A contingency plan for King v. Burwell and related cases

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If the Supreme Court sides with the plaintiffs in King v. Burwell and related cases, and thus invalidates the payment of premium subsidies in states that have relied on the federal government to build and run the Affordable Care Act (ACA) insurance exchange, Congress will come under great pressure to enact a remedy to stabilize insurance markets and coverage. Congress should enact such a remedy, including a temporary extension of the existing subsidy program. But it should also allow states to opt into an alternative reform structure, with a simplified tax credit plan and elimination of the ACA’s federal insurance rules. In this alternative, there would be no individual or employer mandate, but individuals who stayed continuously insured would be protected from higher premiums or restricted coverage based on their health status.

Our linked cases before the Supreme Court (the most prominent being King v. Burwell) could affect how millions of Americans get their health care—and necessitate the most significant congressional action on health care since the passage of the Affordable Care Act (ACA) in 2010. If the Supreme Court rules in favor of the plaintiffs this June, Congress has the opportunity to advance health care policies that expand consumer choice, increase coverage, deliver better value for the dollar, and allow state governments more say over health care policy. The purpose of this paper is to lay out a series of policy recommendations to advance these goals in the event of such a ruling.

The court cases concern the health insurance exchanges and federal subsidies that are at the heart of the ACA, also known as Obamcare. The plaintiffs in the case contend that the subsidies can be paid only in states that established their own exchanges, not in states that relied on the federal government to build and run them.

In fact, most state governments—34 of them—chose not to establish exchanges for the 2014 plan year. (Several other states failed to maintain fully functioning exchanges for 2015, so the federal government is operating exchanges for 37 states this year.)

Nonetheless, the Internal Revenue Service (IRS) decided to offer premium subsidies in these states. The availability of those subsidies triggers other provisions of the act. The subsidies make coverage “affordable” for many individuals under the terms of the act, and thus expose those individuals to a tax if they decline to enroll in a qualified insurance plan. Employers can be subject to a penalty if some or all of their workers receive subsidies through an exchange. The Supreme Court is considering whether the subsidies can be legally paid through the federal
exchanges and thus also whether the triggered mandates apply in the affected states.

If the court sides with the plaintiffs in *King* and the other cases, the subsidies will be ruled illegal in states that have not established their own exchanges and relied instead on federal exchanges. Assuming no further legislative action at either the state or federal level, as many as an estimated 9.3 million people in those states will lose their subsidies by 2016 (Blumberg, Buettgens, and Holohan 2015). They would not necessarily lose these subsidies immediately, since it can take weeks for a Supreme Court ruling to be fully enforced. The court, or the IRS, might take the unusual step of delaying the cutoff further—perhaps even until the end of 2015. Even after the subsidies disappear, exchange participants who would have difficulty paying the full premium without them arguably could retain access to their insurance benefits a while longer, since current federal regulations require their insurance to continue for a month after nonpayment of premiums (US Department of Health and Human Services 2012).

Before too long, however, we could expect many exchange participants to drop their coverage because the costs to them would be too high without subsidies. Insurers could find that they have to substantially raise the next year’s premiums for their remaining customers on federal exchanges or withdraw from participation in those exchanges.¹

We can also expect widespread demands for action to protect those covered under the federal exchanges from losing their plans or seeing major cost increases.²

Congress will be urged to pass a short-term bill to allow subsidies for people who buy insurance on federal exchanges. States will also be urged to set up their own exchanges, although some states are unlikely to consider such action.

We can expect widespread demands for action to protect those covered under the federal exchanges from losing their plans or seeing major cost increases.

Merely resuming the subsidies for participants in the federal exchanges, however, would be an unattractive option. Majorities in both chambers of Congress strongly believe that Obamacare is too prescriptive and moves too much authority over the health system to the federal government. Bringing back the subsidies (and linked mandates) in the affected states would entrench—and, for a time, give a bipartisan imprimatur to—that flawed and misguided model of health care policy. It could fairly be described as more expansive legislation than the ACA, since it would authorize subsidies in circumstances that the court would have just ruled that law did not cover.

On balance, the political pressure would probably make it impossible for Congress to do nothing—and it would be wrong for Congress to do nothing. Millions of Americans would be exposed to hardship through no fault of their own. Congress should do what it can to protect these Americans while also improving health policy.

A Targeted Response

The form of a congressional response to a Supreme Court decision in favor of the plaintiffs in *King* and related cases would matter a great deal.

Congress would need to refuse demands to simply undo the effects of the court’s decision, but that refusal would of course yield partisan

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¹ For a somewhat lower estimate of six million people losing their subsidies this year, see Senate Republican Policy Committee (2015).
² Insurers may not have the flexibility under current federal rules for private health insurance to make those changes before January 2016 because of requirements under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for minimum notice before planned offerings can be modified or withdrawn. The uncertainty of what could be accommodated in the short time between a decision in June 2015 and the next open enrollment period in the fall will add to the instability of the ACA exchanges in the affected states.
circumstances (and which should last through 2015 amounts under revised rules.) using the federal exchanges term legislative response should begin with a short
Subsidies for Current Enrollees
1. Court decision in favor coercion. The health are involved in the case because their residents should provide the affected states more responsive to the decision would be more affected by the care arrangements in states that are not much exchanges. And it would have to change health care arrangements in states that are not much affected by the court’s decision. Legislation that is more responsive to the decision would be more likely to yield a focused and productive debate and a better policy outcome.

That legislation should offer affordable coverage to the people affected by the court’s decision. It should provide the affected states—most of which are involved in the case because their residents disliked Obamacare so much that they refused to set up their own exchanges—with options that are more attractive to them. And it should improve the health care system, making it more patient-centered, more affordable, and less reliant on coercion.

An effective legislative response to a Supreme Court decision in favor of the plaintiffs in the pending cases would have four elements.

1. Short-Term Extension of Modified Subsidies for Current Enrollees. A legislative response should begin with a short-term replacement of current subsidies in states using the federal exchanges with equivalent amounts under revised rules. This extension, which should last through 2015 at a minimum (and no longer than mid-2016 under any circumstances), would be necessary to implement steps 2 through 4 Congress might even consider enacting a short-term extension quickly to give it time to legislate those steps. Either way, the short-term extension should not extend subsidies to new enrollees in the exchanges. A bill with this short-term authorization of existing subsidies should also specify that reinstating the subsidies does not trigger the application of the individual and employer mandates in the affected states, and therefore, no penalties will be imposed or collected. The limited purpose of the new subsidies would be to prevent an immediate disruption of existing enrollees’ health care arrangements, not to entrench the ACA.

2. State Option for an Alternative Tax Credit Structure. Congress should grant states additional options beyond either establishing health exchanges (to regain access to exchange-based subsidies) or letting their residents endure Obamacare’s other regulations without either its subsidies or the employer and individual insurance mandates. These options should involve substantial relief from those other regulations and better versions of taxpayer assistance for purchasing insurance. Congress should consider two approaches to providing this assistance:

Congress should allow residents of states that have not established exchanges to receive tax credits to purchase insurance under a much more relaxed federal regulatory regime. For

3 A ruling in the King case against the legality of federal tax credits for coverage in federal exchange states would create new risks for the Medicaid programs in those states that should be addressed in the same legislation providing a short-term extension of the existing subsidies. A careful reading of the ACA statute reveals that a proper definition of an “exchange established by the state” in King would also retrigger the ACA’s latent maintenance-of-effort (MOE) requirement for Medicaid programs in states without their own exchanges. State officials would be prohibited from changing the pre-March 2010 eligibility rules for Medicaid unless and until they establish a new ACA-compliant state exchange. Otherwise, they would risk forfeiture of all of their federal matching funds under Medicaid. Such a perpetual requirement is ill-advised, unilateral, coercive, and undoubtedly illegal, but overturning it in court—in line with the Supreme Court’s 2012 ruling in National Federation of Independent Business v. Sebelius—still would take several years. Congress should step in more quickly to repeal this MOE provision as part of its first legislative response to a court ruling for the petitioners in King.

4 A case also could be made for insisting that the IRS “refund” any individual mandate or employer mandate penalties imposed on residents of states that did not establish their own exchanges.
reasons of administrative feasibility and simplicity, the tax credits could be set initially as fixed-dollar amounts based on age. (Older people would get larger subsidies, reflecting their tendency to use health services more.) They should be sufficiently generous to ensure that anyone receiving them could purchase an affordable health insurance policy. These subsidies should be available to people who are ineligible for employer coverage (and thus ineligible for the tax benefit already attached to such plans).

Many different levels of tax credits could accomplish the goals of this proposal. One option would be to set the credits at $1,200 for nondependents under age 35; $2,100 for persons between 35 and 50 years old; and $3,000 for persons over age 50. In addition, households would get $900 per dependent child. Previous modeling indicates these credits would be sufficient to ensure a large percentage of the eligible population would be able to find and enroll in attractive insurance offerings.

Congress should consider whether these tax credits should be means tested, as in Obamacare. Means testing would reduce the revenue impact of the subsidies that we estimate but also would make the credits harder to administer, make them less attractive to some voters, and raise effective marginal tax rates.

If Congress is ready and able to achieve longer-lasting reform of health insurance subsidies, it should also consider matching the tax credits more closely to the varying costs of care and insurance that purchasers will face in the less-regulated markets ahead. This second option would make the tax credit amounts more responsive to premiums that may vary by age and geography. Structuring the tax credits as a uniform fixed percentage of premium costs would provide all purchasers with the same subsidized discount rate in choosing insurance plans. This initial floating cost-based subsidy structure then could be adjusted in later years to set a ceiling on maximum tax benefits (to curb overspending) and allow increased subsidies for more economically or medically vulnerable populations. It might even facilitate a gradual convergence in the tax treatment of health care purchasing for consumers in the traditional employer group market and the individual market.

For states that elect either of these new options, the federal employer and individual mandates would remain inoperative, as should the federal definition of essential benefits and the federal age band restrictions. States electing this option would be given the authority to regulate the available insurance options according to state law and policy, but they should be encouraged to make those markets as competitive, accountable, and consumer-driven as possible.

3. Continuous Coverage Protection. Under this alternative system, states, rather than the federal government, would be in charge of regulating health insurance. There should be only one federal requirement, extending the reach of a long-standing provision of federal law to ensure that people with preexisting conditions have access to affordable health insurance: to qualify for the new federal tax credits, insurance policies offered in these states must be available to all who have maintained continuous insurance coverage. Insurers would not be allowed to charge a higher premium to people who have been continuously insured and come to them with a preexisting health condition. Insurers would also be prevented from charging higher premiums to customers who subsequently develop serious health conditions and from imposing coverage restrictions tied to changes in a person’s health status.

In other words, insurance plans offered in the state must be available to people who are sick at the same premium that would be charged to people who are healthy, so long as they had established and maintained continuous insurance enrollment (measured as three or fewer months without coverage over the preceding three-year period). States would be free to regulate

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6 States would be free to establish more flexible policies for providing this protection during the transition from the ACA’s structure to the new alternative regulatory approach. Additional federal funding for high-risk pools could provide some transition assistance for people who have not been in continuous coverage for a sufficient number of months at the time of the switch. States could also establish an “open season” to allow the uninsured to secure continuous coverage protection if they enroll in insurance during a specified period.
insurance offerings differently for those without continuous insurance enrollment.

This regulation extends to individual-market consumers the same kind of protections that HIPAA rules provide to those continuously covered in the employer group market. It differs from the Affordable Care Act’s guaranteed-issue rule. That rule bars insurers from assessing preexisting conditions at any time, which creates an incentive for people to forgo insurance until they become sick. The ACA attempts to balance the incentive to drop insurance by imposing the individual mandate. The protection we favor would, unlike the Obamacare rule, apply only to people who maintain continuous insurance coverage. That would create an incentive to stay covered, obviating any need for an individual mandate.

4. Default Enrollment. State governments taking advantage of the new option should be allowed (but not required) to adopt default enrollment. If someone has not used his allotted tax credit to purchase health insurance, he would be enrolled (with advance notice) in a policy whose premium is equal to his forgone credit. If the individual does not decide to opt out upon receiving this notice, providers can use his insurance benefits to claim reimbursement for the care that they provide. This would effectively provide such a person with the benefits of catastrophic-level insurance coverage at no cost.

The default enrollment option would increase insurance coverage in the states that adopt it. However, state governments doing so must develop the necessary administrative infrastructure to match beneficiaries to default coverage, minimize fraudulent insurance claims, and ensure informed consent each year by default enrollees.

**The Fixed Allotment Alternative**

An alternative to this multipart reform program is a straightforward block grant or capped allotment to the states, with the states taking the lead on designing and implementing some kind of bridge in the aftermath of a Supreme Court decision.

State governments might find a capped allotment more attractive than federal tax credits because they would have even greater flexibility to implement a program of their choosing. Some members of Congress might prefer this approach because they could avoid some of the controversial or difficult policy choices that necessarily come with the design of a federal tax credit for health insurance.

On the other hand, it is not clear that allotment to states will necessarily result in a market-based reform plan. The Children’s Health Insurance Program is a flexible allotment program to the states, and it has not been a model of consumer-driven health care. Indeed, the program can best be described as an add-on to the traditional Medicaid structure in most states.

Further, if the court rules with the plaintiffs in the pending ACA cases, then individuals at risk of higher premiums or losing insurance policies might be more reassured by federal legislation that provides a new approach to providing assistance directly to them than by legislation that makes their continued coverage contingent on state governments’ decisions. Ensuring that individuals have the ability to participate in a deregulated marketplace will also make it easier for the nation to see the advantages and disadvantages of an alternative to Obamacare.

### Budgetary Considerations

A court decision in favor of the plaintiffs in *King* and the related cases would create an unusual budgetary situation. The Congressional Budget Office (CBO) projects federal spending based on current law; a court decision invalidating tens of billions of dollars in federal subsidy payments for health insurance would constitute a substantial change in law and thus also a substantial change in baseline spending estimates.

Legislation to temporarily extend the invalidated subsidies or to provide an alternative to the ACA’s structure would increase federal spending relative to an updated current-law baseline that assumes the invalidated subsidy payments will no longer be made. That could prove to be an

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of time. High-risk pool funding could also be used to stabilize premiums for this population.
insurmountable impediment to consideration of a rational legislative response by Congress.

The budget plan Congress adopted this year recognized this potential problem and offers a solution that will facilitate initial consideration of a response to a court ruling in *King* that strikes down federal exchange tax credits. For purposes of evaluating such a potential legislative response, the budget resolution allows the House to use baseline spending estimates CBO issued in January 2015. This would allow consideration of a legislative response against a baseline that assumes continuation of the subsidy payments in all 50 states.

**It is important to be realistic about the political environment that would emerge in the wake of a decision for the plaintiffs in *King***.

But this approach may be too accommodating of additional federal spending. And it would certainly be preferable for Congress to consider a post-*King* legislative response based on the new, current-law baseline that does not include the invalidated subsidy payments in the spending assumptions. That would force Congress to couple transitional continuation of the subsidies and a new alternative for state reform plans with restraint of other federal spending. Among other things, Congress might consider eliminating some of the other spending approved in the ACA.

Moreover, the workaround Congress adopted might not work. Pay-as-you-go provisions passed in an earlier 2010 measure remain part of permanent law and cannot be overridden by a budget resolution. Further, the interpretation of whether new spending has been properly offset under the pay-as-you-go rules is entrusted to the Office of Management and Budget in the executive branch, not CBO. It is far from certain that the Obama administration would go along with the baseline adjustment adopted in Congress. So even with a baseline adjustment in Congress, the path to restoring subsidies for health insurance may not be clear.

At the same time, it is important to be realistic about the political environment that would emerge in the wake of a decision for the plaintiffs in *King*. It is highly unlikely that the president and the Congress would allow several million people to lose substantial subsidies for their health insurance overnight. One way or another, a response will be necessary to prevent an abrupt termination of health coverage for those enrolled in coverage through the federal exchanges.

**An Opportunity for Progress**

If the court rules for the plaintiffs in *King*, Congress should solve the problems created by the ACA by giving states an alternative approach to providing secure and affordable insurance options. That alternative would be free of the mandates and most of the regulation that marks Obamacare and would therefore result in lower premiums. But it would also be likely to yield high coverage levels and offer protection for people with preexisting conditions.

If this model works over time and residents of the states choosing it find it attractive, that success could pave the way for a larger replacement effort of the ACA.

For supporters of the ACA, congressional action along the lines advocated here ought to be more attractive than letting millions of people lose their subsidies with no replacement. For conservatives, demonstrating that there are other ways to help people get the coverage they prefer, without following the government-centric model of Obamacare, ought to be more attractive than doing nothing or passing legislation that expands and entrenches the ACA. The broader public, we suspect, will find this prospect more attractive as well.

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References


