt out of Medicaid expansion, and both parties see partnership with managed care as a viable means for cutting their growing deficits.

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[41] *Id.* (Alaska, Florida, Georgia, Idaho, Kansas, Missouri, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Wisconsin, and Wyoming).

[42] *Id.*

[43] Mohit Kaushal & Bob Kocher, *Why The Supreme Court Decision On Health Care Reform Doesn't Really Matter*, Forbes.com (June 20, 2012), http://www.forbes.com/sites/kerryadolan/2012/06/20/why-the-supreme-court-decision-on-health-care-reform-doesnt-really-matter/.

[44] News Release, HHS.gov, Obama Administration and States Move Forward to Help States Implement Affordable Insurance Exchanges (June 29, 2012), *available at* http://www.hhs.gov/news/press/2012pres/06/20120629a.html.

[45] *See* Martin Willard, *Preparing for Sequestration and Budget Cuts*, Government Contracts Issue Update (Winter 2012), http://op.bna.com/hl.nsf/r?Open=bbrk-8w5qhv.

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