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ISSUE BRIEF

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Impact of *King v. Burwell*: The ACA's Key Design Flaws

Edmund F. Haislmaier

On March 4, the Supreme Court will hear oral arguments in *King v. Burwell*, a challenge to an IRS ruling related to the Affordable Care Act (ACA) granting premium support subsidies to those enrolled in federal exchanges. While claims that a ruling in favor of King would disrupt coverage to millions,[1] it is important to recognize that the ultimate source of any dislocation would be a direct result of the ACA's fundamental design flaws.

Many of the ACA's key components—and in particular related to this case—the exchanges, the premium tax credits, the cost-sharing subsidies, and the individual and employer mandates—are complicated, confusing and disruptive. The complexity and cascade of adverse effects are the inescapable byproducts of major flaws in the legislation's basic design.

Design Flaw #1: Overly Generous Subsidies

One of the biggest mistakes in the design of the ACA was that Congress made the new premium tax credits overly generous, and then sought to limit the cost of the program by restricting eligibility for those new tax credits to a narrow subset of the population.

Specifically, the ACA offers substantial premium tax credits, but only to individuals who have incomes between 100 percent and 400 percent of the federal poverty level (FPL), and only if they also do not have access to another source of coverage, such as an employer-sponsored plan.

Even within those limits, this design still creates a major financial incentive for millions of Americans with employment-based coverage to shift to plans that qualify for the new, more generous, premium tax credits. Furthermore, in cases where most of an employer's workers have incomes in the 100 percent to 400 percent of FPL range, it also creates a corresponding incentive for such employers to discontinue their group plans so that their workers can qualify for the better deal offered by the new premium tax credits.

In an attempt to prevent those effects, Congress added mandates to the ACA that employers with 50 or more full-time workers offer their employees "minimum essential coverage" and make a "minimum contribution" toward the cost of that coverage, along with requirements that employers report to the government detailed information on their plans and the coverage status of each employee.[2]

Of course, this complicated design requires some kind of administrative mechanism to screen applicants and determine their eligibility—so Congress vested the new exchanges with responsibility for performing those complicated, confusing, and disruptive tasks.

Design Flaw #2: Complex Tax Credit Design

A second major design flaw in the ACA is its inordinately complex rules for calculating the amount of the premium tax credit for each recipient. Even

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when someone qualifies for a premium tax credit under the law's eligibility rules, calculating the correct amount is absurdly complicated. The amount varies not only based on the recipient's income but *also* according to the size of his family, and *also* according to the price of the second-lowest-cost Silver-level plan in the county where he lives.

Thus, another major administrative task assigned to the exchanges is calculating the correct premium tax credit amount for each qualified enrollee. Yet, such calculations create new complexities.

Because the premium tax credits are applied on a monthly basis, the amount must be *recalculated* every time there is a change in the enrollee's family income, or in the size of the enrollee's family, or in the premium for the "reference" plan in the county where the enrollee lives. Furthermore, all of those calculations must be redone, and any advance-payment amounts reconciled, on a new two-page, 36-line tax form (accompanied by a 15-page set of instructions containing three additional worksheets), which must be included with the enrollee's annual federal income tax return.[3]

The source of this administrative nightmare is the fundamental error made by the authors of the ACA when they specified that the amount of the premium tax credit be calculated based on the recipient's income relative to the FPL. There is no other comparable provision in the federal tax code that bases the amount of a tax, or a tax preference, on the filer's income relative to the FPL. That is because the calculation of income relative to the FPL is not compatible with the basic structure of the income tax system, which uses just four filing categories—(1) individual, (2) head of household, (3) married filing jointly, and (4) married filing separately. Furthermore, even in other cases where a tax benefit is calculated with reference to the number of dependents—such as personal exemptions or child tax credits—the calculation is simply the number of qualified dependents times the statutorily set amount per dependent.

Moreover, from the context of health care, measuring household income with reference to the FPL is also incompatible with how health insurance is generally priced—on the basis of "self only" or "family" (two or more related individuals) coverage.

Design Flaw #3: A Blanket Prohibition on Pre-Existing Condition Exclusions

Yet another major mistake made by the authors of the ACA was their ill-considered and ham-fisted approach to addressing the issue of access to health insurance for individuals with pre-existing medical conditions. In the process, they not only created a major *new* problem but also discarded an earlier—more sensible—approach that had been working successfully for the vast majority of Americans.

Before the ACA was enacted, people with pre-existing medical conditions being denied health insurance was only a problem in the individual market—which accounts for 10 percent of all private health insurance. It was not a problem for the other 90 percent of Americans with private coverage through employer plans.

In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress set in place rules for employer-group coverage that specified that individuals switching from one group plan to another could not be denied new coverage, subjected to pre-existing-condition exclusions, or charged higher premiums because of their health status.[4]

While Congress required that both individual and group plans be guaranteed to be renewable, it did not

1. Edmund F. Haislmaier, *"King v. Burwell*: Assessing the Claimed Effects of a Decision for the Plaintiffs," Heritage Foundation *Issue Brief* No. 4349, February 20, 2015, http://report.heritage.org/ib4349.
2. Internal Revenue Service, "DRAFT: Form 1094-C: Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns," October 15, 2014, http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf (accessed February 18, 2015); Internal Revenue Service, "DRAFT: Form 1095-C: Employer-Provided Health Insurance Offer and Coverage," October 15, 2014, http://www.irs.gov/pub/irs-dft/f1095c--dft.pdf (accessed February 18, 2015); and Internal Revenue Service, "DRAFT: 2014 Instructions for Forms 1094-C and 1095-C," August 28, 2014, http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf (accessed February 18, 2014).
3. Internal Revenue Service, "Form 8962, Premium Tax Credit (PTC)," http://www.irs.ustreas.gov/pub/irs-pdf/f8962.pdf (accessed February 18, 2015), and Internal Revenue Service, "Instructions for Form 8962 Premium Tax Credit (PTC)," http://www.irs.gov/pub/irs-pdf/i8962.pdf (accessed February 18, 2015).
4. For a detailed discussion of HIPAA insurance market rules, see Edmund F. Haislma er, "Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms," Heritage Foundation *Backgrounder* No. 2703, June 22, 2012, http://www.heritage.org/research/reports/2012/06/saving-the-american-dream-the-us-needs-commonsense-health-insurance-reforms.

generally apply HIPPA's group-market rules to the individual market. The one exception was for workers who lost group coverage and subsequently exhausted any available continuation coverage. Those workers (and their dependents) were then entitled to obtain individual coverage at standard rates, with no pre-existing-condition exclusions. However, even in those circumstances, Congress allowed states the alternatives of assigning such individuals either to a particular insurer or to a state high-risk pool. Prior to the ACA, 19 states and the District of Columbia used the "federal fallback" of providing choice of any individual-market policy, three states used the "assigned carrier" option, and the remaining 28 states covered such individuals through a state high-risk pool.[5]

The fundamental mistake made by the authors of the ACA was discarding prior law and imposing on both the group and non-group markets a blanket federal prohibition on the application of pre-existing-conditions exclusions under *any* circumstances. Of course, as even the authors of the law understood, that change creates a new and destabilizing incentive for healthier individuals to delay purchasing health insurance until they need it. Consequently, to try to mitigate those effects, they added to the ACA a mandate on individuals to buy coverage.

Design Flaw #4: Rating Rules that Increase Premiums

Another error of the ACA was including a provision that limits age variation of premiums for adults to a maximum ratio of three to one. In other words, for the same plan, an insurer is not permitted to charge a 64-year-old a rate that is more than three times the rate it charges a 19-year-old.

The natural age variation in medical costs among adults is five to one, as the oldest group of (non-Medicare) adults consumes five times as much medical care as the youngest group.[6] Thus, the effect of this mandated "rate compression" is to force insurers to both artificially underprice coverage for older adults and artificially overprice coverage for younger adults.

Yet, while younger adults tend to be in better health, they also tend to earn less than older workers with more experience. That combination makes young adults more sensitive to changes in the price of health insurance and more likely to decline coverage if it becomes more expensive. That is also why the uninsured population consists disproportionately of young adults. According to the U.S. Census Bureau, in 2013, individuals aged 19 to 34 accounted for 45 percent of all uninsured adults.[7]

Thus, imposing rating rules that artificially increase health insurance premiums for young adults is not only unfair, but counter-productive, since it increases the costs of coverage for those most likely to already be uninsured.[8] Indeed, that was the experience in states that previously imposed misguided insurance rating rules similar to the ones that were later included in the ACA.[9] It also needlessly increases the cost of the ACA by necessitating larger premium subsidies to help lower-income young adults purchase artificially overpriced insurance.

Design Flaw #5: Costly and Prescriptive Benefit Mandates

Given that a central objective of the ACA's authors was to extend coverage to more of the uninsured, it was pure counterproductive folly to also

5. Kaiser Family Foundation, "State Health Facts: Non-Group Coverage Rules for HIPAA Eligible Individuals [for 2012]," http://kff.org/other/state-indicator/hipaa-rules/ (accessed February 18, 2015).
6. Oliver Wyman, "Impact of Changing Age Rating Bands in 'America's Healthy Future Act of 2009,'" September 28, 2009.
7. Jessica C. Smith and Carla Medalia, "Health Insurance Coverage in the United States: 2013," U.S. Census Bureau, "Table 2. Type of Health Insurance Coverage by Age: 2013," p. 7, September 2014, http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf (accessed February 18, 2015).
8. Even those predicting dire consequences from a Court ruling in favor of the plaintiffs in the *King* case implicitly recognize that this misguided provision of the ACA is a significant source of the dislocation they expect will occur. See Evan Saltzman and Christine Eibner, "The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces," RAND Corporation, 2015, http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf (accessed February 18, 2015). Saltzman and Eibner note, "Those who are young and healthy have a higher price elasticity for health insurance, meaning that they are more reactive to price and are more likely than older and less healthy people to forgo coverage if premiums are high."
9. Leigh Wachenheim and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets," Milliman, Inc., March 2012, http://www.ahipcoverage.com/wp-content/uploads/2012/03/Updated-Milliman-Report.pdf (accessed February 18, 2015).

impose additional benefit mandates and coverage requirements that inherently *increase* the costs of health insurance.

For instance, the ACA mandates coverage for "habilitative services," which virtually no plan previously covered.[10] Not only do increased coverage costs make it more difficult to insure the existing uninsured, they also risk pricing some of the currently insured out of coverage—potentially creating *new* uninsured individuals. Furthermore, they needlessly increase the cost of any premium subsidies.

Conclusion

The complexity and adverse effects of the ACA's key provisions have already increased costs and dislocated millions from coverage. Thus, it is the ACA's fundamental design flaws—not how the Supreme Court eventually rules in the *King* case—that are the ultimate source of disruption and will continue to plague the law's implementation.

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10. 42 U.S. Code § 18022(b)(1)(G).

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ISSUE BRIEF

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Eight Groups Harmed by the ACA's Flawed Policies

Alyene Senger

The Supreme Court will hear oral arguments on March 4 in the case of *King v. Burwell*—a challenge to an IRS rule under the Affordable Care Act (ACA) allowing the payment of premium subsidies to individuals enrolled in the federal exchange. Supporters of the ACA have made various claims about the harm that would supposedly occur were the court to find for the plaintiffs (King) in this case.[1] While it is not surprising that those claims have attracted attention, an important, though often missing, context is the harm being caused by the ACA itself.

Following are eight groups of individuals who have been, or will be, specifically harmed by the law's flawed policies:

1. **Taxpayers.** The federal government continues to run annual budget deficits, incurring ever-mounting levels of national debt largely fueled by the existing entitlement programs. Despite the nation's current fiscal issues, the ACA creates a new entitlement program (exchange subsidies) and expands an already broken one (Medicaid), costing almost $2 trillion over the next decade.[2] To offset some of this new spending, the law includes 18 new or increased taxes that cost taxpayers an estimated $771 billion from 2013 to 2022.[3]

2. **Seniors.** To partially offset the ACA's new spending, the law contains spending cuts to Medicare that amount to $716 billion from 2013 to 2022.[4] The Medicare Trustees have warned since the law's passage that if these cuts are implemented as the law requires, they will significantly impact seniors' access to and quality of care.[5] For example, the law reduces payments in the Medicare Advantage (MA) program, the private insurance option under Medicare, by $156 billion from 2013 to 2022.[6] These cuts are already causing MA plans to adjust their benefit packages by restricting provider networks. The end result of course is that seniors have fewer provider options and in some cases are forced to find new doctors.[7]

3. **Workers**. The ACA requires employers with 50 or more full-time workers (defined as a minimum of 30 hours a week), to either offer government-approved health coverage or pay a penalty, starting in 2014. However, the Obama Administration issued regulations that delayed and then phased in the implementation and enforcement of the employer mandate and related provisions of the ACA.[8] There is a plethora of anecdotal evidence that employers are cutting workers' hours to fall below the 30-hour threshold.[9] Moreover, in the first nine months of 2014, nearly 5 million people were no longer receiving employer-sponsored coverage.[10]

4. **Faith-Based Employers.** The ACA requires all employers that offer non-grandfathered health plans to pay for coverage for contraception, sterilization, and abortion-inducing drugs and devices. While this mandate exempts formal houses of wor-

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ship, other religious employers, such as hospitals, schools, social-service organizations, as well as for-profit businesses, must comply or risk steep fines of up to $100 per employee per day. Many employers believe that complying with this mandate would violate the tenets of their faith. Over 300 plaintiffs in more than 100 cases have filed lawsuits over the rule, with the vast majority of plaintiffs winning temporary or permanent injunctions against the coercive anti-conscience mandate.[11]

5. **Doctors.** The ACA exacerbates the worst features of our health care system by doubling down on the third-party payment arrangement that compromises the independence and integrity of the medical profession. As the government expands its role as payer, doctors face new layers of bureaucracy and administrative burden.[12] All of this contributes to physicians' already low morale. One survey found that in 2014, 46 percent of physicians gave the ACA a failing grade as the vehicle for health care reform.[13]

1. Edmund F. Haislmaier, "*King v. Burwell*: Assessing the Claimed Effects of a Decision for the Plaintiffs," Heritage Foundation *Issue Brief* No. 4349, February 20, 2015, http://www.heritage.org/research/reports/2015/02/king-v-burwell-assessing-the-claimed-effects-of-a-decision-for-the-plaintiffs.
2. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline," Table B-1, https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf (accessed February 20, 2015).
3. Joint Committee on Taxation, "Estimated Revenue Effects of a Proposal to Repeal Certain Tax Provisions Contained in the 'Affordable Care Act ("ACA")'," June 15, 2012, and Congressional Budget Office, "Table 2: CBO's May 2013 Estimate of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act," https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2013-05-ACA.pdf (accessed February 20, 2015). The total amount of tax revenue collected from the individual mandate, employer mandate, and 40 percent excise tax on high-cost health plans comes from the CBO's May 2013 estimate. For all other taxes, the amount of tax revenue totaled comes from the Joint Committee on Taxation's June 2012 estimation.
4. Douglas W. Elmendorf, letter to Speaker of the House John Boehner (R-OH), July 24, 2012, pp. 13-14, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf (accessed September 25, 2014). The CBO estimates the cost of repealing the ACA, which would increase Medicare spending due to the absence of the ACA's Medicare cuts. If the law were repealed, "[w]ithin Medicare, net increases in spending for the services covered by Part A (Hospital Insurance) and Part B (Medical Insurance) would total $517 billion and $247 billion, respectively. Those increases would be partially offset by a $48 billion reduction in net spending for Part D."
5. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, July 28, 2014, pp. 208 and 209, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf (accessed February 17, 2015).
6. Elmendorf, letter to Speaker of the House John Boehner (R-OH), July 24, 2012, p. 14.
7. Melinda Beck, "UnitedHealth Culls Doctors From Medicare Advantage Plans," *The Wall Street Journal*, November 16, 2013, http://www.wsj.com/news/articles/SB10001424052702303559504579200190614501838?mod=WSJ_hp_LEFTWhatsNewsCollection (accessed February 17, 2015).
8. "Shared Responsibility for Employers Regarding Health Coverage; Final Rule," *Federal Register*, Vol. 79, No. 29, February 12, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/html/2014-03082.htm (accessed February 20, 2015). The authority of the Administration to take those actions is being challenged in another lawsuit, *United States House of Representatives v. Sylvia Mathews Burwell*, Case No. 14-cv-01967, http://online.wsj.com/public/resources/documents/HouseACAcomplaint112014.pdf (accessed February 20, 2015).
9. Jed Graham, "ObamaCare Employer Mandate: A List Of Cuts to Work Hours, Jobs," *Investor's Business Daily*, September 5, 2014, http://news.investors.com/politics-obamacare/090514-669013-obamacare-employer-mandate-a-list-of-cuts-to-work-hours-jobs.htm (accessed February 13, 2015).
10. Edmund F. Haislmaier and Drew Gonshorowski, "Q3 2014 Health Insurance Enrollment: Employer Coverage Continues to Decline, Medicaid Keeps Growing," Heritage Foundation *Backgrounder* No. 2988, January 29, 2015, http://www.heritage.org/research/reports/2015/01/q3-2014-health-insurance-enrollment-employer-coverage-continues-to-decline-medicaid-keeps-growing.
11. Becket Fund for Religious Liberty, "HHS Information Central," http://www.becketfund.org/hhsinformationcentral/ (accessed February 17, 2015).
12. Amy Anderson, "The Impact of the Affordable Care Act on the Health Care Workforce," Heritage Foundation *Backgrounder* No. 2887, March 18, 2014, http://www.heritage.org/research/reports/2014/03/the-impact-of-the-affordable-care-act-on-the-health-care-workforce.
13. The Physicians Foundation, "2014 Survey of America's Physicians: Practice Patterns and Perspectives," p. 15, http://www.physiciansfoundation.org/uploads/default/2014_Physicians_Foundation_3iennial_Physician_Survey_Report.pdf/ (accessed February 12, 2015).

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ISSUE BRIEF

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King v. Burwell: An Opportunity for Congress and the States to Clear Away Obamacare's Failed Policies

Nina Owcharenko and Edmund F. Haislmaier

On March 4, the Supreme Court will hear oral arguments in *King v. Burwell*—a case challenging the Obama Administration's IRS ruling granting premium support subsidies to those enrolled in federal exchanges under the Affordable Care Act (ACA). While a ruling against the Administration would preclude paying those subsidies to individuals who obtain coverage through the federally run exchange, that would merely add one more effect to the ongoing complexity and cascade of adverse effects produced by the law's complex and flawed design.[1]

Congress and the states should therefore seize the opportunity and clear the way for patient-centered, market-based reforms to take root in the states. To start, Congress should devolve the regulatory authority over insurance back to the states. In anticipation of such an exemption, states should use their authority now to put in place their own policies governing insurance.

What Congress and the States Should *Not* Do

It is critical that any response at the federal or state level not prop up or strengthen the ACA's troubled framework. Therefore:

- **Congress should not preserve the flawed ACA subsidy scheme.** Congress should not perpetuate the complex and costly subsidies in the ACA. The design of the subsidies creates major financial incentive for millions of Americans to shift to plans that qualify for the new subsidies; it involves additional rules, restrictions, and penalties; and is administratively complicated.[2]

- **States should not adopt state exchanges.** States should not pursue efforts to adopt a state exchange. States gain no meaningful flexibility from administering the exchanges,[3] while their long-term costs fall squarely on the states—as any state implementing a state exchange must develop its own revenue source to fund the exchange's annual operations.[4]

What Congress and the States *Should* Do

Federal Action: Congress should exempt individuals, employers, and insurance plans in states that have no state exchange from the ACA's costly rules, regulations, and mandates. The exemption should include items such as the ACA's rating rules and benefits mandates, as well as formally exempting residents of the affected states from the individual and employer mandates, among others.[5] As is evident from basic premium analysis, in many of the potentially affected states, the cost of coverage was less before the ACA.[6]

State Action: States should pass pre-emptive legislation that would ensure a smooth transition from ACA-compliant plans to state-regulated coverage. States should take the opportunity to review and assess their pre-ACA rules and regulations

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TABLE 1

Effects of Obamacare Regulations on Health Insurance Premiums in the 34 Federal Exchange States

This table shows the difference in average monthly premiums between 2014 exchange plans—the first year for which premiums reflect the imposition of the ACA's benefit mandates and rating rules—and 2013 non-group market plans.

n Up 100%+
n Up 51%–100%
n Up 26%–50%
n Up 0%–25%
Down

	ADULT AGE 27			ADULT AGE 50			FAMILY OF FOUR		
	BEFORE	EXCHANGE	% change	BEFORE	EXCHANGE	% change	BEFORE	EXCHANGE	% change
Alabama	$165.00	$216.12	31.0%	$285.00	$368.31	29.2%	$676.66	$730.01	7.9%
Alaska	$198.00	$341.58	72.5%	$398.00	$582.05	46.2%	$1,020.45	$1,153.84	13.1%
Arizona	$102.00	$261.87	156.7%	$315.00	$446.24	41.7%	$792.38	$884.51	11.6%
Arkansas	$105.00	$285.00	171.4%	$215.00	$385.00	79.1%	$761.26	$948.82	24.6%
Delaware	$129.35	$258.60	99.9%	$267.00	$440.71	65.1%	$731.44	$873.52	19.4%
Florida	$151.40	$264.45	74.7%	$257.00	$450.67	75.4%	$724.98	$893.27	23.2%
Georgia	$98.12	$263.28	168.3%	$263.00	$448.69	70.6%	$732.34	$889.32	21.4%
Illinois	$116.45	$249.72	114.4%	$298.00	$425.56	42.8%	$753.23	$843.50	12.0%
Indiana	$197.45	$264.77	34.1%	$249.00	$451.21	81.2%	$712.80	$894.38	25.5%
Iowa	$205.00	$230.21	12.3%	$347.00	$392.32	13.1%	$729.00	$777.61	6.7%
Kansas	$87.40	$200.14	129.0%	$198.00	$341.08	72.3%	$553.92	$676.05	22.0%
Louisiana	$129.20	$266.38	106.2%	$315.00	$453.96	44.1%	$800.56	$899.79	12.4%
Maine	$225.00	$282.59	25.6%	$329.00	$341.00	3.6%	$945.86	$954.57	0.9%
Michigan	$117.30	$255.85	118.1%	$305.00	$436.01	43.0%	$771.41	$864.22	12.0%
Mississippi	$163.00	$213.00	30.7%	$364.00	$500.00	37.4%	$854.92	$943.00	10.3%
Missouri	$159.00	$244.06	53.5%	$299.00	$415.92	39.1%	$743.80	$824.39	10.8%
Montana	$150.00	$213.80	42.5%	$278.00	$364.35	31.1%	$666.11	$722.19	8.4%
Nebraska	$125.00	$213.34	70.7%	$298.00	$363.57	22.0%	$680.98	$720.62	5.8%
New Hampshire	$220.00	$221.71	0.8%	$359.00	$377.84	5.2%	$739.09	$748.91	1.3%
New Jersey	$329.00	$319.33	-2.9%	$550.00	$544.20	-1.1%	$1,081.50	$1,078.66	-0.3%
North Carolina	$135.00	$257.39	90.7%	$364.00	$438.64	20.5%	$824.85	$869.41	5.4%
North Dakota	$116.00	$247.30	113.2%	$215.00	$421.44	96.0%	$634.81	$835.33	31.6%
Ohio	$247.00	$243.12	-1.6%	$421.00	$414.32	-1.6%	$824.47	$821.21	-0.4%
Oklahoma	$135.00	$213.02	57.8%	$298.00	$363.02	21.8%	$680.29	$719.53	5.8%
Pennsylvania	$167.00	$220.36	32.0%	$289.00	$374.05	29.4%	$689.38	$744.13	7.9%
South Carolina	$205.00	$246.19	20.1%	$315.00	$419.56	33.2%	$762.59	$831.60	9.0%
South Dakota	$159.00	$308.64	94.1%	$305.00	$525.99	72.5%	$853.71	$1,042.56	22.1%
Tennessee	$135.00	$214.70	59.0%	$278.00	$365.90	31.6%	$667.91	$725.24	8.6%
Texas	$115.00	$229.95	100.0%	$205.00	$391.88	91.2%	$599.72	$776.74	29.5%
Utah	$126.00	$220.91	75.3%	$268.00	$338.04	26.1%	$648.54	$693.88	7.0%
Virginia	$165.00	$193.07	17.0%	$278.00	$335.27	20.6%	$704.76	$774.34	9.9%
West Virginia	$215.00	$229.48	6.7%	$359.00	$391.07	8.9%	$757.83	$775.14	2.3%
Wisconsin	$140.00	$277.91	98.5%	$289.00	$473.61	63.9%	$788.82	$938.72	19.0%
Wyoming	$289.00	$364.95	26.3%	$540.00	$621.96	15.2%	$1,186.00	$1,232.78	3.9%

Sources: Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief* No. 4086, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.

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with attention to making coverage more affordable and available. Action taken in 2011 by the state of Maine provides a template for such pre-emptive legislation.[7] States should consider more flexible rating rules, more affordable benefit packages, more competition through state reciprocity agreements, and other changes that help to facilitate more choice and competition while retaining or restoring pre-ACA portability rules and consumer protections.

The ACA and Its Flawed Policies: Still the Problem

It is important to remember that it is the ACA's flawed policies that are responsible for the adverse effects that have characterized this law since its inception. Many of the law's key components—the exchanges, the premium and cost-sharing subsidies, the rating rules, benefit requirements, as well as the individual and employer mandates—are complicated, confusing, and disruptive. A ruling against the Administration creates a unique opportunity to provide individuals who live in states that do not operate an exchange with immediate relief from the costly ACA rules and mandates.

Clearing away the ACA's flawed policies is the first step toward a patient-centered, market-based health care alternative. That will require a new approach to the tax treatment of health insurance and health care entitlement programs that empowers individuals—not the government or employers—by giving them direct choice and control that allows them to make their own health care decisions.[8]

*—**Nina Owcharenko** is Director of the Center for Health Policy Studies and Preston A. Wells, Jr., Fellow, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation. **Edmund F. Haislmaier** is Senior Research Fellow in the Center for Health Policy Studies, of the Institute for Family, Community, and Opportunity..*

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3. Edmund F. Haislmaier, "Less Than Meets the Eye: The Obamacare Exchange Regulations," The Daily Signal, July 12, 2011, http://dailysignal.com/2011/07/12/less-than-meets-the-eye-the-obamacare-exchange-regulations/.
4. Nina Owcharenko and Edmund F. Haislmaier, "Medicaid Expansion and State Health Exchanges: A Risky Proposition for the States," Heritage Foundation *Issue Brief* No. 3802, December 12, 2012, http://www.heritage.org/research/reports/2012/12/obamacares-medicaid-expansion-and-state-exchanges-risky-for-states.
5. A ruling against the Administration would render the employer mandate effectively unenforceable and would increase the number of people who would qualify for an affordability exemption from the individual mandate. See Tom Miller and Grace-Marie Turner, "What Happens to the ACA if the Petitioners in King v. Burwell Win at the Supreme Court?" *Forbes*, February 12, 2015, http://www.forbes.com/sites/gracemarieturner/2015/02/12/what-happens-to-the-aca-if-the-petitioners-in-king-v-burwell-win-at-the-supreme-court/ (accessed February 26, 2015).
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7. Maine offers an example of such pre-emptive legislation. See Tarren Bragdon and Joel Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite,'" Heritage Foundation *Backgrounder* No. 2582, July 19, 2011, http://www.heritage.org/research/reports/2011/07/health-care-reform-in-maine-reversing-obamacare-lite.
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ISSUE BRIEF

No. 4360 | FEBRUARY 27, 2015

King v. Burwell: An Opportunity for Congress and the States to Clear Away Obamacare's Failed Policies

Nina Owcharenko and Edmund F. Haislmaier

On March 4, the Supreme Court will hear oral arguments in *King v. Burwell*—a case challenging the Obama Administration's IRS ruling granting premium support subsidies to those enrolled in federal exchanges under the Affordable Care Act (ACA). While a ruling against the Administration would preclude paying those subsidies to individuals who obtain coverage through the federally run exchange, that would merely add one more effect to the ongoing complexity and cascade of adverse effects produced by the law's complex and flawed design.[1]

Congress and the states should therefore seize the opportunity and clear the way for patient-centered, market-based reforms to take root in the states. To start, Congress should devolve the regulatory authority over insurance back to the states. In anticipation of such an exemption, states should use their authority now to put in place their own policies governing insurance.

What Congress and the States Should *Not* Do

It is critical that any response at the federal or state level not prop up or strengthen the ACA's troubled framework. Therefore:

- **Congress should not preserve the flawed ACA subsidy scheme.** Congress should not perpetuate the complex and costly subsidies in the ACA. The design of the subsidies creates major financial incentive for millions of Americans to shift to plans that qualify for the new subsidies; it involves additional rules, restrictions, and penalties; and is administratively complicated.[2]

- **States should not adopt state exchanges.** States should not pursue efforts to adopt a state exchange. States gain no meaningful flexibility from administering the exchanges,[3] while their long-term costs fall squarely on the states—as any state implementing a state exchange must develop its own revenue source to fund the exchange's annual operations.[4]

What Congress and the States *Should* Do

Federal Action: Congress should exempt individuals, employers, and insurance plans in states that have no state exchange from the ACA's costly rules, regulations, and mandates. The exemption should include items such as the ACA's rating rules and benefits mandates, as well as formally exempting residents of the affected states from the individual and employer mandates, among others.[5] As is evident from basic premium analysis, in many of the potentially affected states, the cost of coverage was less before the ACA.[6]

State Action: States should pass pre-emptive legislation that would ensure a smooth transition from ACA-compliant plans to state-regulated coverage. States should take the opportunity to review and assess their pre-ACA rules and regulations

This paper, in its entirety, can be found at
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TABLE 1

Effects of Obamacare Regulations on Health Insurance Premiums in the 34 Federal Exchange States

This table shows the difference in average monthly premiums between 2014 exchange plans—the first year for which premiums reflect the imposition of the ACA's benefit mandates and rating rules—and 2013 non-group market plans.

n Up 100%+
n Up 51%–100%
n Up 26%–50%
n Up 0%–25%
Down

	ADULT AGE 27			ADULT AGE 50			FAMILY OF FOUR		
	BEFORE	EXCHANGE	% change	BEFORE	EXCHANGE	% change	BEFORE	EXCHANGE	% change
Alabama	$165.00	$216.12	31.0%	$285.00	$368.31	29.2%	$676.66	$730.01	7.9%
Alaska	$198.00	$341.58	72.5%	$398.00	$582.05	46.2%	$1,020.45	$1,153.84	13.1%
Arizona	$102.00	$261.87	156.7%	$315.00	$446.24	41.7%	$792.38	$884.51	11.6%
Arkansas	$105.00	$285.00	171.4%	$215.00	$385.00	79.1%	$761.26	$948.82	24.6%
Delaware	$129.35	$258.60	99.9%	$267.00	$440.71	65.1%	$731.44	$873.52	19.4%
Florida	$151.40	$264.45	74.7%	$257.00	$450.67	75.4%	$724.98	$893.27	23.2%
Georgia	$98.12	$263.28	168.3%	$263.00	$448.69	70.6%	$732.34	$889.32	21.4%
Illinois	$116.45	$249.72	114.4%	$298.00	$425.56	42.8%	$753.23	$843.50	12.0%
Indiana	$197.45	$264.77	34.1%	$249.00	$451.21	81.2%	$712.80	$894.38	25.5%
Iowa	$205.00	$230.21	12.3%	$347.00	$392.32	13.1%	$729.00	$777.61	6.7%
Kansas	$87.40	$200.14	129.0%	$198.00	$341.08	72.3%	$553.92	$676.05	22.0%
Louisiana	$129.20	$266.38	106.2%	$315.00	$453.96	44.1%	$800.56	$899.79	12.4%
Maine	$225.00	$282.59	25.6%	$329.00	$341.00	3.6%	$945.86	$954.57	0.9%
Michigan	$117.30	$255.85	118.1%	$305.00	$436.01	43.0%	$771.41	$864.22	12.0%
Mississippi	$163.00	$213.00	30.7%	$364.00	$500.00	37.4%	$854.92	$943.00	10.3%
Missouri	$159.00	$244.06	53.5%	$299.00	$415.92	39.1%	$743.80	$824.39	10.8%
Montana	$150.00	$213.80	42.5%	$278.00	$364.35	31.1%	$666.11	$722.19	8.4%
Nebraska	$125.00	$213.34	70.7%	$298.00	$363.57	22.0%	$680.98	$720.62	5.8%
New Hampshire	$220.00	$221.71	0.8%	$359.00	$377.84	5.2%	$739.09	$748.91	1.3%
New Jersey	$329.00	$319.33	-2.9%	$550.00	$544.20	-1.1%	$1,081.50	$1,078.66	-0.3%
North Carolina	$135.00	$257.39	90.7%	$364.00	$438.64	20.5%	$824.85	$869.41	5.4%
North Dakota	$116.00	$247.30	113.2%	$215.00	$421.44	96.0%	$634.81	$835.33	31.6%
Ohio	$247.00	$243.12	-1.6%	$421.00	$414.32	-1.6%	$824.47	$821.21	-0.4%
Oklahoma	$135.00	$213.02	57.8%	$298.00	$363.02	21.8%	$680.29	$719.53	5.8%
Pennsylvania	$167.00	$220.36	32.0%	$289.00	$374.05	29.4%	$689.38	$744.13	7.9%
South Carolina	$205.00	$246.19	20.1%	$315.00	$419.56	33.2%	$762.59	$831.60	9.0%
South Dakota	$159.00	$308.64	94.1%	$305.00	$525.99	72.5%	$853.71	$1,042.56	22.1%
Tennessee	$135.00	$214.70	59.0%	$278.00	$365.90	31.6%	$667.91	$725.24	8.6%
Texas	$115.00	$229.95	100.0%	$205.00	$391.88	91.2%	$599.72	$776.74	29.5%
Utah	$126.00	$220.91	75.3%	$268.00	$338.04	26.1%	$648.54	$693.88	7.0%
Virginia	$165.00	$193.07	17.0%	$278.00	$335.27	20.6%	$704.76	$774.34	9.9%
West Virginia	$215.00	$229.48	6.7%	$359.00	$391.07	8.9%	$757.83	$775.14	2.3%
Wisconsin	$140.00	$277.91	98.5%	$289.00	$473.61	63.9%	$788.82	$938.72	19.0%
Wyoming	$289.00	$364.95	26.3%	$540.00	$621.96	15.2%	$1,186.00	$1,232.78	3.9%

Sources: Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief* No. 4086, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.

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with attention to making coverage more affordable and available. Action taken in 2011 by the state of Maine provides a template for such pre-emptive legislation.[7] States should consider more flexible rating rules, more affordable benefit packages, more competition through state reciprocity agreements, and other changes that help to facilitate more choice and competition while retaining or restoring pre-ACA portability rules and consumer protections.

The ACA and Its Flawed Policies: Still the Problem

It is important to remember that it is the ACA's flawed policies that are responsible for the adverse effects that have characterized this law since its inception. Many of the law's key components—the exchanges, the premium and cost-sharing subsidies, the rating rules, benefit requirements, as well as the individual and employer mandates—are complicated, confusing, and disruptive. A ruling against the Administration creates a unique opportunity to provide individuals who live in states that do not operate an exchange with immediate relief from the costly ACA rules and mandates.

Clearing away the ACA's flawed policies is the first step toward a patient-centered, market-based health care alternative. That will require a new approach to the tax treatment of health insurance and health care entitlement programs that empowers individuals—not the government or employers—by giving them direct choice and control that allows them to make their own health care decisions.[8]

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1. Edmund F. Haislmaier, "King v. Burwell: Assessing the Claimed Effects of a Decision for the Plaintiffs," Heritage Foundation *Issue Brief* No. 4349, February 20, 2015, http://www.heritage.org/research/reports/2015/02/king-v-burwell-assessing-the-claimed-effects-of-a-decision-for-the-plaintiffs.
2. Edmund F. Haislmaier, "Impact of King v. Burwell: The ACA's Key Design Flaws," Heritage Foundation *Issue Brief* No. 4350, February 20, 2015, http://www.heritage.org/research/reports/2015/02/impact-of-king-v-burwell-the-acas-key-design-flaws.
3. Edmund F. Haislmaier, "Less Than Meets the Eye: The Obamacare Exchange Regulations," The Daily Signal, July 12, 2011, http://dailysignal.com/2011/07/12/less-than-meets-the-eye-the-obamacare-exchange-regulations/.
4. Nina Owcharenko and Edmund F. Haislmaier, "Medicaid Expansion and State Health Exchanges: A Risky Proposition for the States," Heritage Foundation *Issue Brief* No. 3802, December 12, 2012, http://www.heritage.org/research/reports/2012/12/obamacares-medicaid-expansion-and-state-exchanges-risky-for-states.
5. A ruling against the Administration would render the employer mandate effectively unenforceable and would increase the number of people who would qualify for an affordability exemption from the individual mandate. See Tom Miller and Grace-Marie Turner, "What Happens to the ACA if the Petitioners in King v. Burwell Win at the Supreme Court?" *Forbes*, February 12, 2015, http://www.forbes.com/sites/gracemarieturner/2015/02/12/what-happens-to-the-aca-if-the-petitioners-in-king-v-burwell-win-at-the-supreme-court/ (accessed February 26, 2015).
6. Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief* No. 4068, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.
7. Maine offers an example of such pre-emptive legislation. See Tarren Bragdon and Joel Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite,'" Heritage Foundation *Backgrounder* No. 2582, July 19, 2011, http://www.heritage.org/research/reports/2011/07/health-care-reform-in-maine-reversing-obamacare-lite.
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ISSUE BRIEF

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King v. Burwell: What State Lawmakers Should Do

Edmund F. Haislmaier

State lawmakers—particularly those in states that would be affected by a Supreme Court ruling against the Obama Administration in the *King* case—should take steps to encourage Congress to put forth a legislative response to the case, specifically by exempting affected states from the costly Obamacare rules, regulations, and mandates.[1]

Reject a State Exchange

State lawmakers should also resist efforts to prop up the flawed Obamacare structure by rejecting any adoption of a state exchange. States gain no meaningful flexibility from administering the exchanges,[2] while their long-term costs fall squarely on the states, as any state implementing a state exchange must develop its own revenue source to fund the exchange's annual operations.[3] Instead, states should lead the way out of Obamacare by demonstrating that they are better equipped to ensure access to affordable coverage.

Adopt Consumer-Focused State Reforms

To encourage Congress to exempt states affected by a Court ruling in favor of *King* from the costly Obamacare rules, regulations, and mandates, state lawmakers should put forward a set of state-based reforms that would minimize any adverse effects on individuals losing subsidies and allow these individuals to transition to new, more affordable coverage in their states. Such action would demonstrate state preparation for and receptiveness to a targeted exemption.

Specifically, state lawmakers should consider four key areas of state insurance law.

Ensure Appropriate Age Rating Rules. State lawmakers should ensure that state insurance law is set to default automatically to a less restrictive age rating ratio for premiums in their individual and group health insurance markets, effective as soon as Congress lifts the ACA's ill-considered federal imposition of a narrower three-to-one ratio. The natural variation in health costs between 64-year-olds and 21-year-olds is about five-to-one.[4]

States should revert to their prior standard or another more appropriate variation. Taking such action would help to minimize disruption in a state's insurance markets by enabling insurers to price coverage for younger adults more appropriately. That would better position insurers to attract and retain a larger portion of this desirable customer segment whose premiums partially offset the higher costs of less healthy enrollees.

Review State Benefit Mandates. Too often, health insurance benefit mandates function as special-interest provisions that are less about protecting consumers and more about protecting the revenues of health care providers. A national actuarial study estimated that the Obamacare essential benefits were responsible for increasing individual market premiums by between 3 percent and 17 percent—with the effects varying by health plan and state, which mainly reflected differences in the extent to

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which states had already mandated coverage for some of the required services.[5]

Congress's enactment of an exemption from Obamacare's federal health insurance benefits mandates would default regulation in that area back to state law. Beyond that, state lawmakers could also look to any previous reviews of the costs of state-mandated benefits in their states as a starting point for reconsidering the appropriateness of their state's benefit requirements.

Restore Individual and Small-Group Market Rules. State lawmakers should also ensure that their state's insurance laws governing individual and small-group health insurance policies are set to default automatically to the pre-Obamacare individual and small-group rules. This is important because the ACA did not just supersede the prior rules; it actually discarded much of that earlier design in the process.

The fundamental mistake made by the authors of the ACA was to discard prior law and impose on both the group and non-group markets a blanket federal prohibition on the application of preexisting-conditions exclusions under *any* circumstances. Consequently, state lawmakers need to ensure that the appropriate default is set in state law.

States should ensure that individual-market plans are guaranteed renewable, as previously established.[6] Beyond that, state lawmakers should also adopt individual-market rules that, similar to the HIPAA group-market rules, would permit someone who has purchased and maintained coverage to obtain new individual health insurance coverage regardless of the individual's health status or past medical history.[7]

Permit Interstate Insurance Competition. State lawmakers do not need federal approval or action to create interstate insurance competition in their states. States can simply enact laws that permit policies regulated in other states to be sold to their state's residents. Allowing a state's residents to purchase coverage regulated by an adjoining state would make the most sense. Doctors and hospitals located near state borders likely already treat patients living in neighboring states and have contracts with insurers regulated by those states.

For instance, as part of its 2011 reform law, Maine allowed its residents to buy coverage that is regulated by Connecticut, Massachusetts, New Hampshire, or Rhode Island.[8] In this respect too, Maine's legislation is a model for other states to consider.

1. Nina Owcharenko and Edmund F. Haislmaier, "*King v. Burwell*: An Opportunity for Congress and the States to Clear Away Obamacare's Failed Policies," Heritage Foundation *Issue Brief* No. 4360, February 27, 2015, http://www.heritage.org/research/reports/2015/02/king-v-burwell-an-opportunity-for-congress-and-the-states-to-clear-away-obamacares-failed-policies.
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4. See Dale H. Yamamoto," Health Care Costs—From Birth to Death," Society of Actuaries, Health Care Cost Institute *Independent Report Series* No. 2013-1, June 2013, http://www.healthcostinstitute.org/files/Age-Curve-Study_0.pdf.
5. James T. O'Connor, "Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014," Milliman, Inc., April 25, 2013, http://www.ahip.org/MillimanReportACA2013/.
6. In the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress set in place rules for employer-group coverage that specified that individuals switching from one group plan to another could not be denied new coverage, subjected to preexisting-condition exclusions, or charged higher premiums because of their health status. While Congress required that both individual and group plans be guaranteed to be renewable, it did not generally apply HIPPA's group-market rules to the individual market. The one exception was for workers who lost group coverage and subsequently exhausted any available continuation coverage. Those workers (and their dependents) were then entitled to obtain individual coverage at standard rates, with no preexisting-condition exclusions. However, even in those circumstances, Congress allowed states the alternatives of assigning such individuals either to a particular insurer or to a state high-risk pool. Prior to the ACA, 19 states and the District of Columbia used the "federal fallback" of providing choice of any individual-market policy, three states used the "assigned carrier" option, and the remaining 28 states covered such individuals through a state high-risk pool.
7. For specifics on how new individual-market rules could be aligned with HIPAA group-market rules, see Edmund F. Haislmaier, "Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms," Heritage Foundation *Backgrounder* No. 2703, June 22, 2012, http://www.heritage.org/research/reports/2012/06/saving-the-american-dream-the-us-needs-commonsense-health-insurance-reforms.
8. State of Maine, Sections C-2, C-3, C-4 and C-5. The Maine legislation does not apply to coverage regulated by Vermont, because at the time that Maine enacted its legislation, Vermont was pursuing a plan to create a state-based, single-payer health insurance system.

Conclusion

Should Congress respond to a Court ruling against the Obama Administration's interpretation in the *King* case with an exemption, states should be prepared to put forth state policies that would minimize any adverse effects on individuals losing subsidies and allow these individuals to transition to new, more affordable coverage.

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Health Care Reform in Maine: Reversing "Obamacare Lite"

Tarren Bragdon and Joel Allumbaugh

Abstract: *This spring, after living under the costly failures of Obamacare-like health care legislation for two decades, the Maine Legislature enacted a set of patient-centered, market-based health care reforms. The Maine experience is both a warning of Obamacare's likely effects and a practical demonstration to other states of how to enact sound free-market health care reforms in spite of Obamacare. Maine has also shown how much more it and other states could accomplish if not hamstrung by Obamacare and how Congress could chart a better course toward more innovative and effective health care reform.*

Faced with the uncertainty surrounding Obamacare, legislators in many states have deferred action on health care reform, instead waiting for final resolution of the constitutional challenges making their way through the federal courts and the outcome of the 2012 elections. During their legislative sessions earlier this year, most states neither enacted Obamacare-enabling legislation nor advanced their own, alternative health care reform designs.

One notable exception is Maine, where a new Republican governor and legislative majorities charted a different course for health care reform. This spring, after living under the costly failures of Obamacare-like health care legislation for two decades, Maine's new state leadership enacted a set of patient-centered, market-based health care reforms. In the process, they reversed a set of policies that mirrored key elements of Obamacare.

Talking Points

- State policymakers should enact market-based health care reforms now. They need not wait for the U.S. Supreme Court to void Obamacare or for Congress to repeal it.
- Maine's past experience demonstrates what the adverse effects will be if Obamacare is fully implemented, while Maine's new approach to health care reform shows how to achieve patient-centered, market-based alternatives to Obamacare.
- States can provide guaranteed access to all without the harmful effects of unrestricted guaranteed issue by reinsuring only high-risk individuals identified at time of application.
- Facts and market forces should dictate how premiums vary for age to protect young adults from extreme premium hikes.
- Purchasing insurance across state lines offers citizens protections against costly regulations enacted by future state politicians.

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Thus, Maine's experience is instructive for other states in two important respects. Maine's past offers lessons on the likely adverse effects of Obamacare if fully implemented, and Maine's new direction shows how to reverse and replace Obamacare with better patient-centered, market-based approaches. In sum, Maine offers other states and Congress a practical example of how to repeal and replace Obamacare with sound free-market health care reforms.

Maine's Obamacare Precedents

Precursors to key elements of Obamacare can be found in health care legislation enacted in a number of states over the past two decades. For example, Maryland's 1993 small-group health insurance law imposed a minimum standard benefit package designed and annually updated by a commission. In 1994, Tennessee authorized TennCare, a massive Medicaid expansion, and in 2006, Massachusetts passed legislation that included an individual mandate to buy health insurance. During the same period, Maine arguably enacted more Obamacare building blocks than any other state.

Round 1: Guaranteed Issue and Community Rating in 1993. As in a handful of other states, Maine policymakers enacted various health insurance regulations in 1993 during the height of the Clinton Administration's failed federal health care reform effort. The Maine legislation phased in guaranteed issue and narrow community rating over three years. Guaranteed issue requires health insurance companies selling individual health insurance plans to issue all plans to all individuals applying for coverage, regardless of health condition or status. It prohibits varying premiums based on health.

Maine's modified community rating law allowed premiums in the individual and small-group markets to vary by just 1.5:1 for age and geography combined. This means that an individual could only be charged up to 1.5 times the lowest rate charged to any other individual for the same insurance.[1] However, pre-retirees consume five times more health care services than young adults do. Starting in 2014, Obamacare will limit insurers to a 3:1 age variation in premiums.

These legislative restrictions on age-rating health insurance force carriers to reduce rates for older individuals while significantly increasing rates for young adults. However, because most young adults are in good health and tend to have lower incomes, artificially increasing their cost of coverage induces more of them to become or remain uninsured.[2]

Today, only New York, Vermont, and Massachusetts retain the kind of harmful, unrestricted guaranteed-issue requirements that Obamacare could impose on the entire country starting in 2014.

Maine was one of eight states that mandated unrestricted guaranteed issue in their individual markets during the 1990s. The other seven states were Kentucky, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington. Maine has since become the fifth of the eight states to repeal or fundamentally rewrite their earlier legislation in response to the damage these laws have inflicted on health insurance markets.[3] Today, only New York, Vermont, and Massachusetts retain the kind of harmful, unrestricted guaranteed-issue requirements that Obamacare could impose on the entire country starting in 2014.

Round 2: Dirigo Health in 2003. In 2002, then-Representative John Baldacci (D–ME) campaigned for governor on a universal health care platform.

1. Georgetown University, Health Policy Institute, "Maine Consumer Guide to Getting and Keeping Health Insurance," January 2006, at *http://healthinsuranceinfo.net/getinsured/maine/individual-health-plans/individual-health-insurance-sold-by-private-insurers/* (July 8, 2011).
2. Edmund F. Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets," Heritage Foundation *WebMemo* No. 3111, January 20, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Insurance-Rating-Rules-Increasing-Costs-and-Destabilizing-Markets*.
3. Leigh Wachenheim and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman, July 10, 2007, pp. 1–2, at *http://alankarz.files.wordpress.com/2007/09/milliman-study-on-gi-20070912.pdf* (July 8, 2011).

After elected, he ushered his Dirigo[4] Health Reform through the Democrat-controlled legislature in June 2003. Dirigo Health dramatically expanded Medicaid, imposed a vast array of new regulations on Maine's health care and health insurance industries, and created DirigoChoice, a state-designed, privately administered health plan with premium and deductible subsidies based on family income. Echoes of each of these elements of Dirigo Health are found in Obamacare.

Dirigo cost taxpayers $183 million over six and one-half years but failed to reduce the number of uninsured even slightly.

Dirigo Health's stated goal was to eliminate all uninsured by 2009,[5] but it failed to meet this goal. In fact, slightly more Maine people were uninsured in 2009 than in 2003,[6] even though taxpayers had spent more than $183 million in premium subsidies alone since DirigoChoice's inception in 2005.[7]

Because of similarities in size, scope, subsidy structure, and insurance market regulations, Dirigo Health has been compared by both supporters[8] and opponents[9] to Obamacare, officially known as the Patient Protection and Affordable Care Act (PPACA). Given that Dirigo cost taxpayers $183 million over six and one-half years but failed to reduce the number of uninsured even slightly, the similarities between the two programs should give both supporters and opponents of Obamacare pause.

On June 16, 2011, the Maine Legislature acknowledged Dirigo's failure by approving—by large bipartisan majorities—legislation that will eliminate the Dirigo Health Program by December 2013.[10]

The Individual Market's "Death Spiral." Since the 1993 so-called reforms, Maine's individual market has gone from covering 102,000 individuals to covering just 57,000 in 2009, a 44 percent drop.[11] The cause is clear. When guaranteed issue and narrow community rating took effect, premiums and deductibles skyrocketed. Essentially, insurance became priced for—and therefore only attractive to—the oldest and sickest enrollees. The young and healthy dropped coverage, leaving fewer and sicker enrollees.

Every state with guaranteed issue and community rating has replicated this death spiral. A recent study of the impact of guaranteed issue and community rating found that "for those reporting excellent health, community rating was associated with

4. The name was taken from the state's Latin motto *Dirigo*, which translates as "I lead."
5. Tarren Bragdon, "Command and Control: Maine's Dirigo Health Care Program," Heritage Foundation *Backgrounder* No. 1878, September 19, 2005, at *http://www.heritage.org/Research/Reports/2005/09/Command-and-Control-Maines-Dirigo-Health-Care-Program* (July 8, 2011).
6. U.S. Census Bureau, Health Insurance Historical Tables, Table HIA-6, at *http://www.census.gov/hhes/www/hlthins/data/historical/files/hihistt6.xls* (July 8, 2011).
7. Authors' calculations based on annual reports and income statements for January 2005 through June 2011 (estimated) from the Dirigo Health Agency.
8. Press release, "Maine Recognized for Leadership in Covering Maine Citizens," Office of Governor John E. Baldacci, September 10, 2010, at *http://www.maine.gov/tools/whatsnew/index.php?topic=Gov+News&id=132377&v=Article-2006* (July 8, 2011).
9. Editorial, "No Maine Miracle Cure: Another State 'Public Option' That Failed," *The Wall Street Journal*, August 21, 2009, at *http://online.wsj.com/article/SB10001424052970204619004574322401816501182.html* (July 8, 2011).
10. It was enacted as part of Maine's FY 2012/FY 2013 biennial budget. An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2012 and June 30, 2013, L.D. 1043, 125th Maine Legislature, 2011, Part BBB-2, p. 593, at *http://www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC380.pdf* (July 12, 2011). L.D. 1043 was passed by votes of 123 to 19 in the Maine House and 29 to 5 in the Maine Senate on June 16, 2011, and was signed by Governor Paul LePage on June 20, 2011. Maine Legislature, "Summary of LD 1043," at *http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280040546* (July 8, 2011).
11. U.S. Census Bureau, Health Insurance Historical Tables, Table HIA-6.

a 22 percent reduction in the probability of having non-group [individual] coverage" and a drop of up to 59 percent in coverage for certain young individuals, yet "no significant change in overall coverage rates among the higher risk individuals." The study also found some higher-risk individuals switching from group to individual coverage, spreading their higher costs across a smaller pool.[12] In sum, the young dropped coverage, but no additional older individuals signed up.

The average premium for individual coverage in Maine in 2009 was $4,061, compared to the national average of $2,985, and family coverage cost $7,260, compared to the national average of $6,328.

Anthem, the dominant carrier in Maine's individual market, accounts for about half of that market.[13] By 2008, 88 percent of those with individual market coverage through Anthem in Maine had a deductible of at least $5,000,[14] and an astounding 40 percent had a deductible of $10,000 or more.[15] In comparison, a national survey of carriers found just 41 percent of individual market enrollees with deductibles of at least $5,000 and just 13 percent with deductibles of $10,000 or more in 2009.[16]

Even with more than three times as many enrollees with extremely high deductibles, the average premium for individual coverage in Maine in 2009 was $4,061, compared to the national average of $2,985, and family coverage cost $7,260, compared to the national average of $6,328. Thus, Maine consumers are paying an average of 36 percent more for single coverage and 15 percent more for family coverage—and that is for plans with much higher deductibles than comparable plans in other states.[17]

According to the Maine Bureau of Insurance, since the beginning of the recession in February 2008, the number of covered individuals in Maine's individual market has declined from 40,932 in December 2007[18] to just 36,195 by March 2011,[19] a 12 percent drop. Typically, enrollment in the individual market expands during a recession as individuals lose access to employer-sponsored coverage.[20] Maine's regulations produced the opposite result.

Maine's experience is a warning about Obamacare, because Obamacare includes similar provisions for guaranteed issue and narrow community rating, which will take effect in January 2014.

A New Way: Proven Patient-Centered, Market-Based Reform in 2011

For years, Maine legislators had proposed and debated reforms in the state's individual insurance market. Usually these reforms proposed repealing

12. Anthony T. Lo Sasso, "Community Rating and Guaranteed Issue in the Individual Health Insurance Market," National Institute for Health Care Management, *Expert Voices*, January 2011, p. 1, at *http://nihcm.org/pdf/EV-LoSassoFINAL.pdf* (July 8, 2011).
13. Maine Bureau of Insurance, "Market Snapshot—Individual Medical," June 9, 2011, at *http://www.maine.gov/pfr/insurance/employer/snapshot_individual.htm* (July 8, 2011).
14. Maine Bureau of Insurance, "Preliminary Report: The Health Insurance Market in Maine," February 2010, Part II.C, at *http://www.maine.gov/pfr/insurance/reports/BOIHealth_Insurance_report2-12-2010finalFSI.htm* (July 8, 2011).
15. William Whitmore, "Prefiled Testimony of William Whitmore," April 7, 2011, p. 6, at *http://www.maine.gov/pfr/insurance/filings/2011_Anthem/Anthem_Prefiled_Testimony_of_Bill_Whitmore_04072011.pdf* (July 8, 2011).
16. America's Health Insurance Plans, Center for Policy Research, "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," October 2009, p. 19, at *http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf* (July 8, 2011). Nationally, only 3 percent of individuals are in plans with deductibles over $10,000, but 37 percent of Maine policyholders have deductibles of $15,000 or more.
17. *Ibid.*, pp. 5–6.
18. Maine Bureau of Insurance, "Preliminary Report," Appendix B.
19. Maine Bureau of Insurance, "Individual Insurance—Market Snapshot." Census Bureau figures include sole proprietors, which are sometimes included in Maine's small-group market, depending on the carrier.
20. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, 2001–2003 and 2008–2009.

guaranteed issue, expanding the rating bands for age and health, and setting up a high-risk pool. In 2006, a Republican-sponsored bill to do just that was passed by the Maine House of Representatives, but it failed in the Senate.[21] In 2007, the Maine Bureau of Insurance commissioned an extensive study on the actuarial and enrollment impact of various reforms.[22] In 2008, a Democrat-sponsored bill proposed to adopt Idaho's hybrid model of a high-risk reinsurance system, in which all individuals applying for individual insurance have guaranteed access to five plans, which are reinsured to fund premiums. This bill was also passed by the Maine House but failed in the Senate.[23]

During the 2011 legislative session, after the 2010 elections had produced a new Republican governor and Republican control of both legislative chambers for the first time since 1964, health care reform was again on the agenda. A group of Republican legislators and health system stakeholders began developing a comprehensive health care reform package.[24] Their work was guided by Maine's past experience, focused on what would most help Maine's citizens and small businesses, and mindful of the constraints imposed by Obamacare. On the last point, given Maine's history of failed health care reforms, they did not want to risk further uncertainty and market instability by enacting measures that directly contravened Obamacare. With minor modifications, the proposal developed by this working group was ultimately passed as Legislative Document (LD) 1333, which became Public Law 90.[25]

The Obamacare Straightjacket

Obamacare imposes expansive new regulations on the health insurance and health care marketplaces. The U.S. Department of Health and Human Services (HHS) has yet to issue regulations filling in the details of many of the Obamacare provisions, and this has created much uncertainty. Among other provisions, Obamacare requires guaranteed access for any individuals applying for coverage from any insurance company,[26] prohibits exclusions for pre-existing conditions,[27] limits variations in premiums for age to 3:1,[28] limits variations in premiums for tobacco use to 1.5:1,[29] limits varia-

21. L.D. 1465 was passed by a vote of 74 to 72 in the Maine House and failed by a vote of 19 to 16 in the Maine Senate. State of Maine Legislature, "Summary of LD 1465," at *http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280020080* (July 11, 2011).
22. Bela Gorman, Don Gorman, Elizabeth Kilbreth, Taryn Bowe, Gino Nalli, and Richard Diamond, "Reform Options for Maine's Individual Health Insurance Market," Maine Bureau of Insurance, May 30, 2007, at *http://www.maine.gov/pfr/insurance/reports/reform_options_individual_health_market.doc* (July 11, 2011).
23. L.D. 1760 was passed by a vote of 79 to 63 in the Maine House but failed by a vote of 18 to 17 in the Maine Senate. State of Maine Legislature, "Summary of LD 1760," at *http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280024649* (July 11, 2011).
24. This group included Republicans from the legislative leadership; representatives from the governor's office and Department of Professional and Financial Regulation (which includes the Bureau of Insurance); the Attorney General's office; health providers; health insurers; health insurance brokers; health policy experts (including the authors); and representatives of the business community.
25. An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-Based Purchasing of Health Care Services," L.D. 1333, 125th Maine Legislature, 2011, at *http://www.mainelegislature.org/legis/bills/bills_125th/chapters/PUBLIC90.asp* (July 11, 2011).
26. Patient Protection and Affordable Care Act, Public Law 111–148, § 2702, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152. For the text of select PPACA provisions incorporating changes by subsequent amendments, see National Association of Insurance Commissioners and Center for Insurance Policy and Research, "The Patient Protection and Affordable Care Act P.L. 111–148: Selected Health Insurance Provisions Incorporating Changes in the Manager's Amendment and the Health Care and Education Reconciliation Act (P.L. 111–152)," January 21, 2011, at *http://www.naic.org/documents/index_health_reform_general_ppaca_ins_provs.pdf* (July 11, 2011).
27. Patient Protection and Affordable Care Act, § 2704.
28. *Ibid.*, § 2701.
29. *Ibid.*

tions in premiums for geography to state-set factors,[30] and prohibits variations in premiums for health or any other status.[31]

The challenge of the Maine reform was to work within the confines of Obamacare while developing a sufficiently robust and flexible design that could also accommodate the Supreme Court voiding Obamacare or Congress repealing or amending it.

The 2011 Maine reform includes five major provisions:

- Guaranteed access to reinsurance funding only for high-risk individuals;
- Individualized pricing for affordable options;
- Purchase of insurance across state lines;
- New options for businesses joining together; and
- New options for long-term unemployed.

Guaranteed Access to Reinsurance Funding Only for High-Risk Individuals. For years, states have created and supported high-risk pools to fund the cost of high-risk individuals who otherwise would not have access to health insurance in an underwritten market. Today, 34 states have high-risk pools.[32]

In 2001, Idaho created a variation on the high-risk funding concept. Idaho guaranteed all individuals continuous access to certain plans, which would be funded through a reinsurance arrangement. Idaho's Individual High-Risk Reinsurance Pool design offers five guaranteed access plans at premiums that vary only by age, gender, and smoking status. All carriers must offer these plans at the designated premiums to all individuals who meet a certain health risk threshold, based on a uniform health questionnaire that all individuals complete as part of their insurance application. Unlike a traditional high-risk pool, these high-risk individuals are not transferred to a separate plan and administrator, and only those individuals within the five designated plans have their claims reinsured. High-cost individuals not identified at time of application are not eligible for reinsurance.

Carriers must contribute a portion of the premium collected for these individuals to the reinsurance pool.[33] These contributions ensure that carriers have no incentive to "push" more people into the reinsurance pool. In addition, Idaho allows premiums to vary based on health status by up to 1.5:1.[34]

Idaho's reinsurance plan has proven to be an effective, targeted solution with little cost to taxpayers. Taxpayers spent only about $6.5 million to cover the 1,430 individuals in the reinsurance plan in 2009 and just $4.4 million to cover the 1,569 individuals in the plan in 2010.[35] In 2009, 165,000 individuals had coverage through Idaho's individual market, more than 12 percent of Idaho's 1.344 million residents under age 65. Since 2000, the size of Idaho's individual market has grown by 47 percent. The reinsurance program covers just 0.8 percent of Idaho's individual market and just 0.1 percent of the total population under 65.[36]

The Maine reform applies the reinsurance structure to all plans, not just a select few as Idaho's plan does. It also allows premiums to vary only for individuals of similar age, geography, and smoking

30. *Ibid.*
31. *Ibid.*, § 2705.
32. Henry J. Kaiser Family Foundation, "State High Risk Pool Programs and Enrollment, as of December 31, 2010," at *http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7* (July 11, 2011).
33. Idaho Department of Insurance, "Individual High Risk Reinsurance Pool Plans for Idaho Residents," July 2010, at *http://www.doi.idaho.gov/Pubs/high_riskbr.pdf* (July 11, 2011), and "Idaho Individual High Risk Reinsurance Pool Mandated Plan Street Premium Rates: Monthly Premium Rates for Policies Issued or Renewed Effective 10/1/2011 Through 12/31/2011," at *http://www.doi.idaho.gov/health/Quarterly_A4.pdf* (July 11, 2011).
34. National Women's Law Center, "The Individual Insurance Market: A Hostile Environment for Women," June 9, 2008, p. 14, at *http://www.nwlc.org/sites/default/files/pdfs/Individual%20Insurance.pdf* (July 11, 2011).
35. AmeriBen, "Idaho Individual High Risk Reinsurance Pool: Monthly Report for February 2011," March 2011, pp. 4 and 9.
36. U.S. Census Bureau, Current Population Survey, 2000 and 2009 Annual Social and Economic Supplements.

status within the applicable rating factor limits of Obamacare.[37]

Beginning July 2012, the Maine reform amends (and functionally repeals) Maine's strict guaranteed-issue requirement and replaces it with a reinsurance structure that provides lower-cost unsubsidized plans to healthy individuals and subsidized coverage, at the same rate, to high-risk individuals. The design will work as follows:

1. A Maine resident applies for individual health insurance with any carrier and completes a health statement as part of the coverage application. The statement is used only to determine eligibility for the Maine Guaranteed Access Reinsurance Plan.
2. If the individual meets the threshold, the qualifying individual will be charged the standard premium, and the carrier will contribute a portion of the premium to the reinsurance plan and be reimbursed for claims for that individual according to the following formula: 0 percent for the first $7,500 in claims; 90 percent for claims between $7,500 and $32,500, and 100 percent for claims over $32,500, with the amounts indexed to the medical Consumer Price Index.
3. If the individual does not meet the threshold, the carrier will not be eligible for reinsurance.
4. In either scenario, the individual will have guaranteed access to the desired plan at the quoted premium—rated only for age, tobacco use, and geography.

The reinsurance is financed from a per-life assessment on almost all privately insured individuals in the state. The assessment is capped at $4 per person per month, but experiences in Idaho and other states indicate that the necessary assessment level will be much less. The assessment could generate as much as $20 million in funding for the Maine reinsurance plan.

Strict guaranteed issue drives up the costs of health insurance by encouraging young and healthy people to drop out of the market. A traditional high-risk pool design diverts high-risk individuals into plans that may differ significantly from the plans available to others. The Maine reform, inspired by Idaho's reinsurance plan, funds high-risk individuals but guarantees access to all. It also adapts to the tight restrictions in Obamacare. If Obamacare is repealed or found unconstitutional, the Maine reforms would allow even greater flexibility and affordability to cover the young and old and the sick and healthy.

Individualized Pricing for Affordable Options. The Maine reform expands Maine's age rating bands from 1.5:1 to 3:1 beginning in July 2012 for the individual market and phases in the shift from 1.5:1 to 3:1 from 2011 to 2014 for the small-group market. If Obamacare is altered or repealed, the Maine reform will extend the age rating bands to 5:1, which is the naturally occurring age-related variation in health care utilization.

Health premiums ultimately reflect actual health care costs and utilization. Thus, premiums that vary according to expected health care utilization for an individual based on the person's age reflect an accurate value proposition. Tighter age rating bands result in premiums that are too high for some and too low for others given their expected use. In reality, age rating bands of less than 5:1 drive up costs for young people while keeping costs for older individuals constant.

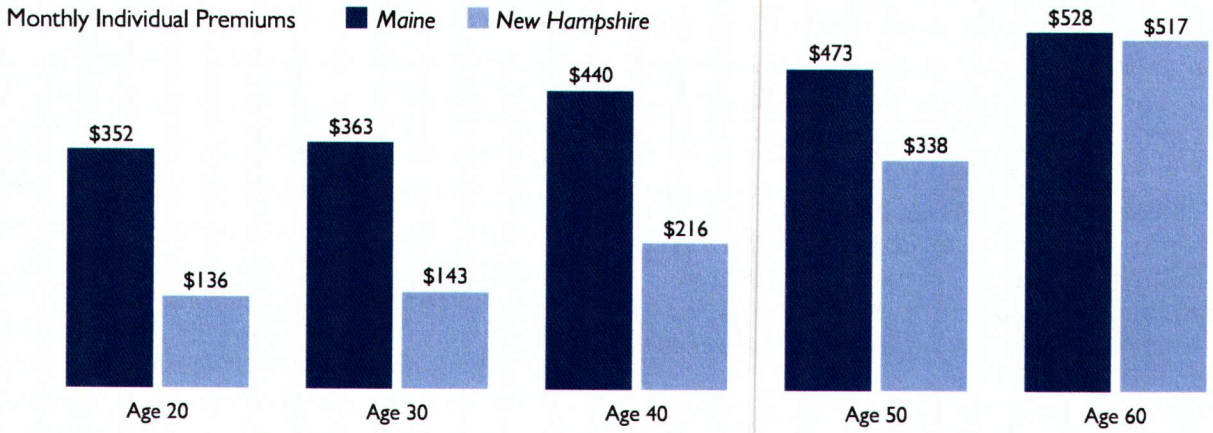
This effect is shown in Chart 1, which compares similar individual plans in Maine with a 1.5:1 pre-reform rating band and New Hampshire with a 4:1 rating band. A 60-year-old pays the same whether in Maine or New Hampshire, but a 20-year-old in Maine pays $352 per month ($4,224 per year) for a plan that costs just $136 per month ($1,632 per year) in New Hampshire. The Maine young adult faces a premium that is 159 percent higher.[38]

The Maine reform changes these age rating bands to the Obamacare standard of 3:1. A more reasonable

37. William Schneider, Maine Attorney General, letter to Robert Nutting, Speaker of the Maine House of Representatives, May 9, 2011.
38. Anthem Blue Cross and Blue Shield, document for public hearing on L.D. 1333, April 26, 2011, p. 1.

Comparing Health Care Premiums: Maine and New Hampshire

Residents of Maine pay more for health care premiums than those living in New Hampshire, especially young adults. Even those age 40 pay twice as much in Maine.



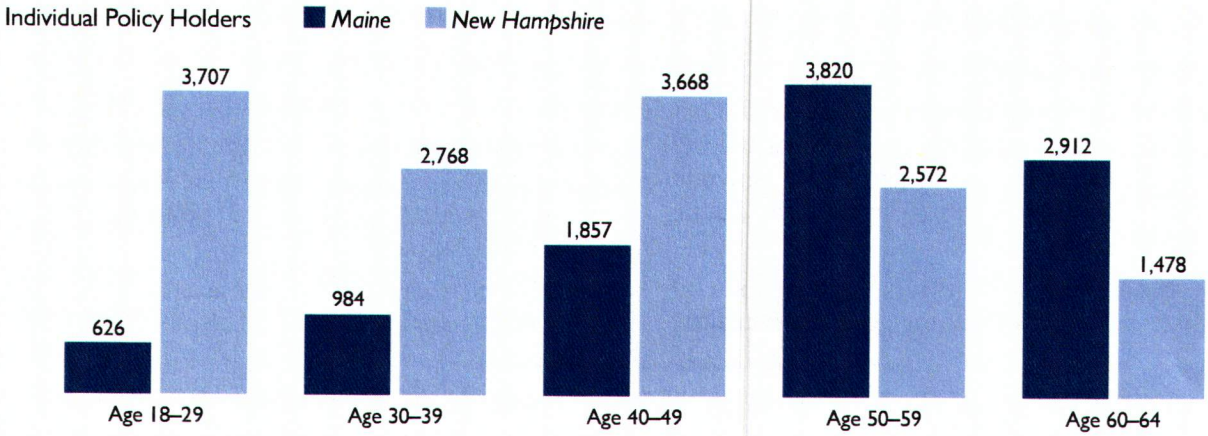
Source: Anthem Blue Cross and Blue Shield, document for public hearing on L.D. 1333, April 26, 2011, p. 1.

Chart 1 • B 2582 heritage.org

rating band would be 4:1 or higher. If Obamacare is voided or repealed, the Maine reform defaults to the more appropriate band of 4:1 and then 5:1 the following year. State lawmakers felt that it was important to build in provisions that would automatically move Maine to the ideal age rating bands if future federal law allows rather than relying on future legislatures to enact additional reforms.

The impact of driving up premiums for young people can be seen in Chart 2, which shows enrollment by age for individual health insurance for Anthem Blue Cross Blue Shield (WellPoint) in Maine and New Hampshire. Just 626 Maine young adults buy this unnecessarily expensive insurance compared to 3,707 in New Hampshire. Costly regulations cause young people to drop or not buy coverage.[39]

Younger Adults in Maine Less Likely to Hold Individual Health Policies



Source: Anthem Blue Cross and Blue Shield, document for public hearing on L.D. 1333, April 26, 2011, p. 1.

Chart 2 • B 2582 heritage.org

The Maine rating reforms allow insurers to phase in these expanded rating bands for plans already in force in order to close their current block of business.

Purchase of Insurance Across State Lines. The Maine reform establishes a process for Maine residents to buy individual insurance from most other New England states, beginning in 2014. The reform disregards Obamacare's convoluted and unnecessary Health Care Choice Compact provisions, which require two or more states each to pass a law authorizing a compact and then apply to HHS for approval.

Maine's reform takes a more free-market approach, relying instead on the reciprocity that states typically grant each other in other areas, such as traffic law enforcement and permits to carry concealed firearms. Under the Maine reform, an insurer approved to sell an individual-market product in any of four other New England states (New Hampshire, Massachusetts, Rhode Island, and Connecticut) may request certification from the Maine Bureau of Insurance to sell the same product in Maine.

To obtain certification, the insurer need only meet Maine's standards for handling policyholder grievances and Maine's consumer protection provisions. Otherwise, the product conforms to the other state's benefit mandates and premium rate regulations. The Maine Superintendent of Insurance then enters into a memo of understanding with that other state's insurance commissioner to ensure communication if any consumer complaints arise and has 30 days to grant or deny certification. Once a regional insurer receives a Maine certificate, which is similar to a Maine license granted through a reciprocity agreement, Maine domestic insurers may start offering similar plans, provided they meet the other state's benefit and premium rate regulations.

Allowing the sale of health insurance across state lines is important for two reasons.

- It increases competition and choice for Maine residents buying insurance on the individual market.
- It protects Maine consumers from premium increases driven by additional benefit mandates or costly regulations added by future Maine legislatures.

Once Maine residents have such choice, it will be difficult to take it away. One New England state, Vermont, was not included in this arrangement because it just approved a single-payer health plan design that is incompatible with patient-centered, free-market health care reform.

This provision to allow the purchase of health insurance across state lines will not take effect until 2014 because Obamacare provisions, if they remain law, will establish uniform rating rules for all states beginning in 2014. This addresses an important concern of insurers worried about potential adverse selection effects. The 18-month implementation delay also allows time for the legislation's other market reforms to take effect, which is important to those insurers who have remained in the state's market. Finally, it will begin during the present term of the current governor, which was an important consideration for state legislators worried about the actions of future legislatures and governors.

New Options for Businesses Joining Together. The Maine reform also allows businesses to join together to create a "captive" health plan. This is akin to an association health plan, except that the participating businesses are not required to be in a similar industry or region, but they must be jointly and severally liable to meet necessary capital and reserve requirements.

The design for this arrangement more closely tracks the "captive insurer" model that states have authorized for other lines of coverage, particularly property insurance. For example, a large corporation might find it advantageous to set up a captive insurer to insure its buildings and equipment against damage. Authorizing a captive insurer model for health benefits gives Maine businesses another way to offer health coverage to their employees.

This provision was driven by a group of employers and health providers who wanted to design their own value-based, wellness-focused employee health benefit outside of traditional health insurance. The law requires the captive insurer to meet small-group

39. *Ibid.*

benefit mandates and rating regulations, although plans may be offered to participating employers of any size.

New Options for Long-Term Unemployed. Many individuals who are unemployed or just starting a new business need short-term health insurance ranging from a few months to two years until they can transition into more conventional coverage. Rather than force these individuals into the individual health insurance market, the Maine reform allows them to buy short-term health insurance for up to 24 months, an increase from the 12-month limit. Monthly premiums for short-term health insurance average $75 to $125, typically about one-third of the cost of traditional COBRA coverage.[40] These plans are fully underwritten and not subject to any state benefit mandate requirements or premium rate regulations, making them very customizable and affordable.

According to national figures for those with individual insurance, about 20 percent drop short-term coverage within six months, one-third within 12 months, and more than half within two years, mostly because they cycle back onto employer-sponsored plans.[41] Therefore, expanding temporary health insurance gives individuals access to plans that are completely underwritten, outside of Obamacare's reach, outside of state benefit mandates and premium rate regulations, and currently available in almost all states.[42]

Conclusion

Maine's experience with the costly failures of a big-government, command-and-control approach to health care reform is a salutary warning of the likely adverse effects of similar provisions in Obamacare. In contrast, Maine's new approach to health care reform shows other states and Congress how to chart a better course toward more innovative and effective health care reform using proven patient-centered, market-based designs.

For Congress, the best strategy is to repeal Obamacare and start anew with simple patient-centered, market-based reforms that allow states the flexibility to craft solutions that work best for each state's particular population and circumstances.

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40. Medsave.com, "Short Term Health Insurance," at *http://www.medsave.com/short-term-health-insurance.html* (July 11, 2011).
41. Henry J. Kaiser Family Foundation and eHealthInsurance, "Update on Individual Health Insurance," August 2004, p. 3, at *http://www.kff.org/insurance/upload/Update-on-Individual-Health-Insurance.pdf* (July 11, 2011).
42. Short-term coverage is not available in Massachusetts, New Jersey, New York, Washington, or Vermont, although individuals may buy coverage in another state and use it in these five states. See Medsave.com, "30 Fast Facts About Short Term Health Insurance," at *http://www.medsave.com/health-insurance-resources/fast-facts-about-short-term-health-insurance.htm* (July 11, 2011).

6. **Young Adults.** The ACA imposes age-rating rules that limit how much premiums can vary based on age. Younger adults typically consume less care, yet these rating rules required them to pay artificially high premiums, while older adults typically consume more care and pay artificially low premiums. Indeed, in 11 states, average premiums for 27-year-olds increased by 100 percent or more for comparable plans from 2013 to 2014, when Obamacare's changes were implemented.[14]

7. **Current Medicaid Enrollees.** The Medicaid program has a long and well-documented history of less access to care and poorer health outcomes than private insurance.[15] However, instead of reforming the program to work better for existing beneficiaries, the ACA expands the program. The Congressional Budget Office (CBO) estimates that 16 million more people will be added to the Medicaid roles by 2025.[16]

8. **The Uninsured.** After a decade of full implementation, the CBO estimates that 31 million people will be without insurance in 2025.[17] The ACA requires Americans to purchase government-approved health coverage or pay an individual mandate penalty. Although the majority of uninsured will qualify for an exemption, millions will not. In fact, the CBO expects that in 2016, 4 million individuals will face the mandate penalty, totaling $4 billion.[18] Of those facing the penalty, 69 percent are expected to be below 400 percent of the federal poverty level.

Finally, even those individuals receiving premium subsidies through an exchange may face unexpected challenges. Due to the complex design of the ACA premium subsidy, it is much more likely that the subsidy will be inaccurately calculated. Any enrollee who receives a greater subsidy than he was eligible for will be required to repay the excess subsidy to the Internal Revenue Service when he files his annual tax returns. Repayments could be significant, depending on the enrollee.[19]

While *King v. Burwell* is currently in the spotlight, in the end, the ACA and its flawed policies are at the root of the problems plaguing this law and are responsible for its harmful effects.

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14. Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief* No. 4068, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.
15. Kevin D. Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 7, 2012, http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured.
16. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline," Table B-2, https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf (accessed February 20, 2015).
17. Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline," Table B-2.
18. Congressional Budget Office, "Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update," June 2014, Table 1, https://www.cbo.gov/sites/default/files/45397-IndividualMandate.pdf (accessed February 20, 2015).
19. Alyene Senger, "Obamacare Makes Tax Time More Taxing," The Daily Signal, February 6, 2015, http://dailysignal.com/2015/02/06/obamacare-makes-tax-time-taxing/.

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ISSUE BRIEF

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King v. Burwell: Assessing the Claimed Effects of a Decision for the Plaintiffs

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Should the Supreme Court rule in *King v. Burwell*—a case challenging the Obama Administration's implementation of the premium tax credit provisions of the Affordable Care Act (ACA)—that the statute restricts the payment of premium tax credits only to individuals obtaining coverage "through an Exchange established by [a] State," its ruling would preclude the Treasury paying the tax credits to those obtaining coverage through the federally run exchange—or what the Obama Administration calls the Federally Facilitated Marketplace (FFM)—currently serving 34 states.[1]

The ACA's defenders have conjured a "parade of horribles" (to use a favorite phrase of the Justices) that they claim would result from such a decision. While there might be some individuals who are adversely affected by such a ruling, it is important to examine these claims more closely.

Claim #1: Millions will lose subsidies.

"About 9.3 million people in FFM states would lose marketplace premium tax credits in 2016 if the Supreme Court finds for King."[2]

Reality: Based on existing enrollment trends, this projection for 2016 is highly unlikely. A more realistic estimate is that around 5.5 million individuals could lose subsidies in 2015.

Last April, the Department of Health and Human Services (HHS) reported that 8 million individuals selected an exchange plan during the 2014 open enrollment period.[3] However, by the end of the year, only about 6.7 million enrollees still had coverage—16.5 percent fewer than had initially selected a plan.[4]

That attrition rate is not surprising. The earlier 8 million figure was for "pre-effectuated" enrollments—meaning individuals who selected a plan, not ones who paid their first month's premium (necessary for coverage to take effect). For various reasons, some people never completed their purchases, and others later dropped coverage.

HHS has now released pre-effectuated enrollment data for 2015 that shows 6,566,837 subsidy-eligible enrollees in the 34 FFM states.[5] Applying last year's 16.5 percent attrition rate to that figure yields an estimate of about 5.5 million actual subsidy recipients in those states this year.[6] While that is still consequential, it is 41 percent less than the projected 9.3 million individuals.

The 9.3 million figure is a projection for 2016.[7] Yet, given that the increase in the number of subsidized enrollees in 2015 will be less than the 1.97 million difference between the 2014 and 2015 pre-effectuated counts—and more likely about 1.65 million, after the inevitable attrition—it is hard to envision how subsidized enrollments could reach 9.3 million in 2016.

Claim #2: The goal of expanding coverage will be thwarted.

"Eliminating subsidies in FFM states would hamper the ACA's ability to accomplish one of its key objectives: expanding access to health insurance coverage."[8]

"This would undermine the ACA's current and future success in reducing the number of uninsured

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Americans, which dropped by an estimated 8 to 10 million during the first open enrollment period."[9]

Reality: This claim is based on the assumption that the vast majority of exchange enrollees would be previously uninsured individuals. Yet, insurance-market data indicates that the actual result has, in fact, been the opposite.

During the first nine months of 2014, individual-market enrollment (both on and off the exchanges) increased by 5.83 million individuals, while enrollment in employer-sponsored plans declined by 4.93 million individuals. Thus, the decline in employment-based coverage offset 85 percent of the increase in individual-market coverage, for a net increase in private coverage of only 893,000 individuals.[10]

In reality, the vast majority of the ACA's coverage expansion has come from increased Medicaid enrollment, which grew by 7.49 million individuals during the same period. So, while 8.38 million Americans gained coverage during the first three quarters of 2014, Medicaid accounted for 89.3 percent of that gain. Consequently, a court finding for the plaintiffs in *King v. Burwell* would not actually thwart, to any meaningful extent, the ACA expanding coverage.

Claim #3: Millions will become uninsured.

"About 8.2 million more people would be uninsured than would be the case with the financial assistance provided under the ACA as currently implemented."[11]

Reality: While this claim has some merit—as there would likely be *some* increase in the number of uninsured, at least initially—many affected individuals would likely seek replacement coverage elsewhere.

Even though the majority of exchange enrollees were apparently already insured, absent subsidies, it will be more difficult for them to afford coverage due to the added costs that Obamacare imposes on all

1. 26 U.S. Code § 368(b)(2)(A). Nevada, New Mexico, and Oregon are all building state-based exchanges while still using the federal Healthcare.gov platform. Proponents as well as opponents of the ACA assume that those states would be treated as having state-based exchanges for purposes of the Supreme Court's eventual decision in *King v. Burwell*. Consequently, those three states are not included with the 34 FFM states in analyses of the effects of the Court's ruling.
2. Linda J. Blumberg, Matthew Buettgens, and John Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums," Robert Wood Johnson Foundation, January 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf417289 (accessed February 18, 2015).
3. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period, for the Period: October 1, 2013-March 31, 2014 (Including Additional Special Enrollment Period Activity Reported through 4-19-14)," May 1, 2014, http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf (accessed February 18, 2015).
4. Brett Norman, Rachana Pradhan, and Joanne Kenen, "Administration Admits Obamacare Enrollment Numbers Error," *Politico*, November 21, 2014, http://www.politico.com/story/2014/11/inflated-obamacare-enrollment-dental-113064.html (accessed February 18, 2015).
5. Data compiled from: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report For the period: November 15, 2014-January 16, 2015," January 27, 2015 http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/Jan2015/ib_2015jan_enrollment.pdf (accessed February 18, 2015); U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplace 2015: Average Premiums After Advance Premium Tax Credits Through January 30 in 37 States Using The Healthcare.gov Platform," February 9, 2015, http://aspe.hhs.gov/health/reports/2015/MarketPlaceEnrollment/APTC/ib_APTC.pdf (accessed February 18, 2015); and HHS.gov/HealthCare, "Open Enrollment Week 12: January 31, 2015-February 6, 2015," February 11, 2015, http://www.hhs.gov/healthcare/facts/blog/2015/02/open-enrollment-week-twelve.html (accessed February 18, 2015).
6. Given that plausible arguments can be made for why the eventual 2015 attrition rate might be either higher or lower than the 2014 rate, it seems reasonable to use the 2014 rate.
7. Blumberg, Buettgens, and Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell."
8. Evan Saltzman and Christine Eibner, "The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces," RAND Corporation, 2015, http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR980/RAND_RR980.pdf (accessed February 18, 2015).
9. David Blumenthal and Sara R. Collins, "The Supreme Court Decides to Hear King v. Burwell: What Are the Implications?" The Commonwealth Fund Blog, November 7, 2014, http://www.commonwealthfund.org/publications/blog/2014/nov/the-supreme-court-decides-to-hear-king (accessed February 18, 2015).
10. Edmund F. Haislmaier and Drew Gonshorowski, "Q3 2014 Health Insurance Enrollment: Employer Coverage Continues to Decline, Medicaid Keeps Growing," Heritage Foundation *Backgrounder* No. 2988, January 29, 2015, http://thf_media.s3.amazonaws.com/2015/pdf/BG2988.pdf.
11. Blumberg, Buettgens, and Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell."

plans. They will also find that their prior, less expensive coverage no longer exists.

Given their predisposition to obtain coverage, many would probably respond to a loss of subsidies by seeking new coverage, most likely under employer plans. But, because the timing and extent of such a response is uncertain, some individuals might initially become uninsured. However, the actual number would likely be much less than the claim of 8 million uninsured.

Claim #4: Health insurance premiums will soar.

"Unsubsidized premiums in the ACA-compliant individual market would increase 47 percent in FFM states."[12]

Reality: While there would likely be some increase in premiums, given the relatively small size of the affected population it would not be near the projected 47 percent.

The logic behind projecting premium increases is that, absent subsidies, the affected enrollees will have to pay the full cost of their coverage. That would likely induce healthier ones to drop coverage—forcing insurers to increase premiums to bring expected revenues back in line with expected costs. While that reasoning is broadly correct, any projections based on it are dependent on the assumptions used.

The study assumes that, without subsidies, "enrollment in the ACA-compliant individual market will decline by 9.6 million" in the FFM states. Yet that projection is 74 percent higher than the more realistic estimate for the total number (5.5 million) of 2015 subsidy recipients in those states.

A better estimate for premium increases can be derived from the HHS data, using enrollee age as a proxy for health status and price sensitivity. Younger adults consume much less medical care, but also generally have less income out of which to pay premiums. The 2015 HHS data for pre-effectuated enrollments reports that young adults (18 to 34 years of age) account for 26.6 percent of all enrollees (subsidized and unsubsidized for all plans) in the FFM states.[13] That is close to the study's baseline estimate that the same group comprises 27.2 of the individual market. Applying the 26.6 percent ratio to the estimate of 5.5 million subsidized enrollees in the FFM states in 2015 yields an estimate of 1.46 million subsidized young adults in 2015.

The authors also "estimate that premiums would increase by 0.44 percent for every 1 percentage point decrease in the share of young adults participating in the market." They also estimate that total individual-market enrollment (both on and off the exchanges) in the FFM states will be 13.7 million individuals. Thus, if *all* of the projected 1.46 million subsidized young adults dropped coverage in response to losing subsidies, the market would shrink by 10.6 percent. Applying the authors' assumption for premium effects to that estimated 10.6 percent reduction in the size of the market yields projected premium increases of only 4.7 percent.[14]

In sum, the claim that premiums would jump by 47 percent appears to be based on an assumption for the number of individuals receiving subsidized coverage that is substantially higher than the likely real figure.

Claim #5: There will be less insurer competition.

"Areas experiencing increased insurer competition under the ACA's initial years are likely to revert to smaller numbers of insurers."[15]

Reality: There has been almost no increase in insurer competition in response to the ACA—and thus, no reason to believe that, absent subsidies, insurer competition would decrease.

A Government Accountability Office (GAO) study found that in every state fewer carriers offered coverage through the exchanges in 2015 than offered individual-market plans in 2013.[16] The Heritage Foundation performed a similar analysis, but applied a more

12. Saltzman and Eibner, "The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces."
13. ASPE January Enrollment Report, Appendix Table B5.
14. The authors also modeled other follow-on interactions, most of which generate relatively modest additional effects. The second-largest effect is derived from their assumption that "if the share of young adults fell by 1 percentage point, total enrollment among older adults and children would fall by about 0.71 percent." Applying that calculus yields a projected enrollment decline of a further 910,000 individuals.
15. Blumberg, Buettgens, and Holahan, "The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell."
16. U.S. Government Accountability Office, "Concentration of Enrollees Among Individual, Small Group, and Large Group Insurers From 2010 Through 2013," December 1, 2014, http://www.gao.gov/assets/670/667245.pdf (accessed February 18, 2015).

restrictive methodology to the base data.[17] Yet, even using that more restrictive methodology, only nine states have more carriers that offer exchange coverage in 2015 than offered individual-market coverage in 2013.[18] Also, four of the nine operate state-based exchanges, and thus would be unaffected by the court's decision.[19]

Claim #6: Insurers will suffer major financial losses.

"Still another effect of a successful challenge to federal subsidies would be major financial losses for the insurance industry, which has seen new growth since the ACA's implementation."[20]

Reality: While a few small insurers might incur notable financial losses, that would not be the case for the industry as a whole, and it certainly would not be true for larger carriers.

That is because individual-market plans (whether offered inside or outside the exchanges) constitute only about 10 percent of total private-market coverage, and a correspondingly small share of the total business of most health insurers. Also, the largest carrier with individual-market coverage as its principal business, Assurant, did not participate in the exchanges in 2014, and is offering exchange coverage in just 16 states in 2015.

Furthermore, the health insurance industry has not "seen new growth." Insurance-market data shows that 85 percent of the growth in the individual coverage has been offset by declines in employer-group coverage. The only significant new growth has been in Medicaid managed-care plans in the states that adopted the Medicaid expansion—which would not be affected by the Court's ruling.

Conclusion

The "horribles" in this particular parade are less frightening than portrayed. Moreover, it is the ACA's fundamental design flaws that are inherently disruptive and unstable. The ultimate source of dislocation is the ACA itself.

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17. Specifically, Heritage only counted those carriers in each state with 1,000 or more individual-market enrollees in 2013, on the assumption that carriers with few covered lives in 2013 were no longer actively writing new individual-market policies. Heritage's methodology also has the effect of making the resulting comparison much more favorable to the ACA. See Alyene Senger, "Measuring Choice and Competition in the Exchanges: Still Worse than Before the ACA," Heritage Foundation *Issue Brief* No. 4324, December 22, 2014, http://thf_media.s3.amazonaws.com/2014/pdf/IB4324.pdf.
18. Ibid. The paper includes tables reporting state-level insurer completion as measured using both the GAO and Heritage Foundation methodologies.
19. The four states with increased insurer competition that operate state-based exchanges are Massachusetts, New York, Rhode Island, and Washington.
20. Blumenthal and Collins, "The Supreme Court Decides to Hear King v. Burwell."