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KING V. BURWELL SUPREME COURT CASE AND CONGRESSIONAL ACTION THAT CAN BE TAKEN TO PROTECT SMALL BUSINESSES AND THEIR EMPLOYEES

HEARING

BEFORE THE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

APRIL 29, 2015

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KING V. BURWELL SUPREME COURT CASE AND CONGRESSIONAL ACTION THAT CAN BE TAKEN TO PROTECT SMALL BUSINESSES AND THEIR EMPLOYEES

WEDNESDAY, APRIL 29, 2015

UNITED STATES SENATE,
COMMITTEE ON SMALL BUSINESS
AND ENTREPRENEURSHIP,
Washington, DC.

The Committee met, pursuant to notice, at 9:36 a.m., in Room SR–428A, Dirksen Senate Office Building, Hon. David Vitter, Chairman of the Committee, presiding.

Present: Senators Vitter, Risch, Fischer, Gardner, Ernst, Shaheen, and Hirono.

OPENING STATEMENT OF HON. DAVID VITTER, CHAIRMAN, AND A U.S. SENATOR FROM LOUISIANA

Chairman VITTER. Good morning, everyone, and welcome to the Senate Committee on Small Business and Entrepreneurship's legislative hearing, the "*King* v. *Burwell* Supreme Court Case and Congressional Action That Can Be Taken To Protect Small Businesses and Their Employees," and special welcome and thanks to our three witnesses today.

We will discuss that case, *King* v. *Burwell*, and its effect on small businesses and their employees if the Court rules in favor of the plaintiff, and we will also be examining and discussing alternative market-based solutions to health care reform as part of that.

I want to thank Senator Jeanne Shaheen, our Ranking Member, and the other members of the committee for participating both before in setting up this hearing and during, and Senator Shaheen is going to be a little late, but will be here in a little bit.

And, I want to welcome our three witnesses who are all involved in this area of public policy. I will introduce them in just a minute.

The next few months will be really important as we await the Supreme Court decision in *King* v. *Burwell*. The effect on small businesses and individual employees is substantial and I appreciate all of you being here today to express your ideas and perspectives.

By the end of June, we expect the U.S. Supreme Court to decide the legality of the IRS's regulation that enables Federal health insurance subsidies to be paid to individuals in 34 States who have a Federal exchange, not having set up a State exchange. This case really is not about ObamaCare per se. It is about whether the exec-

utive branch executes and enforces laws passed by Congress as written, in my opinion.

That is the fundamental issue in *King* v. *Burwell*, whether the IRS exceeded its authority under the Affordable Care Act by promulgating a final rule that expanded the provision of the health insurance subsidy beyond what was clearly in the statute. King is not a constitutional challenge, but, rather, a challenge to the IRS regulation as being inconsistent with the Act in light of the statutory language.

If the Supreme Court decides in favor of the administration, then not much changes. But, our purpose here today is to review this question from the perspective of a Court decision in favor of the plaintiff and to examine the effects of such a decision, the consequences for individuals who have purchased insurance on the Federal exchange, the effect on other employees, and actions Congress may want to take.

This litigation is set against the backdrop of a highly partisan legislative battle five years ago and continuing, with the final result the Affordable Care Act passed into law, apparently before it was thoroughly read or fully understood by many who voted for it. For those who did understand it and who opposed it, including, I think, a majority of Americans, it remains clearly unpopular.

I think that is so for several reasons. It raised their taxes. It mandated that they buy a product that, in many cases, they did not want. And promised by their President that health insurance premiums would go down by $2,500 for those with employer-sponsored insurance, they instead went up an average of $3,500. For those in the individual markets, premiums went up 50 percent, on average, in the first year the law took effect. It also narrowed the selection of health care providers for many by forcing them into narrow networks. It limited the number of hours they could work for many folks and imposed penalties on individual Americans, their families, and businesses that provide their livelihood.

So, clearly, a larger issue above and beyond the focus of the Supreme Court case and the effects of a ruling in favor of the plaintiff is a question of what is the best approach to health care reform. The creators of ObamaCare have come down on the side of those government mandates and price controls, I believe, because they do not fully trust people, giving them the choices and freedom that alternative approaches could yield them.

On the other hand, when you do trust people, you enable greater freedom, freedom to choose that is at the center of an alternative approach to health care reform, and I think we will hear about those alternatives today from some of our witnesses.

There are also alternatives to the subsidy currently being offered on the Federal exchange, a subsidy in the forms of an advanceable tax credit that actually flows directly from the government into the pockets of the insurance company, not into the hands of consumers under the present system. These alternatives, which we will hear about shortly, would help those who may be caught in the lurch if the Court sides with the plaintiff and throws down the gauntlet to the administration over this poorly constructed law and IRS regulation.

At the end of the day, our greatest concern as Senators should be the folks we represent, our fellow Americans who sent us here to represent them and who, when all is said and done, will be directly affected by the Court's decision and our decisions. So, when the Supreme Court has made its decision, it will be decision time for us and we must ask ourselves, how do we best represent those fellow citizens.

Again, I very much look forward to hearing from our witnesses and let me introduce them now.

Michael F. Cannon is the Cato Institute's Director of Health Policy Studies. With Jonathan Adler, a Professor of Administrative and Constitutional Law at Case Western, Mr. Cannon conducted the legal and legislative research and wrote the leading scholarly treatise that laid the foundation for *King* v. *Burwell* and three similar challenges.

After Mr. Cannon, we are going to hear from Linda J. Blumberg of the Urban Institute. She is a Senior Fellow there, having joined the Institute in 1992. From 1993 through 1994, she was the Health Policy Advisor to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy. She is an expert on private health insurance, both employer and non-group, on health care financing, and on health system reform.

And, finally, we will hear from Jeffrey H. Anderson of the 2017 Project. He is the Executive Director of the 2017 Project, a Washington, D.C. based organization that is operating at the nexus of policy and politics, advancing a conservative reform agenda. Mr. Anderson was the Senior Speech Writer at the U.S. Department of Health and Human Services from 2008 to 2009, and his other writings have been published in the Wall Street Journal, the Weekly Standard, National Affairs, National Review, and a host of other publications.

Again, welcome to you all, and we will start with Mr. Cannon.

STATEMENT OF MICHAEL F. CANNON, DIRECTOR OF HEALTH POLICY STUDIES, CATO INSTITUTE

Mr. CANNON. Thank you, Mr. Chairman and Ranking Member Shaheen, for your invitation to discuss the *King* v. *Burwell* case concerning the Patient Protection and Affordable Care Act that is currently before the Supreme Court.

King v. *Burwell* challenges as unauthorized by Congress both the premium subsidies that the Internal Revenue Service is issuing in 38 States whose health insurance exchanges are operated by Healthcare.gov and the tax penalties those subsidies trigger. The Court heard oral arguments on March 4 and Court watchers expect a ruling by the end of June.

If the Court sides with the challengers, more than 57 million employers and individuals in those 38 States will be freed from the ACA's employer and individual mandates. They include Americans like Kevin Pace, a jazz musician whose income fell by $8,000 because his employer cut his hours to avoid the IRS's illegal taxes. They include small business owners who would like to expand and hire more workers, but are today prohibited from doing so by the threat of illegal taxes. Such a ruling would cause a smaller number

of Americans, an estimated 6.7 million, to lose access to subsidies that no Congress ever authorized but that the IRS is, nevertheless, dispensing illegally.

The problem with current proposals about how to respond to a Supreme Court ruling in *King* v. *Burwell* is that Congress is right now sitting on top of a scandal bigger than Watergate and it is debating whether to let the burglars keep breaking into DNC headquarters for another two years. It is actually worse than that, because one side of this debate wants to give the burglars guns and badges and let them keep breaking into the DNC forever.

What limited oversight Congress has conducted to date shows that the IRS is currently taxing and borrowing and spending tens of billions of dollars contrary to the clear limits the ACA imposes on the IRS's power. The IRS's actions lack—those investigations, limited though they are, show the IRS's actions lack any support in either the ACA or its legislative history or any other Federal law. Yet, in effect, the IRS pledged—those investigations have found that the IRS pledged and ultimately spent taxpayer dollars on a multiyear, multi-billion-dollar contribution to the reelection campaigns of members of Congress who enacted and a President who signed a law that voters and Congress otherwise would have scrapped as unworkable.

By far, the most important thing that members of Congress can do to prepare for a King ruling is to launch an investigation that fits the scale of corruption exposed by *King* v. *Burwell*. Such an investigation would reveal that IRS officials made no serious effort to research the statute or its legislative history before expanding the reach of the ACA's taxes and subsidies beyond the clear limits imposed by Congress. Such an investigation would reveal the IRS did so repeatedly, offering premium subsidies not only in Federal exchanges, but to undocumented aliens and lawful residents below the poverty line who overestimate their income.

University of Iowa law professor Andy Grewal recently revealed the IRS, quote, "effectively provides the largest tax credits to persons who do not satisfy the statutory criteria." Those illegal subsidies, likewise, trigger illegal taxes against employers.

Finally, such an investigation would reveal the IRS tried to hide its actions from the public and has been stonewalling Congress on this issue of monumental importance for nearly four years.

I thank you very much for this opportunity, again, Mr. Chairman, and I look forward to your questions.

[The prepared statement of Mr. Cannon follows:]

U.S. Senate Committee on Small Business and Entrepreneurship hearing on *King v. Burwell* and Congressional Action to Protect Small Businesses and Their Employees, testimony of Michael F. Cannon, Director of Health Policy Studies, Cato Institute[1]

April 29, 2015

Chairman Vitter, Ranking Member Shaheen, and members of the Committee, thank you for your invitation to discuss *King v. Burwell*, a case concerning the Patient Protection and Affordable Care Act (ACA) currently before the Supreme Court. *King v. Burwell* challenges as unauthorized by any Congress both the premium subsidies the Internal Revenue Service is issuing in 38 states with federally established Exchanges, and the tax penalties those subsidies trigger.[2] The Court heard oral arguments on March 4, 2015. Court watchers expect a ruling by the end of June.

If the Court sides with the challengers, its ruling will free more than 57 million employers and individuals in those federal-Exchange states from the ACA's employer and individual mandates.[3] Those 57 million Americans include Kevin Pace, a jazz musician and Virginia resident whose income fell by $8,000 when his employer cut his hours to avoid the IRS's illegal taxes.[4] They include small business owners who would expand and hire more workers, but are prohibited from doing so by threat of illegal taxes. A ruling for the challengers would protect small businesses and their employees from an out-of-control IRS. Such a ruling would cause a smaller number of Americans—an estimated 6.7 million[5]—to lose access to subsidies that no Congress ever authorized.

A ruling for the government, on the other hand, would for the first time allow the IRS to usurp Congress' exclusive powers to tax and spend. Few things could be more destructive to small businesses, liberty, or our constitutional order.

Even if the Court makes the right decision and frees 57 million Americans from the IRS's illegal taxes, the ACA would continue to harm tens if not hundreds of millions of employers and individuals, and an additional 6.7 million Americas would see their health-insurance bills soar as the loss of those illegal subsidies brings them face-to-face with the full cost of the ACA's very expensive coverage.

By far, the most important way this Committee and other congressional committees can prepare for a *King* ruling, and ensure Congress provides appropriate assistance to those affected by the ruling, is to investigate how the IRS came to tax, borrow, and spend tens of billions of dollars in violation of the clear limits the ACA places on the IRS's authority.

Oversight hearings would showcase that those limits are clear and unambiguous. Even the IRS's defenders sometimes admit as much. Harvard law professor Noah Feldman, a former clerk for U.S. Supreme Court Justice David Souter, confesses the weakness of the IRS's case:

> The uncomfortable truth (for liberals, at least) is that [*King v. Burwell*] arises from a piece of statutory language that on its face explicitly says that tax subsidies are only available for health insurance purchased on an exchange "established by the state."
>
> Liberals have tried to explain why, correctly interpreted, this language really means "established by the state or the federal government on the state's behalf." But their theories seem forced.[6]

Investigative hearings would reveal how the IRS initially included in its implementing regulations the statutory requirement that subsidy recipients purchase coverage "through an Exchange established by the State," but reversed itself and dropped that requirement after a political appointee at the Treasury Department objected.[7]

Investigative hearings would reveal the IRS officials made no serious effort to research the statute or its legislative history before expanding their agency's powers, and the reach of the ACA's taxes and subsidies, beyond the clear limits imposed by Congress.[8]

Oversight hearings would reveal that this decision by IRS officials to expand their agency's powers unilaterally is not an isolated incident but part of a pattern at the IRS. University of Iowa law professor Andy Grewal found the IRS is also issuing subsidies to two other ineligible groups: certain undocumented aliens and lawful residents below the poverty line who over-estimate their income. Indeed, Grewal found the IRS "effectively provides the *largest* [subsidies] to persons who do *not* satisfy the statutory criteria."[9] Those illegal subsidies likewise trigger illegal taxes against employers.

Oversight hearings would reveal the IRS's actions contradict what the government told the Supreme Court. The government told the Court that the phrase "an Exchange established by the State" is a statutory "term of art" that means *an Exchange established by either the State or the federal government*.[10] But if the government believed that, there would have been no reason for the IRS to drop that "term of art" from its regulations.

Investigative hearings would reveal the IRS has been stonewalling Congress on this issue for nearly four years. As Ranking Member of the Senate Finance Committee, Sen. Orrin Hatch (R-UT) first asked the IRS in December 2011 for documents related to the agency's creation of these illegal taxes and subsidies.[11] More than three years later, Sen. Hatch has risen to the chairmanship of the Finance Committee, yet the IRS still has not honored to his request. For the better part of one year, the IRS has been ignoring a subpoena for those documents from the House Committee on Oversight and Government Reform.[12]

Oversight hearings would allow Congress to ask important questions of other administration officials.

Since late 2013, the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicare Services (CMS) have enrolled millions of Americans in HealthCare.gov. From the beginning, HHS and CMS officials knew the subsidies that prop up HealthCare.gov could disappear with one court ruling. Yet they never informed enrollees of this inherent risk of the coverage they were selling. Even after the Supreme Court granted cert in *King v. Burwell* in November 2014, defendant HHS Secretary Sylvia Burwell[13] and CMS administrator Marilyn Tavenner[14] publicly proclaimed, "Nothing has changed." Each knew it was not true. The risks that those subsidies would disappear had become so significant that HealthCare.gov-participating insurers demanded protection from an adverse court ruling. Burwell and Tavenner obliged. They granted insurers the right to terminate their relationship with HealthCare.gov if the subsidies disappeared.[15] Oversight hearings would give Burwell and Tavenner a chance to explain why they told consumers "nothing has changed," and whether Tavenner believes that was fair to say while testifying before Congress under oath.

With respect to those risks, Secretary Burwell could at any time announce that she would issue hardship exemptions to any HealthCare.gov enrollee who loses a subsidy, a step that would allow enrollees to switch to lower-cost catastrophic plans. She could, at any time, announce that she would create a "special enrollment period" to allow everyone in HealthCare.gov states to switch to lower-cost plans.

She could, at any time, announce she will hold HealthCare.gov enrollees harmless through the end of the year by immediately issuing to insurers the subsidies they would otherwise receive on a monthly basis for the remainder of 2015. Oversight hearings would allow Secretary Burwell to explain whether she is considering these steps to protect HealthCare.gov enrollees, or at least to explain why she refuses to discuss contingency plans that would protect consumers when she has already taken steps to protect insurance companies.

Oversight hearings would reveal that *King v. Burwell* is actually not about health care at all, but rather an example of political corruption and abuse of power at the IRS that goes beyond what any of us have seen in our lifetimes. Lacking any statutory basis for its actions, the IRS first pledged and ultimately spent taxpayer dollars on a multi-year, multi-billion-dollar contribution to the re-election campaigns of members of Congress who enacted, and a president who signed, a law that voters and Congress otherwise would have scrapped as unworkable. Instead, the law remains on the books.

Investigative hearings can thus point Congress toward appropriate responses to a *King* ruling, and away from proposals that expand the ACA and authorize even more government spending than ACA supporters could have enacted at the height of their power. Oversight would point the way to full repeal of the ACA as the only way to provide relief for HealthCare.gov enrollees without rewarding the IRS for breaking the law. And hearings might suggest that, given the insurance industry's complicity in the IRS's illegal taxing and spending, an appropriate way to hold HealthCare.gov enrollees harmless through 2015 would be to require participating insurers to keep covering those enrollees at the same premium enrollees were paying before the subsidies were invalidated.

I look forward to your questions.

(Attachments)

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[1] Michael F. Cannon is the director of health policy studies at the Cato Institute (www.cato.org), a non-partisan, non-profit, educational foundation dedicated to advancing the ideas of individual liberty, limited government, free markets, and peace. To preserve its independence, the Cato Institute accepts no government funding. Cannon has been described as "the intellectual father" of *King v. Burwell* (by *Modern Healthcare*), "ObamaCare's single most relentless antagonist" (*The New Republic*) and "the man who could bring down ObamaCare" (*Vox*). His work on *King v. Burwell* is extensive. From 2010 through 2013, he counseled state officials not to implement the Patient Protection and Affordable Care Act's (ACA) health-insurance "Exchanges." He was the first to criticize the Internal Revenue Service (IRS) when it announced in August 2011 it would issue premium subsidies and impose the ACA's employer mandate in states with federal Exchanges. With Jonathan H. Adler, a professor of administrative and constitutional law at Case Western Reserve University, Cannon conducted the legal and legislative research, and wrote the leading scholarly treatment, that laid foundation for *King v. Burwell* and three similar challenges to the IRS's overreach. He has participated in numerous debates, advised congressional investigators, and filed several amicus briefs related to these cases. He blogs about *King v. Burwell*, the ACA, and health care reform at DarwinsFool.com.

[2] *See generally* Jonathan H. Adler and Michael F. Cannon, The Halbig Cases: Desperately Seeking Ambiguity in Clear Statutory Text, *Journal of Health Politics, Policy and Law* (Nov. 25, 2014); and Brief of Amici Curiae Jonathan H. Adler and Michael F. Cannon, *King v. Burwell*, No. 14-114 (U.S. Dec. 29, 2014).

[3] Michael F. Cannon, King v. Burwell Would Free More Than 57 Million Americans From The ACA's Individual & Employer Mandates, DarwinsFool.com (Jul. 21, 2014).

[4] Sandhya Somashekhar, "Health-Care Law Is Tied To New Caps on Work Hours for Part-Timers," *Washington Post*, July 23, 2013.

[5] Charles Gaba, "Mazel Tov, GOP: Winning King v. Burwell Will Screw Your Base While Helping Those You Hate!", ACASignups.net, April 16, 2015.

[6] Noah Feldman, "Justices Drop Another Clue About Obamacare's Future," Bloomberg View, April 22, 2015.

[7] Staff of H. Comm. on Oversight and Gov't Reform, 113th Cong., Administration Conducted Inadequate Review of Key Issues Prior to Expanding Health Law's Taxes and Subsidies (Comm. Print 2014).

[8] Staff of H. Comm. on Oversight and Gov't Reform, 113th Cong., Administration Conducted Inadequate Review of Key Issues Prior to Expanding Health Law's Taxes and Subsidies (Comm. Print 2014).

[9] Andy Grewal, "Lurking Challenges to the ACA Tax Credit Regulations," SSRN.com, April 23, 2015. Emphases added.

[10] Brief for the Respondents, *King v. Burwell*, No. 14-114 (U.S. Jan. 21, 2015).

[11] Sen. Orrin G. Hatch, U.S. Senate, Letter to Timothy Geithner, Sec'y, Dep't of the Treasury and Douglas Shulman, Comm'r, Internal Revenue Serv. (Dec. 1, 2011).

[12] Rep. Darrell Issa, Chairman, Committee on Oversight and Government Reform, U.S. House of Representatives, Subpoena Letter to Treasury Secretary Jacob Lew (Sept. 23, 2014).

[13] Secretary Burwell on Health Insurance Enrollment, C-SPAN.org, November 10, 2014.

[14] U.S. House of Representatives, Committee on House Oversight and Government Reform, hearing on Health Care Law Enrollment, C-SPAN.org, December 9, 2014.

[15] Michael F. Cannon, "Insurers' Demand For A 'Halbig' Contingency Plan Demonstrates Need For Immediate SCOTUS Review," DarwinsFool.com, October 21, 2014.

Chairman VITTER. Thank you very much, Mr. Cannon.

And, next, we will be happy to hear from Ms. Blumberg. Welcome.

STATEMENT OF LINDA J. BLUMBERG, SENIOR FELLOW, URBAN INSTITUTE

Ms. BLUMBERG. Thank you very much. Chairman Vitter, Ranking Member Shaheen, and members of the committee, I appreciate the opportunity to testify today. The views that I express are my own and should not be attributed to the Urban Institute or its sponsors. My testimony draws on my own and my colleagues' research on the ACA, private insurance markets pre- and post-2014, and the *King* v. *Burwell* case.

Small employers historically have been much less likely to offer health insurance to their employees than large employers, and their employees historically have been much more likely to be uninsured. These differences have grown considerably over time, a trend that long predates the ACA, with offer rates among small employers, particularly small low-wage firms, falling dramatically over the last 15 years while remaining steady for large firms. For example, offer rates among low-wage firms with fewer than 25 workers dropped by 46 percent between 2000 and 2013, while offer rates across all employers fell by 16 percent.

In June 2013, prior to implementation of the ACA's non-group reforms and tax credits for the purchase of coverage, 30.4 percent of the self-employed and 23.5 percent of small firm employees were uninsured, compared to only 7.6 percent of employees in large firms, according to the Urban Institute's Health Reform Monitoring Survey.

Prior to implementation of the ACA's coverage provisions, many small firm employees, the self-employed, and their dependents had only their State's non-group insurance market as a coverage option. These were small markets with limited ability to meet insurance need due to very high administrative costs, coverage denials, and health status discrimination against those in less than perfect health. Thus, the ACA's reforms of non-group insurance markets benefit disproportionately small firm employees and the self-employed, those least likely to have access to employer-based insurance.

By March of 2015, a year after implementation of the ACA's reforms, uninsurance among the self-employed had fallen by 10.8 percentage points, or 36 percent, and among small firm employees it had fallen by 10.8 percentage points, or 44 percent. Meanwhile, the share of employees receiving offers of health insurance from their employers stayed steady across all firm sizes. Thus, the ACA's non-group market reforms foster choice for employment and small firm or self-employment, facilitating hiring and entrepreneurship.

If the ACA's premium tax credits and cost sharing reductions are eliminated in 34 States by a Supreme Court ruling, the number of uninsured in these States would increase by a total of 8.2 million people in 2016. Additional analyses by place of employment reveal that 5.8 million people losing premium tax credits under a decision for the plaintiffs, or 63 percent of those losing them, have at least

one family member employed by a small firm. Of these 5.8 million people, 4.1 million, or 70 percent, would become uninsured. Two-and-a-half million people in self-employed families would lose tax credits, 1.6 million of whom would become uninsured. Those who retain insurance would face much higher premiums.

Once tax credits are eliminated, the mix of health risks in these non-group insurance markets would change promptly. The healthy who lose tax credits would be first to drop their insurance, increasing significantly the market's average health care costs. As a consequence, the average premiums would increase for the non-group markets both inside and outside the new health insurance exchanges as they are treated as a single risk pool. As average premiums increase, even those who would not have received financial assistance would reassess their ability to afford coverage, and some would leave the markets, become uninsured, and drive premiums even higher for those who remained.

Therefore, another 3.4 million people in small firm families who would not have received tax credits regardless of King would face substantially higher premiums under a ruling for the plaintiffs, and about 840,000 of them would become uninsured. About two million people in self-employed families would face large premium increases, and about 360,000 of them would become uninsured, even though they were never eligible for tax credits.

If the King plaintiffs prevail, the median person or family buying non-group insurance fully with their own funds would pay a premium 55 percent higher to maintain the same coverage that they would have had otherwise. For those who otherwise would have qualified for the tax credits, the premium increases would be much larger.

Small firm employees, the self-employed, and their family members benefit disproportionately from changes the ACA brought to the non-group insurance markets. Thus, they would be disproportionately harmed due to destabilization of these markets engendered by elimination of premium tax credits. New legislation to reinstate the ACA's financial assistance in any State in which it would be prohibited would be required to reverse such damage.

Thank you very much, and I am happy to answer any questions.

[The prepared statement of Ms. Blumberg follows:]

The Implications of a Finding for the Plaintiffs in *King v. Burwell* for Small Employers, their Workers, and the Self-Employed

Oral Statement of

Linda J. Blumberg, Ph.D.

Senior Fellow

The Urban Institute

Health Policy Center

United States Senate

Committee on Small Business and Entrepreneurship

April 29, 2015

Chairman Vitter, Ranking Member Shaheen, and members of the Committee, I appreciate the opportunity to testify today. The views that I express are my own and should not be attributed to the Urban Institute or its sponsors. My testimony draws on my own and my colleagues' research on the ACA, private insurance markets pre- and post-2014, and the *King v. Burwell* case.

Small employers historically have been much less likely to offer health insurance to their employees than large employers, and their employees historically have been much more likely to be uninsured. These differences have grown considerably over time, a trend that long predates the ACA, with offer rates among small employers—particularly small, low-wage firms—falling dramatically over the last 15 years, while remaining steady for large firms. For example, offer rates among low-wage firms with fewer than 25 workers dropped by 46 percent between 2000 and 2013 while offer rates across all employers fell by 16 percent (table 1).[1]

In June 2013, prior to the implementation of the ACA's nongroup reforms and tax credits for the purchase of coverage, 30.4 percent of the self-employed and 23.5 percent of small firm (fewer than 50 employees) employees were uninsured, compared to only 7.6 percent of employees in large firms, according to the Urban Institute's Health Reform Monitoring Survey (table 2).

Prior to implementation of the ACA's coverage provisions, many small firm employees, the self-employed, and their dependents had only their state's nongroup insurance market as a coverage option. These were small markets with limited ability to meet insurance need, due to very high administrative costs, coverage denials, and health status discrimination against those in less than perfect health.

Thus, the ACA's reforms of nongroup insurance markets benefit disproportionately small firm employees and the self-employed, those least likely to have access to employer sponsored insurance. By March of 2015, a year after implementation of the ACA's reforms, uninsurance among the self-employed had fallen by 10.8 percentage points or 36 percent, and among small firm employees it had fallen by 10.8 percentage points or 44 percent (table 2). Meanwhile, the share of employees receiving offers of health insurance from their employers stayed steady across all firm sizes.[2] Thus, the ACA's nongroup market reforms, foster choice for employment in a small firm or self-employment, facilitating hiring and entrepreneurship.

If the ACA's premium tax credits and cost-sharing reductions are eliminated in 34 states by a Supreme Court ruling, the number of uninsured in these states would increase by a total of 8.2 million people in 2016.[3] Additional analyses by place of employment reveal that 5.8 million people losing premium tax credits under a decision for the plaintiffs, or 63 percent, have at least one family member employed by a small firm.[4] Of these 5.8 million people, 4.1 million, or 70 percent, would become uninsured. 2.5 million people in self-employed families would lose tax credits, 1.6 million of whom would become uninsured. Those who retain insurance would face much higher premiums.

Once tax credits are eliminated, the mix of health risks in these nongroup insurance markets

would change promptly. The healthy who lose tax credits would be first to drop their insurance, increasing significantly the markets' average health care costs. As a consequence, the average premiums would increase for the nongroup markets both inside and outside the new health insurance exchanges, as they are treated as a single risk pool. As average premiums increase, even those who would not have received financial assistance would re-assess their ability to afford coverage, and some would leave the markets, become uninsured and drive premiums even higher for those who remained.

Therefore, another 3.4 million people in small firm families who would not have received tax credits regardless of *King* would face substantially higher premiums under a ruling for the plaintiffs, and about 840,000 of them would become uninsured.[5] About 2 million people in self-employed families would face large premium increases and about 360,000 of them would become uninsured, even though they were never eligible for tax credits.

If the *King* plaintiffs prevail, the median person or family buying nongroup insurance fully with their own funds would pay a premium 55 percent higher to maintain the same coverage that they would have had otherwise.[6] For those who otherwise would have qualified for tax credits, the premium increases would be much larger.

Small firm employees, the self-employed, and their family members benefit disproportionately from changes the ACA brought to the nongroup insurance markets. Thus, they would be disproportionately harmed due to destabilization of these markets engendered by elimination of premium tax credits. New legislation to re-instate the ACA's financial assistance in any state in which it would be prohibited would be required to reverse such damage.

Table 1.
Share of Establishments Offering Health Insurance, by Firm Size, 2000 and 2013

	Total	< 25 employees	25-99 employees	100-999 employees	1000 or more employees
Share of establishments offering health insurance, total					
2000	59.3%	44.9%	84.5%	95.0%	99.2%
2013	49.9%	32.3%	77.2%	93.4%	99.3%
Percentage point change 2000-2013	-9.4%	-12.5%	-7.3%	-1.6%	0.1%
Relative change 2000-2013	-15.9%	-27.9%	-8.6%	-1.7%	0.1%
Share of establishment with 50% or more low wage employees that offer health insurance					
2000	42.5%	28.9%	73.5%	94.2%	96.4%
2013	37.1%	15.7%	52.8%	86.5%	99.3%
Percentage point change 2000-2013	-5.4%	-13.2%	-20.7%	-7.7%	2.9%
Relative change 2000-2013	-12.7%	-45.6%	-28.2%	-8.2%	3.0%

Source: Author's calculations of data from the Medical Expenditure Panel Survey, Insurance Component, 2000 and 2013.

Table 2. Share of Workers Who Are Uninsured, June 2013 and March 2015, by Firm Size and Family income Categories

	All Nonelderly Workers				Nonelderly Workers with Family Income <250% FPL				Nonelderly Workers with Family Income ≥250% FPL			
	June 2013 (Quarter 2)	March 2015 (Quarter 1)	Percentage Point Change		June 2013 (Quarter 2)	March 2015 (Quarter 1)	Percentage Point Change		June 2013 (Quarter 2)	March 2015 (Quarter 1)	Percentage Point Change	
All workers	13.9%	7.7%	-6.2	***	30.9%	18.0%	-13.0	***	4.1%	1.8%	-2.3	***
Sample Size	5025	5443			1622	1784			3403	3659		
Self-employed workers	30.4%	19.6%	-10.8	***	44.7%	28.6%	-16.1	***	14.4%	10.1%	-4.2	
Sample Size	594	567			250	265			344	302		
Workers at small firms (fewer than 50 workers)	23.5%	13.2%	-10.3	***	38.3%	22.3%	-16.0	***	8.0%	3.7%	-4.3	**
Sample Size	1136	1225			542	566			594	659		
Workers at large firms (50 or more workers)	7.6%	3.8%	-3.8	***	21.6%	11.6%	-10.0	***	1.8%	0.6%	-1.2	***
Sample Size	3275	3622			819	940			2456	2682		

SOURCE: Health Reform Monitoring Survey, 2013 Quarter 2 and 2015 Quarter 1.

NOTES: Estimates are regression-adjusted. "Workers" includes nonelderly adults working for pay and self-employed adults. Adults who refuse to report work status and those who report working for pay but refuse to report firm size are excluded.

*/**/*** Estimate is significantly different from June 2013 at the 0.1/0.05/0.01 level, using two-tailed tests.

Endnotes

[1]Authors calculations from the Medical Expenditure Panel Survey, Insurance Component. Agency for Healthcare Research and Quality. Rockville, MD. www.meps.ahrq.gov.

[2] Fredric Blavin, Adele Shartzer, Sharon K. Long and John Holahan. "An Early Look At Changes in Employer-Sponsored Insurance Under the Affordable Care Act." *Health Affairs*, 34, no. 1 (2015):170-177.

[3] 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." Timely Analysis of Immediate Health Policy Issues. January 2015. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000062-The-Implications-King-vs-Burwell.pdf

[4] Linda J. Blumberg, Matthew Buettgens, John Holahan. "Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in King v. Burwell." Timely Analysis of Immediate Health Policy Issues. January 2015. http://www.urban.org/research/publication/characteristics-those-affected-supreme-court-finding-plaintiff-king-v-burwell

[5] Ibid.

[6] Ibid.

Chairman VITTER. Thank you very much. I appreciate your being here again.

And last but certainly not least, we will hear from Jeffrey H. Anderson of the 2017 Project. Welcome.

STATEMENT OF JEFFREY H. ANDERSON, EXECUTIVE DIRECTOR, THE 2017 PROJECT

Mr. ANDERSON. Thank you, Chairman Vitter, Senators. It is good to be here. Thank you for the invitation.

For many years, Americans have expressed a clear desire for real health care reform, reform that would lower costs, increase choice, and improve the quality of care. Unfortunately, the Patient Protection and Affordable Care Act, commonly known as ObamaCare, has taken us in the wrong direction in each of these areas. Moreover, ObamaCare consolidates and centralizes power at the expense of Americans' liberty. A nation conceived in liberty is living under a health care law predicated on coercion.

Americans have been waiting for six years for ObamaCare opponents to unite around a free market alternative that deals with costs, deals with coverage, and deals with the individual market without disrupting the employer-based market. The 2017 Project's winning alternative to ObamaCare would accomplish these goals, and the Supreme Court case of *King* v. *Burwell* provides a welcome opportunity to advance such an alternative.

If the Court rules that, in states with Federal exchanges, the Obama Administration has been paying out subsidies in defiance of the law, Congress could choose to pass legislation that would do the following: Give the 37 affected States as well as the 13 others an off ramp from ObamaCare that would lower costs, secure liberty, and ensure that anyone who wants to buy insurance is able to do so. This off ramp should lead to a replacement that would fix what the government had already broken in our health care system even before ObamaCare was passed.

For 70 years, the government has provided a tax break for millions of Americans with employer-based insurance, while millions of Americans who buy insurance on their own have been denied such a tax break. This is unfair and it has undermined the individual market.

The alternative advanced by the 2017 Project, the group I run, would address this unfairness in the tax code by offering simple, non-income tested, refundable tax credits to individuals who buy insurance through the individual market. Unlike ObamaCare subsidies, which go directly to insurance companies, these would be actual tax credits going directly to individuals or families. For most Americans, they would come in the form of a tax cut.

Because the tax credits would not be income-based, they would be far simpler, reduce the IRS's role, avoid disincentivizing work, avoid imposing a marriage penalty, and let every person or family quickly compute what they would be getting. Perhaps most importantly, they would finally address the longstanding inequality in the tax code for all Americans.

The 2017 Project's alternative would offer tax credits of $1,200 for those under the age of 35, $2,100 for those between 35 and 49, and $3,000 for those 50 and over, plus $900 per child. Those who

find a policy for less could deposit the savings in a Health Savings Account. The alternative would also offer a one-time $1,000 per person tax credit for having or opening an HSA.

According to a GAO report released on the eve of ObamaCare's implementation, tax credits in these amounts would be sufficient for healthy Americans to be able to buy insurance even if they paid no more than $15 a month of their own money toward the plans, except in five States, and people in those States could buy across State lines.

If Congress were to respond to a ruling against the administration in *King* v. *Burwell* by offering such non-income tested tax credits, it would benefit millions of middle class Americans who get nothing from ObamaCare but the tab.

According to the Kaiser calculator, the typical single woman who is 40 years old or younger and makes $35,000 a year or more does not get a dime in ObamaCare subsidies. She is too young and too middle class. Under the 2017 Project's alternative, she would get a $2,100 tax credit to help her buy insurance of her choice.

Even though it would benefit far more people than ObamaCare, such an alternative would actually cost much less. According to the nonpartisan Center for Health and Economy co-chaired by Princeton's Uwe Reinhardt and former CBO Director Douglas Holtz-Eakin, the 2017 Project's alternative would save $1.1 trillion in Federal spending over a decade versus ObamaCare while increasing the number of people with private health insurance by six million versus ObamaCare. It would also provide common sense consumer protections as well as funding for State-run high-risk pools to ensure that no-one could be denied affordable insurance on the basis of a preexisting condition.

If Congress were to give States an off ramp that leads to a simple, flat, age-based tax credit for everyone in the individual market, protections for those with preexisting conditions, and the elimination of all of ObamaCare's liberty sapping mandates, it would be a very popular proposal.

The millions of Americans who have been getting ObamaCare subsidies in defiance of the law's plain language and who will be getting nothing in the wake of a ruling against the administration would get a generous tax credit to help them buy affordable insurance of their choice. Moreover, because they were already covered, if they were to switch to a more affordable plan they could not be charged more or denied coverage because of a preexisting condition.

Meanwhile, the millions, perhaps tens of millions, of middle-class Americans who have never gotten anything out of ObamaCare would get a long overdue tax break to buy insurance of their choice. Such tax breaks would be worth thousands of dollars to millions of Americans, would finally fix what the government has broken through the tax code, and would allow the individual market to flourish.

States deserve an off ramp from ObamaCare that leads to a winning alternative. For six years, Americans have opposed ObamaCare and have waited to be offered something better. Now is the time to give it to them.

Thank you.

[The prepared statement of Mr. Anderson follows:]

Jeffrey H. Anderson
Executive Director
The 2017 Project

Testimony before the Senate Committee on Small Business and Entrepreneurship
April 29, 2015

For many years, Americans have expressed a clear desire for real health-care reform. They want reform that would lower costs, increase choice, and improve the quality of care. Unfortunately, the Patient Protection and Affordable Care Act, commonly known as Obamacare, has taken us in the wrong direction in each of these areas.

Even more than that, Obamacare consolidates and centralizes power at the expense of Americans' liberty. It severely restricts a free people's ability to contract freely with one another. It mandates that, for the first time in more than 200 years of United States history, private American citizens must buy a product or service of the federal government's choosing or else pay a penalty — what the law calls an "individual responsibility penalty" — for failure to comply with this command. A nation "conceived in Liberty" is living under a health-care law that is predicated on coercion.

What's more, the Congressional Budget Office (CBO) now projects that Obamacare will cost American taxpayers $1.7 trillion over ten years for its insurance-coverage provisions alone — roughly double the $871 billion tab that was cited at the time of its passage through this body on Christmas Eve 2009.

At the same time, however, Americans are not particularly eager to return to the pre-Obamacare status quo. They have been waiting patiently — for six years now — for Obamacare opponents to unite around a free-market alternative that deals with costs, deals with coverage, and deals with the individual market without disrupting the employer-based market. The 2017 Project's "Winning Alternative to Obamacare" would accomplish these goals, and the Supreme Court case of *King v. Burwell* provides a welcome opportunity to advance such an alternative, offer real reform, and give the American people what they want.

If the Court rules that, in states with federal exchanges, the Obama administration has been paying out subsidies in defiance of the law, Congress will have a prime opportunity to pass legislation that would do the following: Give the 37 affected states — as well as the 13 others — an off-ramp from Obamacare that would lower health costs, secure liberty, and ensure that anyone who wants to buy health insurance is able to do so. The result would be the effective repeal and replacement of Obamacare in up to 37 states — or even more, if some of the 13 states with their own exchanges chose to take the off-ramp as well.

This off-ramp should lead to a replacement that would fix what the federal government had already broken in our health-care system even before Obamacare was passed. For roughly 70 years, the government has provided a generous tax break for millions of Americans with employer-based health insurance, while millions of Americans who buy insurance on their own have been denied such a tax break. This is unfair, and it has undermined the individual market.

The "Winning Alternative to Obamacare" advanced by the 2017 Project — the organization I run — would address this unfairness in the tax code without touching the tax treatment of the typical American's employer-based insurance. Those with employer-based insurance would continue to get their full tax break on insurance that costs up to $20,000 for a family or $8,000 for an individual, and anyone with a more expensive plan would still get the full tax break on that first $20,000 or $8,000.

An alternative advanced in the context of *King v. Burwell* would not have to address the employer-based market in any event, as that would be beyond the scope of the ruling. Such an alternative need only provide an overdue tax break for those in the individual market, in the form of a simple, non-income-tested, refundable tax credit.

Unlike Obamacare's subsidies, which almost always go directly to insurance companies, these would be actual tax credits, going directly to individuals or families. For most Americans, they would come in the form of a tax *cut*.

Because the tax credits would not be income-based, they would be far simpler, reduce the IRS's role, avoid disincentivizing work, avoid imposing a marriage penalty, and let every person or family quickly compute what they'd be getting. Perhaps most importantly, they would finally address the longstanding inequality in the tax code for all Americans.

The 2017 Project's alternative would offer tax credits of $1,200 for those under the age of 35, $2,100 for those between 35 and 49, and $3,000 for those 50 and over — plus $900 per child. A family of four with 40-year-old parents would therefore get a tax credit of $6,000 to use for buying health insurance of their choice. If they shopped for value and found a policy for less, they could deposit the difference in a health savings account (HSA). The 2017 Project's alternative would also offer a one-time, $1,000-per-person tax credit for having or opening an HSA, which would give a family of four another $4,000 in seed money to help cover out-of-pocket costs.

According to a Government Accountability Office report released on the eve of Obamacare's implementation, tax credits in these amounts would be sufficient for healthy Americans to be able to buy insurance even if they paid no more than $15 a month of their own money toward the plans — except in five states, and people in those states could buy across state lines.

If Congress were to respond to a ruling against the Obama administration in *King v. Burwell* by offering such non-income-tested tax credits, it would benefit millions — perhaps tens of millions — of middle-class Americans who get nothing from Obamacare but the tab.

That's because, for all of its expense and coercion, Obamacare did not solve the longstanding inequality in the tax code. Not only does Obamacare give subsidies to insurance companies, rather than tax cuts to Americans, but a wide swath of America has no access to the subsidies. According to the Kaiser Family Foundation calculator, the typical single woman who is 40 years old — or younger — and makes $35,000 a year — or more — doesn't get a dime in Obamacare subsidies. She's too young and too middle class.

Under the 2017 Project's alternative, every 40-year-old single woman would get a $2,100 tax credit, to help her buy health insurance of her choice.

Even though it would benefit far more people than Obamacare, such an alternative would actually cost much less — which is a testament to how expensive Obamacare is and how lavish its subsidies are for the chosen few. According to the nonpartisan Center for Health and Economy, which is co-chaired by Princeton health policy expert Uwe Reinhardt and former CBO director Douglas Holtz-Eakin, the 2017 Project's "Winning Alternative to Obamacare" would save $1.1 trillion in federal spending over a decade versus Obamacare, while *increasing* the number of people with private health insurance by 6 million versus Obamacare. It would also substantially lower premiums and dramatically expand access to doctors. It would provide the sort of real reform Americans want.

The 2017 Project's alternative would also provide commonsense consumer protections, as well as funding for state-run "high risk" pools, to ensure that no one could be denied affordable health insurance on the basis of a preexisting condition. For example, no one could be dropped from his or her existing insurance, or be re-priced, due to a health condition. When young men or women turn 18, or leave school and go off of their parents' insurance, they would have a one-year buy-in-period during which they could not be denied coverage, or charged more, for a preexisting condition. Parents would have a similar one-year buy-in-period for newborns. People could move from employer-based plans to individual plans, or move from one individual plan to a similar or cheaper individual plan, without being denied coverage or being re-priced because of a preexisting condition. And $7.5 billion a year in federal funding for state-run high-risk pools would ensure that anyone could buy partially subsidized insurance, through these pools, that covers preexisting conditions.

If Congress were to give states an off-ramp that leads to simple, flat, age-based tax credits for everyone in the individual market, protections for those with preexisting conditions, and the elimination of all of Obamacare's liberty-sapping mandates, it would be a very popular proposal.

The millions of mostly lower-income Americans who had been getting Obamacare subsidies in defiance of the law's plain language — and who would be getting nothing in the wake of a ruling against the administration — would get a generous tax credit to help them buy affordable insurance of their choice. Moreover, because they were already covered, if they were to switch to a more affordable plan, they could not be charged more — or denied coverage — because of a preexisting condition.

Meanwhile, the millions — perhaps tens of millions — of middle-class Americans who have never gotten anything under Obamacare would get a long-overdue tax break to buy insurance of their choice. Such tax breaks would be worth thousands of dollars to millions of Americans. They would finally fix what the federal government has broken through the tax code and allow the individual market to flourish.

States deserve an off-ramp from Obamacare that leads to a winning alternative. For six years, Americans have opposed Obamacare and have waited to be offered something better. Now is the time to give it to them.

(The 2017 Project's full proposal, entitled "A Winning Alternative to Obamacare," follows.)

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A Winning Alternative to Obamacare

The 2017 Project

Introduction

Obamacare was passed as "comprehensive" legislation, and it calls out for comprehensive repeal. But even though the American people detest Obamacare, they won't support its comprehensive repeal if that means going back to the pre-Obamacare status quo. While most Americans would personally like to see Obamacare repealed, they are not likely to yank newly obtained insurance away from millions of their fellow citizens. It is therefore crucial for conservatives to advance a winning alternative that alleviates this concern and leads to Obamacare's ultimate defeat.

There are three reasons why advancing an alternative is so important: (1) politically, one cannot expect to beat something with nothing; (2) policy-wise, our health-care system already needed to be fixed pre-Obamacare, because the federal government had already broken it; and (3) if Obamacare continues to unravel but conservatives offer no viable alternative, liberals will seize the opening to push for the government monopoly over American medicine ("single payer") they have always desired.

The common formulation is that we need to "repeal and replace" Obamacare. The truth is more nearly the reverse: We need to advance a winning alternative to pave the way to full repeal.

A well-conceived conservative alternative would be able to make the following winning claim: Under the conservative plan, health costs would drop, liberty would be secured, and any American who wants to buy health insurance would be able to do so.

Before Obamacare, Americans had three core concerns with our health-care system, and a victorious alternative needs to offer compelling solutions to all three: the large number of people without insurance; the no-man's-land plight of those who are uninsured and have expensive pre-existing conditions; and the high cost of care. To a large extent, the solution to all three problems involves fixing what the federal government had already broken even before liberal politicians defied public opinion and rammed Obamacare into law, making things far worse. As such, real reform requires shifting things in a conservative direction from the pre-Obamacare status quo.

In the absence of such a conservative alternative, President Obama's signature legislation will survive. But a well-conceived alternative would lead to Obamacare's complete undoing and unconditional defeat, to the great benefit of the American people.

To invoke the second-greatest Republican president, now is a time for choosing. Conservatives can advance a winning alternative to Obamacare and thereby strike a historic blow for limited government and liberty. Or else—whether because any alternative won't be quite what they might have chosen in a political vacuum, because of political miscalculations, or simply because of inertia—they can watch Obamacare, or whatever it spawns, become cemented on these shores.

A Proposed Alternative

Whatever an alternative's exact features, there are three elements that are important, and perhaps essential, to its being a political and policy winner—and thus to its being instrumental in bringing about Obamacare's full repeal. *First, a winning alternative must be something that can be sold to the American people on the political stump.* It must therefore be suitably simple and explainable. *Second, it cannot afford to invite a political backlash by proposing ideas that are lightning rods for criticism.* For example, it shouldn't veer into important but nevertheless tangential issues like Medicare reform, and it shouldn't threaten the existence of the tax break for those with employer-provided health insurance (although it can—and should—prevent that tax break from being an open-ended public subsidy for ever-more-expensive plans). *Third, and most importantly, it must meaningfully address Americans' trio of core goals for real health-care reform*: lowering costs, dealing with preexisting conditions, and significantly increasing the number of people who are insured versus the pre-Obamacare status quo. Indeed, failing to offer solutions to each of these concerns is the easiest way for a conservative alternative to become a target for criticism. An alternative that meaningfully addresses only two of these three core goals would be toppled over like a two-legged stool.

In that spirit, we present the following "three legged" proposal, which borrows extensively from ideas advanced by a wide array of conservative commentators and policymakers, as an alternative to Obamacare's 2,700 pages of unprecedented federal largess.

The First Leg: Ending the Unfairness in the Tax Code—by Offering Tax Credits to the Uninsured and Individually Insured

The core of any winning alternative must be its ability to provide a solution to the longstanding problem of too few people having health insurance. Fortunately, such a solution mostly involves fixing what the federal government had already broken pre-Obamacare. For decades, the federal government has had its foot on the scale, favoring employer-provided health insurance by giving it preferential treatment in the tax code. Why should millions of Americans who get insurance through their employer get a tax break, while millions who buy it on their own through the individual market, do not? This is unfair, and it makes no sense.

What's more, this is a place where a conservative alternative would prove very popular, because it would solve a problem that Obamacare—despite its extraordinary expense and brazen recourse to government coercion—has failed to solve. In addition to the myriad ways in which Obamacare undermines our liberty and our health-care system, it fails to equalize the tax treatment of health insurance.

Obamacare provides massive taxpayer-funded subsidies to older Americans at the expense of younger ones, and to the near-poor at the expense of the middle class. But it provides no subsidies and no tax breaks in the individual market to most single people in their 20s or 30s who make over $35,000 a year, none to most single people under 50 who make over $40,000 a year, and (thanks to its marriage penalty) none to any married couples without children who make over $65,000 a year (see the 2017 Project's Study on Obamacare's Subsidies and Penalties, specifically "Median Obamacare Subsidies by Age and Income"). All of those solidly middle-class Americans continue to have to pay federal taxes on their income and then use a portion of what's left to buy

health insurance, while millions of their fellow Americans get to have their health insurance provided with tax-free income, simply because they get it through their employer.

In a political vacuum, one might consider addressing this unfairness in the tax code by ending and replacing the tax break for employer-provided health insurance. But as James Capretta, Tom Miller, Ramesh Ponnuru, Yuval Levin, and others have noted, this would be politically foolish and would badly undermine efforts to repeal Obamacare. If that weren't already clear beforehand, the experience of lost plans under Obamacare has surely made it plain. The American people do not want anyone messing with their existing insurance.

Rather than ending the employer-provided tax break, the sensible solution, then, is to offer a corresponding tax break in the individual market, thereby more or less leveling the playing field. To avoid suffering a tremendous decline in the number of people who have insurance (versus the number of insured under Obamacare), such a tax break needs to take the form of a tax credit. This is the approach that Senator Jim DeMint wisely advocated as far back as 2009, and that Senators Tom Coburn, Richard Burr, and Orrin Hatch have more recently advanced.

We propose providing a refundable health insurance tax credit of $1,200 for those under 35 years of age, $2,100 for those between 35 and 50 years of age, and $3,000 for those over 50, in addition to $900 per child. These tax credits would be made available to those, and only to those, who purchase health insurance through the individual market.

The value of the credits would rise 3 percent per year. That is less than the historical rate of health-care inflation, but the point of these credits is to revitalize an individual market that the federal government has broken, thereby lowering health costs. Besides, Congress can always raise such spending, but it is better to require an affirmative vote for such a change than to put such spending increases on excessively generous autopilot, as has too often been done before.

Every American citizen or family who is looking to buy insurance through the individual market would be able to use such a tax credit to help buy an insurance policy of their own choosing. There would be no more Obamacare decrees forcing everyone to buy insurance that covers such things as maternity care, pediatric dental care, or the abortion drug ella, and no more corralling of free citizens into government-run exchanges. Moreover, the tax credit would go directly to individuals or families, not to insurance companies like the Obamacare subsidies do.

The vast majority of Americans shopping in the individual market would supplement this tax credit with their own expenditures, freely choosing to buy insurance that costs more than the tax credit would cover. For them, the tax credit would be a source of savings, freeing them from the burden of paying for all of their insurance costs with after-tax dollars, while those with employer-based insurance have theirs paid for with pre-tax dollars. For example, for a family of four with parents in their early 30s, the tax credit would cover the first $4,200 in premiums ($1200 x 2 + $900 x 2), and they could, of course, supplement that with whatever amount they choose. Meanwhile, those who buy insurance that costs less than the amount of the tax credit would be allowed to keep the difference and put it into a health savings account (HSA).

Even those who didn't contribute a dime of their own money would still be able to use the credit to buy basic coverage providing protection against a potentially catastrophic illness. Indeed, tax

credits of these amounts would make it possible for people in most of the 50 states who choose to buy health insurance, to buy it—based on a report on individual-market insurance premiums published by the Government Accountability Office. The exception would be those living in one of a handful of extremely liberal states, where hyper-regulation has caused insurance prices to skyrocket.

That GAO report examined individual-market premiums in all 50 states for a 30-year-old single man, a 30-year-old single woman, a 40-year-old couple with two children, and a 55-year-old couple without children. It reflected premiums in 2013 and therefore took into account the massive premium spike in 2011, when, in the wake of Obamacare's passage the previous year, premiums went up 9.5 percent across all markets combined, according to the Kaiser Family Foundation—roughly twice the average annual premium increase over the previous five years.

The GAO report showed the following: Using the tax credits recommended in this proposal, members of all four examined demographic groups could have purchased insurance through the individual market in any of the 50 states, either just by using the tax credit or else by supplementing it with no more than $15 a month of their own money—except in the liberal havens of Maine, Massachusetts, New Jersey, New York, or Rhode Island. (Some smokers would also have had to pay a bit more to cover premiums in Alaska, Washington, and Wyoming.)

Even people in those five liberal states, however, would be able to buy insurance using just the tax credits under this proposal, as we would let them buy affordable insurance across state lines (see Part 3: Lowering Health Costs).

Contrast this $15-a-month-or-less cost with Obamacare. Under Obamacare, the typical person who makes $40,000 a year cannot get health insurance for ten times that price. That bears repeating: *he or she cannot get health insurance for ten times that price.* According to a 2017 Project study that examined the 50 largest counties in the United States, the median amount that a 26-year-old who makes $40,000 has to pay per month for Obamacare's cheapest "bronze" (lowest tier) plan is $159. (Despite Obamacare's extravagant cost, such a person isn't eligible for a taxpayer-funded subsidy—being too young and too middle class.) At that same $40,000 level of income, the typical 36-year-old has to pay $191 a month, the typical 46-year-old has to pay $202 a month, and the typical 56-year-old—the only person on this list who gets a taxpayer-funded subsidy—has to pay $193 a month (post-subsidy).

In each instance, that's a far cry from paying no more than $15 a month—a ten-fold difference. For the typical American shopping in the individual market, there would be no comparison between how affordable health insurance would be under this proposal and under Obamacare.

* * *

In all, a tax credit to buy health insurance through the individual market would offer myriad benefits. It would end the unfairness in the tax code, grease the wheels for Obamacare's repeal, open up access to affordable coverage, fuel competition among insurers, breathe new life into a moribund individual market, and greatly increase the number of people with insurance versus the pre-Obamacare status quo at just a fraction of Obamacare's cost. Moreover, because the credit wouldn't remotely cover the cost of the lavish prepaid health plans that aren't really (merely)

insurance, it would also encourage the purchase of genuine insurance that protects against unforeseeable costs, while putting people in control of their own day-to-day health-care dollars. This would provide more people with the opportunity and incentive to shop for value, which in turn would cause providers to show prices as they compete to attract value-conscious customers. The result would be significantly lower health costs.

Ending the unfairness in the tax code by offering a refundable tax credit for the purchase of insurance through the individual market is the core element of a well-conceived alternative. Indeed, this first leg is the most important of the three legs that any winning alternative to Obamacare must feature—and, with it in place, Obamacare would be poised to fall.

Question & Answer: Who would receive a tax credit to purchase health insurance?

In addition to those currently buying (or looking to buy) insurance through the individual market, the tax credit would be made available to those who currently get insurance through a relatively small employer. If employees of such small businesses choose to buy insurance in the individual market, rather than getting their insurance through their employer, they would be free to do so—and thus to claim the individual-market credit. Those who work for larger employers and get insurance through them would continue doing so (so long as their employer continues to offer it), thereby protecting those employees' employer-provided coverage while also protecting their employers from a selective exodus into the individual market by their healthier employees, which would lead to higher costs for those who remained behind.

In addition, the tax credit would be available to anyone who is eligible for Medicaid but who would prefer to receive the credit and purchase private health insurance.

The only (very minimal) requirement, in all cases, would be that the credit be used to purchase real insurance—namely, insurance that is licensed and solvent, that has very high or nonexistent annual and lifetime caps on coverage, and that frees the enrollee of any cost-sharing obligation past a certain point (by declaring the enrollee's maximum out-of-pocket expenditure).

No one would be auto-enrolled in any insurance plan. And the credit would be received only by those who purchase insurance, not by those who don't.

Q & A: Why offer a tax credit rather than a tax deduction?

Obamacare is perhaps the worst piece of legislation in American history. The central purpose of any conservative alternative, therefore, must be to pave the way to its full repeal. The key to achieving this result is to meet Americans' trio of core goals for real health-care reform: substantially increasing the number of people who are insured versus the pre-Obamacare status quo; solving the problem of prohibitively expensive preexisting conditions; and lowering health costs. A tax deduction cannot effectively meet the first of these three key goals, so an alternative that centers around a tax deduction would struggle to pave the way to full repeal.

The vast majority of the benefits from an income-tax deduction would go to the top half of income-earners (as the *New York Times* would be quick to point out). As is well known by now, a significant portion of Americans don't pay any income taxes, so an income-tax deduction would

have no effect whatsoever on such Americans' income-tax burden. A deduction that also applies to payroll taxes would benefit all workers, but it would also further reduce the number of Americans who don't pay any federal taxes whatsoever (whereas a tax credit would leave payroll taxes alone). At the same time, a deduction that includes payroll taxes would likely still fail to meet the goal of substantially increasing the number of people who are insured versus the pre-Obamacare status quo.

A specific example might help illustrate the difficulty of relying on a tax deduction in this regard. Even a very large tax deduction of, say, $10,000 for an individual, which applies to both income and payroll taxes—and which applies in full regardless of whether someone spends anywhere near that much on health insurance—would still net a tax break of only $765 for someone who pays only payroll taxes (a pittance compared to Obamacare's lavish taxpayer-funded subsidies for the near-poor, which are slated to grow more lavish over time). At the same time, it would provide a tax break of over $3,200 for millions of Americans in the upper half of the income stratum.

For an alternative to be able to make the winning claim that, under its provisions, any American who wants to buy health insurance would be able to do so, a tax credit—not a deduction—must be a centerpiece of the proposal. Whatever understandable theoretical misgivings some might have about refundable tax credits, supporting one in this context is a small price to pay to take down Obamacare.

Q & A: Why not means-test the tax credits?

Most of these tax credits will take the form of a tax cut for the uninsured and individually insured. But the portions that don't—because the credits' recipients don't pay as much money in income taxes as they will get through the credits—will count as spending. Most of that spending—more than two-thirds, in fact—will be paid for by the top ten percent of income-earners. Not making the credit available to people at that income level would therefore be like having ten people order dinner together in a restaurant, having one of them pick up two-thirds of the tab, and then telling that person that he or she can't have any of the food.

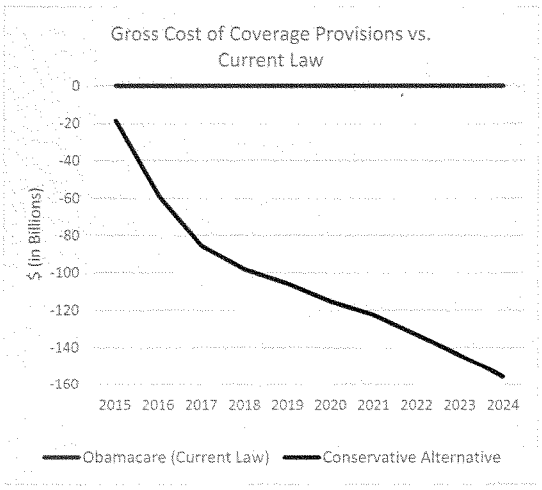
The credits would already be quite progressive in their impact: the wealthier would cover most of the cost of them, while the less-wealthy would receive most of the benefits from them. Yet there is also a level of equality, fairness, and simplicity involved: each person would get the same credit, subject only to his or her age (a factor that directly relates to health costs). To make the program available to all but, say, the top 10 percent of income-earners would shift it from being a program for all Americans to being something more akin to a welfare program for the middle class.

Additionally (and importantly), the goal here—apart from paving the way to full repeal—is to end the unfairness in the tax code. Wealthier Americans already get a tax break for employer-provided health insurance and will continue to get one. (Under this proposal, however, that tax break would no longer be open-ended and wouldn't offer ever-higher tax-breaks for ever-pricier plans.) To deny wealthier Americans a tax break in the individual market, therefore, would not only be unfair but would artificially incentivize them to seek insurance through an employer (if at all possible), rather than through the individual market.

Many conservatives believe that Medicare should be means-tested, but these two positions (espousing means-testing for Medicare and opposing means-testing for these tax credits) are mutually consistent. Medicare is a huge, liberal-designed program whose runaway costs are careening us toward bankruptcy and whose financing offers no pretense of involving anything other than a massive redistribution of wealth (unlike Social Security, whose financing is at least based on the general principle, however imperfectly applied, of paying in for oneself).

What's more, there is an important difference between fixing a broken program (like Medicare) and designing a new one (as an alternative to another liberal-created monstrosity—Obamacare). A program of conservative design should reflect conservative principles. One of Obamacare's worst features is its obsession with income, which pits Americans against one another and empowers the federal government to redistribute money from young to old and from the middle class to the near-poor (leaving a good chunk of cash behind in Washington, D.C., of course). The conservative alternative shouldn't focus on income but should instead embrace simplicity and treat all Americans equally. It's quite enough that the top ten percent of income-earners will have to pay for most of the cost of the tax credits. They don't also need to be denied their benefits.

Q & A: How much would this cost, and how would it affect the middle class?



Obamacare's taxpayer-funded subsidies and its Medicaid expansion are poised to cost over $2 trillion from 2015 to 2024, according to the CBO (see Table B-1). The CBO says that over 90 percent of that amount—$1.863 trillion (assuming the same rate of growth from 2023 to 2024 as from 2022 to 2023)—would come in the form of direct spending (new outlays).

This alternative, meanwhile, is estimated (based on internal scoring) to cost only $977 billion—and most of that "cost" (that's how the CBO would label it) would come in the form of a tax cut. It would save taxpayers more than $1 trillion versus Obamacare from 2015 to 2024—with the annual savings increasing each year, as the accompanying chart shows. In terms of direct spending, this alternative is estimated to cost only $399 billion over a decade—less than a quarter as much as Obamacare—a savings of $1.464 trillion.

It is therefore amazing that—even apart from this alternative's beneficial effects on their liberty, their health care, and their role as taxpayers—the vast majority of Americans would personally fare much better under this proposal than under Obamacare, as the following chart demonstrates:

	21-year-olds		41-year-olds		61-year-olds	
Income:	Obamacare Subsidy	Tax Credit (Alternative)	Obamacare Subsidy	Tax Credit (Alternative)	Obamacare Subsidy	Tax Credit (Alternative)
$20K	$1,507	$1,200	$2,240	$2,100	$4,822	$3,000
$30K	$16	$1,200	$780	$2,100	$4,096	$3,000
$40K	$0	$1,200	$0	$2,100	$2,808	$3,000
$50K	$0	$1,200	$0	$2,100	$0	$3,000
$75K	$0	$1,200	$0	$2,100	$0	$3,000
$100K	$0	$1,200	$0	$2,100	$0	$3,000

For year-1 of the Alternative and year-1 of Obamacare, based on the 2017 Project's study of the median taxpayer-funded Obamacare subsidies across the 50 largest U.S. counties for the lowest-cost "bronze" plan.

How, in light of this chart, can Obamacare be so expensive? First, its outlays for its Medicaid expansion—a part of Obamacare that President Obama rarely emphasizes—are huge, making up 43 percent of Obamacare's direct spending over the next decade, according to the CBO. In fact, in terms of direct spending, Obamacare's Medicaid expansion alone is poised to cost more than this entire alternative. Second, the taxpayer-funded subsidies for Obamacare's exchange plans are projected to skyrocket in future years in response to the premium spikes that the health-care overhaul is causing. The CBO projects (see Table B-1) that Obamacare's taxpayer-funded premium and cost-sharing subsidies will cost a hefty $20 billion in 2014 but a whopping $159 billion in 2024—nearly an eight-fold increase in just ten years. Third, Obamacare's subsidies, not only for premiums but also for the out-of-pocket costs of care (copays, deductibles, etc.—95 percent of which would be covered by taxpayers in some cases), are massive for those who make under $20,000 and those who make under $30,000 and are over 60 years of age—as Obamacare redistributes huge amounts of wealth from younger to older Americans and from the middle class to the near-poor. Thus, its benefits are narrowly distributed, while its costs are widely felt. With the right alternative on the table, that's a recipe for political defeat.

Q & A: How would this be paid for?

As noted above, the tax credits proposed through this alternative would largely take the form of a tax cut for the uninsured and the individually insured. But the portions that wouldn't—because the credits' recipients don't pay as much in income taxes as they would get through the credits—would count as spending. That spending, an estimated $390 billion from 2015 to 2024, would be more than offset by the estimated $679 billion in increased revenue that would result from closing the tax loophole that currently provides an open-ended public subsidy for ever-more-expensive employer-based plans (see Part 3). Meanwhile, an estimated $86 billion in funding for "high risk" pools (see Part 2) would be mostly offset by an estimated $77 billion reduction in Medicaid spending versus the pre-Obamacare status quo, resulting from some Medicaid beneficiaries freely choosing to use tax credits to buy private insurance in lieu of staying on Medicaid. After factoring in the remaining "cost" of the tax credits ($578 billion), a shortfall of $298 billion would remain—but it's a shortfall that would result from a tax cut. This could be paid for in a variety of ways, including by reducing all non-defense spending—across all federal departments and agencies—by just three-quarters of 1 percent (0.75 percent) from 2015 to 2024.

That certainly compares favorably to the funding for Obamacare, which (according to CBO figures) involves *cutting Medicare spending by about 12 percent* from 2015 to 2024 and using that money to pay for Obamacare (even as the Obama administration disingenuously claims that it's somehow also using that same money to extend the life of Medicare) and raising taxes by more than over $1 trillion over that same 10-year span.

Q & A: Is this Obamacare Lite?

If not repealed, Obamacare will increase direct federal spending by the better part of $2 trillion over the next decade (2015 to 2024), even though we're already more than $17 trillion in debt. Over that same span, it will funnel about $1 trillion from taxpayers, through Washington, to insurance companies. It will siphon about $1 trillion out of Medicare, to be spent on Obamacare. It will cut Medicare reimbursement rates to the point where Medicare providers will be paid less than Medicaid providers by the end of this decade. It will establish the unelected 15-member Independent Payment Advisory Board, whose largely unaccountable decrees won't be reversible even by a simple majority of the House and Senate and the signature of the president. It will provide taxpayer funding of abortion. It is already causing millions of Americans to lose their health plans and their doctors. It is causing health insurance premiums to soar. It is causing many if not most of the newly insured to be dumped into the broken Medicaid system at taxpayer expense. It is causing employers to dump their employees into Obamacare's exchanges at taxpayer expense. It is forcing the young to help pay the bills of those who are older and generally more affluent. It is exacerbating a looming doctor shortage. It is providing huge disincentives for businesses to hire new workers, which is a large part of why this "recovery" still looks a lot like a recession. It is mandating—in a way that the federal government has never done before—that private American citizens must buy a product of the federal government's choosing merely as a condition of living in the United States.

This alternative would do none of those things.

Instead, it would pave the way to Obamacare's full repeal, wipe the slate clean, and then implement real health-care reform that shifts things to the right of the pre-Obamacare status quo.

Here's what Obamacare Lite looks like: Conservatives fail to advance a winning alternative, and Obamacare isn't repealed but is merely "tweaked," "improved," or "fixed." Its basic structure remains the same—built according to its 2,700-page, Constitution-defying blueprint—but portions of it are made somewhat less objectionable at the margins. In all, Obamacare generally survives, becoming perhaps 80 percent as bad as it once was. In other words, it becomes what it would have been from the start had Obama not so arrogantly refused to work with a handful or two of overly accommodating Republican senators back in 2009—a foolish rejection of bipartisanship that left the door wide open for the full repeal of his resulting monstrosity. But Obama's greatest political blunder never comes back to haunt him, as conservatives refuse to offer up the alternative that would lead to full repeal. As a result, power and money are consolidated in the nation's capital to a heretofore unprecedented degree—at great loss to American medicine, Americans' liberty, and America's fiscal solvency.

The Second Leg: Solving the Problem of Expensive Preexisting Conditions

Predictably, Obamacare's use of heavy-handed coercion in dealing with preexisting conditions has caused health insurance premiums to skyrocket. In order to expand insurance coverage to those who are already sick, Obamacare bans insurers from basing the price of a policy on the health status of an applicant. In doing so, it encourages people to game the system by waiting until they get sick or injured before purchasing insurance, which is a lot like letting people buy homeowners' insurance after the fire trucks have already arrived on the scene.

Fortunately, there are ways to meet this same goal that don't send insurance costs soaring and don't uproot the very notion of what insurance is. In that spirit, we offer the following six-part proposal:

First, we propose that no one be able to be dropped from their existing health insurance plan, or have their premiums or other costs increased, on the basis of a health condition. This protection would apply both to health conditions that developed after a policy took effect and to ones that were already in existence when a policy took effect and were not willfully hidden from the insurer. This protection would apply to all plans, including those purchased during the unfortunate Obamacare era. This alternative—very much unlike Obamacare—wouldn't cause people to lose the health insurance they already have.

Second, we propose a one-year buy-in-period for young adults who are looking to buy health insurance on their own for the first time, during which time they would be exempted from paying more or being treated differently due to preexisting conditions. This one-year buy-in-period would start on a person's 18th birthday. For those who remain covered under their parents' health insurance (perhaps because they are full-time students), this one-year grace-period would begin once they cease to be covered under their parents' insurance, or on their 25th birthday—whichever comes first. With this framework in place, no responsible young person would face higher health insurance costs simply because he or she happens to suffer from an inborn medical condition or a condition that was acquired as a child.

Third, we propose that parents be granted a similar one-year buy-in-period for newborns, during which time they couldn't be denied insurance for their child, or be charged more, because the child was born with, or had quickly acquired, a preexisting condition. And once insured, the child couldn't be charged more for that condition going forward, either under that plan (per our first proposal in this section) or under a different plan at that same level of coverage (see the fifth proposal, below).

Fourth, we propose easing the transition from employer-based insurance to the individual market in the following manner: Those who have maintained continuous employer-sponsored coverage (for a period of at least a year), but then lose access to that coverage, should be able to transition to a plan in the individual market—one of their own choosing—without paying higher premiums because of a preexisting condition. We would allow a two-month grace-period between the time that someone leaves a job (or otherwise loses access to an employer-provided plan) and the time that he or she buys insurance through the individual market, during which time those protections would apply.

Fifth, drawing upon the work of health policy experts such as James Capretta and Tom Miller, we propose new regulations to protect Americans if they stay continuously insured and want to switch from one individual-market plan to another. Under these regulations, those who have remained continuously insured in the individual market (again, for at least a year) could switch to a different plan—either with their existing insurer or another—that provides the same level of coverage (with such classifications to be determined by the states), without paying more because of a preexisting condition that has developed since they first became insured under their current plan.

Sixth, we propose allocating $7.5 billion a year (with a 3 percent annual increase following year-1) in federal funding for state-run "high risk" pools, an insurance framework championed by Capretta, Miller, and others. Those with expensive preexisting conditions would be able to purchase policies through state-run, federally subsidized high-risk pools. Through such high-risk pools, a person could purchase a partially subsidized health insurance policy, and his or her share of the premiums could not exceed some set percentage (say, 150, 200, or 250 percent)—with the exact percentage to be set by each separate state—of the average cost of a policy for a person without preexisting conditions in that same demographic group (based on age, sex, and geography). No one could be denied coverage through such high-risk pooling, no matter how unhealthy he or she might be.

Crucially, this federal funding would be provided to each state as a defined contribution. Each state would get a set amount each year (to spend only on its intended purpose) based upon its population of American citizens. While most states would likely supplement this federal funding with funding of their own, states' outlays would not trigger any matching federal funds. As Medicaid and other examples have sufficiently demonstrated, the practice of matching states' contributions with federal money merely encourages states to be generous in spending money (as every dollar spent nets them more in federal revenues) and reluctant to stop spending money (as every dollar cut nets them only some portion of that in savings).

In combination, these six provisions would ensure that no one in America would be denied affordable health insurance on the basis of an expensive preexisting condition.

The Third Leg: Lowering Health Costs Across the Board

It would be hard *not* to lower health costs in relation to Obamacare, and the American people know it. Indeed, even before liberals wilfully passed President Obama's signature legislation into law, the CBO projected that, by 2016, Obamacare would cause the average health insurance premium in the individual market to be 10 to 13 percent higher, per person, than it otherwise would have been. Earlier that same month, the CBO had projected that the 2009 House Republican health-care bill would cause the average health insurance premium in the individual market to be 5 to 8 percent *lower*, per person, than it otherwise would have been. That's a 15 to 21-point swing in premiums between the House GOP proposal and Obamacare.

For families, the projections for Obamacare were even worse. The CBO projected that, by that same year, Obamacare would cause the average family's premium in the individual market to be 16 percent—and $2,100—higher than it otherwise would have been. Adding in the CBO's projected savings on the Republican side ($655 at 5 percent, $1,048 at 8 percent), the average

American family's health insurance premium would have been about $3,000 a year lower under the Republican plan than under Obamacare. For the typical American family, that's a lot of money.

To be sure, that's before factoring in Obamacare's expensive taxpayer-funded subsidies. However, the typical middle-class American would fare much better under the tax credits proposed in this alternative than under the Obamacare subsidies—as those subsidies aren't remotely geared toward the middle class (see the chart in Part 1).

The key to lowering health costs is to inject new life into the individual market, which has long labored under a huge government-created disadvantage. The tax credits proposed herein would have the effect of taking the government's foot off the scale, more or less equalizing the tax treatment of individual and employer-based plans, and the individual market would flourish as a result. In addition, however, we propose borrowing from the 2009 House Republican bill, from the Republican Study Committee's recently released America Health Care Reform Act, and from the Coburn-Burr-Hatch proposal, all of which would liberalize rules regarding contributions to, and spending from, health savings accounts (HSAs).

To further encourage the use of HSAs, and to help people cover the day-to-day costs of care, we additionally propose a one-time tax credit of $1,000 per person to anyone who opens an HSA for the first time in the individual market, as well as to anyone who has already opened an HSA in the individual market but has never claimed this credit. (The credit would continue to be offered in subsequent years, but no person could claim it more than once, and its value would not increase over time.) The credit would be deposited directly into an HSA, and the result would be that anyone in America who opens an HSA would effectively start with $1,000 in it (or $2,000 for a couple, or $4,000 for a family of four). At relatively minimal cost (since it's a one-time credit, per person), this would incentivize the use of HSAs, which encourage people to take control of their own health-care dollars and allow them to spend those dollars tax-free. It would also help to rebut the inevitable criticism from the left that some people cannot afford to cover the out-of-pocket cost of *any* of their care. In these ways, such a one-time tax credit would complement the tax credit for purchasing health insurance on the open market.

We also propose lowering costs by having Congress free up the interstate purchase of health insurance. There is no good reason why a couple in New Jersey, for example, should be prevented from purchasing a health insurance plan that originates in Texas and meets Texas's rules (rather than New Jersey's) regarding what things the policy must cover, any limitations on pricing, etc. As such, our alternative would replicate proposals introduced by Sen. Jim DeMint, Rep. Tom Price, and the Republican Study Committee (among others), by allowing people to shop for and purchase health insurance across state lines.

While encouraging people to maintain more control of their own health-care dollars and giving them more opportunity to shop for value, it is also important that a winning conservative alternative move away from the open-ended subsidizing of health insurance that undermines such cost-consciousness. Thus, we propose capping the now-limitless deduction for employer-sponsored health insurance. To be clear, *every employer-based plan would continue to get a tax break*. But in place of the open-ended deduction for employer-sponsored insurance, we propose capping the maximum deduction at the 75th percentile of employer-sponsored plans, in terms of

the cost of their premiums (so, at a level where only the 25 percent of employer-based plans that are the most expensive would be affected at all), and having that amount rise 3 percent annually from there. The CBO projects that, in 2015, the only insurance plans that would be affected by this provision would be those that cost roughly $8,000 per individual or $20,000 per family. If a family plan costs, say, $22,000 and the cap is set at $20,000, a family with that plan would continue to get a tax break on the first $20,000 of its cost; it simply wouldn't get a tax break on the last $2,000.

Closing this tax loophole, which incentivizes people to spend more on health insurance than they would if it weren't tax-free, would not only help equalize the tax treatment of employer-sponsored and individual-market insurance—while offsetting most of the revenue loss from the tax credit—but it would also help lower health costs. In the example provided above, the family in question might decide to buy a plan that's $2,000 less expensive and spend that extra $2,000 on something else, and their slightly cheaper insurance plan—being a bit less like prepaid health care and bit more like genuine insurance that protects against unforeseen costs—would likely give them a bit more opportunity and incentive to shop for value. And the more people are shopping for value (and not just have their expenses covered by a middleman), the more health costs will come down across the board.

We also propose letting people reap the rewards if their lifestyles minimize their risk of needing costly care. Obamacare gives insurers no leeway to reward such healthy behavior and in fact bans them from doing so. But as Rep. Paul Ryan, Sen. Tom Coburn, Sen. Richard Burr, and Rep. Devin Nunes noted in their 2010 bill, the Patient's Choice Act, "five *preventable* chronic conditions consume 75 percent of our health spending and cause two-thirds of American deaths." The 2009 House conservative bill would have allowed health insurers to vary the price of premiums by as much as 50 percent, contingent upon the policyholder's participation in a wellness program. We would allow insurers to go even further, by removing any provision that keeps insurers from encouraging healthier lifestyles and from pricing policies accordingly.

Yet another contributor to high health costs that Obamacare ignores is frivolous medical malpractice lawsuits. Doctors seeking to protect themselves from legal action often feel compelled to assign extra tests or treatments, which inconvenience patients and greatly increase premiums and out-of-pocket costs. According to a survey of doctors conducted by Jackson Healthcare and Gallup, a staggering one-quarter of all health-care spending is a product of defensive medicine, totaling some $650 to $850 billion annually.

To reduce such wasteful spending, states should implement creative policies that will cut back on the number of frivolous medical malpractice suits and expedite the resolution of credible suits. States should consider capping noneconomic damages in medical malpractice suits at $250,000. Moreover, medical malpractice tribunals would likely offer a more efficient and affordable framework for resolving such suits. These tribunals could replace a traditional 12-man jury with a smaller panel of medical experts, who could decide on the merits of the suit and award damages accordingly.

The combination of these provisions would lower health costs substantially in relation to the pre-Obamacare status quo—and all the more in relation to Obamacare.

Conclusion

This "three legged" proposal is as intelligibly simple as Obamacare is unintelligibly complex. If conservatives were to advance something along these lines, Americans would get it, and they would embrace it. The vast majority of Americans, and particularly younger Americans and the middle class, would come out far better under this proposal than under Obamacare, even before factoring in how much they would save in taxes—or gain in liberty.

Chairman VITTER. Thank you very much.

Now, we will go to questions for members of the panel. I will get us kicked off.

Let me ask Michael and Jeffrey, what specifically would be the legal impact of a decision in *King* v. *Burwell* in favor of the plaintiff on the employer and the individual mandate in those States affected that do not have a State exchange?

Mr. CANNON. Well, Senator, unfortunately, as with many aspects of the ACA, the answer is complex. But, what *King* v. *Burwell* does is it challenges as unlawful an IRS regulation that purports to authorize premium subsidies—we call them tax credits or cost sharing subsidies—in exchanges established by the Federal Government. The way—so, if the plaintiffs win before the Supreme Court, then that rule is invalidated and those subsidies must end when the Court's mandate takes effect.

Under the employer mandate, an employer is penalized for not providing adequate coverage to its workers only if one of those workers is eligible for a premium assistance tax credit. So, if the Supreme Court invalidates that IRS rule and all those premium assistance tax credits disappear in all 38 States, 38 Healthcare.gov States, then no employer in any of those 38 States can be penalized under the employer mandate because there are no tax credits to trigger penalties against that employer.

So, if the *King* v. *Burwell* challenges prevail, the employer mandate will be a dead letter in 38 States, and any State that wanted to exempt its employers from the employer mandate could do so by disestablishing their exchange, and there would be an incentive for them to do so because they might lose jobs to the States where the employer mandate does not operate.

The connection to the individual mandate is even more complicated, but there is an exemption from the individual mandate for people whose coverage is unaffordable or for whom coverage would be unaffordable, and the availability of tax credits makes coverage affordable for more people. So, if those tax credits disappear, coverage will be considered unaffordable under the law's definition for more people and many more people will be exempt from the individual mandate.

I have estimated that if the challengers prevail in *King* v. *Burwell*, then another eight million people, another eight million Americans in Federal exchange States will be exempt from the individual mandate. And what that suggests is that if Congress were to turn around and—I wanted to say reauthorize, but those premium assistance tax credits were never authorized in the first place—if Congress turned around and wanted to reinstate those premium assistance tax credits, make them legal, then it would be imposing the employer mandate in 38 States where it would not be operating and imposing the individual mandate on eight million Americans. Likewise, any State that established an exchange after *King* v. *Burwell* that caused those premium tax credits to start flowing again would be imposing the employer mandate on their employers and the individual mandate on many of their citizens.

Chairman VITTER. Okay. Mr. Anderson, number one, do you agree with that general legal analysis? Number two, the alternative you proposed, should the Court decide in favor of the plain-

tiff, would it specifically resurrect either the employer mandate or the individual mandate in those States?

Mr. ANDERSON. I do agree with that, with Michael's analysis, and I—yes—well, no, I am sorry. The alternative that we are proposing would not resurrect the individual mandate or the employer mandate in any of the States. It would—the alternative would repeal those if it were passed as a stand-alone alternative.

In the context of *King* v. *Burwell*, the proposal we have advocated is that an off ramp be provided to States that would eliminate all of the mandates, the employer mandate, the individual mandate, the coverage mandates, and would offer tax credits that people could use to buy insurance that they wish.

Chairman VITTER. So, the alternative you are talking about would not resurrect the mandates because in the language you would specifically repeal them, among other reasons?

Mr. ANDERSON. Correct.

Chairman VITTER. Okay.

Mr. CANNON. Senator, if I may, I am not a fan of health insurance tax credits because they resemble an individual mandate so closely. They effectively tell citizens, either buy a health insurance plan that is approved by the government or you will pay more money to the IRS.

Chairman VITTER. Right.

Mr. CANNON. So, I would dispute what Mr. Anderson said to the extent that I think that health insurance tax credits would effectively—creating a new health insurance tax credit would effectively reinstitute an individual mandate.

Chairman VITTER. Okay. But, you would agree, it would not be a mandate per se. You are talking about—you are saying it would be sort of an incentive.

Mr. CANNON. It would have the same economic impact as an individual mandate without Congress saying, you must buy health insurance.

Chairman VITTER. Right. Okay. Mr. Cannon, you have also written about a related issue, which is the way Congress and Congressional employees get subsidized health care through the D.C. Small Business Exchange. Can you summarize your findings and views on the legality of that.

Mr. CANNON. Well, that is actually a mirror image of the issue that is presented by *King* v. *Burwell*. In *King* v. *Burwell*, we have a case where the IRS exceeded its powers under Federal law to issue subsidies to people through the—under the Affordable Care Act, and in a way, that really prevents Congress from reopening the law, or if the IRS were not issuing these subsidies in Federal exchanges, then what all those subsidies do is they hide the cost of the ACA's individual mandate and its insurance regulations, and if the IRS were not issuing those subsidies, then many more people would be exposed to those costs and Congress would be forced to reopen the law.

There is a parallel issue, or parallel problem here in Congress. The Office of Personnel Management, which administers the Federal Employees Health Benefits Program, has no authority under Federal law to contribute to the premiums for health plans that members of Congress purchase through the D.C. Health Insurance

Exchange established under the ACA, and yet the Office of Personnel Management is doing so and it has the same effect. It is preventing those illegal subsidies—in both cases, are preventing Congress from reopening the law.

I have likened those subsidies to bribes that members of Congress are taking not to reopen the ACA, because there are a lot of very important, very powerful special interest groups in Washington, D.C. The most important and powerful special interest group in Washington is members of Congress and their staffs. And, if they were being harmed by the ACA, if their premiums went up because of the ACA, you can bet your bottom dollar that they would reopen the ACA and change that.

That is exactly why, I think, President Obama personally intervened and got the OPM to reverse its decision, because supporters of this law, or at least the powers that this law gives to the Federal Government did not want Congress reopening this law because they did not want Congress to make other changes that would take away some of those powers.

So, I really think it is a—they are almost identical issues where executive branch agencies are spending taxpayer dollars without Congressional authorization to protect the powers that the ACA gives to the Federal Government and to—and, as I said in my opening statement, they are really also a campaign contribution to the reelection campaigns of the people who voted for this law.

Chairman VITTER. Okay. Thank you.

Senator Hirono.

Senator HIRONO. Thank you, Mr. Chairman.

I have to say, Mr. Cannon, that it is very astounding to me that you have this rather, I would say, a conspiracy theory of those who supported ACA. So, I will set that aside, but I find it astounding that you accuse those people who support ACA of engaging in illegal campaign contributions. You should pursue that with the appropriate authorities.

Mr. CANNON. I think I am.

Senator HIRONO. I think that is through another system.

Okay. Well, let us get to health care in this country. Both Republicans and Democrats agree that we had a broken health care system. So, I consider the ACA, among other things, to be remedial legislation that should be interpreted in a way to effect the purpose of the legislation, which is to enable more people to get health insurance. Forty million people in our country did not have any health insurance at all. So, we obviously have a very different perspective on what government action should occur.

I did want to ask Ms. Blumberg, can you provide some more information on how individuals may be hampered by an inability to get and pay for health insurance if the decision in King eliminates the subsidies as they attempt to become self-employed or start a small business. Can you talk a little bit more about the impact to these folks.

Ms. BLUMBERG. Sure. As I was mentioning, there has always been a big divide in insurance coverage between workers in small firms and the self-employed and those who are employed in large firms or who have a family member in a large firm, and that is because the price differential of purchasing insurance coverage——

Senator HIRONO. Yes.

Ms. BLUMBERG [continuing]. Is very large and always has been. So, the administrative cost of selling coverage, for example, to a small firm are significantly larger than to a large firm, because as someone goes to sell, if they are selling to 5,000 potential enrollees, they are getting a lot for that stop relative to if they are selling coverage for—a sales call for ten employees and their dependents. And, so, the administrative costs of actually selling that coverage are higher for a small firm.

In addition, prior to the implementation of the Affordable Care Act's coverage provisions in 2014, the risk of—the greater risk of providing health insurance coverage in a small firm was also an issue with those small employers offering. So, a smaller employer had fewer workers over which to spread health care risk, and so if they had high-cost workers in their pool, they would be charged much higher premiums than a firm that had healthier younger workers.

And, so, what the Affordable Care Act does is basically begin to spread the health care risk of those in a firm across all of those in the small employer market. It also brought down administrative costs, to some extent, but administrative costs will always be higher in small firms than large firms for health insurance coverage.

So, when you provide a non-group market for the first time in the vast majority of States that is both stable, does not discriminate by health status, and has lower administrative costs and has more transparency in terms of what is being offered and insurers are held to be more accountable for what they are offering, then what you are doing is not only making it somewhat easier for small employers to offer, but you are, in particular, helping out the workers in those firms.

Senator HIRONO. So, basically, you find it totally appropriate that the ACA does provide more of a level playing field for small businesses and people in that situation to be able to afford insurance for their employees.

Ms. BLUMBERG. I think it was completely necessary, because the way that the markets were structured before really discriminated against them and their workers.

Senator HIRONO. I hate to interrupt you, but I am running out of time. Are you familiar with the 2017 Project that Mr. Anderson proposes?

Ms. BLUMBERG. I had not heard of it before finding out that he was going to be testifying here today. Am I familiar with the proposal?

Senator HIRONO. Well, you might want to take a look at it, and I——

Ms. BLUMBERG. I have looked at the proposal, yes.

Senator HIRONO. Do you have any preliminary observations or comments?

Ms. BLUMBERG. I think the main difference between his proposal and some of the other similar ones that are out there is that, as I was talking about, the ACA is really structured to spread risk more broadly, to share the costs of the sick among the majority who are healthy and to make it more accessible and affordable and adequate for everyone. A lot of the proposals, including the one

that Mr. Anderson laid out, is really focused more on segmenting risk, separating the risks of the healthy and the sick. This can lower the cost, definitely, for those who are healthy, but it makes coverage less accessible and less adequate for those who have health problems or who have health problems at a given point in time.

Senator HIRONO. I have a really short question for Mr. Anderson. Hawaii has had the Prepaid Health Care Law, which mandates that all employers with full-time employees provide coverage for—health care coverage for their employees, and there is no exception for small businesses, and this law has been in place for 40 years. The world did not come to an end for businesses in Hawaii. And, in fact, it is one of the reasons that Hawaii people are among the healthiest in the country.

Are you familiar with Hawaii's Prepaid Health Care Law?

Mr. ANDERSON. Only what you just told me.

Senator HIRONO. I would ask you, just as I asked Ms. Blumberg to take a look at your plan, you might want to take a look at Hawaii's Prepaid Health Care Law, which has been in place for over 40 years. Thank you.

Thank you, Mr. Chairman.

Chairman VITTER. Thank you, Senator.

Our Ranking Member has joined us, so we will now go to Senator Shaheen for any opening comments and also questions of our witnesses.

OPENING STATEMENT OF HON. JEANNE SHAHEEN, A U.S. SENATOR FROM NEW HAMPSHIRE

Senator SHAHEEN. Well, thank you very much, Chairman Vitter, and I apologize to the panelists for being late this morning. I had a previous commitment that, unfortunately, I could not change, so thank you all very much for being here.

I would like to state for the record that I believe that the Affordable Care Act is working. Millions of Americans, including tens of thousands of New Hampshirites, now have access to affordable health care coverage.

And despite the success of the law, I do understand that there are changes that need to be made to make it work better, especially for small businesses. Unfortunately, we have yet to have a real discussion about how to make well-intentioned changes to improve the Affordable Care Act and instead we have seen mostly attempts to repeal the law or have it destroyed through favorable court cases. *King* v. *Burwell*, which we are here to talk about this morning, is just another attempt to repeal the law with no plan on how to replace it.

So, I believe this hearing is premature. I appreciate that our panelists and the Chairman are very interested in talking about the issue. But, we do not yet know how the Supreme Court will rule on *King* v. *Burwell*, and as someone who voted for it, I understand that the intent of the Affordable Care Act is clear, that it provide all Americans with access to affordable health insurance regardless of the State in which they live.

A ruling for the plaintiffs in *King* v. *Burwell* will have enormously troubling consequences for families across the country, jeop-

ardizing affordable access to coverage. In New Hampshire, we have 53,000 people who have received tax credits to help with the cost of their insurance premiums and almost three-quarters of them receive some kind of subsidy. If the Supreme Court rules for the plaintiffs, many of these people will not only pay higher premiums, but many will forego coverage altogether.

And, it would impact small businesses and their owners. Take, for example, Steve, who is a self-employed real estate broker from Londonderry. Steve is 61 years old. He had a bypass 11 years ago. Because of his medical history, he was unable to purchase health insurance. Once the ACA was enacted, he purchased a silver plan, and two months later, he had a quadruple bypass. This year, Steve pays $246 a month for coverage after the tax credit is taken into account. This insurance has saved Steve from financial ruin and it has allowed him to continue to work.

Another example is Bill from Concord. Bill owns his own public relations company and he has three young children, one who has special needs. Since 2014, Bill and his wife have bought insurance on New Hampshire's marketplace. Prior to the ACA, Bill spent about $40,000 a year on health insurance for what he considered terrible coverage. He now receives a tax credit, saving about $1,200 a month on a better plan than he was able to afford previously. He says that the tax credit was "like getting a new client for me"—that is a quote from Bill—and it helped him through a slow year in business.

Now, while I believe there are changes that can and should be made to the law, it is clear to me that the ACA is working for individuals, for business owners and for employees, and that a ruling by the Supreme Court that undercuts the law would be devastating to millions of Americans.

Again, I thank you all for being here today. I look forward to having the opportunity to ask questions and to hearing the discussion.

Thank you, Mr. Chairman.

Chairman VITTER. Sure. Absolutely. Do you want to go ahead and go into your questions?

Senator SHAHEEN. Sure. Ms. Blumberg, I think Senator Hirono was asking you about how the insurance reforms were working in the Affordable Care Act, but I wonder if you could talk about what would happen in both the individual market and also with small businesses if those tax credits were no longer available to people.

Ms. BLUMBERG. Sure. Once the tax credits were eliminated under a decision for the plaintiffs, the first thing that would happen is we would see those who are low-income and who are receiving the tax credits to help them afford insurance coverage, the healthiest among them would be the first to drop their coverage. It would happen quickly because they are billed monthly for their share of the premium. So, from one month to the next when this change was implemented, if it was, they would see a huge increase in their out-of-pocket costs that they would have to pay for a premium. So, you would see a big drop in insurance coverage among that population.

Since that is going to disproportionately occur among those who are healthy, what happens is the rest of the pool in the non-group

markets in that State, on average, become sicker and more high-cost. So, the premiums need to go up in order to compensate that so that the insurers are bringing in the right amount of revenue. We could talk separately about what happens if that happens in the middle of a plan year when rates are already set, because that would be a complete situation of chaos for the insurers. But, let us say that is not happening in the middle of a plan year for now.

So, then what happens is everyone else who, even those who were not receiving tax credits but were buying in that market, also see a big increase in their premiums because the risk pool has worsened, and so they, then, need to reevaluate their decisions to buy and what is affordable, and a number of them will also leave the market, making the premiums increase further and increasing the number of uninsured.

And, many of these people—not all of them, but a very significant percentage of them, over half, are either families that have a small firm worker in their family or have a self-employed worker or both. And, so, what you are seeing is a very big impact on that population precisely because they are among those that are least likely to have access to employer-based insurance. This is not going to do anything to change the offer decisions of small employers, since those are staying pretty steady and even historically have been dropping enormously for reasons outside of the Affordable Care Act, so——

Senator SHAHEEN. When you say——

Ms. BLUMBERG [continuing]. Have a lot of impact on that population.

Senator SHAHEEN. Excuse me for interrupting, but when you say this is not going to change what small employers offer, what are you—you are referring to the decision, a Court decision?

Ms. BLUMBERG. Yes. Small employers are historically much less likely to offer health insurance to their workers than large employers for a variety of reasons related to the composition of the workforce and the administrative costs involved in selling to small groups and risk-related issues. So, those small employers, just because this assistance disappears, is not going to change their decision and make them all offer. They are making those decisions for separate circumstances, and what the law has done by reforming the non-group market and providing this assistance, it has made the non-group market for the first time in almost all of these States someplace where you can get adequate, affordable insurance coverage with stable premiums, which has not been the case in the past. So, it was basically a place to catch these folks without access to employer-based insurance, and without that, these markets would become much smaller again, much more expensive, and you would have a lot more uninsured.

Senator SHAHEEN. So, I have a lot of small businesses in New Hampshire and one of the things that I do hear from them is concern about the current law with respect to small businesses. So, are there improvements to the law that you could suggest that would help small employers?

Ms. BLUMBERG. I think I would come at this from two places. One, I think that the resources and attention of the early implementation of the Act have been focused with, I think, good reason,

on the non-group insurance market. But, as a consequence of that, I do not think that the implementation has given enough attention and resources to the small group market, and we see that in how small the shop exchanges are in most States.

And, I think there are some things we could do there. I think we could do better with regard to both informing small employers about the availability of this option. When we talk to folks in different States, many of these small employers do not even know anything about the shop. They do not know the value that it is supposed to bring. You know, having a concise, clear explanation about what that does that could be worked out across all of the States, I think, would be really helpful.

I think we have to help brokers more see the value here and make it easier for them to use the IT system and for there to be more business functionality that they are used to getting directly from insurers there to make it more attractive to them, because they sell the vast majority of policies to small employers still.

So, I think there are a number of ways there that we can bolster the functionality of the shop exchanges and get small employers to know more.

I also think we have an issue in the small group market that needs to be addressed with regard to self-insurance, because as we spread risk more broadly in small group, those reforms, which ended price discrimination against those that had unhealthy groups, those rules do not apply to self-insuring firms of any size and they do not apply to reinsurance products that make it feasible for small employers to self-insure. And, so, as a consequence, I think there is a danger that we are setting up an adverse selection problem that also is going to cause trouble for—legal problems for these small employers that may be moving to self-insurance and do not know the legal ramifications of it. So, I think that is another area where we can do better to strengthen the small group market.

Senator SHAHEEN. Thank you very much.

Thank you, Mr. Chairman.

Chairman VITTER. Thank you.

And, next, we will go to Senator Ernst.

Senator ERNST. Thank you, Mr. Chair.

Thank you to our panelists for being here today. I appreciate your time and thought on this issue. This is a tough issue, and this summer proves to be very interesting, I think, for a number of us.

Mr. Cannon, you mentioned in your statement University of Iowa law professor Andy Grewal, who had found that the IRS is also issuing subsidies to two other ineligible groups, certain undocumented aliens and lawful residents below the poverty line who overestimate their income, and you go on to talk a little bit more about that.

And, interestingly enough, just a couple weeks ago in our Homeland Security and Governmental Affairs Committee, we spoke with the Commissioner of the IRS on the challenges regarding ObamaCare, and in this committee meeting I asked the Commissioner if the IRS had a backup plan if the subsidies to States with Federal health exchanges are struck down, and he reiterated, as so many others have, also, that the IRS nor the administration have a strategy or a plan if this should happen. And, actually, I think

what happened in that committee meeting was everybody was doing this, it is not my problem, basically is what it was coming down to. Somebody else can deal with this.

And, in addition, I asked him what the IRS had discussed about how ruling in favor of the plaintiff would impact States that have a hybrid State-Federal exchange, such as Iowa does, and again, he reiterated that the IRS has not thought this through, and again, basically, that it is not the IRS's problem.

Can you discuss that—really, anyone on the panel, if you would, please, talk about some of those issues and how we resolve these issues.

Mr. CANNON. I think that it has been, as you say, a consistent message from the administration that there is nothing they can do or will do to try to mitigate the impact of the ACA on people in Federal exchange States once those subsidies disappear, because, remember, all those subsidies do is hide the costs of the ACA from consumers, taxpayers.

So, the administration is doing this for a pretty clear reason. It is to try to prejudice the Court against the plaintiffs. If the administration stands there and says that there is absolutely nothing we can do and premiums will go up for millions of people if you rule for the challenges—and, I should say, I probably agree with everything Ms. Blumberg said about what would happen after a ruling. Where we disagree is whether it is the ruling that does that or the ACA itself. The whole point of *King* v. *Burwell* and the meaning of a Supreme Court ruling for the challengers is that those subsidies are illegal and, therefore, what is happening to consumers and taxpayers is a result of the ACA itself. So, all that list of horribles is—and I agree, they are horrible—are results of the ACA and not of the *King* v. *Burwell* ruling.

So, the administration, I think, figures that if it can try to scare the Court and thereby prejudice them against the challengers by saying there is absolutely nothing we can do, when, in fact, there are lots of things that the administration could do.

Right now, the Secretary of Health and Human Services could announce that, as I have mentioned in my written testimony, that they will create a special enrollment period to allow people who lose—anyone in a Federal exchange State to switch to a lower-cost health plan if those subsidies disappear. She could announce that right now. She has not done so.

She could say, we will offer hardship exemptions to anyone who loses a subsidy. She could announce that right—so that they would not be penalized under the individual mandate. Some would be automatically exempt from the individual mandate, others would not. She has not done so.

I do not—I would not approve of this step, but the statute actually gives the Secretary of HHS the authority to protect every Healthcare.gov enrollee from losing their coverage through the end of 2015. All the Secretary has to do is change the periodic basis on which the Treasury Department—because the HHS makes its decision for Treasury—the periodic basis on which the Treasury Department makes those payments to insurance companies, what we call advance payment and tax credits to insurance companies, change it from a monthly basis to an annual basis. It could send

that money to the insurance companies for the rest of the year. No-one would lose those subsidies or their coverage through the end of 2015. I think it would be unethical for them to do so, but I do not think they would think it is unethical because they think that their—or at least they argue that those subsidies are lawful.

There has been no discussion of this. I think that the only explanation for that is that they are trying to intimidate the Court and trying to influence the outcome in that way. So, unfortunately, I do not think that the IRS Commissioner was being honest with Congress when he said there have been no discussions of this.

Senator ERNST. Okay. I appreciate that very much.

My time has expired. Thank you, Mr. Chair.

Chairman VITTER. Thank you.

Now, Senator Fischer.

Senator FISCHER. Thank you, Mr. Chairman.

Mr. Cannon, how do you think individuals and businesses are likely to react if that subsidy is no longer available?

Mr. CANNON. I think that they are going to be unhappy, because they will be exposed for the first time to the full costs of the very expensive coverage that the ACA requires them to purchase. I think that they will intuitively understand why their health insurance bills have doubled or tripled, and it is because, once again, the Federal Government misled them about this law and how it works, just as it did when it promised that if you like your health plan, you can keep it.

If you remember what happened in November of 2013, when people started getting these cancellation notices, they said, wait a second. I was promised by countless supporters of this law that I would be able to keep my health plan. It turned out that, notwithstanding what supporters of this law said was their intent, their actual intent was to take away your health insurance—the health insurance plans from millions of people.

In this case, we hear from lots of supporters of this law, our intent was to offer subsidies in Federal exchanges, but the same thing happened here. What they said did not reflect the law that they passed. The law that they enacted said, no subsidies in Federal exchanges. Those residents will be exposed to the full cost of the ACA. And, I think that the public will intuitively know who is responsible for that.

Senator FISCHER. Thank you.

Mr. Anderson, should Congress be ready to have a response that is going to lessen that impact on individuals who may lose their subsidy, and would you recommend going beyond the scope of limited transition assistance?

Mr. ANDERSON. Thank you for that question, Senator Fischer. Yes, I think Congress—I think it is essential that Congress have a response ready. There are families under ObamaCare—let me give an example. In Milwaukee, a family of five who makes $30,000 a year gets more than $20,000 a year in ObamaCare subsidies, and the notion that those subsidies could be ruled illegal, disappear overnight, and that nothing would happen, I think, is unrealistic. So, something is going to happen.

One scenario is that States that have not set up State-based ObamaCare exchanges might do so, which would presumably

mean—well, it would mean an expansion of ObamaCare and more of a bipartisan quality to it, which, I think, would be very bad from the standpoint of those of us who think that we need to repeal ObamaCare and move in a totally different direction.

I think another mistake would be to try to negotiate fixes to ObamaCare because this simply is not fixable.

I think it is very important that Congress put forward a proposal that this is a great opportunity to finally unite around an alternative, something that I think Americans have wanted from the start of this debate, that actually deals with the issue of health coverage and costs. It does not have all of ObamaCare's intrusions upon liberty, its cost increasing mandates, et cetera.

And, we think a proposal like the one that we advanced at the 2017 Project would be one that could unify people, and it would not only solve the problem of giving people assistance who lose these subsidies which could be ruled illegal, but would also finally fix this inequality in the tax code for the vast majority of the middle class who has really been left out of this whole equation. I mean, it does not make any sense that someone should get a generous tax break for employer-based insurance and then their next-door neighbor who goes out and buys insurance on their own does not get anything. And, that has been the case for 70 years. It did not change under ObamaCare and I think it is time to fix that, which has been the root of our problem and has helped really keep the individual market from being vibrant.

Senator FISCHER. I agree with you, there is a lot to fix. In fact, in Iowa and Nebraska, I do not know if you heard about Co-Opportunity and that co-op under the ACA, one of those established. We have a number of individuals and businesses who purchased insurance through that and are really now left high and dry. They are not receiving—it closed. They are not getting their money back. They have had to purchase insurance, many of them from private insurers, in order to cover their employees, and it has really been very disturbing that taxpayer dollars were pumped into these and then you see it fail and you see the impact on families in my State. And, I think it is just a glimpse into the future and what we are going to see unfold as we continue this.

In your opinion, is there a philosophical difference between the approach to health care reform that is embedded in the ACA and maybe some of the alternatives that have been proposed out there by Senator Hatch, for example, or Senator Johnson?

Mr. CANNON. I think there is a profound philosophical difference, and I think the quick version of that would be that ObamaCare basically is top-down control. Its entire treatment of the subject is to say, if we want something to happen, let us simply mandate that it happen. If we want people to have insurance, let us force them to buy insurance. The first time in all of American history the Federal Government has told private citizens they have to buy a product or service from a private company simply as a condition of living in the United States. That is the general approach, the belief that you can control a fifth or a sixth of the economy from a centralized planning apparatus in Washington, D.C.

The other approach is one that respects Americans' liberty, wants to allow people as much freedom as possible to contract with

one another, hopefully have as many options available as possible, start to see prices come available, actually have the sort of vibrant market that we have in most facets of our country where we do not have so much government intrusion.

Senator FISCHER. Well, thank you. I know all of us know people who have been helped by the ACA who now have insurance. The issue now is their deductibles that they have to meet, and I am starting to hear from those people who are not able to meet the deductibles even with the subsidy, and I can tell you, in Nebraska, I have heard from thousands and thousands of people who have been hurt by this because they have lost the insurance that they wanted. They have lost the doctor that they had gone to. And, in many cases, they have lost the hospital. And, those are cases that are so heart-wrenching, because they deal with children, they deal with cancer, and certain cancer hospitals now who will not be offering help to those children who so desperately need it.

Thank you, sir. Thank you, Mr. Chairman.

Chairman VITTER. Thank you, Senator Fischer.

And, I think the Ranking Member and I each have a few closing questions. Senator Shaheen, why do you not go ahead.

Senator SHAHEEN. Well, Mr. Chairman, I know that we are supposed to be back at the Senate chamber for Prime Minister Abe's address to Congress, so I am going to defer my questions. Thank you.

Chairman VITTER. Okay. I have just a few closing questions.

Mr. Cannon, I want to go back to our discussion about the parallel between this ObamaCare issue and the Congress ObamaCare issue, because I do agree with you that there are very clear parallels. Do you think there is any statutory basis in ObamaCare for giving subsidies for folks on Federal exchanges in States versus State exchanges?

Mr. CANNON. No, there is not, and, in fact, if you read the statute, you will find that it is very carefully worded. It creates a very—a tightly worded, carefully crafted scheme that only offers tax credits, premium tax credits, in States that establish their own exchanges and does so to encourage States to take on that task that Congress wanted them to perform, because Congress cannot command States to enact Federal programs. Congress did this elsewhere in the ACA. It has told States, as it has told States for almost 50 years now, if you establish a compliant Medicaid program, you will get Federal grants to finance that program, and if you do not, you get nothing. You get no Medicaid grants.

Congress offered to States establishment grants, to help them establish an exchange, and it conditioned the renewal of those grants on States taking adequate steps or sufficient steps toward establishing an exchange as well as implementing other parts of the statute.

So, Congress does this sort of thing all the time. The statute is very clear. The tax credits are authorized only in States that establish their own exchanges, not through Federal exchanges.

Chairman VITTER. So, you not only think that the language is clear, you also think that was not a mistake.

Mr. CANNON. It was not a mistake, and there is——

Chairman VITTER. And, then, to draw the parallel, do you think there is any statutory basis for members of Congress and their staff to get the subsidy that they are getting on the Small Business Exchange?

Mr. CANNON. None whatsoever. The ACA itself is silent about whether the Federal Government can contribute to the health insurance premiums that members of Congress get through a health insurance plan created under the ACA, such as the D.C. Shop Exchange or an individual market exchange. But, the Office of Personnel Management needs some authorization from Congress somewhere in Federal law in order to make those contributions and there simply is not.

Chairman VITTER. Now, there is authorization for that under the Federal Employees Health Benefits Plan.

Mr. CANNON. That is correct.

Chairman VITTER. But, that is—I assume what you are saying is that is different from and does not just magically transfer under ObamaCare to the Small Business Exchange.

Mr. CANNON. Yes. So, those who did not want small Congress to reopen the ACA had a problem because the ACA does tell members of Congress you can no longer participate in the FEHBP. You cannot get your coverage there anymore. And, you can only get coverage under—you can only get coverage that was authorized by this Act, so, basically, coverage through an exchange.

And, that meant that members of Congress could only get coverage, really, through an individual market exchange or through a shop exchange. If they got it through an individual market exchange, then Congress could, in neither case could the Office of Personnel Management continue to make contributions to members of Congress—premiums for members of Congress and their staff. That is explicitly prohibited in individual market exchanges. Employers are allowed to do so through the shop exchange, through an exchange such as the D.C. Shop Exchange, but the problem there is that those exchanges are only for small businesses——

Chairman VITTER. Well, that was going to be my next question. In terms of statutory law, the ObamaCare law, is it not clear that that D.C. Small Business Exchange we are talking about is limited to small employers of 100 employees or less, and it has actually been limited by D.C. under the law to 50 employees or less.

Mr. CANNON. That is correct. And, so, what this committee tried to subpoena last week was the document that somebody filed on behalf of Congress with the D.C. Exchange attesting that Congress had, I think it was 45 employees, when, in fact, Congress has a thousand or more employees. So, someone falsified a Federal document in order to get members of Congress into the D.C. Shop Exchange and facilitate these premium contributions that the OPM is not authorized by Federal law to make.

So, there are two problems there. There are these illegal subsidies that members of Congress are receiving and there is the problem that someone falsified the Federal document in order to facilitate those, and I think those are both examples of corruption that Congress needs to investigate.

Chairman VITTER. And with regard to that fraudulent filing, presumably, that was done because the exchange under clear statutory law is limited to employers of 50 employees or less?

Mr. CANNON. Presumably, yes.

Chairman VITTER. Okay. Well, thank you all very, very much for your testimony, for your work, for your participation. The committee really appreciates it.

And with that, we are adjourned.

[Whereupon, at 10:40 a.m., the committee was adjourned.]

APPENDIX MATERIAL SUBMITTED

Journal of Health Politics, Policy and Law

King v. Burwell: Desperately Seeking Ambiguity in Clear Statutory Text

Jonathan H. Adler
Case Western Reserve University

Michael F. Cannon
Cato Institute

Editor's Note: JHPPL *has started an ACA Scholar-Practitioner Network (ASPN). The ASPN assembles people of different backgrounds (practitioners, stakeholders, and researchers) involved in state-level health reform implementation across the United States. The newly developed ASPN website documents ACA implementation research projects to assist policy makers, researchers, and journalists in identifying and integrating scholarly work on state-level implementation of the ACA. If you would like your work included on the ASPN website, please contact web coordinator Phillip Singer at pmsinger@umich.edu. You can visit the site at http://ssascholars.uchicago.edu/jhppl/.*

JHPPL *seeks to bring this important and timely work to the fore in Report on Health Reform Implementation, a recurring special section. Thanks to funding from the Robert Wood Johnson Foundation, all essays in the section are published open access.*
—Colleen M. Grogan

Abstract Does the Patient Protection and Affordable Care Act (ACA) of 2010 authorize tax credits within the thirty-six states that failed to establish health insurance exchanges? That is the question presented in *Pruitt v. Burwell*, *Halbig v. Burwell*, *King v. Burwell*, and *Indiana v. IRS*. The plaintiffs argue that the statute is clear and forecloses any possibility of tax credits in federal exchanges. The government argues that the statute plainly authorizes tax credits in federal exchanges, or is at least ambiguous on the question. Mere disagreement is not evidence of ambiguity. Reaching the truth requires wading deep into each side's arguments. Whether the relevant text is viewed in isolation or in its full statutory context, the ACA only authorizes tax credits in exchanges established by the states.

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Introduction

Section 1311 of the Patient Protection and Affordable Care Act (ACA) directs states to establish health insurance exchanges, and section 1321 directs the federal government to establish exchanges within states that fail to do so (Patient Protection and Affordable Care Act of 2010, 26 U.S.C. (2010)). Confounding expectations, thirty-six states failed to establish exchanges.

Section 1401 offers "premium-assistance tax credits" to individuals who meet certain requirements, including a requirement that they enroll in health insurance—quoting the statute—"through an Exchange established by the State under section 1311" (26 U.S.C. § 36B(b)(2)(A), (c)(2)(A)(i)). But does the act authorize tax credits within the thirty-six states that *failed* to establish exchanges? That is the question presented in *Pruitt v. Burwell*, *Halbig v. Burwell*, *King v. Burwell*, and *Indiana v. IRS*.

The Internal Revenue Service (IRS) initially recognized the requirement that tax-credit recipients must enroll through an exchange "established by the State" (Committee on Oversight and Government Reform 2014). Nevertheless, in January 2014, it began issuing tax credits through both state-established and federal exchanges.

These "tax credits" take the form of payments from the IRS to insurance companies and also trigger penalties under the act's individual and employer mandates. In the thirty-six federal exchange states, therefore, the IRS's reinterpretation has resulted in the Treasury sending billions of dollars to insurers on behalf of 5 million federal exchange enrollees (Burke, Misra, and Sheingold 2014) and subjecting more than 57 million individuals and employers to those penalties (Cannon 2014), neither of which would have occurred if the IRS followed the statute's plain text and its initial draft regulations.

The plaintiffs in *Pruitt*, *Halbig*, *King*, and *Indiana* have challenged the final IRS regulation (U.S. Department of the Treasury, Internal Revenue Service, Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377 (May 23, 2012) (final rule)) purporting to authorize tax credits in states with federal exchanges. They argue that the rule is contrary to the clear language of the ACA and subjects them to penalties without statutory authorization.

Once dismissed as "screwy . . . nutty . . . [and] stupid" (quoted in Eichelberger 2013), the plaintiffs' arguments have been validated in and

out of court.[1] At the district court level, the plaintiffs won in *Pruitt* and lost in *Halbig* and *King*.[2] At the appellate level, they have won in *Halbig* and lost in *King*. At press time, two of three standing opinions found for the plaintiffs.[3] The Supreme Court has granted certiorari in the third, *King v. Burwell*, with oral arguments to take place on March 4, 2015. A ruling is expected to issue by June.

The stakes in this litigation are whether the act's exchange provisions, like its Medicaid provisions, are workable without state buy-in. Were the stakes not so high, the plaintiffs' claims would be uncontroversial. The text of the ACA is clear. And while existing legal doctrines permit agencies to depart from clear statutory language in rare cases, none of those doctrines can rescue the IRS's statutory misconstruction.

This article (1) demonstrates that the statutory requirement that tax-credit recipients enroll "through an Exchange established by the State" is clear; (2) examines whether the IRS rule can be upheld under either the "absurd results" or "scrivener's error" doctrines; (3) considers the government's claim that the act plainly deems federal exchanges to be "established by the State"; and (4) examines whether the IRS rule is eligible for "*Chevron* deference."

The Text Is Plain

Sections 1401 and 1321 demonstrate that the requirement that tax-credit recipients enroll "through an Exchange established by the State" is clear and part of a larger scheme designed to induce states to implement multiple provisions of the act.

The Tax-Credit Eligibility Rules

Section 1401 specifies that premium-assistance tax credits are available through only one type of exchange: "an Exchange established by the State."

1. Jonathan Gruber, the ACA's architect, once described the plaintiffs' claims as "screwy . . . nutty . . . [and] stupid." Shortly after the D.C. Circuit ruled for the *Halbig* plaintiffs, multiple recordings from 2012 surfaced of Gruber (2012) telling audiences: "If you're a state and you don't set up an exchange, that means your citizens don't get their tax credits."

2. The district court has heard oral arguments in *Indiana v. IRS*, but is holding the case in abeyance pending Supreme Court consideration of *King v. Burwell*.

3. The full D.C. Circuit had agreed to reconsider the *Halbig* ruling en banc, a move that technically vacates the original panel's judgment, though not its opinion (D.C. Cir. R. 35(d)). Oral arguments were to be held December 17, 2014, yet the court is holding *Halbig* in abeyance pending the Supreme Court's resolution of *King v. Burwell*.

This requirement is not "a few isolated words" (Ruling on Cross-Motions for Summary Judgment, Halbig v. Sebelius, No. 13-623 (D.D.C. Jan. 15, 2014)). The ACA's authors imposed it twice explicitly and reinforced it seven times by cross-reference. When the act describes the people who qualify for credits, the health plans to which credits may be applied, and the premiums used to calculate the credit amount; when it requires recipients to pay their portion of the premium; and when it describes the rating areas in which to find those people, plans, and premiums, it specifies that all these things are found or occur exclusively in "an Exchange established by the State."

The tax-credit eligibility rules never mention federal exchanges or ever use broad language that would encompass federal exchanges (e.g., "an Exchange"), as appears elsewhere in the act.

A Coherent Scheme to Induce State Cooperation

Section 1321 further conditions those tax credits on states implementing other parts of the act. That section lists various "requirements," including "the establishment and operation of Exchanges" and the act's community-rating rules (42 U.S.C. § 18041(a)(1)). It then provides that states may "elect[]" to adopt those requirements into state law (42 U.S.C. § 18041(b)).

Section 1321(c) explains that the consequence of "failure to establish Exchange or implement requirements" is that "the Secretary shall . . . establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements" (42 U.S.C. § 18041(c)). Failure to comply with *any* of these requirements therefore results in an exchange established *by the federal government*, which precludes the issuance of tax credits. If section 1321's purpose were simply to direct the federal government to perform tasks states failed to perform, it would direct the secretary to establish exchanges only when states failed to establish them. Instead, Congress imposed a federal exchange in the manner of a penalty for any failure to comply with the requirements listed in section 1321.

Additional Evidence

Further evidence, including legislative history, supports the plain meaning of the ACA's tax-credit eligibility provisions. The act's authors added language limiting tax credits to "an Exchange established by the State."

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and language clarifying that requirement, multiple times and at multiple stages of the legislative process, including under the supervision of Senate leaders and White House officials. This eligibility requirement survived multiple rounds of revisions, including revisions to the cross-references attached to it. The reconciliation bill made several amendments to section 1401, yet left this requirement undisturbed (Brief of Amici Curiae Jonathan H. Adler and Michael F. Cannon, King v. Burwell, No. 14-114 (U.S. Dec. 29, 2014)).

In January 2010, all eleven House Democrats in the Texas delegation interpreted the ACA's exchange provisions as categorically denying "any benefit" to residents of states that failed to establish exchanges (Rep. Lloyd Doggett et al., letter to President Barack Obama, January 11, 2010). They voted for it anyway.

Neither a Drafting Error nor Absurd

Many defenders of the IRS claim that this requirement was a drafting error that would produce absurd results if followed literally. The Supreme Court has held that agencies may ignore "scrivener's errors," but only in "unusual" cases where there is "overwhelming evidence" showing that Congress could not have intended what the statute says (U.S. National Bank of Oregon v. Independent Insurance Agents of America, 508 U.S. 439, 462 (1993)). Similarly, the Court has held that agencies may ignore plain meaning where it would produce an absurd result (United States v. Ron Pair Enters., Inc., 489 U.S. 235, 242 (1989)). But, again, this requires a "most extraordinary showing" that the statute cannot mean what it says (Garcia v. United States, 469 U.S. 70, 75 (1984)).

The disputed text may or may not be good policy. But the ACA's congressional supporters offered far too many similar proposals to claim that Congress could not possibly have meant to enact it.

The ACA works largely by creating financial incentives to induce states to implement its provisions. Section 1311 gave the secretary unlimited authority to issue start-up grants to states establishing exchanges. The act requires states to maintain their Medicaid eligibility levels, a costly requirement, until they establish exchanges (ACA § 2001(B)(2)). Until the Supreme Court set it aside, one infamous provision of the act conditioned all federal Medicaid grants on states implementing the act's Medicaid expansion. In 2009 even Senate Republicans proposed offering subsidies only in states that established exchanges (Patients' Choice Act of 2009, S. 1099, 111th Cong. (2009)).

Some argue it is implausibile that Congress would impose the act's community-rating price controls without guaranteeing subsidies and mandates to mitigate the resulting adverse selection. Yet many of the act's authors concede that in 2009 they advanced another bill that imposed even stricter community rating but still withheld exchange subsides in uncooperative states (Brief of Amicus Curiae Members of Congress and State Legislatures, King v. Sebelius, No. 14-1158 (4th Cir. Mar. 20, 2014); Affordable Health Choices Act of 2009, S. 1679, 111th Cong. (2009)). Amici for the government concede that the ACA imposes community rating with weak subsidies and no mandate in US territories (Brief of Amicus Curiae for Economic Scholars in Support of Appellee, King v. Sebelius, No. 14-1158 (4th Cir. Mar. 21, 2014)). Finally, the act also imposed community rating with neither subsidies nor a mandate in both the CLASS Act and the market for child-only coverage.

The Government's Stalking-Horse Argument: The Text Plainly *Does* Authorize Credits in Federal Exchanges

Interestingly, the government has never invoked the scrivener's-error or absurd-results doctrines itself. Instead, as clever lawyers can always do with a complex, intricate statute, the government mines the ACA's two thousand pages for provisions to which it can ascribe odd interpretations and emerges arguing that when read in context, the act plainly *does* authorize credits in federal exchanges. Yet no amount of clever lawyering can reconcile this theory with the statute.

"Such Exchange"

The government argues that when section 1321 says that "the Secretary shall . . . establish and operate such Exchange within the State," the phrase "such Exchange" indicates that a federal exchange is the same exchange that the state would have created—that is, an exchange "established by the State." In doing so, the government ignores this passage's subject and verb, which tell us that it is *the secretary*, not the state, who establishes federal exchanges. Moreover, section 1323 provides that when a US territory creates "such an Exchange," the territory "shall be treated as a State" (42 U.S.C. 18043(a)(1)). The fact that Congress considered it necessary to insert that explicit equivalence language shows that Congress did not consider the word *such* to have the meaning the government claims. The

phrase "such Exchange" may indicate that federal exchanges have the same *intrinsic* characteristics as a state-established exchange, but tax-credit eligibility hinges on the *extrinsic* characteristic of who established the exchange.

The government further argues that the federal government "steps into the State's shoes" when establishing an exchange (Brief for the Appellees, Halbig v. Burwell, No. 14-5018 (D.C. Cir. Nov. 3, 2014) (en banc)). These claims have no basis in the statute. Section 1321 is clear: the secretary establishes an exchange "within" the state—not on its behalf, or in its name, or in its shoes.

"A System of Nested Provisions"

Alternatively, the government argues, the ACA contains "a system of nested provisions that, when you walk through them, lead to the conclusion that" the statute considers a federal exchange to have been "established by the State" in which it operates (Oral Arguments Transcript, Halbig v. Sebelius (D.C. Cir. Mar. 25, 2014)). First, the government claims that various ancillary provisions circuitously define federal exchanges—which are actually established under section 1321—as having been established under section 1311. Next, it claims that when section 1311(d)(1) says that "an Exchange shall be a governmental agency or nonprofit entity that is established by a State," that provision defines any exchange established under section 1311 as having been "established by a State."

The plain text of the act squarely forecloses this theory. Section 1311(d)(1) is not a definition. The act twice describes that provision as a "requirement." Its purpose is clear on its face and becomes even clearer when we read it in context: "Each State shall . . . establish an American Health Benefit Exchange . . . that . . . meets the requirement[] [that] [a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State" (ACA § 1311(b)(1), (d)(1)). This provision does not define anything as having been established by anyone. It prevents for-profit exchanges by requiring state-established exchanges to be either government agencies or nonprofits.

Interpreting section 1311(d)(1) as a definition turns the provision on its head. If this passage defines federal exchanges as having been established by a state, then it must also define for-profit exchanges as governmental agencies or nonprofit entities. The government's interpretation would thus allow exactly what Congress designed this provision to prevent.

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The Government's Strategy: Create the Appearance of Ambiguity

The government is likely just pushing those stalking-horse arguments to create the appearance of ambiguity, in the hope that courts will grant "*Chevron* deference" to the IRS rule. To determine whether an agency's interpretation of a statute is reasonable under the *Chevron* doctrine and thus entitled to deference, courts must first determine whether the statute as a whole speaks clearly to the precise question at issue. If the statute is clear, the agency must implement the statute according to its plain meaning. If the statute is ambiguous on that precise question, the court must ask whether Congress delegated authority to resolve such ambiguities to the agency and whether the agency's interpretation is arbitrary, capricious, or contrary to law. The IRS rule fails every step of the *Chevron* test.

Chevron Step One

Chevron Step One is not an invitation for agencies to create ambiguity in an otherwise clear statute. As noted above, the tax-credit eligibility rules are clear, and the rest of the ACA is fully consistent with their plain meaning.

Section 1401's Information-Reporting Requirements. The government argues that a reporting requirement in section 1401 indicates that Congress intended to offer credits in federal exchanges and therefore creates ambiguity about Congress's intent.

Section 1401 requires exchanges to report information related to enrollees' tax-credit eligibility to the Treasury secretary. It imposes this requirement on state-established and federal exchanges, mentioning each separately (sec. 1401, IRC § 36B(f)(3)). There would be no reason to impose this requirement on federal exchanges, the government argues, unless Congress intended to offer credits there.

On the contrary, the D.C. Circuit found that "even if credits are unavailable on federal Exchanges, reporting by those Exchanges still serves the purpose of enforcing the individual mandate—a point the IRS, in fact, acknowledged" (Halbig v. Burwell, No. 14-5018 (D.C. Cir. Jul. 22, 2014)). Thus there is no tension between those provisions. Moreover, referring to federal exchanges separately supports the plain meaning of "established by the State" because it shows that Congress recognized federal exchanges as distinct.

"Qualified Individuals". The government argues that the phrase "established by the State" cannot be interpreted literally because section 1312 says that "qualified individuals" must "reside[] in the State that established the Exchange" (42 U.S.C. § 18032(f)(1)(A)(ii)). "If an HHS[US Department of Health and Human Services]-created Exchange does not count as established by the State it is in, there would be no individuals 'qualified' to purchase coverage in the 34 states with HHS-created Exchanges" (Halbig v. Burwell, No. 14-5018 (D.C. Cir. Jul. 22, 2014) (J. Edwards, dissenting)). This absurd result, the government claims, creates ambiguity about the meaning of that phrase.

When read in context rather than isolation, though, this requirement supports the plain meaning of "established by the State." Section 1312 defines "qualified individuals" in terms of "the State that established the Exchange" because in sections 1311, 1312, and 1313 Congress is speaking to the states, directing them to establish exchanges, detailing related requirements, and *presuming that states will cooperate*. In the very next section, section 1321, Congress drops that presumption and explains what happens when states fail to establish an exchange. Up to that point, this requirement imposed on "qualified individuals" makes perfect literal sense. After that point, the requirement still has meaning because section 1321 directs the secretary to implement "such" a requirement for federal exchanges—that is, that "qualified individuals" must reside in the state "within" which "the Secretary . . . establish[es]" an exchange (ACA § 1321(a), (c)).

"Maintenance of Effort". The government argues that it would be "disharmonious" to interpret "established by the State" literally, because section 2001 requires states to maintain their prior Medicaid eligibility levels until "an Exchange established by the State . . . is fully operational" (42 U.S.C. § 1396a(gg)(1)), and a literal interpretation would impose this costly requirement indefinitely. Such a provision is not disharmonious in a statute that pushed the practice of offering such financial inducements to states "pas[t] the point at which pressure turns into compulsion" (NFIB, 132 S. Ct. at 2604 (quoting Steward Machine Co. v. Davis, 301 U.S. 548, 590 (1937))).

Moreover, the government's interpretation leads to anomalous and even absurd results when applied throughout the statute. Here, it would condition a state's freedom to alter its Medicaid eligibility rules on *federal* action (i.e., whether the federal government establishes an operational

exchange). Elsewhere, it would allow *states* to decide whether *federal* exchanges may contract out certain responsibilities (42 U.S.C. § 18031(f)(3)(A)), and would condition a state's eligibility for Medicaid grants on whether the *state* can control the *federal* government (i.e. whether the state can ensure that the federal government has set up a secure interface between the federal Exchange and state agencies) (42 U.S.C. § 1396w-3(b)(1)(D)).

Chevron Step Two

Even if the statute were ambiguous, there is no evidence Congress sought to delegate to the IRS authority to determine where tax credits will be issued.[4]

The Supreme Court has repeatedly warned executive agencies that "Congress . . . does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions—it does not . . . hide elephants in mouseholes" (Whitman v. Am. Trucking Ass'ns, Inc., 531 U.S. 457, 468 (2001)). Put differently, Congress does not override plain text and delegate discretionary authority to tax, borrow, and spend hundreds of billions of dollars per year via "a system of nested provisions" hidden within a statute. Moreover, in claiming that the relevant provisions are ambiguous, the government effectively concedes that Congress was comfortable with denying tax credits in nonestablishing states, for if the statute is ambiguous, the IRS (and a future administration) retains the authority to make that choice.

Conclusion

The ACA is not a model of legislative drafting. Nonetheless, the act's tax-credit eligibility provisions are crystal clear. Section 1401 only authorizes tax credits for insurance purchased through an exchange "established by the State." If the administration or other health care reform advocates are uncomfortable with this result, it must be fixed by Congress, rather than by administrative fiat.

4. For reasons we explain elsewhere, the IRS rule is also arbitrary, capricious, and contrary to law (Adler and Cannon 2013).

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Michael F. Cannon has been described by the *Washington Post* as "an influential health-care wonk at the libertarian Cato Institute," where he is director of health policy studies. His work focuses on making medical care better and more affordable and making access to medicine more secure. His scholarship has appeared in the *New York Times*, the *Wall Street Journal*, *Forum for Health Economics and Policy*, *Harvard Health Policy Review*, and the *Yale Journal of Health Policy, Law, and Ethics*. He is coeditor of *Replacing Obamacare: The Cato Institute on Health Care Reform* (2012). His recent work includes "Taxation without Representation: The Illegal IRS Rule to Expand Tax Credits under the PPACA," *Health Matrix: Journal of Law-Medicine* (with Jonathan H. Adler; 2013).

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No. 14-114

In the Supreme Court of the United States

DAVID KING, ET AL.,
Petitioners,

v.

SYLVIA BURWELL, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF JONATHAN H. ADLER AND MICHAEL F. CANNON AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*[1]

Amici were among the first to question the federal government's authority to issue subsidies for coverage purchased through federally established Exchanges. They have since, separately and together, published numerous articles, delivered lectures and testimony, and advised government officials on that issue and, in particular, on the regulation challenged here. They are the authors of the leading scholarly treatment of this issue, Jonathan H. Adler & Michael F. Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 Health Matrix J. L. Med. 119 (2013). *See also* Jonathan H. Adler & Michael F. Cannon, *The* Halbig *Cases: Desperately Seeking Ambiguity in Clear Statutory Text*, 40 J. Health Politics, Pol'y & L. (forthcoming 2015).

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[1] By letters on file with the Clerk, all parties have consented to the filing of this brief. No counsel for any party authored this brief in whole or in part, and no person other than *amici curiae* or their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

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SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act of 2010 ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119, authorizes tax credits for the purchase of health insurance in state-established Exchanges, and only in such Exchanges. Insofar as the IRS has sought to provide tax credits for the purchase of health insurance in federally established Exchanges, its actions are contrary to law and must be set aside.

Section 1311 of the PPACA (42 U.S.C. § 18031) declares that "Each State shall . . . establish" an "Exchange" to regulate health insurance within the state. Section 1321 (42 U.S.C. § 18041) directs the federal government to "establish" Exchanges "within" states that "[f]ail[] to establish [an] Exchange" or implement other specified provisions of the Act. Section 1401 (26 U.S.C. § 36B) offers health-insurance "tax credits" to certain taxpayers who enroll in a qualified health plan "through an Exchange established by the State." The statute limits tax credits to state-established Exchanges in a manner that is plain and unambiguous. The remainder of the statute and the

PPACA's legislative history are fully consistent with those provisions.

Such conditions are not anomalous. To induce state cooperation, Congress routinely conditions federal benefits to individuals — via both direct spending and the tax code — on their states carrying out congressional priorities. Congress conditioned federal subsidies on state action on multiple occasions throughout the PPACA. It did so here as well.

The text of the PPACA is sufficient to resolve this case. Resort to legislative history only reinforces this conclusion. That history supports the plain meaning of the text, and reveals why PPACA supporters approved this requirement even if many of them would have preferred otherwise. Political necessity required the Act's authors to give states a leading role in operating health-insurance Exchanges. In so doing, the Act's authors expressly conditioned premium-assistance tax credits on states establishing Exchanges and performing other tasks. Many of the Act's supporters preferred a different approach. But after those supporters lost their filibuster-proof majority in the U.S. Senate, no other approach could satisfy the constitutional requirements of bicameralism and presentment.

In 2012, the Internal Revenue Service issued a rule that altered that political tradeoff. The IRS rule offers premium-assistance tax credits through Exchanges that were established not *by the State*, but rather *by the federal government*. The agency is presently issuing those tax credits in the 36 states that refused or otherwise failed to establish an Exchange.

The IRS rule is contrary to the plain language of the PPACA. The statutory text speaks directly to the question at issue. Thus the IRS has no authority to provide tax credits in federal Exchanges. Nor is the IRS due deference in its interpretation of the Act. Contrary to the Government's argument that the rule supports one of the Act's general goals, the rule actually *subverts* congressional intent by altering the balance Congress struck between the Act's competing goals. It tries to achieve through regulatory fiat what PPACA supporters could not achieve through the political process: a health care bill that does *not* rely on state cooperation.

The Government has not identified any statutory provisions that conflict with the plain meaning of the PPACA's tax-credit eligibility provisions. Nor has the agency identified a single contemporaneous statement indicating PPACA supporters expected *this* bill to offer tax credits in *federal* Exchanges. The IRS simply rewrote the statute. The IRS's regulation is therefore contrary to law and should be set aside.

ARGUMENT

I. The PPACA Authorizes Premium-Assistance Tax Credits Only in Exchanges "Established by the State."

The PPACA offers premium-assistance tax credits only in states that establish and operate health-insurance Exchanges and perform other tasks that Congress cannot command states to perform. Section 1401's tightly worded tax-credit eligibility rules (26 U.S.C. § 36B) explicitly and carefully limit eligibility

to those who enroll in a qualified health plan "through an Exchange established by the State." These provisions condition the availability of tax credits on states establishing Exchanges, and prevent the issuance of tax credits in federal Exchanges. Section 1321 reinforces and works in conjunction with Section 1401 to condition tax credits on states establishing Exchanges and implementing other features of the law. These conditions mirror conditions Section 1311 imposes on federal grants to states.

The meaning of "established by the State" is plain. Congress defined "State" to mean "each of the 50 States and the District of Columbia." 42 U.S.C. § 18024(d). When Congress sought to expand the meaning of "State" beyond its common usage, it did so explicitly. In addition to defining the District of Columbia as a "State," it provided that U.S. territories that "establish[] such an Exchange . . . shall be treated as a State." PPACA § 1323(a)(1), 42 U.S.C. 18043(a)(1)). The Government has identified nothing in the statute or legislative history suggesting that Congress understood "established by the State" to have any other meaning.

Section 1401 reinforces this requirement at every turn. When it describes the *taxpayers* who are eligible for premium-assistance tax credits, describes the *type of health plan* to which a premium-assistance tax credit may be applied, describes the *premiums* to be used in calculating the credit amount, requires taxpayers *to pay a premium* to be eligible for the credit, and describes the *rating areas* in which to find those plans and premiums, these items and actions are al-

ways "enrolled . . . through" or "enrolled in" or "offered through" or found in "an Exchange established by the State." *See* 26 U.S.C. § 36B(b)(2)(A), (c)(2)(A)(i) (direct language); 26 U.S.C. § 36B(b)(3)(B), (b)(3)(B)(i), (b)(3)(C), (b)(3)(D), (b)(3)(E), (c)(2)(A)(ii), (e)(A) (cross-references).

Nowhere in the rules defining eligibility for tax credits does Congress refer to federal Exchanges, or use language (e.g., "*an* Exchange") encompassing both state-established Exchanges *and* federal Exchanges. Yet Congress did use such phrasing in other provisions of the statute. *See, e.g.*, PPACA § 1421(b)(1), 26 U.S.C. § 45R(a)(1) (offering tax credits to small businesses that offer health plans to employees through "*an* Exchange"). Such differences in usage are plain indicia of statutory meaning and legislative intent.

Section 1321 further reinforces that Congress expected states would make a choice, and that choice would have consequences. Section 1321(a) authorizes the Secretary of Health and Human Services to develop standards for meeting several requirements imposed by Title I, including the operation of Exchanges and implementation of other features of the Act such as reinsurance programs, risk-adjustment programs, guaranteed-issue, and community rating. Section 1321(b) provides: "Each State that elects . . . to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect" a law that meets those standards. Section 1321(c) provides that if a state "Fail[s] To Establish Exchange or Implement Requirements," either because "a State is not an electing State under subsec-

tion (b)" or because "the Secretary determines, on or before January 1, 2013, that an electing State" will not meet the standards, then "the Secretary shall . . . establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements."

The purpose of Section 1321(c), as given in its heading, is to detail the *consequences* of a "Failure To Establish [an] Exchange or Implement Requirements." 42 U.S.C. 18041(c). One consequence of failure is the loss of tax credits. When section 1321(c) directs *the Secretary* to "establish" the Exchange "required" by Section 1311, it prevents taxpayers in that State from receiving tax credits because it precludes *the state* from establishing "an Exchange . . . under section 1311" as required under Section 1401. 26 U.S.C. § 36B(b)(2)(A), (c)(2)(A)(I). Non-compliance with the requirements detailed in Section 1321(c) *automatically* triggers the federal government's obligation to establish an Exchange, rendering state residents ineligible for tax credits. Section 1321 is thus the linchpin of a carefully worded statutory scheme that gives states a choice between implementing various provisions of the Act or forgoing tax credits. *See infra* Part IV (pp. 22–28).

Tax credits are not the only subsidy that the PPACA conditions on states choosing to implement Exchanges. The conditions that Congress imposed on tax credits are mirrored in the conditions it imposed on the renewability of Exchange "establishment grants." Section 1311 authorizes the Secretary of Health and Human Services to issue unlimited sums

of money to states to assist them with "establishing an American Health Benefit Exchange." 42 U.S.C. § 18031(a)(2), (a)(3). Congress conditioned *renewal* of these grants on states "making progress . . . toward" establishing an Exchange, implementing the Act's guaranteed-issue and community-rating requirements, and "meeting such other benchmarks as the Secretary may establish." 42 U.S.C. § 18031(a)(4)(A).

Further confirming that these conditions reflect congressional intent, Section 1413 categorizes Exchanges with other health programs that make benefits to individuals conditional on state action. The Act defines Medicaid, the State Children's Health Insurance Program, *and* Exchanges — with specific reference to "the premium tax credits under section 36B of the Internal Revenue Code" — as "State health subsidy programs." 42 U.S.C. § 18083(e).

Sections 1311, 1321, and 1401 present states with a choice: a state's residents are eligible for tax credits if and only if state officials establish and operate an Exchange. This plain-meaning interpretation is the only interpretation that respects the text of the statute and creates no surplusage.

II. The Evolution of the Statutory Text Demonstrates that This Restriction Was Intentional.

Restricting tax credits to Exchanges "established by the State" was no accident. This phrasing was added to Section 1401 in multiple places at multiple times in the drafting process.

The first draft of § 36B's tax-credit eligibility rules appeared in the America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009), § 1205 (approved by the Senate Finance Committee on Oct. 13, 2009). That initial draft authorized tax credits only for those who enroll in coverage "through an Exchange established by the State" via one use of, and five cross-references to, that explicit phrase. America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009), § 1205, *proposing* 26 U.S.C. § 36B(b)(2)(A)(i), (b)(3)(B)(i), (b)(3)(C), (c)(2)(A)(i), (c)(2)(A)(ii), (e)(1)(A), https://beta.congress.gov/111/bills/s1796/BILLS-111s1796pcs.pdf.

By the time the PPACA passed the Senate, the bill's authors had reinforced that requirement in three ways. First, they added language to paragraph (b)(3)(C) to require the Secretary to calculate "adjusted monthly premiums" using premiums from the rating area of "an Exchange established by the State" (cross-reference). Second, they added language to paragraph (b)(3)(D) to require the Secretary to exclude certain benefits when calculating the "premium assistance amount" for plans purchased "through an Exchange established by the State" (cross-reference).

Third, and most importantly, S. 1796 as reported already defined "coverage months" via cross-reference as occurring only when a taxpayer enrolled in coverage "through an Exchange established by the State." S. 1796, 111th Cong. (2009), § 1205, *proposing* § 36B(c)(2)(A)(i). By the time the PPACA passed the Senate, however, its authors augmented that *cross-reference* with a clause *explicitly* defining "coverage

months" as occurring only when the taxpayer is enrolled "through an Exchange established by the State." PPACA § 1401, 26 U.S.C. § 36B(c)(2)(A)(i).[2]

These identical restrictions were added at a later stage of the legislative process, under the supervision of Senate leaders and White House officials, in the days before the PPACA went to the Senate floor.[3] If there were no difference between an Exchange established "under Section 1311" and an Exchange established *"by the State* under Section 1311," there would have been no reason to use (and to keep adding) the italicized phrase.

This requirement survived multiple rounds of revisions throughout the drafting process, including revisions to the cross-references attached to it.

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[2] *Compare* America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009), § 1205, *proposing* 26 U.S.C. § 36B(c)(2)(A)(i) (limiting credits to those "covered by a qualified health benefits plan described in subsection (b)(2)(A)(i)," a cross-reference to plans "enrolled in through an exchange established by the State"), *with* PPACA § 1401, 26 U.S.C. § 36B(c)(2)(A)(i) ("covered by a qualified health plan described in subsection (b)(2)(A) *that was enrolled in through an Exchange established by the State under section 1311*" (emphasis added)).

[3] *See* David M. Herszenhorn & Robert Pear, *White House Team Joins Talks on Health Care Bill*, N.Y. Times (Oct. 15, 2009), http://www.nytimes.com/2009/10/15/health/policy/15health.html; Perry Bacon Jr., *Small Group Now Leads Closed Negotiations on Health-Care Bill*, Wash. Post (Oct. 18, 2009), http://www.washingtonpost.com/wp-dyn/content/article/2009/10/17/AR2009101701810.html (merger of Finance Committee bill and HELP Committee bill performed by Senate leaders, committee chairman, their staffs, and White House officials).

Compare, e.g., S. 1796, 111th Cong. (2009), § 1205, *proposing* 26 U.S.C. § 36B(b)(2)(A)(i) ("and which were enrolled in through an exchange established by the State *under subpart B of title XXII of the Social Security Act*" (emphasis added)), *with* PPACA § 1401, *creating* 26 U.S.C. § 36B(b)(2)(A) ("and which were enrolled in through an Exchange established by the State *under* [*section*] *1311 of the Patient Protection and Affordable Care Act*" (emphasis added)).

This requirement was similar to another provision of S. 1796. That bill also conditioned new small-business tax credits on states adopting community-rating. *See* S. 1796, 111th Cong. (2009), § 1221(a), *proposing* 26 U.S.C. § 45R(c)(2) ("STATE FAILURE TO ADOPT INSURANCE RATING REFORMS. — No credit shall be determined under this section . . . for any month of coverage before the first month the State establishing the exchange has in effect the insurance rating reforms . . . ."); S. Rep. No. 111-89, at 48 (2009), http://www.gpo.gov/fdsys/pkg/CRPT-111srpt89/pdf/CRPT-111srpt89.pdf ("If a State has not yet adopted the reformed rating rules, qualifying small business employers in the State are not eligible to receive the credit"). The PPACA's authors dropped this condition while merging the Finance Committee and HELP Committee bills — i.e., at the same time they reinforced the language conditioning tax credits for individuals on states establishing Exchanges and implementing other features of the Act, including community-rating.

After the PPACA became law on March 23, 2010, Congress made seven amendments to Section

36B through the "budget reconciliation" process; in none of these amendments did Congress disturb the language that expressly made tax credits conditional. *See* Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010); House Office of the Legislative Counsel, *PPACA & HCERA; Public Laws 111-148 & 111-152: Consolidated Print* 105–13 (2010), http://www.ncsl.org/documents/health/ppaca-consolidated.pdf.

Prior to its being amended by the HCERA, Section 36B bore no mention at all of federally established Exchanges. *See* PPACA § 1401 (enrolled bill), https://beta.congress.gov/111/bills/hr3590/BILLS-111hr3590enr.pdf. The HCERA introduced the first and only such mention when it imposed identical reporting requirements on both state-established and federal Exchanges. *See* 26 U.S.C. § 36B(f)(3). Congress clearly meant this requirement to apply to both types of Exchange, and so referred to each type explicitly. Rather than somehow expand the meaning of "established by the State," this reporting requirement demonstrates that Congress saw *state*-established and *federally* established Exchanges, created under Sections 1311 and 1321 respectively, as distinct.

Indeed, the HCERA elsewhere shows how Congress expanded the reach of "established by the State" when that was its aim. It was through the HCERA that Congress amended the PPACA to provide that "[a] territory that elects . . . to establish an Exchange . . . and establishes *such* an Exchange . . . shall be treated as a State." HCERA § 1204(a), 42 U.S.C. § 18043 (emphasis added). In this provision, Congress

shows it did not understand the word "such" to have the power to transform Exchanges established by non-states into "an Exchange established by the State." We know this because Congress inserted the *subsequent* clause that created equivalence between territories and "States." Yet the HCERA contained no provision erasing or blurring the bright line that Congress drew between the *federal* government and a "State."

The Government would have the Court believe that Congress, which supposedly intended the PPACA to authorize tax credits in federal Exchanges, noticed and remedied the bill's failure to authorize tax credits in *territorial* Exchanges but somehow did not notice the bill's failure to authorize them in *federal* Exchanges. This notion defies credulity.

III. The Government's Efforts to Manufacture Ambiguity Fail.

Both the Government and the court below have strained to find ambiguity in otherwise straightforward statutory provisions, or sought to import potential ambiguity from other portions of the PPACA into Section 1401. These efforts have stretched the statutory text beyond recognition.

A. "Such Exchange"

Section 1321 requires that if a state "fail[s] to establish [an] Exchange or implement [other] requirements," then "the Secretary shall . . . establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements." 42 U.S.C.

§ 18041(c). The Government places great weight on the word "such," to the exclusion of the rest of this provision and the rest of the statute. Contrary to the Government's claims, neither the word "such" nor any other part of the statute transforms federal Exchanges into "an Exchange established by the State."

Section 1321 is clear. Federal Exchanges are "establish[ed]" by "the *Secretary*," not the State. The Secretary establishes an Exchange when a state "fail[s]" to establish one. The Secretary establishes an Exchange "*within* the State" — not "on behalf of" the State. The Government's interpretation that the Secretary "stands in the shoes" of the State is without any statutory basis and is contrary to the Government's own implementation of the Act. For example, Section 1311(a) authorizes the Secretary to issue unlimited amounts of money to states for the purpose of establishing Exchanges. 42 U.S.C. § 18031(a). If the Government actually believed its own argument that the Secretary "stands in the shoes" of the state when establishing an Exchange, the Secretary would have funded the creation of federal Exchanges by using that authority to issue grants to her own agency. Yet that is not how federal exchanges were funded. *See* J. Lester Feder, *HHS May Have to Get 'Creative' on Exchange*, Politico (Aug. 16, 2011), http://www.politico.com/news/stories/0811/61513.html.

The Government has ignored other Section 1311 requirements on the grounds that they apply only to state-established Exchanges, and not to federal Exchanges. Specifically, Section 1311 provides that "No federal funds for continued operations" are allowed for

Section 1311 Exchanges. 42 U.S.C. § 18031(d)(5)(A). The Secretary concluded that this provision does not apply to federal Exchanges, which she is financing with federal funds raised through a 3.5 percent premium tax ("user fee") imposed on participating insurers. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,830 (Mar. 11, 2014) (final rule). Thus, by its actions, the Government has acknowledged that federal Exchanges are not fully equivalent to state-established Exchanges.

The directive that the Secretary shall establish "such" Exchange does not make federal Exchanges and state-established Exchanges equivalent in all respects. *See infra* p. 18. They may share *intrinsic* characteristics. But tax-credit eligibility hinges on the *extrinsic* characteristic of *who establishes* the Exchange. *Accord Halbig v. Burwell*, 758 F.3d 390, 400 (D.C. Cir. 2014) ("The problem confronting the IRS Rule is that subsidies also turn on a third attribute of Exchanges: who established them."), *vacated by grant of reh'g en banc*, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014).

B. The Government's Misconstruction Creates Surplusage and Anomalies.

The Government's claim that "an Exchange established by the State" may be read to include federally established Exchanges renders each use of that phrase surplusage. The PPACA refers to Exchanges "established by the State" in provisions designed either to facilitate coordination between

state Exchanges and other programs, or to provide incentives for state action. The Government's attempt to expand the meaning of "established by the State" effectively renders this phrase meaningless and leads to anomalous and even absurd results when applied throughout the statute.

For example, Section 1311 provides that a "State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange." 42 U.S.C. § 18031(f)(3)(A). Under the plain meaning of "an Exchange established by the State," this makes perfect sense. The Government's interpretation that "an Exchange established by the State" also encompasses Exchanges established by the federal government would create an anomalous situation where *a state* that elected not to create its own Exchange would decide whether *the federal government* may contract out responsibilities of a federal Exchange.

Likewise, Section 2201 requires that states receiving Medicaid funds "shall establish procedures for . . . ensuring that . . . an Exchange established by the State under section [1311] . . . utilize[s] a secure electronic interface" to determine eligibility for various forms of assistance. 42 U.S.C. § 1396w-3(b)(1)(D). Under a plain-meaning interpretation of "established by the State," this provision also makes sense. But interpreting "an Exchange established by the State" to include Exchanges established by the federal government creates an anomalous situation where the *federal* government's failure to "utilize a secure elec-

tronic interface" could jeopardize a *state's* receipt of federal Medicaid funds.[4]

States can certainly implement such provisions with respect to the Exchanges they create and control. States cannot, however, tell federal entities what to do. Yet that is the anomalous and absurd implication of the Government's statutory misconstruction.

C. "Qualified Individuals"

The Government has argued that Section 1312's mandate that "qualified individuals" must "reside[] in the State that established the Exchange," 42 U.S.C. § 18032(f)(1)(A)(ii), demonstrates that Congress did not understand "established by the State" to mean what it plainly says. *Accord Halbig*, 758 F.3d at 424 (Edwards, J., dissenting) ("If an HHS-created Exchange does not count as established by the State it is in, there would be no individuals 'qualified' to purchase coverage in the 34 states with HHS-created Exchanges. This would make little sense."). When read in context, however, this provision makes perfect sense. But even if it did not, a potential ambiguity in Section 1312 would not make Section 1401 any less plain.

Congress defined "qualified individuals" in Section 1312 as residing in "the State that established

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[4] It is possible that any such condition would be unenforceable under *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2601–07 (2012), but that possibility does not alter the plain meaning of the statutory text.

the Exchange" for an obvious reason. In Sections 1311, 1312, and 1313, Congress is speaking to the states and presuming that states would follow Section 1311's directive to establish Exchanges. 42 U.S.C. §§ 18031, 18032, 18033. The requirement that qualified individuals reside "in the State that established the Exchange" disappears when Congress drops that presumption in the very next section: Section 1321.

Section 1321(c) explains what happens when a state "[f]ail[s] to establish [an] Exchange." 42 U.S.C. § 18041(c). *See supra* Part I (pp. 6–7). In that event, "the Secretary shall take such actions as are necessary to implement such [a] requirement[]." That is, the Secretary shall require that "qualified individuals" must reside in the state "within" which "the Secretary . . . establish[es]" the Exchange. 42 U.S.C. § 18041(c). Unlike alternative interpretations, this plain-meaning interpretation creates no surplusage or anomalies, considers both text and context, and is consistent with the structure of the relevant sections.

The Government's approach to other Section 1311 requirements when implementing federal Exchanges belies its claim that a literal interpretation of the "qualified individuals" definition would paralyze federal Exchanges. As noted above (*supra* p. 14), the Government has ignored other Section 1311 requirements on the grounds that they apply only to state-established Exchanges, and not to federal Exchanges. The Government has thus acknowledged by its own actions that federal Exchanges are not equivalent to state-established Exchanges in all respects, belying its claim that a literal interpretation of the

"qualified individuals" definition would paralyze federal Exchanges.

D. "Maintenance of Effort"

The PPACA requires states to maintain their Medicaid programs' eligibility standards until the federal government determines "an Exchange established by the State under [Section 1311] is fully operational." 42 U.S.C. § 1396a(gg)(1). According to the Government, a plain-meaning interpretation of this provision would create disharmony in the statute by turning this provision into "an obligation that extends forever in States that opt to have HHS establish Exchanges on their behalf." Petition for Rehearing En Banc 11 (filed Aug. 1, 2014), in *Halbig v. Burwell*, No. 14-5018 (D.C. Cir.).

Contrary to the Government's claim, it is not disharmony but consistency when the plain meaning of "established by the State" in this Medicaid provision serves the same purpose — inducing state action — that this Court found in the PPACA's other Medicaid provisions. *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012) (*NFIB*).

Indeed, it is the Government's interpretation that a federally established Exchange is somehow "established by the State" that creates disharmony. First, the Government's interpretation does not change the fact that a state may obtain the freedom to alter its eligibility rules by establishing an Exchange. It does, however, add an anomalous condition. Under the Government's strained interpretation, in states that refused to establish Exchanges, the

state's ability to modify its Medicaid eligibility rules would become conditional on *federal* action — i.e., on whether and when the federal government met its obligation to establish an Exchange. The Government's interpretation thus transforms this provision from one that offers states a clear choice to one that puts resistant states at the mercy of the Secretary's diligence in creating compliant Exchanges. Here, as elsewhere, the Government's efforts to conjure up ambiguity about the meaning of "established by the State" creates more problems that it purports to solve.

E. Section 1311 Does Not Define Exchanges as "Established by the State."

The Fourth Circuit deferred to the IRS because it found the statute ambiguous. The court hung its finding of ambiguity entirely on its claim that one may reasonably interpret Section 1311(d)(1) as defining federal Exchanges as having been "established by a State." *See* Pet. App. 14a-25a. This interpretation unreasonably requires treating a *requirement* as a *definition* and thereby rendering another clear provision inoperable.

Section 1311(d), titled "REQUIREMENTS," provides: "(1) IN GENERAL. — An Exchange shall be a governmental agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(d)(1). "*Given that* Congress defined 'Exchange' as an Exchange established by the state,'" the court reasoned, "it makes sense to read § 1321(c)'s directive that HHS establish 'such Exchange' to mean that the federal government acts *on behalf of* the state when it establishes its own Exchange." Pet. App. 18a (emphases

added). The Fourth Circuit's interpretation of Section 1311(d)(1) is directly contradicted by the plain text of that provision and other provisions of the Act.

Section 1311(b)(1)(C) and the heading of Section 1311(d) both make clear that Section 1311(d)(1) is a "requirement," not a definition, and the provision clearly operates as such. 42 U.S.C. § 1311(b)(1)(C). Combining the relevant language of these provisions reveals there is nothing remotely definitional about this requirement: "Each State shall . . . establish an American Health Benefit Exchange . . . that . . . meets the requirement[] [that] [a]n Exchange shall be a governmental agency or nonprofit entity that is established by a State." 42 U.S.C. § 18031(b)(1), (b)(1)(C), (d)(1). Context confirms that the ambiguity purportedly seen by Fourth Circuit is simply not there. *See Halbig*, 758 F.3d at 400 ("The premise that (d)(1) is definitional, however, does not survive examination of (d)(1)'s context and the [PP]ACA's structure.").

Indeed, reading this "requirement" as a definition would make a mess of the relevant text. If Section 1311(d)(1)'s "shall be" *defines* any given Exchange as having been "established by the State," then it must also *define* any given Exchange as "a governmental agency or nonprofit entity" as well. Under the Fourth Circuit's interpretation, if *either* the federal government or the Commonwealth of Virginia were to contract with Amazon.com to operate that state's Exchange at a profit, Section 1311(d)(1) would *define* Amazon.com as a government agency or non-profit that was established by Virginia. That interpretation turns Section 1311(d)(1) on its head. It transforms a

provision that was designed to *prevent* private, for-profit Exchanges into a provision that instead *allows* them.

IV. Congress Routinely Induces States to Carry Out Federal Priorities by Conditioning Subsidies on State Action, and It Considered Many Such Proposals in Drafting the PPACA.

Conditioning individual benefits on state cooperation with federal priorities is a policy lever that Congress, and the very members who authored and approved the PPACA, have proposed and employed repeatedly. Such "deals" often include tax benefits for state residents, and were ubiquitous throughout the congressional debate.

The federal government "may not compel the states to implement, by legislation or executive action, federal regulatory programs." *Printz v. United States*, 521 U.S. 898, 925 (1997); *see also New York v. United States*, 505 U.S. 144, 162 (1992); *NFIB*, 132 S. Ct. at 2602–03 (Roberts, C.J.). But Congress can, and routinely does, provide various incentives to encourage states to implement federal programs or enact desired legislation. As the Court noted in *New York*, Congress may sometimes indicate its intent to provide incentives for state cooperation using language that appears to compel state action. 505 U.S. at 169–70. *New York* counsels that when a statute provides that states "shall" perform specific functions, courts may either view such language as an unconstitutional command or as the source of an incentive for state cooperation. *Id.*

Since 1966, Congress has conditioned health-insurance subsidies to individuals on states enacting and operating Medicaid programs that meet federal specifications. 42 U.S.C. § 1396c; *NFIB*, 132 S. Ct. at 2601–02. It has done so through the State Children's Health Insurance Program since 1997. *See* 42 U.S.C. §§ 1397aa–1397mm; Cong. Res. Serv., *State Children's Health Insurance Program (CHIP): A Brief Overview* (Mar. 18, 2009). All states and U.S. territories participate in these programs.

In 2002, Congress made "health coverage tax credits" ("HCTCs") available to certain taxpayers. 26 U.S.C. § 35. As with the PPACA's tax credits, HCTCs were allowed only during "coverage months," which occurred only when a taxpayer enrolled in "qualified health insurance." 26 U.S.C. § 35(b), (e). As with the PPACA, the definitions of these terms constituted the HCTC eligibility rules. Those rules required states to enact specified laws before certain of their residents could claim the HCTC. *See* 26 U.S.C. § 35(e)(2); *see also* Cong. Res. Serv., *Health Coverage Tax Credit Offered by the Trade Act of 2002*, at ii (Jan. 31, 2008) ("The HCTC can be claimed for only 10 types of qualified health insurance specified in the statute, *7 of which require state action to become effective.*" (emphasis added)).

The PPACA's primary author was Senate Finance Committee Chairman Max Baucus (D-Mont.). Sen. Baucus not only sponsored the HCTC, but he also sponsored a version that would have conditioned the credits on even more state actions than the final law. *Compare* 26 U.S.C. § 35, *with* Trade Adjustment

Assistance Improvement Act of 2002, S. 2737, 107th Cong. (2002) (additionally requiring states to impose minimum-loss ratios and other regulations). The 2009 Finance Committee report on Sen. Baucus' S. 1796 cited § 35's HCTC as an antecedent to § 36B's tax credit. *See* S. Rep. No. 111-89, at 35–36.

Beginning in 2004, Congress allowed certain individuals to make tax-free contributions to health savings accounts ("HSAs"), but only if their state provided the regulatory environment required by federal law. 26 U.S.C. § 223(c)(2); *see also* Timothy Jost, *State-Run Programs Are Not a Viable Option for Creating a Public Plan* (June 16, 2009) ("These tax subsidies were only available . . . in states where high deductible plans were permitted. This in turn meant that some states had to repeal or amend laws limiting plan deductibles.").

Thus, not only was Congress using a common legislative tool when it chose to condition premium-assistance tax credits on States doing what Congress wanted — establishing an Exchange — but members of both parties introduced similar measures throughout the debate that produced the PPACA.

The PPACA's other major health-insurance entitlement conditioned all existing Medicaid grants, plus the Act's new federal Medicaid grants, on states implementing the Act's Medicaid expansion. 42 U.S.C. § 1396a(a)(10)(A)(i)(VII) (as amended by PPACA § 2001(a)(1)(C)); *see also* America's Healthy Future Act of 2009, *supra*, at § 1601. It is scarcely strange to find Congress conditioning benefits to individuals on state cooperation in a statute that pushed this prac-

tice "pas[t] the point at which 'pressure turns into compulsion.'" *NFIB*, 132 S. Ct. at 2604 (quoting *Steward Machine Co. v. Davis*, 301 U.S. 548, 590 (1937)). The amount of money Congress conditioned on states establishing Exchanges is less than a fifth of the amount Congress had sought to condition on states implementing the Medicaid expansion,[5] and is still less than the amount of "new" Medicaid subsidies that this Court in *NFIB* permitted Congress to condition on states implementing the Medicaid expansion.[6]

One of the PPACA's two antecedent bills — the Affordable Health Choices Act, or S. 1679, reported by the Senate Health, Education, Labor & Pensions ("HELP") Committee — contained a provision almost *identical* to the one at issue in this case. S. 1679 withheld its Exchange subsidies if states failed to establish Exchanges or implement other provisions of that

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[5] *Compare* Cong. Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* 11 (Mar. 13, 2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf ("Exchange Subsidies and Related Spending" for 2014–2022: $802 billion), *with* Cong. Budget Office, *Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline* (Mar. 13, 2012), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf (total federal Medicaid spending for 2014–2022: $4.315 trillion). In *NFIB*, this Court permitted Congress to condition only the PPACA's new Medicaid grants on states implementing the expansion. 132 S. Ct. at 2607–08. Though the original conditions were invalidated, there is no dispute about what Congress sought to accomplish or the meaning of the relevant statutory text.

[6] *See* Cong. Budget Office, *Updated Estimates*, *supra* note 5, at 11 ("Medicaid and CHIP Outlays" for 2014–2022: $931 billion).

bill. Affordable Health Choices Act, S. 1679, 111th Cong. (2009).

S. 1679 asked each state to adopt certain health insurance regulations, and either establish an Exchange itself or ask the federal government to establish one "in" the state. *Id.*, § 142(b), *proposing* section 3104(d)(1)(A) of the Public Health Service Act. S. 1679 withheld Exchange subsidies, as well as many of its insurance regulations, for up to four years until the state complied. After four years, the federal government would establish an Exchange "in" the state and implement guaranteed-issue and community-rating rules even stricter than those found in the PPACA.[7] If a state thereafter failed to implement the bill's employer mandate, S. 1679 withheld Exchange subsidies *permanently* — even in a *federal* Exchange. *Id.*, *proposing* section 3104(d)(2).[8]

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[7] *Compare id.*, § 101(5), *proposing* section 2701(a)(1)(D) of the Public Health Service Act (allowing no more than a 2 to 1 variation in health insurance premiums based on age), *with* 42 U.S.C. § 300gg(a)(1)(A)(ii) (allowing a 3 to 1 variation in premiums based on age).

[8] *See also* Adler & Cannon, *Taxation Without Representation*, *supra*, at 154–55; Timothy Jost, *Health Insurance Exchanges in Health Care Reform Legal and Policy Issues*, Washington and Lee Public Legal Studies Research Paper Series 7 (Oct. 23, 2009) (on S. 1679: "A state's residents will only become eligible for federal premium subsidies . . . if the state provides health insurance for its state and local government employees."). *Amici* for the Government have conceded the point. *See* Brief *Amici Curiae* of Members of Congress and State Legislatures 17 (filed Feb. 15, 2014) ("if a state chose not to adopt specified insurance reform provisions and make state and local government employers

During the HELP committee's mark-up of S. 1679, Republicans offered alternative legislation that would have conditioned new Medicaid payments to states on states establishing Exchanges. *See* Patients' Choice Act, S. 1099, 111th Cong. (2009).

As noted above, the PPACA's other antecedent bill — the America's Healthy Future Act of 2009, or S. 1796, reported by the Senate Finance Committee — both conditioned tax credits to individuals on states establishing Exchanges and conditioned health-insurance tax credits for small businesses on states enacting specified health insurance regulations. *See supra* pp. 9–10. The latter proposal demonstrates that the idea of conditioning tax credits on state co-operation was part of the legislative debate over the PPACA from its beginning, in 2008. *See* Sen. Max Baucus, *Call to Action: Health Reform 2009*, at 20, Senate Comm. on Finance White Paper (Nov. 12, 2008) ("Initially, the credit would be available to qualifying small businesses that operate in states with patient-friendly insurance rating rules.").

As a further inducement to state action, the PPACA (like its antecedents) offered states unlimited Exchange start-up funds to establish Exchanges. *See* America's Healthy Future Act of 2009, S. 1796, 111th Cong., § 2237(c) (2009); Affordable Health Choices Act, S. 1679, 111th Cong., § 142(b) (2009), *proposing* section 3101(a) of the Public Health Service Act;

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subject to specified provisions of the statute, 'the residents of such State shall not be eligible for credits'" (quoting S. 1679, § 142(b), *proposing* section 3104(d)(2))), in *Halbig v. Burwell*, No. 14-5018 (D.C. Cir.).

PPACA, § 1311, 42 U.S.C. § 18031(a)(2). In contrast, the PPACA authorizes no funds for the creation of federal Exchanges.

As another example, the PPACA creates new federal grants for states that adopt medical malpractice liability reforms. 42 U.S.C. § 280g-15. That language originated in the Finance Committee bill. *See* S. Rep. No. 111-89, at 285–86. The House-passed Affordable Health Choices for America Act created a similar program. *See* H.R. 3962, 111th Cong., § 2531 (2009). During the Finance Committee's mark-up, Republican senators offered amendments that would have conditioned new Medicaid grants on states enacting medical malpractice reforms. *See* S. Rep. No. 111-89, at 449.

In sum, there were simply too many similar proposals offered by PPACA supporters and opponents alike to claim Congress could not have meant what it said in Section 36B.

V. PPACA Supporters Complained that the Bill Conditioned Exchange Benefits on State Cooperation.

Many House members disapproved of the Senate-passed PPACA, some *because* they recognized it conditioned subsidies on states creating Exchanges.

In early 2010, all 11 Texas Democrats in the House of Representatives warned the President and House leadership about the PPACA's Exchange provisions. The representatives acknowledged that "[i]f the state does not set up the exchange, then the Secretary of Health and Human Services is required to

set up an exchange for the state." Yet they warned that uncooperative states could nonetheless prevent residents from receiving "any benefit" from the Exchanges, which they likened to another conditional-grant program:

> [The PPACA] relies on states with indifferent state leadership that are unwilling or unable to administer and properly regulate a health insurance marketplace . . . . Not one Texas child has yet received any benefit from the Children's Health Insurance Program Reauthorization Act . . . since Texas declined to expand eligibility or adopt best practices for enrollment . . . . *The [PPACA] would produce the same result — millions of people will be left no better off* than before Congress acted.

U.S. Rep. Doggett: Settling for Second-Rate Health Care Doesn't Serve Texans, My Harlingen News (Jan. 11, 2010) (emphasis added); *see also* Julie Rovner, *House, Senate View Health Exchanges Differently*, Nat'l Public Radio (Jan. 12, 2010) (the letter's authors "worry that because leaders in their state oppose the health bill, they won't bother to create an exchange, leaving uninsured state residents with *no way to benefit* from the new law" (emphasis added)).

The letter's authors nevertheless voted for the PPACA without any changes to the language requiring tax credit recipients to enroll in coverage through state-established Exchanges. *See* U.S. House of Representatives, Final Vote Results for Roll Call 165

[H.R. 3590] (Mar. 21, 2010), http://clerk.house.gov/evs/2010/roll165.xml.

VI. The Text Reflects Congressional Intent, and the IRS Is Not Free to Rewrite the Law Just Because Congressional Assumptions Proved Faulty.

Political necessity required the authors of the PPACA to rely on states to operate the law's health-insurance Exchanges. The widespread expectation that all or nearly all states would establish Exchanges made the requirement tying tax credits to state co-operation all but unremarkable. Yet the IRS may not rewrite a statute simply because Congress' assumptions about how the statute would be received turned out wrong.

Many PPACA supporters initially advocated a federal Exchange. *See generally* Baucus, *Call to Action*, *supra*. Yet key U.S. Senators favored a system of 50 state-run Exchanges. *See* Patrick O'Connor & Carrie Brown, *Nancy Pelosi's Uphill Health Bill Battle, Politico* (Jan. 9, 2010) ("Two key moderates — Sen. Ben Nelson (D-Neb.) and Sen. Joe Lieberman (I-Conn.) — have favored the state-based exchanges over national exchanges."); *see also* Reed Abelson, *Proposals Clash on States' Roles in Health Plans*, N.Y. Times (Jan. 13, 2010) ("Senator Ben Nelson, Democrat of Nebraska, is a former governor, state insurance commissioner and insurance executive who strongly favors the state approach. His support is considered critical to the passage of any health care bill."). The need to reach 60 votes to overcome a promised filibuster required PPACA supporters in

the Senate (and House) to hew to the preferences of moderate senators who preferred state-run Exchanges. *See* Bacon, *supra* note 3 ("the final legislation is expected to resemble more closely the version in the Senate, where final passage would require support from more-conservative Democrats").

Authors of both the Finance Committee and the HELP Committee bills therefore abandoned their initial support for a single, nationwide Exchange in favor of 50 state-run Exchanges, with the federal government operating Exchanges only in those states that declined to do so. *See* America's Healthy Future Act of 2009, S. 1796, 111th Cong. (2009); Affordable Health Choices Act, S. 1679, 111th Cong. (2009).

To avoid an unconstitutional commandeering of states, both the Finance and HELP bills conditioned their health insurance subsidies to individual taxpayers on states establishing compliant Exchanges and implementing other elements of the bills' regulatory schemes. *See supra* pp. 25–27 (discussing HELP bill). Those requirements were consistent with other incentives the bills created to encourage state-run Exchanges, including unlimited start-up funds and the Finance Committee bill's costly Medicaid "maintenance of effort" requirement.

It may be the case that few PPACA supporters expected it to be the bill that would become law. When PPACA supporters lost their filibuster-proof Senate majority in early 2010, however, the *only* comprehensive health care bill that Congress could enact was the already Senate-passed PPACA. The choice was either the PPACA, which many members

of Congress found quite unsatisfactory, or no health care bill at all.[9]

House Democrats grudgingly agreed to enact the PPACA, making only limited changes through the reconciliation process. *See generally* Cong. Res. Serv., *The Budget Reconciliation Process: The Senate's "Byrd Rule"* (July 2, 2010) (requiring only 51 rather than 60 votes in the Senate to make certain legislative changes). As noted above, the HCERA amended Section 36B seven times, but did not alter the rules restricting credits to state-established Exchanges; recognized state-established and federal Exchanges as distinct; demonstrates Congress did not understand the word "such" as transforming Exchanges established by non-states into Exchanges "established by the State"; and demonstrates how Congress did expand the meaning of "established by the State"

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[9] *See* Harold Pollack, *47 (Now 51) Health Policy Experts (Including Me) Say "Sign the Senate bill,"* New Republic (Jan. 22, 2010), http://www.newrepublic.com/blog/the-treatment/47-health-policy-experts-including-me-say-sign-the-senate-bill; *see also* CNN, *Obama Willing to Work with GOP on Health Care; Jobless Aid Restored* (Mar. 3, 2010), http://www.edition.cnn.com/TRANSCRIPTS/1003/03/cnr.05.html (quoting correspondent Gloria Borger on House passage of the PPACA: "I was talking with a senior White House adviser today . . . who put it to me this way. He said, 'This is the last helicopter out of Saigon,' meaning they have made a political decision that they're going to use their Democrats to get this through, because what they need, this aide says, is they need an accomplishment. And they believe that once this passes, people will begin to see the benefits of it, and it will not ricochet against them, but will work for them.").

when that was its intent. *See* Pub. L. No. 111-152, 124 Stat. 1029, 1035 (2010); *see also* Adler & Cannon, *supra*, at 162–63.

It is for these reasons the PPACA authorizes tax credits only in compliant states despite the fact some of its supporters may have preferred otherwise. Whatever their preferences might have been, *none* of the Act's authors deleted, expanded, or amended the language conditioning tax credits on states establishing Exchanges despite many opportunities to do so. What matters in a constitutional system is what the law actually says. "Established by the State" was the only language to pass both chambers of Congress because, when the time came for members of Congress to vote, it was the only language that *could* pass both chambers. The choice faced by supporters was between a bill many considered flawed and no bill at all. *See* Pollack, *supra* note 9 (urging House passage of the "imperfect" PPACA, because otherwise "we doubt that any bill would reach the President's desk"); *see also* Bacon, *supra* note 3 (quoting Senate Majority Leader Harry Reid: "Neither I nor any other senator has the luxury of passing a perfect bill . . . that conforms exactly to his or her beliefs . . . ."). Members of Congress *intended* for *this requirement* to become law, because had they intended anything else *there would have been no law*. *See* CNN, *supra* note 9 ("This is the last helicopter out of Saigon."). The PPACA's tax-credit eligibility rules thus are not only clear, but accurately reflect congressional intent.

As was widely reported at the time of the PPACA's enactment, PPACA proponents were confident that all states would establish Exchanges, and they scarcely contemplated the possibility that many states would refuse.[10] This mistaken assumption accounts for why Congress did not authorize funding for the creation of federal Exchanges. It accounts for why the Congressional Budget Office scored the PPACA without considering whether tax credits would be limited to state-run Exchanges. It accounts for why the CBO scored the bill as if the federal government would not have to spend any money to implement federal Exchanges. Adler & Cannon, *Taxation Without Representation*, *supra*, at 186–88; Feder, *supra*. Finally, it accounts for why the CBO likewise scored S. 1679 (the HELP bill) as providing Exchange subsidies in all states, even though — as all sides

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[10] *See* Remarks on Health Insurance Reform in Portland, Maine, 2010 Daily Comp. Pres. Doc. 220 (Apr. 1, 2010) (quoting President Obama: "by 2014, each state will set up what we're calling a health insurance exchange"); *see also Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2011: Hearings Before a Subcomm. of the House Comm. on Appropriations*, 111th Cong. 171 (Apr. 21, 2010) (statement of Health and Human Services Secretary Kathleen Sebelius) ("We have already had lots of positive discussions, and States are very eager to do this. And I think it will very much be a State-based program."), http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg58233/pdf/CHRG-111hhrg58233.pdf; *see also* Nicholas Bagley, *Three Words and the Future of the Affordable Care Act*, 40 J. Health Politics, Pol'y & Law (forthcoming 2015) (acknowledging that the PPACA's text reflects "Congress's assumption, unchallenged at the time, that the states would establish their own exchanges").

acknowledge — the bill withheld Exchange subsidies in non-compliant states.[11]

By the rule at issue in this case, the IRS is trying to rewrite the statute because supporters failed to anticipate the widespread rejection by states of the role the law had assigned them. Yet the IRS cannot rewrite the statute simply because this assumption proved false. It nevertheless did so, without any serious attempt to ascertain Congress' intent. *See* H.R. Comm. on Oversight and Gov't Reform, 113th Cong., *Administration Conducted Inadequate Review of Key Issues Prior to Expanding Health Law's Taxes and Subsidies* (Comm. Print 2014) (key IRS and Treasury staff describe to congressional investigators how the agencies never seriously considered that "established by the State" might reflect congressional intent).

Because the Government can identify no textual or other basis for its rule, it can provide no limit to the power the IRS asserts here. If the IRS can offer tax credits to those who purchase health insurance in federally created Exchanges, citing the PPACA's overarching purpose of expanding access to affordable health insurance, there is nothing to stop it from offering them to other ineligible categories of individuals, such as households with income below 100 percent or above 400 percent of the poverty level, Medicare and

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[11] *See* Sen. Comm. on Health, Education, Labor, and Pensions, Draft of Title I of the Affordable Health Choices Act (June 9, 2009); Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Sen. Edward M. Kennedy, Chairman, Sen. Comm. on Health, Education, Labor, and Pensions (Jul. 2, 2009).

VA enrollees, workers with employer-sponsored health insurance, undocumented residents, or purchasers of non-qualified health plans. Such choices must be made by Congress, not the IRS.

VII. The Legislative Process Is the Proper Remedy.

Many provisions of the PPACA have not worked the way its supporters had hoped. *See, e.g., PPACA Implementation Failures: Answers from HHS: Hearing Before the House Comm. on Energy & Commerce*, 113th Cong. (2013) (testimony of Secretary Kathleen Sebelius on the failures of Healthcare.gov). Other provisions of the Act have been invalidated by this Court. *See NFIB*, 132 U.S. at 2601–07 (mandatory Medicaid expansion). Still other provisions have been repealed. *See, e.g.*, American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 642, 126 Stat. 2313, 2358 (2013) (repealing the CLASS Act). Even President Obama has acknowledged: "Obviously, we didn't do a good enough job in terms of how we crafted the law." NBC News, Interview with President Obama (Nov. 7, 2013), http://www.nbcnews.com/video/nbc-news/53492840.

The decision to limit the availability of premium-assistance tax credits to the purchase of qualified health insurance plans in Exchanges established by states under Section 1311 may or may not have been a sound policy decision. But that is not the question before this Court. The text of the PPACA unambiguously does so limit such availability, and the remainder of the Act and its legislative history fully support the unambiguous meaning of the text. If the PPACA's

premium-assistance tax credit eligibility rules are flawed, the legislative process is the proper remedy.

By this rule, the IRS claims the power to tax and spend outside the legislative process. Such "administrative hubris," *Brungart v. BellSouth Telecommunications, Inc.*, 231 F.3d 791, 797 (11th Cir. 2000), *cert. denied*, 532 U.S. 1037 (2001), cannot stand. The more significant the agency's overreach, the *more* important it is that the Court enforce — and ensure that the Government derives no benefit from disregarding — the clear limits that Congress imposed on the agency's delegated powers. To vitiate this or any other condition that Congress imposed on premium-assistance tax credits would "transcend[] the judicial function." *Iselin v. United States*, 270 U.S. 245, 251 (1926).

CONCLUSION

The judgment of the court of appeals should be reversed, and the challenged rule should be vacated.

Respectfully submitted.

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King v. Burwell Would Free More Than 57 Million Americans From The ACA's Individual & Employer Mandates

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UPDATE (Jan. 22, 2015): This post was published the day before the D.C. Circuit ruled against the government in Halbig v. Burwell *and the Fourth Circuit ruled for the government in* King v. Burwell. *The Supreme Court has since agreed to review* King, *and the D.C. Circuit has put* Halbig *on hold pending the Supreme Court's ruling. I therefore changed the title of this post from "Halbig v. Burwell" to "King v. Burwell" to reflect the fact that* King *is now the lead case and because the effects of a* King *ruling would be identical to those described here. But since this was written months ago and specifically about* Halbig, *I did not make that substitution in the body of the post. mfc*

The U.S. Court of Appeals for the D.C. Circuit, often described as the second-highest court in the land, could rule on *Halbig v. Burwell* as early as tomorrow. *Halbig* is one of four lawsuits challenging the legality of the health-insurance subsidies the IRS is dispensing in the 36 states that did not establish a health-insurance Exchange under the Patient Protection and Affordable Care Act, or "ObamaCare," and thus have Exchanges established by the federal government. Though the PPACA repeatedly states those subsidies are available only "through an Exchange established by the State," and there are indications IRS officials knew they did not have the authority to issue subsidies through federal Exchanges, the IRS is dispensing billions of dollars of taxpayer subsidies through federal Exchanges anyway. The *Halbig* plaintiffs are employers and individuals from six federal-Exchange states who are being injured by the IRS's actions because those illegal subsidies trigger taxes against them under the PPACA's employer and individual mandates. The plaintiffs want relief from those illegal taxes, and the only way to get it is to ask federal courts to put a stop to

the illegal subsidies. Recent media coverage of *Halbig*, driven by one-sided blog posts from the consultant group Avalere Health and the left-leaning Urban Institute and Robert Wood Johnson Foundation, has misrepresented the impact of a potential ruling for the plaintiffs by ignoring three crucial facts: (1) a victory for the *Halbig* plaintiffs would increase no one's premiums, (2) if federal-Exchange enrollees lose subsidies, it is because those subsidies are, and always were, illegal, and (3) the winners under such a ruling would outnumber the losers by more than ten to one.

Halbig Critics & Media Allies Overlook Three Crucial Facts

Avalere Health's Elizabeth Carpenter blogs, "nearly 5 million Americans would receive an average premium increase of 76 percent if the courts ultimately rule that consumers in the federal exchange cannot receive premium subsidies." In another brief post, Linda Blumberg, John Holahan, and Matthew Buettgens of the Urban Institute estimate "7.3 million people, or about 62 percent of the 11.8 million people expected to enroll in federally facilitated marketplaces by 2016, could lose out on $36.1 billion in subsidies." These brief analyses are either misleading or outright false, because they fail to note three crucial facts.

First, a victory for the *Halbig* plaintiffs would not increase anyone's premiums. What it would do is prevent the IRS from *shifting* the burden of those premiums from enrollees to taxpayers. Premiums for federal-Exchange enrollees would not rise, but those enrollees would face the full cost of their "ObamaCare" plans.

Critics will respond that, as dozens of economists who filed an *amicus* brief on behalf of the government have predicted, a *Halbig* ruling would also cause the full premium to rise by unleashing adverse selection. This claim is based on a fundamental misunderstanding of *Halbig* and the PPACA. If a lack of subsidies in federal Exchanges leads to adverse selection, *Halbig* is not the cause. The cause is Congress tying those subsidies to state-established Exchanges, and 36 states refusing to cooperate. *Halbig* will not and cannot cause adverse selection. It merely asks the courts to apply the law as Congress enacted it.

The Forbes eBook On Obamacare
Inside Obamacare: The Fix For America's Ailing Health Care System explores the ways the Affordable Care Act will affect your health care and is available for download now.

Second, Avalere Health, the Urban Institute, and media outlets that have repeated their estimates typically neglect to mention that a victory for the plaintiffs would mean the second-highest court in the land ruled the Obama administration *had no authority to issue those subsidies or impose the*

resulting taxes in the first place – that those taxes and subsidies are, and always were, illegal. Regardless of one's position on the PPACA, we should all be able to agree that the president should not be allowed to tax and spend without congressional authorization. That's what's at stake in *Halbig*. It is why the *Halbig* cases are far more important than "ObamaCare."

The termination of those subsidies and the taxes they trigger takes on an entirely different flavor when we introduce that small detail. If the courts rule for the plaintiffs, I'll be interested see how many news agencies use headlines like, "Ruling Denies Subsidies to Millions," versus the more accurate, "Court Rules Obama Gave Illegal Subsidies to Millions."

Though that small detail doesn't change the fact that 5 million people have been deeply wronged, it does clarify who wronged them: not the *Halbig* plaintiffs or a few judges, but a president who induced 5 million low- and middle-income Americans to enroll in overly expensive health plans with the promise of subsidies he had no authority to offer, and that could vanish with single court ruling.

Third, these reports and the ensuing media coverage uniformly neglect to mention that a victory for the *Halbig* plaintiffs would free not only those plaintiffs but tens of millions of Americans from the PPACA's individual and employer mandates. Indeed, *Halbig* would free from potential illegal taxation more than *ten times* as many people as lose an illegal subsidy.

Halbig Would Free More than 8 Million People from the Individual Mandate

In a Cato Institute study released last year, I estimated the number of previously uninsured individuals in each state who would be exempt from the individual-mandate tax if their state declined to establish an Exchange. In the 36 states that did not establish Exchanges, those figures provide a conservative estimate of the number of residents the IRS is unlawfully subjecting to that tax simply by issuing subsidies through federal Exchanges.

Table 1 shows that in the 36 states with federal Exchanges, a victory for the *Halbig* plaintiffs would free more than 8.3 million residents from being subject to those unlawful taxes. (The correct word is "free," not "exempt." By law, these individuals are already exempt, because their state's decision not to establish an Exchange exempts them. The ruling would free them from being subjected to that tax anyway.) Such a ruling would free nearly 1 million Floridians and more than 1.5 million Texans from the individual-mandate tax. In 2016, it would free families of four earning as little as $24,000 per year from an illegal tax of $2,085.



Table 1 – Residents of Federal-Exchange States whom *Halbig* Would Free from Individual Mandate	
Alabama	141,495
Alaska	35,631
Arizona	289,207
Arkansas	129,162
Delaware	25,695
Florida	925,276
Georgia	420,277
Idaho	77,820
Illinois	455,272
Indiana	195,627
Iowa	89,566
Kansas	96,370
Louisiana	210,359
Maine	36,854
Michigan	288,130
Mississippi	127,693
Missouri	208,010
Montana	42,434
Nebraska	65,976
New Hampshire	40,966
New Jersey	328,802
New Mexico	94,363
North Carolina	400,994
North Dakota	18,647
Ohio	386,751
Oklahoma	167,876
Pennsylvania	357,679
South Carolina	220,882
South Dakota	25,695
Tennessee	235,565

Tennessee	253,565
Texas	1,553,367
Utah	103,320
Virginia	287,102
West Virginia	61,620
Wisconsin	140,859
Wyoming	26,625
Subtotal	***8,311,967***

Estimates of previously uninsured residents whom the IRS tax-credit rule would unlawfully subject to individual-mandate penalties, and thus would be freed from penalties by a ruling for the *Halbig* plaintiffs. Source: Michael F. Cannon, 50 Vetoes: How States Can Stop the Obama Health Care Law, Cato Institute *White Paper*, March 21, 2013.

Table 2 gives an indication of how many residents the 14 states with state-established Exchanges could exempt from individual-mandate penalties by opting for a federal Exchange in the wake of a *Halbig* victory. In that case, California could exempt more than 1.7 million residents from penalties under the individual mandate. Idaho and New Mexico have already switched to a federal Exchange, exempting roughly 78,000 and 94,000 residents, respectively. Oregon and Rhode Island are considering making the same move, which would exempt roughly 157,000 and 29,000 residents, respectively.

Table 2 - Residents Potentially Exempt from Individual Mandate in Establishing "States"	
California	1,744,687
Colorado	175,169
Connecticut	82,078
District of Columbia	11,306
Hawaii	20,899
Kentucky	157,549
Maryland	198,808
Massachusetts	35,386
Minnesota	130,630
Nevada	144,187
New York	640,278
Oregon	157,304
Rhode Island	29,023
Vermont	12,187
Washington	253,282
Subtotal	***3,792,773***

Estimated number of previously uninsured residents whom the IRS tax-credit rule would unlawfully subject to individual-mandate penalties. Source: Michael F. Cannon, 50 Vetoes: How States Can Stop the Obama Health Care Law, Cato Institute *White Paper*, March 21, 2013.

Halbig Would Free 250,000 Firms and 57 Million Employees from the Employer Mandate

In the 36 states with federal Exchanges, a *Halbig* victory would free — not "exempt" — all employers with more than 50 workers from the employer-mandate penalties to which the Obama administration is unlawfully subjecting them. Census Bureau data indicate that in all, more than 250,000 firms and 57 million workers could be freed from those unlawful taxes. That's more than the population of 27 states. Table 3 shows the number of

firms and employees in each of the 36 states with federal Exchanges. In Florida, a *Halbig* victory would free more than 16,000 firms and 5.1 million employees from the employer mandate. In Texas, it would free more than 24,000 firms and nearly 7 million employees from the employer mandate.

Table 3 – Firms and Employees Whom *Halbig* Would Free from the Employer Mandate in Federal-Exchange States

	Firms >50	Employees	State Employees	Total Employees
Alabama	6,070	1,143,499	77,517	1,221,016
Alaska	1,165	170,449	24,918	195,367
Arizona	7,745	1,597,199	58,514	1,655,713
Arkansas	4,004	705,692	57,847	763,539
Delaware	2,497	262,049	23,291	285,340
Florida	16,264	4,969,299	164,607	5,133,906
Georgia	11,397	2,470,358	112,991	2,583,349
Idaho	2,539	310,726	18,373	329,099
Illinois	16,156	3,728,559	103,578	3,832,137
Indiana	8,657	1,810,843	75,516	1,886,359
Iowa	4,886	921,166	40,529	961,695
Kansas	5,043	795,207	43,464	838,671
Louisiana	6,399	1,134,086	72,132	1,206,218
Maine	2,258	317,344	18,437	335,781
Michigan	10,574	2,417,281	110,576	2,527,857
Mississippi	3,785	636,616	52,720	689,336
Missouri	8,272	1,682,209	76,691	1,758,900
Montana	1,743	191,009	16,670	207,679
Nebraska	3,363	576,718	26,690	603,408
New Hampshire	2,694	388,255	14,911	403,166
New Jersey	10,911	2,388,145	132,767	2,520,912
New Mexico	3,225	405,826	39,561	445,387
North Carolina	10,577	2,381,206	131,676	2,512,882
North Dakota	1,691	204,117	15,721	219,838
Ohio	13,437	3,302,101	108,649	3,410,750
Oklahoma	5,280	874,569	57,853	932,422
Pennsylvania	14,914	3,736,101	141,130	3,877,231
South Carolina	5,940	1,098,946	70,684	1,169,630
South Dakota	1,763	212,882	13,062	225,944
Tennessee	8,176	1,739,701	75,441	1,815,142
Texas	24,019	6,715,193	274,987	6,990,180
Utah	4,289	748,401	44,301	792,702
Virginia	10,121	2,218,226	107,379	2,325,605
West Virginia	2,666	401,871	36,387	438,258
Wisconsin	8,061	1,708,445	56,094	1,764,539
Wyoming	1,396	123,377	12,463	135,840
Subtotals	***251,977***	***54,487,671***	***2,508,127***	***56,995,798***

Sources: U.S. Census Bureau, "Number of Firms, Number of Establishments, Employment, and Annual Payroll by Small Enterprise Employment Sizes for the United States and States, NAICS Sectors: 2011," 2011 County Business Patterns, release date: 12/2013; and U.S. Census Bureau, "State Government Employment and Payroll Data: March 2012," 2012 Census of Governments, Initial Data Release: 3/6/2014.

A *Halbig* victory would not directly affect subsidies for Exchange enrollees in the 14 states (plus D.C.) that established their own Exchanges. But it would create pressure for those states to switch to a federal Exchange. Such

a ruling would (finally) give those states' officials the power to exempt large employers in the state from the PPACA's employer mandate. Table 4 shows how many firms and individuals each state and D.C. could exempt.

Table 4 – Firms and Employees that Establishing "States" Could Exempt from Employer Mandate after a *Halbig* Victory

	Firms >50	Employees	State Employees	Total Employees
California	31,532	9,025,806	326,477	9,352,283
Colorado	7,724	1,389,145	54,751	1,443,896
Connecticut	5,541	1,041,638	52,297	1,093,935
D.C.	2,980	380,270	41,843	422,113
Hawaii	2,177	345,315	51,888	397,203
Kentucky	5,806	1,074,182	74,613	1,148,795
Maryland	8,094	1,508,341	77,971	1,586,312
Massachusetts	9,550	2,213,965	86,528	2,300,493
Minnesota	8,172	1,766,990	65,879	1,832,869
Nevada	4,630	769,242	23,454	792,696
New York	19,549	5,197,289	225,854	5,423,143
Oregon	5,546	890,784	56,703	947,487
Rhode Island	2,142	280,571	17,149	297,720
Vermont	1,407	170,255	13,630	183,885
Washington	8,340	1,626,495	94,477	1,720,972
Subtotals	***123,190***	***27,680,288***	***1,263,514***	***28,943,802***

Sources: U.S. Census Bureau, "Number of Firms, Number of Establishments, Employment, and Annual Payroll by Small Enterprise Employment Sizes for the United States and States, NAICS Sectors: 2011," 2011 County Business Patterns, release date: 12/2013; "State Government Employment and Payroll Data: March 2012," 2012 Census of Governments, Initial Data Release: 3/6/2014; and "2012 Public Employment and Payroll Data: Local Governments: WASHINGTON DC," 2012 Census of Governments: Employment.

Officials in these states might be reluctant to exercise that option because it would come at the price of forgoing the Exchange subsidies many residents are currently receiving. But switching to a federal Exchange would benefit employers and individual residents seeking relief from their respective mandates. For example, many of the 32,000 firms, 1.7 million individual taxpayers, and 9.4 million employees California could exempt from those mandates could pressure state officials to make the switch. Opponents of the PPACA are also likely to apply political pressure.

Finally, state officials would also feel pressure to make the switch in order to maintain their tax bases. The employer mandate increases the cost of doing business. States where the employer mandate is operative would therefore be at a disadvantage when competing for employers against states where it is inoperative. Establishing states might fail to attract new firms and could even see existing firms relocate to federal-Exchange states. That fear alone could spur a state to make the switch.

Conclusion

Defenders of the IRS and uncritical media outlets are doing the public a disservice by misrepresenting the nature and the facts of *Halbig v. Burwell.* It is crucial that the public get the straight story. The *Halbig* cases are much bigger than partisan squabbles over "ObamaCare."

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Lurking Challenges to the ACA Tax Credit Regulations

Andy S. Grewal[*]

Introduction

By the end of its current term, the Supreme Court will decide *King v. Burwell* and address whether the Section 36B[1] premium tax credit extends to purchases of health care policies made on federally established exchanges.[2] The stakes of the litigation are high because only 14 states have set up their own health insurance exchanges, for which the availability of credits is not disputed.[3] If the challengers to the Treasury's regulation win,[4] millions of individuals will lose out on tax credits that they relied on when purchasing policies on federal exchanges. This could lead to a collapse[5] of the entire Patient Protection and Affordable

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[1] Except when noted otherwise, Section references are to the Internal Revenue Code of 1986, as amended (26 U.S.C.).

[2] King v. Burwell, 759 F.3d 358 (4th Cir.), *cert. granted* 135 S. Ct. 475 (2014). Standing alone, Section 36B(b)(2)(A) refers to credits only for persons "enrolled in through an Exchange established by the State," but the government argues that related statutory provisions support its view, reflected in regulations, that credits are available for purchases of policies on federal exchanges. See 26 C.F.R. § 1.36B–2(a)(1) (providing tax credit eligibility to anyone "enrolled in one or more qualified health plans through an Exchange") and " 26 C.F.R. § 1.36B–1(k) (defining "Exchange" to include federally established exchanges).

[3] Kaiser Family Foundation, State Health Insurance Marketplace Types, 2015, http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/ (last visited April 12, 2015) (describing marketplace attributes in each state).

[4] For a discussion of the regulatory challenge by two of its key architects, see Adler & Cannon, *Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA*, 23 Health Matrix 119 (2013).

[5] Brief for Respondent at 11-13, 23-27, King v. Burwell, No. 14-114 (U.S. filed Oct. 2014) (describing in detail the implications of an adverse ruling).

Care Act,[6] popularly referred to as the ACA or Obamacare.

However, even if the government wins *King v. Burwell*, there remain potential challenges to the Treasury's rulemaking under Section 36B. A Treasury regulation that extends premium tax credits to individuals whose household incomes fall below the floor established by Section 36B(c)(1)(A) lacks statutory authority.[7] Another Treasury regulation that extends those credits to some unlawful aliens suffers from a similar infirmity.[8]

This article explains the legal problems with the Treasury's extension of premium tax credits to some low-income individuals and unlawful aliens. The goal here is not to attack the ACA, whose wisdom I am not qualified to pass on.[9] Nor do I wish to present some philosophical objection to the extension of health care to our country's most impoverished individuals. (Who could be against such a thing?) Instead, I wish to use Section 36B to highlight the pitfalls associated with Treasury's failure to recognize limits on its administrative authority.[10]

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[6] Public Law 111-148 (124 Stat. 119 (2010)).

[7] *See* Treas. Reg. 1.36B-2(b)(6), discussed infra Part II.

[8] *See* Treas. Reg. 1.36B-2(b)(5), discussed infra Part III..

[9] *Compare, e.g.*, Timothy Jost, "If The ACA Were Repealed, Just What Would Replace It?," Health Affairs Blog (Apr. 14, 2015) (listing some achievements of the ACA and arguing that it "has been largely successful" in accomplishing stated goals), *with* Michael Cannon, *50 Vetoes: How States Can Stop the Obama Health Care Law*, Cato Institute White Paper (Mar. 21, 2013) ("President Obama's health care law remains harmful, unstable, and unpopular.").

[10] *See also, e.g.*, Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,381 (May 23, 2012) (acknowledging that Section 36B(c)(2)(C)(iii) flatly denies premium tax credit for any month in which employee pays for and obtains minimum essential coverage under employer plan, even if such coverage is unaffordable or does not provide minimum value, but breaking from statute and proposed regulations to "clarify," in Treas. Reg. 1.36B-2(c)(3)(vii)(B), that Section 36B(c)(2)(C)(iii) does not apply in some circumstances where employee obtains coverage via automatic enrollment). Although the stakes for this regulatory expansion are lower than those identified in the main text of this article, the Treasury's action seems particularly likely to generate controversy, given that the regulation leads to an increased Section 4980H(b) employer penalty for a given month, even though the employer actually provided minimum essential coverage to the employee for that month.

The ACA has become such a hot button issue that some will view any criticism as an inherently political attack. There is nothing that I can do about those with such a jaundiced view. But I hope that others will find that this article furthers their understanding of Section 36B and the administrative challenges related to making health care accessible to low income individuals.

I. "Applicable taxpayers" and Low-Income Individuals

Under Section 36B(a), an "applicable taxpayer" receives a tax credit determined by her premium assistance amount for a taxable year. The premium assistance amount general depends on the premiums paid by the taxpayer for her and her dependents' health insurance coverage.[11] As household income rises, the taxpayer's credit generally shrinks.[12]

Section 36B(c)(1)(A) specifically defines "applicable taxpayer" and therefore the type of person eligible for the credit. The statute limits the term to "a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved." In other words, a taxpayer can enjoy a premium tax credit only if her household income hits a floor (100 percent of the relevant poverty line amount) but does not cross a ceiling (400 percent of that amount).[13]

Although it might seem odd to deny credits to taxpayers

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[11] *See* Section 36B(b)(2).

[12] If Section 36B(b)(2)(A)'s limitation does not apply, the premium tax credit will generally be determined by the cost of a silver plan over the applicable percentage of the taxpayer's household income, and the applicable percentage increases as household income rises. See Sections 36B(b)(2)(B) & (b)(3). A taxpayer's household income generally includes his modified adjusted gross income along with the aggregate modified adjusted gross incomes of the persons for whom he is allowed a deduction under Section 151. For further relevant definitions, see Section 36B(d).

[13] The poverty line amounts are determined by reference to Social Security law. *See* Section 36B(d)(3)(A).

with the lowest levels of income, Congress contemplated that Medicaid would cover them. The ACA essentially commanded states to provide Medicaid coverage to individuals with income up to 133 percent of the relevant poverty line amount.[14] This reflected a significant expansion of prior law, under which some states offered Medicaid only to individuals whose income fell significantly below the 100 percent amount.[15]

However, in *NFIB v. Sebelius*, the Supreme Court found that the severe consequences associated with a state's failure to expand Medicaid (loss of significant federal funding) reflected unconstitutional Congressional coercion.[16] Consequently, states can reject Medicaid expansion without losing federal funding. Several million individuals now earn too much income to qualify under their state's non-expanded Medicaid program but earn too little to enjoy premium tax credits under Section 36B. These individuals fall within the so-called Medicaid coverage gap.[17]

II. Regulatory Expansion of Section 36B(c)(1)(A)

Under Treas. Reg. 1.36B-2(b)(6), an individual qualifies as an "applicable taxpayer" and can enjoy the premium tax credit even if his household income falls below the 100 percent statutory floor. This rule applies when the taxpayer or his family member

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[14] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2601 (2012) (discussing Medicare expansion).

[15] *See id.* ("On average States cover only those unemployed parents who make less than 37 percent of the federal poverty level, and only those employed parents who make less than 63 percent of the poverty line.").

[16] *Id.* at 2604 (2012) ("[T]he financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'—it is a gun to the head. Section 1396c of the Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that 'further payments will not be made to the State.'").

[17] *See* Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid (2015) (noting that 22 states chose not to expand Medicaid and about 4 million poor uninsured adults fall into the Medicaid gap).

enrolls in a plan on an exchange, the exchange estimates his household income falls with the 100-400 percent statutory range, advance credits are authorized and paid and the taxpayer would qualify under the statute if the 100-400 percent limitation did not apply.[18] These taxpayers are generally given larger credits than are given to those who actually meet the statutory criteria.[19]

The regulation addresses an imperfection in the tax credit regime.[20] Under Section 36B, an applicable taxpayer's premium tax credit depends on her household income for a taxable year.[21] However, taxpayers generally purchase health insurance during open enrollment seasons, well in advance of the close of their taxable years. Consequently, taxpayers may enroll in health plans and receive advance payments of their premium tax credits without knowing whether they are in fact eligible for those credits.[22]

Under Section 36B(f), taxpayers generally must repay any excess credits that they received. But Treas. Reg. 1.36B-2(b)(6) contradicts that rule. The regulation allows a taxpayer to fully keep her tax credits even if, at the close of the taxable year, the taxpayer's household income did not meet the statutory floor and

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[18] *See* Treas. Reg. 1.36B-2(b)(6)(i)-(iv).

[19] See Treas. Reg. 1.36B-2(b)(7), under which the credit for beneficiaries of the special rule is computed by reference to taxpayer's actual household income rather than the 100 percent statutory floor, and Section 36B(b)(2), under which lower levels of income generally increase the premium assistance credit amount, such that a person with (for example) household income at the 57 percent amount will receive a greater credit than someone at the 100 percent amount. Aside from household income, other factors influence the size of the credit, including the cost of the plan in a particular locality and the scope of desired coverage (e.g., coverage for spouse or dependents). However, in absolute dollar terms, and holding all else equal, Treas. Reg. 1.36B-2(b)(7) effectively provides the largest tax credits to persons who do not satisfy the statutory criteria.

[20] *See generally* Lawrence Zelenak, *Choosing Between Tax and Nontax Delivery Mechanisms for Health Insurance Subsidies*, 65 Tax L. Rev. 723, 733-37 (2012) (questioning whether current year income reflects the proper standard for determining premium tax credit allowances).

[21] *See* Section 36B(b).

[22] Taxpayers need not apply the full amount of their estimated credits to their monthly premiums.

the taxpayer was not entitled to any credits.[23]

As a matter of abstract policy, the Treasury regulation seems reasonable. But under the familiar *Chevron* framework, reasonableness depends on the agency's construction of the governing statute. And here, the statute leaves no room for interpretation: An applicable taxpayer includes only individuals whose income meets the 100 percent floor but does not cross the 400 percent ceiling. Wisely or not, "Congress has directly spoken to the precise question at issue," and a "court, as well as the agency, must give effect to th[at] unambiguously expressed intent."[24] Because Treas. Reg. 1.36B-2(b)(6) contradicts the congressionally prescribed criteria, it reflects an impermissible interpretation of the statute.

The Treasury indirectly acknowledged this when it responded to public comments on the premium tax credit regulations. In its Notice of Proposed Rulemaking, the Treasury stated that Treas. Reg. 1.36B-2(b)(6) would merely "clarify" that individuals outside of the statutory range could enjoy premium tax credits.[25] In response, commentators urged the Treasury to expand the regulation such that individuals whose actual household incomes exceeded the statutory range would also get to keep their credits, if those individuals received advance payments in circumstances similar to those described for low-income individuals.[26] However, the Treasury rejected those comments,

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[23] Taxpayers described in Treas. Reg. 1.36B-2(b)(6) could even receive tax refunds if their premium assistance amounts exceeded their advance payments, which seems quite possible given the special rule in Treas. Reg. 1.36B-2(b)(7).

[24] Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 842-843 (1984).

[25] Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,931, 50,934 (Aug. 17, 2011) ("The proposed regulations clarify the treatment of a taxpayer who receives advance credit payments but has household income below 100 percent of the FPL for the taxable year.").

[26] *See* Health Insurance Premium Tax Credit, 77 Fed. Reg. 30,377, 30,378 (May 23, 2012) ("Commentators requested that the final regulations treat a taxpayer whose household income exceeds 400 percent of the FPL for the taxpayer's family size as an applicable taxpayer if, at enrollment, the Exchange estimates that the taxpayer's

concluding that they ran "contrary to the language of section 36B."[27]

It's hard to reconcile Treas. Reg. 1.36B-2(b)(6) with the Treasury's response to the commentators. The Treasury would not provide tax benefits to individuals whose incomes exceed the 400 percent ceiling because doing so runs contrary to the statute. Yet the Treasury maintains that individuals with household incomes below the 100 percent floor may qualify as applicable taxpayers. In other words, the Treasury thinks that it's ambiguous whether a taxpayer at the 99 percent level comes within the 100-400 percent statutory range but that a taxpayer at the 401 percent level unambiguously exceeds it.

A court probably won't have trouble seeing the similarity between the situations. Taxpayers outside of the statutory range, whether at the high end or the low end, do not qualify as applicable taxpayers and are not entitled to premium tax credits. Nothing in Section 36B allows the Treasury to rewrite the criteria for qualifying as an applicable taxpayer.

In arguing that the Treasury should indirectly expand the availability of premium tax credits, one group relied on Section 36B(g)(1).[28] That statute authorizes regulations providing for "the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412" of the ACA. But the group misunderstood the direction of the statutory scheme.

Section 36B(g)(1) does not contemplate that premium tax credits are available whenever a taxpayer gets an advance payment. Instead, it contemplates that advance payments will be made for credits that are "allowed under this section [36B]." The

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household income will be between 100 and 400 percent of the [poverty line] for the taxpayer's family size and approves advance credit payments.").

[27] *See id.* at 30,378.

[28] *See* AFL-CIO Criticizes Proposed Health Insurance Premium Tax Credit Regs, 2011 TNT 220-24 (arguing that Section 36B(g)(1) allows for Treasury to limit repayment obligations under Section 36B(f) when a taxpayer's circumstances change during taxable year).

statute's plain language reiterates that Section 36B governs credit determinations. If the fact of an advance payment fixed a taxpayer's right to a tax credit, much of Section 36B would be pointless.[29] Section 36B(g)(1) does not authorize regulations allowing individuals to keep whatever advance payments they receive, and the Treasury properly rejected the group's comments.

Although this result may seem harsh, Section 36B(f) provides significant relief for poor individuals. If a taxpayer whose household income falls below the 200 percent amount receives advance payments that exceed the credit properly allowed, her repayment obligation will be limited to $600.[30] One need not qualify as an applicable taxpayer to enjoy the benefits of this limitation, and a low-income individual will not face thousands of dollars of tax credit repayments.

Of course, repaying even $600 may impose severe hardships on taxpayers with few dollars to spare. However, the Treasury regulation encourages behavior that may lead to bigger problems. Under the regulation, a taxpayer who believes that he will fall short of the floor may be encouraged by an unscrupulous tax advisor or enrollment counselor to engage in unethical behavior and inflate income, especially if she is caught by the Medicaid coverage gap.[31]

The ACA, however, contains extraordinary penalties for those who negligently or intentionally supply incorrect

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[29] *See, e.g.*, Section 36B(f)(1) (reducing allowable credit on account of advance payments); Section 36B(f)(2)(A) (requiring repayment [i]f "the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section"). The various provisions related to current year tax attributes would also be pointless, because exchange estimates depend on prior year attributes.

[30] *See* Section 36B(f)(2)(B)(i) (maximum $600 tax liability increase for persons whose household income is less than 200 percent of the relevant poverty line).

[31] *See also* Jack L. Millman, Gambling for Healthcare, 76 Ohio State Law Journal *Furthermore* (2015) (suggesting an "absurd tax planning" technique under which poor persons may use wagering activities to inflate household income and arguing that this "illustrate[s] the perversity of the current situation and the need for Congress or states to act").

information to an exchange. Under Section 1411(h)(1) of the ACA, an individual who negligently provides incorrect information when enrolling on an exchange faces a $25,000 penalty, and someone who intentionally provides incorrect information faces a $250,000 penalty.[32] To the extent that the IRS actually enforces these crippling provisions, taxpayers encouraged by Treas. Reg. 1.36B-2(b)(6) to inflate income may face problems much more severe than those associated with being caught in the Medicaid gap.

Also, unlike other regulations that provide benefits to taxpayers, Treas. Reg. 1.36B-2(b)(6) could face judicial challenge. Sections 4980H(a) & (b) impose penalties on large employers who fail to offer health coverage or who fail to offer affordable minimum essential coverage.[33] Those penalties are triggered or increased when a full-time employee receives a Section 36B tax credit for her purchase of a health policy on an exchange.[34] Because the regulation expands the scope of applicable taxpayers and therefore the persons eligible for the credit,[35] it increases the number of individuals who might trigger the Section 4980H(a) penalty or increase the Section 4980H(b)

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[32] The reasonable cause defense applies to the negligence penalties. See ACA Section 1411(h)(1)(A)(ii).

[33] *See* Section 5000A(f) (defining minimum essential coverage).

[34] *See* Sections 4980H(a)(2) & (b)(1)(B). The receipt of a cost-sharing reduction under Section 1402 of the ACA of the ACA may also trigger a penalty.

[35] The annual household income of most full-time employees probably exceeds the 100 percent poverty line amount, such that the regulation will not apply to them. However, a full-time employee's annual household income may fall below the poverty line amount if, for example, he has a large family or if he is employed for only a few months during the year.

penalty.[36] In appealing the assessment of any penalty,[37] an employer can argue that the regulation invalidly extended a credit to a full-time employee.

III. Regulatory Expansion of Section 36B(c)(1)(B)

Although Section 36B(c) generally denies applicable-taxpayer status to individuals below the 100 percent poverty line, the statute contains a special rule for some individuals lawfully present in the United States. Under Section 36B(c)(1)(B), a lawfully present alien with household income below the 100 percent amount who is ineligible for Medicaid by reason of her alien status will be treated as if her household income were equal to the 100 percent amount.[38] Unlike very low-income citizens, whom Congress thought would obtain Medicaid coverage, some low-income lawful aliens may enjoy premium tax credits under Section 36B.

Treasury regulations, however, expand the statute and provide tax credits to individuals not lawfully present. Under Treas. Reg. 1.36B-2(b)(5), the special rule applies when "the

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[36] For employers who do not offer health coverage, the allowance or payment of a credit for a single full-time employee triggers a penalty based on the number of the employer's full-time employees. See Section 4980H(a). For an employer who offers some type of health coverage, the penalty depends on the number of full-time employees who are actually allowed or paid credits. See Section 4980H(b). If, for a given month, an individual can obtain affordable minimum essential coverage through her employer, she will not be eligible for a Section 36B credit for that month. *See* Sections 36B(c)(2)(A)-(C).

[37] *See* Section 1411(f)(2)(A) of the ACA (directing the HHS to establish a "separate appeals process for employers who are notified . . . that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee"). HHS procedures are in addition to the appeal rights generally found in the tax code. See id.

[38] Under many Medicaid programs, aliens become eligible for benefits only after the expiration of a 5-year waiting period. See generally Karla Guerrero, *Waiting Five Years for Healthcare: How Restricting Immigrants' Access to Medicaid Harms All*, 21 Annals Health Law Advance Directive 109 (2011); Vinita Andrapalliyal, *"Healthcare for All"? The Gap Between Rhetoric and Reality in the Affordable Care Act*, 61 UCLA L. Rev. Discourse 58 (2013).

taxpayer *or a member of the taxpayer's family* is lawfully present in the United States," and "the lawfully present taxpayer *or family member* is not eligible for the Medicaid program." The italicized language, not found in the governing statute, allows the lawful status of a family member to qualify an unlawful alien as an applicable taxpayer.

The regulation's preamble offers no explanation or authority for going beyond the statutory language, but policy objections to Section 36B(c)(1)(D) might have prompted the Treasury to act. Under that statute, an individual for whom a section 151 deduction is allowable to another person cannot take the premium tax credit. Consequently, if a lawfully present alien obtains health coverage but is the dependent of an unlawful alien, the statute denies the availability of the credit. The regulation overrides the statutory limitation and effectively permits a credit in these circumstances.

Once again, the Treasury regulation seems reasonable as a matter of abstract policy. But Section 36B(c)(1)(B) does not present any interpretive gap for the Treasury to fill. In precise terms, Congress crafted a special rule that treats an alien whose household income falls outside of the statutory range as an applicable taxpayer only if the alien himself enjoys lawful status, and it specifically denied credits to dependents.

Nonetheless, it seems doubtful that a judicial challenge to Reg. 1.36B-2(b)(5) will arise. The Section 4980H penalty is triggered or increased when an employee obtains a tax credit for his own coverage on an exchange.[39] The regulation, however, extends credits to dependents of employees, not employees themselves. Consequently, it seems unlikely, though not impossible, that Reg. 1.36B-2(b)(5) will lead to further employer penalties.[40]

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[39] *See* Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8,544, 8,544 (Feb. 12, 2014) ("[C]overage for a dependent only will not result in liability for the employer under section 4980H.").

[40] The regulation might lead to an employer penalty in some highly convoluted circumstances, such as where the unlawful alien and the dependent lawful alien are both full time employees of the same employer and other requirements are met.

Any blowback to the Treasury for contradicting the statute will likely be political. Literally speaking, the regulation allows unlawful aliens to obtain tax credits, and issues related to unlawful aliens reflected a controversial issue during debates over the ACA. The statute itself allows unlawful aliens to take credits on behalf of lawful family members when household income falls within the 100-400 percent statutory range,[41] but a further extension of credits without statutory authority could raise the ire of some lawmakers.

Conclusion

As the Treasury and other agencies issue guidance under the ACA, more and more problems in the statute come to light. Current regulations reflect a desire to implement the ACA as the Treasury thought it should have been drafted, rather than as it was drafted. In the long run, it's doubtful that a complex statute can offer stability if agency guidance contradicts fundamental provisions, especially given the shifting priorities and viewpoints of different administrations.

Administrative regulations that lack statutory foundation also jeopardize those who rely on them. Ordinarily, no one enjoys standing to challenge beneficial tax regulations.[42] But the ACA's structure pits taxpayers against each other, where a credit to one class of persons triggers or increases penalties on another class.

Going forward, the Treasury should re-consider its unilateral approach to the ACA. The current legislative majority

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[41] Section 36B(a) does not carve unlawful aliens from its general rule. However, such persons cannot legally obtain coverage for themselves on an exchange. See Treas. Reg. 1.36B-2(b)(4).

[42] Somewhat perversely, invalid regulations that provide benefits to low-income persons may give rise to challenges, but taxpayers will lack standing to challenge invalid regulations that provide benefits to large employers. See, e.g., Treas. Reg. 54.4980H-5(e)(2) (although Section 4980H(b) imposes penalty for failure to offer affordable minimum essential coverage and receipt of premium tax credit by an employee increases the penalty, an employer that provides unaffordable coverage will be exempt from penalty under various nonstatutory safe harbors).

might not seem amenable to the amendments that the Treasury has effected by regulation, but no canon of statutory construction expands an agency's authority upon a showing that it is acting against the will of Congress. To amend Section 36B and provide health care to our society's most vulnerable individuals, Treasury should do everything possible to reach a compromise with our elected representatives.[43]

[43] *See* Jonathan Adler, "How the IRS repeatedly rewrites Obamacare tax credit provisions," Wash. Post Volokh Conspiracy Blog (Apr. 14, 2015) ("Congress has already made over one dozen changes to the PPACA that have been signed into law, and there is no reason it could not make others."); Zelenak, *supra* note 20 at 727 (noting that Congress has twice amended Section 36B(f) advance payment reconciliation rules).

NATIONAL REVIEW

Seven Things You Should Know about the IRS Rule Challenged in *King v. Burwell*

And none of them make the IRS look very good.

By Michael F. Cannon — March 4, 2015

This week, the Supreme Court considers *King v. Burwell*. At issue is whether the IRS exceeded its authority under the Patient Protection and Affordable Care Act by issuing a final IRS rule that expanded the application of the Act's subsidies and mandates beyond the limits imposed by the statute. *King v. Burwell* is not a constitutional challenge. It challenges an IRS rule as being inconsistent with the Act it purports to implement. The case is a straightforward question of statutory interpretation.

Here are seven things everyone needs to know about how the IRS developed the rule at issue in *King v. Burwell*. But first, a little background. If you're familiar with the case, you can skip to number one.

Background

Section 1311 of the Act directs states to establish health-insurance "Exchanges." Section 1321 directs the Secretary of Health and Human Services to establish Exchanges in states that "fail[]" to establish Exchanges. Confounding expectations, 38 states failed to establish Exchanges, in almost every case due to opposition to the Act.

Section 1401 (creating I.R.C. § 36B) authorizes health-insurance subsidies (nominally, tax credits) "through an Exchange established by the State." The availability of those subsidies triggers tax penalties under the law's individual and employer mandates. In January 2014, the IRS began issuing those subsidies and imposing the resulting penalties through not only state-established Exchanges but also Exchanges established by the federal government as well (i.e., HealthCare.gov).

In *King v. Burwell*, the plaintiffs allege that the IRS exceeded its powers under the Act

by issuing a so-called final rule that purports to authorize subsidies in states with Exchanges established by the federal government. The plaintiffs claim that the rule and the subsidies being issued in such states are unlawful, because these federal Exchanges are not "established by the State." The plaintiffs claim they are injured because those subsidies trigger also-illegal penalties against them under the Act's individual mandate. (In similar challenges to the same IRS rule, employer-plaintiffs claim injury because those subsidies likewise trigger penalties against them under the Act's employer mandate.)

The government counters that the phrase "an Exchange established by the State" is "a term of art" that includes Exchanges established by the federal government. At a minimum, the government argues, the Act is ambiguous on the precise question at issue, and the IRS's interpretation is reasonable.

In *King v. Burwell*, the government prevailed before both the district court and the Fourth Circuit Court of Appeals. Even though the Fourth Circuit wrote, "The court cannot ignore the common-sense appeal of the plaintiffs' argument; a literal reading of the statute undoubtedly accords more closely with their position," the court deferred to the IRS because it found the statute ambiguous and the IRS's interpretation reasonable.

The government fared less well in other cases challenging the IRS rule. In *Halbig v. Burwell*, the district court found that the Act unambiguously supports the government's interpretation. But a three-judge panel of the D.C. Circuit reversed in a split decision, finding that the Act "unambiguously forecloses" the IRS's interpretation. The full D.C. Circuit agreed to reconsider the panel's ruling, a move that technically vacated the ruling — but not the opinion. In *Pruitt v. Burwell*, the Eastern District of Oklahoma ruled that the IRS rule was "invalid." The D.C. Circuit and Tenth Circuits have put *Halbig* and *Pruitt* aside pending Supreme Court consideration of *King*. The district court for the Southern District of Indiana has not yet issued a ruling in *Indiana v. IRS*, a fourth challenge to the IRS rule, and is likewise waiting to see what the Supremes do with *King*.

Here are seven things you should know about the embattled IRS rule.

1. The IRS's draft rule originally included the statutory language restricting tax credits to Exchanges "established by the State," but IRS officials deleted it and inserted broader language when political appointees approached them about it.

Treasury and IRS officials permitted investigators for two congressional committees to interview officials involved in the formulation of the IRS's tax-credit rule, and to review some (but not all) relevant documents.

The investigators report that in early 2011, Deputy Assistant Treasury Secretary for Tax Policy Emily McMahon read a *Bloomberg BNA* article in which critics discussed how the Act offers tax credits only in states that establish Exchanges. McMahon raised the issue with her colleagues. According to one Treasury Department attorney, McMahon inquired whether this was "a glitch in the law we needed to worry about." Congressional investigators reported what happened next:

> An early draft of the 36B proposed rule included the language "Exchange established by the State" in the section entitled "Eligibility for the Premium Tax Credit." Between March 10, 2011, and March 15, 2011, the explicit reference to "Exchanges established by the State" was removed and the phrase "or 1321" was inserted in its place.

The deletion suggests IRS officials knew this language posed an obstacle to offering tax credits in federal Exchanges. If it didn't, there would have been no reason to delete it.

2. IRS officials knew the statute did not authorize them to issue tax credits in federal Exchanges, but they decided to issue them anyway for political reasons.

The investigators found additional evidence that Treasury and IRS officials knew they had no statutory authority to issue tax credits in federal Exchanges.

IRS officials recognized that what they wanted to find in the statute simply wasn't there. In a March 25, 2011, e-mail, Treasury and IRS officials described the lack of authorization for subsidies in federal Exchanges as a "drafting oversight."

IRS officials also recognized the "apparently plain" language limiting tax credits to state-established Exchanges. Investigators found that a draft of the final rule contained a discussion of this issue that "stated that agencies have broad discretion to reasonably interpret a [law] if the 'apparently plain statutory language' is inconsistent with the purpose of the law." Agency officials dropped that discussion from the final rule shortly before issuing it.

IRS officials chose to issue tax credits in federal Exchanges "because they concluded this was required for the new health-care initiative to succeed," the *Washington Post* reported. "And, the officials reasoned, Congress would not have passed a law that it wanted to fail."

In other words, IRS officials did not do their job, which is to implement the law according to the terms spelled out by Congress. Instead, they knowingly disregarded the "apparently plain" statutory text in pursuit of the political goal of helping the law succeed.

3. The IRS performed little or no analysis of the statute or legislative history, and it failed to consider important dimensions of the issue.

Investigators found that the IRS never considered that the ACA's authors had a clear preference for state-run Exchanges; or that Congress might have conditioned tax credits on states' establishing Exchanges as a way of motivating states to implement this part of the law; or that a leading health-law scholar proposed conditioning premium subsidies on states' establishing Exchanges in early 2009; or that another leading Senate bill also conditioned Exchange subsidies on state cooperation; or that House Democrats complained that states that refused to establish Exchanges would prevent their residents from receiving "any benefit" from the ACA. Finally, IRS officials were not able to produce any written record showing they actually researched the ACA's legislative history.

Agency officials did admit that, in attempting to ascertain Congress's intent, they relied on statements House members made about the House bill. Such statements are irrelevant, of course, because they pertain to a different bill: one with different language than the ACA, one that explicitly did authorize subsidies in state-run Exchanges, and one that did not and *could not have* passed Congress.

4. The IRS offered almost no explanation for its decision.

The IRS announced its decision to issue subsidies in federal Exchanges when it released its proposed rule in August 2011. The proposed rule contained no explanation for this departure from the statute.

Congressional investigators found that "the only written analysis produced by Treasury

and IRS regarding the availability of premium subsidies in federal exchanges before the proposed rule was issued" was a one-paragraph explanation for the IRS's decision buried in a March 2011 memorandum from the IRS's Chief Counsel's Office that the agency never made public.

The only public explanation the IRS offered for its interpretation prior to issuing the final rule came in a November 2011 letter to members of Congress who claimed that the IRS was exceeding its authority:

> The statute includes language that indicates that individuals are eligible for tax credits whether they are enrolled through a State-based Exchange or a Federally-facilitated Exchange. Additionally, neither the Congressional Budget Office score nor the Joint Committee on Taxation technical explanation of the Affordable Care Act discusses excluding those enrolled through a Federally-facilitated [E]xchange.

When the IRS issued its final rule in May 2012, it offered only this one-paragraph, non-substantive explanation:

> The statutory language of section 36B and other provisions of the Affordable Care Act support the interpretation that credits are available to taxpayers who obtain coverage through a State Exchange, regional Exchange, subsidiary Exchange, and the Federally-facilitated Exchange. Moreover, the relevant legislative history does not demonstrate that Congress intended to limit the premium tax credit to State Exchanges. Accordingly, the final regulations maintain the rule in the proposed regulations because it is consistent with the language, purpose, and structure of section 36B and the Affordable Care Act as a whole.

This paragraph from the final rule, which constitutes the agency's entire explanation for its decision in the administrative record, identifies neither the "statutory language," nor the "language, purpose, and structure" of section 36B and the Act, nor the "relevant" legislative history, upon which the agency supposedly relied in taking this action. Indeed, the agency carefully avoids saying either that the Act plainly authorizes tax credits in federal Exchanges, or that the Act is ambiguous on this question.

5. The IRS waited five months after the final rule was issued, and after it had been challenged in court, before identifying any supposed statutory support.

The first time the IRS even cited part of the Act in support of its decision was in an October 2012 response to the chairman of the House Oversight committee. Assistant Treasury Secretary Mark Mazur claimed that the Act's language contained "no discernible pattern that suggests Congress intended the particular language of section 36B(b)(2)(A) to limit the availability of the tax credit."

Then again, as discussed above, the IRS made no discernible effort to check. The evidence is right there in Mazur's own words. He mentions only section 36B(b)(2)(A) and ignores (or is unaware) that section 36B also contains a second explicit passage and seven cross-references limiting tax-credit eligibility to those who enroll in coverage "through an Exchange established by the State."

6. The deletion of "established by the State" from the proposed rule and the insertion of "or 1321" contradict two separate arguments the government offers before the Supreme Court — and reveal those arguments to be post-hoc rationalizations.

The government now claims the phrase "Exchange established by the State" is a statutory "term of art" that poses no obstacle to issuing tax credits in federally established Exchanges. But if that were true, there would have been no reason for the IRS to delete that phrase from the proposed rule.

The government also argues before the Supreme Court that Section 1321 Exchanges are *by definition* Section 1311 Exchanges. But if that were true, there would have been no reason for the IRS to list the two types of Exchanges separately in the proposed rule. Alternatively, having listed both, the IRS should have explained that federal Exchanges are, technically, Section 1311 Exchanges. But it didn't.

Indeed, it is clear that at the time, the administration saw state-established and federal Exchanges as distinct. In March 2012, between the issuance of the proposed and final IRS rules, the Department of Health and Human Services issued a regulation explaining that a "federally-facilitated Exchange" is "an Exchange established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act."

The fact that these arguments are not only absent from but also contradicted by the administrative record shows that they are post-hoc rationalizations for the IRS's decision. And poor ones, at that.

7. IRS officials tried to hide their reasoning from the public.

This week, the *Washington Post* reported that as critics began to scrutinize the IRS's departure from the apparently plain language of the statute, the agency sought to hide its reasoning and avoid drawing attention to its decision:

> The Treasury and IRS team writing the regulations recognized that the environment was becoming highly charged. . . . Discussions intensified inside Treasury and the IRS over how to show that the government had considered the opponents' views but not draw media attention to the debate over subsidies, former officials recalled. "The overriding concern was not generating negative news stories," one former official said.

That concern appears to have prevailed over reasoned decision-making and accountability.

And it continues to do so: To this day, the Treasury Department and IRS are ignoring a congressional subpoena of documents related to development of the IRS's tax-credit rule.

So where does all this leave us?

The available evidence shows that the IRS developed the challenged regulation knowing that Congress had expressly denied the agency the authority to implement the challenged taxes and subsidies and penalties. The IRS initially drafted regulations incorporating that limitation on its authority but then reversed itself after receiving input from political appointees at the Treasury Department. The purpose of that reversal was not to effectuate Congress's "apparently plain" intent, but to subvert it. The IRS has consistently tried to shield its decision and its reasoning from public scrutiny. And the government's defenses of the IRS rule are post-hoc rationalizations.

Keep that in mind while you're enjoying the public debate over *King v. Burwell*.

— Michael F. Cannon is the director of health policy studies at the libertarian Cato Institute and co-author (with Jonathan H. Adler) of Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA.

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The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums

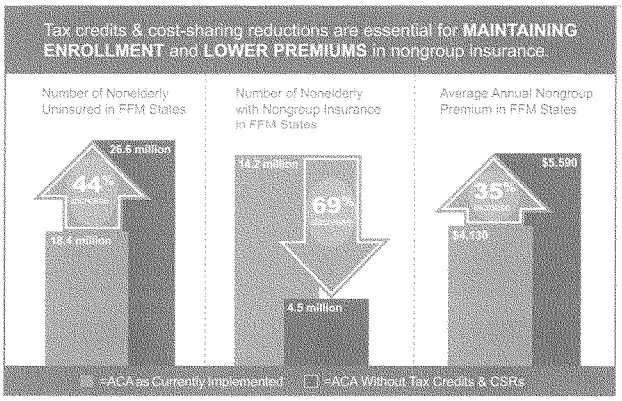
Linda J. Blumberg, Matthew Buettgens, John Holahan

Timely Analysis of Immediate Health Policy Issues JANUARY 2015

In-Brief

The Supreme Court will hear the King v. Burwell case in early 2015, in which the plaintiff argues that the Affordable Care Act (ACA) prohibits the payment of premium tax credits and cost-sharing reductions to people in states that have not set up state-managed marketplaces. We estimate that a victory for the plaintiff would increase the number of uninsured in 34 states by 8.2 million people (a 44 percent increase in the uninsured relative to the number uninsured under the law as currently implemented) and eliminate $28.8 billion in tax credits and cost-sharing reductions in 2016 ($340 billion over 10 years) for 9.3 million people. In addition, the number of people obtaining insurance through the private nongroup markets in these states would fall by 69 percent, from 14.2 million to 4.5 million, with only 3.4 million of these remaining in the ACA's marketplaces.[1]

If tax credits and cost-sharing reductions are eliminated, there will also be indirect effects. The mix of individuals enrolling in nongroup insurance would be older and less healthy, on average. The lack of tax credits would make coverage unaffordable for many. As a result, fewer people would be required to obtain coverage or pay a penalty because the cost of insurance would exceed 8 percent of income, the affordability threshold set under the law. With lower cost individuals and families leaving the market, average premiums in the nongroup insurance market would increase by an estimated 35 percent, affecting not just marketplace enrollees but those purchasing outside the marketplaces as well. For example, virtually all of the 4.9 million people (mostly with incomes over 400 percent of the FPL) who are estimated to buy nongroup insurance without financial assistance in 2016—under the law as currently implemented—would also face these large premium increases.[2]



Source: HIPSM 2014. ACA simulated in 2016

Note: CSR stands for cost-sharing reduction. FFM stands for Federally Facilitated Marketplace and refers to the 34 states included in this analysis.

Introduction

The Supreme Court will hear oral arguments in the King v. Burwell case in the spring of 2015. The case challenges the Obama Administration's interpretation of the Affordable Care Act (ACA) as it relates to the legality of payments of tax credits and cost-sharing reductions for nongroup insurance coverage[3] through the new health insurance marketplaces (a.k.a., exchanges). The plaintiff argues that wording in the text of the law prohibits the federal government from providing this financial assistance to moderate income individuals if their state does not run its own marketplace but has instead left the responsibility of its administration to the federal government. Elimination of tax credits and cost sharing reductions has direct implications for affordability of coverage and household financial burdens and has indirect yet substantial implications for premiums in the nongroup insurance market.

The direct implications are straightforward: if tax credits and cost-sharing reductions are eliminated, the cost of purchasing coverage will increase for those with incomes up to four times the federal poverty level (FPL), which is $46,680 for a single adult and $95,400 for a family of four in 2015. Fewer people will therefore choose to enroll, and the number of insured individuals will decrease. Those who continue to purchase coverage will only be able to do so by incurring the full cost of the premium themselves, thereby increasing their health care financing burdens.

The premium increases, which will exacerbate the decline in insurance coverage beyond the direct effects, result from the interconnected nature of the ACA's tax credits and cost-sharing reductions with the nongroup market consumer protections and the individual responsibility requirement (a.k.a. the individual mandate). Eliminating insurance discrimination in pricing and coverage for those with health problems (e.g., through guaranteed issue, modified community rating, provision of essential health benefits) requires a mechanism to ensure that the pool of insured individuals includes the healthy as well as those with health problems. Without such a mix, a pool providing comprehensive insurance to all individuals at an average price would be more attractive to the sick than to the healthy. As a result, the average cost of coverage would be very high with many healthy individuals choosing to stay out of the market. Thus, the law includes an individual mandate (i.e., most individuals must obtain minimum essential coverage or pay a penalty) in order to induce the healthy to obtain and maintain coverage, thereby bringing down the average health care costs in the insurance pool. Fairness, however, dictates that individuals cannot be required to purchase coverage that they cannot afford, so tax credits are provided to make coverage affordable to most individuals. Cost-sharing reductions are also provided to tax credit recipients with incomes at or below 250 of the FPL in order to lower their deductibles, co-payments, and other out-of-pocket costs relative to what would otherwise be required in a silver (70 percent actuarial value) plan.

Because the insurance market reforms are interwoven with the measures to expand coverage, removing the tax credits would make coverage unaffordable for more individuals and exempt them from the individual mandate and reduce the number insured. Those most likely to drop coverage would be disproportionately young and healthy. Such a change in the mix of enrollees would increase the average cost of individuals remaining in the nongroup insurance market, increasing nongroup insurance premiums as a consequence. Since the ACA treats the nongroup market inside and outside the marketplace as a single insurance pool,[4] elimination of tax credits affects not just marketplace enrollees but all those covered by private nongroup insurance in the same geographic area.

Our analysis uses The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the changes in insurance coverage and premiums that would result from eliminating the premium tax credits and cost-sharing reductions for otherwise eligible individuals residing in Federally Facilitated Marketplace (FFM) states. In addition, we provide state-by-state estimates of tax credits and cost-sharing reductions that would be foregone, the number of people that would lose the financial assistance, and the increase in the number of people uninsured. This analysis updates our previous work on this topic using the most recent marketplace premium data and expands upon it with a complete assessment of the likely coverage and premium implications.[5]

Methods

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, tax credits for the purchase of health insurance, and insurance market reforms.[6] The model estimates changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA for 2016. The model simulates full implementation equilibrium of the ACA in 2016 (i.e., knowledge of the law and its provisions are assumed to have peaked and individual and employer behavior to have fully adjusted to the reforms). Individuals age 65 and over eligible for Medicare are excluded from the analysis.

Marketplaces for which the federal government has taken on at least some of the responsibilities of administration are often referred to as FFMs. The delineation of FFMs from their State Based Marketplace (SBM) counterparts is challenging, since different states have taken on different degrees of marketplace administration and neither the text of the ACA nor the associated federal regulations provide a definition of the minimum responsibilities a state must take on to be considered to have a marketplace established by the state. For purposes of this analysis, we include 34 states, including those where the federal government has taken on complete responsibility (19), those with explicit agreements with the federal government where the state takes on some responsibilities but not others (7), and states without explicit agreements but have taken responsibility for plan management nonetheless (8). We do not include states

that had created the legal framework for an SBM but for which technical problems led to use of the federal IT system. While some of these 34 states may decide to take the necessary steps to establish a state marketplace once the required steps are delineated, doing so would undoubtedly require the investment of significant state resources and the presence of sufficient political will. Given the high degree of uncertainty around state marketplace establishment, our analysis assumes no change in status of the 34 states.

The version of the model used for this brief incorporates a number of model enhancements from the results previously reported in a brief on tax credits in FFM states.[7] Most importantly, premium tax credits are based on final 2015 reference premiums for each state adjusted for inflation to 2016. Earlier estimates were based on national premiums computed before 2014 premiums were finalized. Premiums for 2014 were lower than many anticipated due to factors such as narrow networks and increased competition in many areas. Reference premiums for 2015 in most states generally saw increases lower than the long-term growth trend.[8]

There is, of course, some uncertainty surrounding the time path along which individuals, families, and employers will respond to policy changes brought about by the ACA. Consistent with the convention followed by the Congressional Budget Office (CBO) and others,[9] we assume that behavioral changes in response to reform will be fully realized by the third year of implementation in 2016. That process, however, could take longer. The Children's Health Insurance Program (CHIP) did not reach a steady state until five years after enactment. If full implementation of the ACA with tax credits and cost sharing reductions is slower than anticipated here, then the foregone credits and the increase in the number uninsured we estimate for 2016 would occur somewhat later. Alternatively, if marketplace enrollment is faster than we assume, the estimated loss of coverage and credits would occur sooner.[10] Marketplace enrollment at the end of the 2015 open enrollment period (February 15) will be informative in these regards. Our estimate of marketplace enrollment nation-wide in 2016 is somewhat lower than the CBO estimate—we estimate 20.6 million will be enrolled nation-wide in 2016 compared to CBO's 24 million.

Results

The findings presented below focus exclusively on the 34 FFM states defined above. Elimination of the premium tax credits and cost-sharing reductions in these states would have the direct effect of decreasing affordability and thus insurance coverage and would indirectly increase nongroup health insurance premiums via the change in the average health status of nongroup insurance enrollees.

Health Care Coverage in FFM States

In 2016, the ACA as currently implemented is estimated to reduce the number of uninsured people in FFM states by 14.4 million (Table 1)—18.4 million people remain uninsured compared to 32.8 million had the ACA not been implemented. We estimate the number of people with nongroup coverage will be 14.2 million compared to 7.3 million without the ACA. The large majority of nongroup enrollment will be in the health insurance marketplaces (13.6 million), the only place where refundable tax credits and cost-sharing reductions for the purchase of health insurance coverage are available.

Table 1. Health Insurance Coverage of the Nonelderly in FFM States

	Without Reform		ACA as Currently Implemented			ACA without Tax Credits & Cost-Sharing Reductions		
	Number	*Rate*	*Number*	*Rate*	*Change*	*Number*	*Rate*	*Change*
Insured	**143,122,000**	**81.3%**	**157,556,000**	**89.5%**	**14,434,000**	**149,405,000**	**84.9%**	**6,284,000**
Employer	102,470,000	58.2%	104,014,000	59.1%	1,544,000	106,142,000	60.3%	3,672,000
Nongroup *(Non-Marketplace)*	7,324,000	4.2%	642,000	0.4%	-6,682,000	1,066,000	0.6%	-6,258,000
Nongroup *(Marketplace)*	0	0.0%	13,584,000	7.7%	13,584,000	3,407,000	1.9%	3,407,000
Medicaid/ CHIP	27,733,000	15.8%	33,721,000	19.2%	5,988,000	33,195,000	18.9%	5,462,000
Other *(Including Medicare)*	5,594,000	3.2%	5,594,000	3.2%	0	5,594,000	3.2%	0
Uninsured	**32,835,000**	**18.7%**	**18,401,000**	**10.5%**	**-14,434,000**	**26,552,000**	**15.1%**	**-6,284,000**
Total:	**175,957,000**	**100.0%**	**175,957,000**	**100.0%**	0	**175,957,000**	**100.0%**	0

Source: HIPSM 2014. ACA Simulated in 2016

Medicaid enrollment will be nearly 6 million higher due to the ACA. Some FFM states have expanded Medicaid eligibility, while others have not, and these estimates reflect their current decisions. The number of people with employer coverage will be slightly higher (1.5 million, or 1 percentage point) due to the ACA.

However, if the Supreme Court rules in favor of King and federal tax credits and cost-sharing reductions are eliminated in these states, health coverage would be dramatically different. 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. The nongroup market would only cover about 4.5 million people, far less than the 14.2 million enrollees with the tax credits and even less than the 7.3 million absent the ACA at all.

Medicaid and CHIP enrollment would be about 500,000 lower without tax credits and cost-sharing reductions. Many children eligible for Medicaid or CHIP have parents eligible for marketplace tax credits under the current implementation. Without tax credits, fewer parents would seek marketplace coverage and, as a result, fewer children would be screened for and enrolled in public insurance.

Table 2. Marketplace Coverage in FFM States, by Income

	ACA as Currently Implemented	ACA without Tax Credits and Cost-Sharing Reductions	Percentage Difference in Persons Covered
	Persons Covered	*Persons Covered*	
Income Relative to FPL			
<200% FPL	4,861,000	442,000	-91%
200-300% FPL	3,460,000	577,000	-83%
300-400% FPL	1,910,000	457,000	-76%
400%+ FPL	3,354,000	1,932,000	-42%
Total:	**13,584,000**	**3,407,000**	**-75%**

Source: HIPSM 2014, ACA Simulated in 2016

Note: A small percentage of individuals enrolling in marketplace coverage with incomes below 400 percent of the FPL purchase coverage without tax credits under the current implementation of the ACA. Many of these individuals have offers of affordable employer-based coverage in their families and some others, particularly single young adults in the 300-400 percent of the FPL range, face full premiums for silver coverage that are low enough that they fall below the level covered by the tax credits (i.e., the premium is less than their applicable percent of income cap).

FFM Enrollment by Income

Under a finding for King, enrollment in these 34 nongroup marketplaces would fall by 75 percent, with the most dramatic enrollment declines among the lowest income people otherwise insured there (Table 2). The number of FFM enrollees with incomes below 200 percent of the FPL would fall by over 90 percent, the number of enrollees between 200 and 300 percent of the FPL would fall by 83 percent, and the number of enrollees between 300 and 400 percent of the FPL would fall by 76 percent. Enrollment by higher income individuals (over 400 percent of the FPL) is estimated to fall by 42 percent. As a consequence,

Table 3. Premium Tax Credits and Cost-Sharing Reductions Lost in FFM States if the Supreme Court Finds for King

	Persons Losing Tax Credits	% of Total	Lost Premium Tax Credits (millions $)	% of Total	Lost Cost-Sharing Reductions (millions $)	% of Total	Total Lost Tax Credits & CSRs (millions $)	% of Total
Income Relative to FPL								
<200% FPL	4,848,000	51.9%	16,438.9	65.3%	3,232.6	87.9%	19,671.5	68.2%
200-300% FPL	3,127,000	33.5%	6,810.5	27.1%	445.7	12.1%	7,256.1	25.2%
300-400% FPL	1,370,000	14.7%	1,910.1	7.6%	0.0	0.0%	1,910.1	6.6%
Total:	**9,346,000**	**100.0%**	**25,159.4**	**100.0%**	**3,678.3**	**100.0%**	**28,837.7**	**100.0%**

Source: HIPSM 2014, ACA Simulated in 2016

Note: Those with incomes below 250 percent of the FPL who are eligible for premium tax credits are also eligible for cost-sharing reductions (CSRs) when enrolling in silver marketplace coverage.

Table 4. Lost Tax Credits and Cost-Sharing Reductions and Increased Numbers of Uninsured Under a Decision in Favor of King, by State, 2016

	Number of People Losing Tax Credits	Total Value of Tax Credits & CSRs Lost (Millions $)	Average Value of Lost Tax Credits & CSRs Per Person ($)	Increase in the Number of People Uninsured
All FFM States	**9,346,000**	**28,837.7**	**3,090**	**8,151,000**
Alabama	165,000	547.1	3,310	124,000
Alaska	42,000	232.8	5,570	34,000
Arizona	266,000	456.1	1,720	237,000
Arkansas	128,000	418.8	3,280	95,000
Delaware	28,000	92.4	3,320	24,000
Florida	1,184,000	3,891.4	3,290	1,073,000
Georgia	461,000	1,524.9	3,310	435,000
Illinois	438,000	1,089.0	2,490	408,000
Indiana	225,000	924.5	4,110	195,000
Iowa	98,000	289.2	2,940	90,000
Kansas	166,000	419.0	2,520	135,000
Louisiana	214,000	857.4	4,010	199,000
Maine	62,000	257.0	4,150	50,000
Michigan	321,000	905.8	2,820	277,000
Mississippi	147,000	568.0	3,860	137,000
Missouri	299,000	1,006.8	3,370	228,000
Montana	70,000	192.3	2,760	61,000
Nebraska	97,000	282.3	2,900	83,000
New Hampshire	44,000	116.0	2,620	37,000
New Jersey	237,000	727.6	3,070	239,000
North Carolina	465,000	1,830.1	3,940	407,000
North Dakota	39,000	122.6	3,160	29,000
Ohio	497,000	1,510.1	3,040	459,000
Oklahoma	208,000	516.0	2,480	153,000
Pennsylvania	414,000	1,082.8	2,610	329,000
South Carolina	241,000	766.3	3,180	192,000
South Dakota	51,000	147.1	2,910	42,000
Tennessee	320,000	782.7	2,450	230,000
Texas	1,566,000	4,358.1	2,780	1,441,000
Utah	162,000	361.6	2,230	97,000
Virginia	321,000	1,071.4	3,340	280,000
West Virginia	41,000	146.3	3,550	49,000
Wisconsin	289,000	1,127.9	3,900	247,000
Wyoming	40,000	216.3	5,350	37,000

Source: HIPSM 2014. ACA simulated in 2016

Note: Those with incomes below 250 percent of the federal poverty level who are eligible for premium tax credits are also eligible for cost-sharing reductions (CSRs) when enrolling in silver marketplace coverage.

the composition of these much smaller marketplaces would shift from predominantly lower income (61 percent below 300 percent of the FPL) to majority higher income (57 percent above 400 percent of the FPL). Nearly all of those with incomes below 400 percent of the FPL who would still enroll in the marketplaces absent tax credits are those who purchased nongroup coverage before the ACA was implemented.

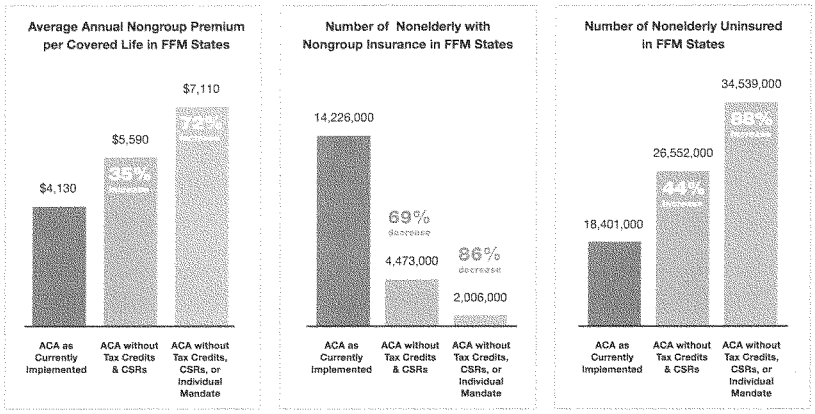
Lost Premium Tax Credits and Cost-Sharing Reductions Under a Supreme Court Finding for King

About 9.3 million people in FFM states would lose marketplace premium tax credits in 2016 if the Supreme Court finds for King (Table 3). Nearly 5 million of these people have incomes below 200 percent of the FPL, 3.1 million individuals have incomes between 200 and 300 percent of the FPL, and the remaining 1.4 million individuals have incomes between 300 and 400 percent of the FPL.

The value of the lost tax credits and cost-sharing reductions is about $28.8 billion in 2016. Foregone premium tax credits amount to $25.2 billion, while foregone cost sharing reductions amount to $3.7 billion. We estimate that, over a 10 year window, the loss of federal financial assistance would be about $340 billion.

In Table 4, for each FFM state, we show the total value of federal tax credits and cost-sharing reductions lost, the number of people who would lose them, the average loss per person who would otherwise receive them, and the number of people who would become uninsured should financial assistance be discontinued. The largest amount of aggregate foregone tax credits and cost-sharing reductions are, not surprisingly, in Texas ($4.4 billion) and Florida ($3.9 billion) because of the size of their populations. The average loss per person varies across states for two reasons. First, there are geographic differences in premiums—individuals of the same income facing higher premiums receive larger tax credits. Second, there are geographic differences in the distribution of income among those eligible

Figure 1. Nongroup Insurance Premiums, Coverage, and the Uninsured in FFM States, 2016



Source: HIPSM 2014. ACA simulated in 2016

Note: CSR stands for cost-sharing reductions

for the credits—areas where higher percentages of those eligible are lower income will have larger average credits since the credits are larger for those in most financial need. The states with the highest average value of lost tax credits and cost-sharing reductions per person are Wyoming ($5,350 per year, about $446 per month) and Alaska ($5,570 per year, about $464 per month), both states with high average premiums. Average nongroup premiums in Arizona are well below average, and thus the average financial assistance lost per person in that state would be considerably lower ($1,720 per year, about $143 per month).

Nongroup Premiums in FFM States

Without federal tax credits, the population purchasing nongroup coverage would be in worse health, on average. As a result, premiums for nongroup coverage would be notably higher in FFM states than they would be with the credits in place. In 2016, the average premium per covered life would increase by 35 percent, from about $4,100 to roughly $5,600 absent marketplace tax credits and cost-sharing reductions (Figure 1). The ACA treats the nongroup market inside and outside the marketplaces as a single risk pool; thus, any policy change that affects premiums in the marketplaces also affects premiums outside them in the same way. The 4.9 million individuals estimated to purchase nongroup coverage fully at their own cost under the ACA as currently implemented would face this 35 percent premium increase. The 9.4 million individuals who would lose federal tax credits would see the out-of-pocket price of their insurance coverage increase by even larger relative amounts, taking both the changing average premiums and lost credits into account.

The Importance of the Individual Mandate

A decision disallowing premium tax credits and cost-sharing assistance would not rescind the ACA's individual mandate, which was upheld by the Supreme Court in July 2010. But millions more would be exempt from the individual mandate because their net cost of insurance would be more than 8 percent of family income. However, the affordability exemption from the requirement is tied to the cost of the lowest cost bronze level coverage available, coverage that is less comprehensive and significantly less costly than the silver level plans most individuals are purchasing thus far through marketplaces. As a consequence, many people would still be subject to the requirement to obtain insurance or pay a penalty.

Older adults with moderate incomes are more likely to be exempt from the individual mandate than younger adults since premiums vary by age, with older adults charged up to 3 times more than younger adults. Thus, the individual mandate plays a larger part in enrolling younger adults than older adults, even absent tax credits. The more young adults enrolled, the lower the average premium in the insurance market. As a result, the 35

percent premium increase would be even higher if not for the individual mandate. Eliminating the mandate would mean an even larger share of young people would leave the nongroup insurance market, further increasing the average health care costs of those remaining.

The Department of Health and Human Services has the authority to define hardship exemptions to the individual mandate requirement and could exempt some or all of those losing tax credit eligibility under a decision in favor of King, just as they have exempted otherwise eligible individuals who live in states not opting for the Medicaid expansion.[11] There is a clear rationale why such a choice would likely be seriously considered. In the absence of tax credits and the subsequent large increases in premiums across all plans, bronze level (60 percent actuarial value) coverage is the tier of plans most likely to still be deemed affordable for those required to obtain coverage or pay a penalty. These plans are generally characterized by large deductibles (e.g., $4000 to $5000 deductibles are not uncommon in this tier) and significant co-payments or co-insurance. Maintaining the individual mandate would require a segment of individuals in the FFM states to purchase coverage with much higher premiums without financial assistance, coverage that has out-of-pocket requirements sufficiently high that many of those with modest incomes would not envision being able to pay the deductibles should the need arise, rendering the policies of little value. Consequently, eliminating the requirement to have coverage or pay a penalty for those affected by a court decision in favor of King would undoubtedly have political and policy appeal.

If the individual mandate is eliminated in the FFM states, premiums per covered life would be 72 percent higher than under the ACA as currently implemented (Figure 1). Nongroup enrollment in those states would fall even more dramatically, to 2.0 million, 86 percent lower than under the ACA as currently implemented. This represents only about 1 percent of the nonelderly population in FFM states. Thus, elimination of both tax credits, cost-sharing reductions and the individual mandate would result in a textbook case of an adverse selection death spiral. Without either credits or the individual mandate, the number of uninsured people in FFM states would rise to 34.5 million, an 88 percent increase relative to the ACA as currently implemented.

Discussion

Elimination of federal premium tax credits and cost-sharing reductions in FFM states would increase the number uninsured by 44 percent and would shrink nongroup insurance markets to levels well below what would have been absent any implementation of reform. As the result of fewer individuals purchasing coverage and the consequent changes in the mix of health status among those remaining, average premiums in those much diminished markets would increase by 35 percent.[12] While HIPSM does not explicitly model the timing of market dynamics, we anticipate the estimated changes to occur quickly. Unlike regulatory changes alone that could take up to a few years to work through a market, eliminating financial assistance will make coverage unaffordable to many enrollees immediately, causing them to drop coverage upon receiving their much higher bills. Insurers can be expected to revise their premiums accordingly at the next opportunity. A forthcoming brief will analyze the characteristics of individuals likely to be affected. Not taken into account here is that such declines in enrollment and the resulting adverse selection is likely to discourage insurers from participating in the marketplaces as well as the larger nongroup markets outside the marketplaces. Areas experiencing increased insurer competition under the ACA's initial years are likely to revert to smaller numbers of insurers, potentially increasing premium costs even further. If the individual mandate is also eliminated in these states, their nongroup markets are unlikely to survive.

FFM states could preserve their tax credits and cost-sharing reductions by assuming responsibility for their marketplaces. As a practical matter, however, doing so would be extremely challenging for most of them. The deadline for states to apply for federal grants to assist the development of SBMs expired in November 2014, leaving the financing of such a change squarely on the states' shoulders. In addition, at least in the near term, the political environments in most of these states are not conducive to participating, and a number of states would be hard pressed to devote the human and financial resources necessary to establish and operate an SBM.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

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Linda J. Blumberg is a senior fellow, Matthew Buettgens is a senior research associate, and John Holahan is an Institute Fellow, all in the Urban Institute's Health Policy Center. The authors are grateful for research assistance from Hannah Recht and for comments and suggestions from Genevieve Kenney, Anna Spencer, and Stephen Zuckerman.

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Notes

1 Estimates presented in this analysis of the number of people of different types that would be affected by a finding for the plaintiff reflect effects at a point in time. Some individuals uninsured or enrolled in nongroup insurance during one part of the year are replaced by other similar individuals during other parts of the year, increasing the number of individuals affected if counting over the course of a year rather at a particular moment. In addition, these estimates also understate the number of people who would be affected over time by this change in implementation of the law. Individuals uninsured or enrolled in nongroup insurance in one year are not necessarily the same people uninsured or covered by nongroup in the following year (since some gain coverage while others lose coverage over time).

2 A small share of these individuals purchasing non-group insurance without a tax credit are expected to remain in grandfathered (non-ACA compliant) policies in 2016. This small share would not be affected by the increased premiums in the ACA compliant market until they ultimately left their grandfathered plans.

3 Nongroup, or individually purchased, insurance is private coverage bought independently as opposed to as part of an employer group.

4 The marketplace and non-marketplace insurance markets are treated as a single risk pool to prevent one market from experiencing adverse selection, a phenomenon where high cost individuals are disproportionately covered in certain plans or markets, greatly increasing the premiums for those selected against and risking their destabilization. Within the single risk pool, increases in the average health care costs of enrollees overall, even if the higher cost enrollees are disproportionately enrolled in some plans relative to others, will lead to increases in premiums charged by all nongroup plans, both inside and outside the marketplace.

5 Our current estimates of aggregate tax credits and cost-sharing reductions are lower than in our previous analysis due to the marketplace premiums being lower than originally anticipated. For the same reason, marketplace enrollment is higher in the current analysis. The earlier analysis is available at: Linda J. Blumberg, John Holahan, and Matthew Buettgens. July 2014. "Potential Implications for ACA Coverage and Subsidies." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/413183-Halbig-v-Burwell-Potential-Implications-for-ACA-Coverage-and-Subsidies.pdf

6 For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities." http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

7 Linda J. Blumberg, John Holahan, and Matthew Buettgens. July 2014. "Halbig v. Burwell: Potential Implications for ACA Coverage and Subsidies." op cit.

8 John Holahan, Linda J. Blumberg, Erik Wengle, Megan McGrath, and Emily Hayes. December 2014. "Marketplace Insurance Premiums in Early Approval States: Most Markets Will Have Reductions or Small Increases in 2015." Washington, DC: The Urban Institute. http://www.urban.org/UploadedPDF/413287-Marketplace-Insurance-Premiums-in-Early-Approval-States.pdf

9 Congressional Budget Office (CBO). April 2014. "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act." Washington, DC: CBO. http://www.cbo.gov/sites/default/files/45231-ACA_Estimates.pdf

10 Total marketplace enrollment may ultimately be lower than we estimated here if purchasers not eligible for tax credits continue to obtain nongroup coverage outside the marketplaces at higher rates than originally anticipated; however, that choice would not affect our estimates of the impact of the King decision on the uninsured, the number purchasing nongroup coverage in total, or nongroup premiums.

11 See point 12, in Healthcare.gov. "Hardship Exemptions from the Fee for Not Having Health Coverage." https://www.healthcare.gov/fees-exemptions/hardship-exemptions/

12 Our findings are roughly consistent in relative terms with those from a study by researchers at the Rand Corporation which simulated the effects of eliminating the ACA's tax credits nation-wide. They estimated a 43 percent increase in nongroup premiums, compared to the 35 percent estimated here, and a 68 percent decrease in ACA compliant nongroup insurance coverage, compared to the 69 percent reduction estimated here. See Christine Eibner and Evan Saltzman. 2014. "The Individual Health Insurance Market – The Effects of Young Adult Enrollment and Subsidies." RAND Corporation Research Highlight. Santa Monica, CA: RAND Corporation. http://www.rand.org/pubs/research_briefs/RB9798.html

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Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in King v. Burwell

Linda J. Blumberg, Matthew Buettgens, John Holahan

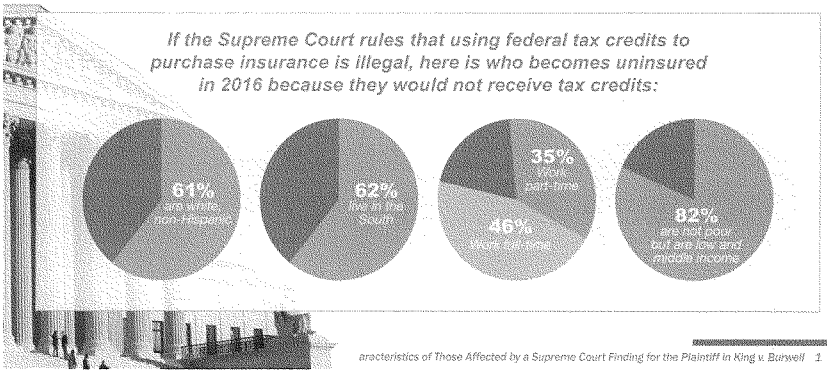
Timely Analysis of Immediate Health Policy Issues JANUARY 2015

In-Brief

In a recent brief, we examined the broad coverage and premium implications of a ruling that would end federal tax credits for marketplace-based private health insurance coverage in states in which the federal government operates the marketplaces.[1] Here, we provide the characteristics of those affected by such a ruling. Of the 9.3 million people estimated to lose tax credits under a finding for King, two-thirds would become uninsured. Most of these are adults with incomes between 138 and 400 percent of the federal poverty level (FPL). Over 60 percent of those who would become uninsured are white, non-Hispanic and over 60 percent would reside in the South. More than half of adults have a high school education or less, and 80 percent are working.

Many others lose nongroup coverage not because of the loss of tax credits but because of the 35 percent premium increase that would occur as healthier people leave the markets. Of the 4.9 million purchasing coverage in the nongroup market without tax credits as the law is currently implemented, about one quarter would become uninsured. Over half of this group who would become uninsured are from the South and over half work full-time. A large share of those who would become uninsured if the Court finds for King have a small-firm worker in their family; almost two million of those who would become uninsured have a self-employed person in the family. A relatively small number of people who would have public insurance or employer-based insurance would also become uninsured as an indirect consequence of eliminating the tax credits.

In order to maintain the same insurance coverage as they have under the law's current implementation, individuals and families would have to pay substantially more as a percentage of their incomes; as a result, most would not keep their coverage. The largest changes in financial burdens would be for the lowest income individuals and for those currently receiving tax credits. For those at the lowest income level, the median direct premium payment would increase from 4.1 percent to 29.6 percent of income for single policies and from 3.6 percent to 48.9 percent of income for family policies. Purchasers in all income groups, however, would be significantly affected. In fact, if the Court decides in favor of King, 99 percent of those who would otherwise have purchased nongroup coverage using premium tax credits would face premiums deemed by the ACA to be unaffordable to them, as they would exceed 8.0 percent of family income (data not shown).



Methods

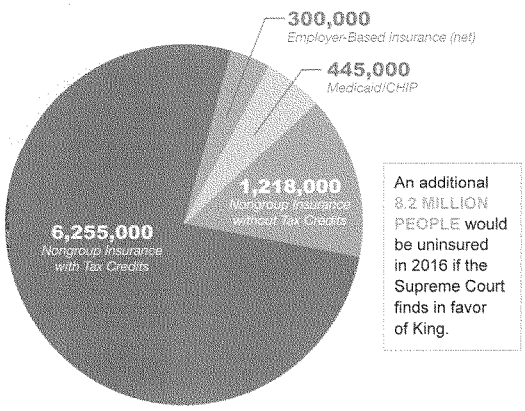
This analysis follows the same methodological approach as the previous brief.[2] We rely upon the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) which simulates full implementation equilibrium of the Affordable Care Act (ACA) in 2016 (i.e., knowledge of the law and its provisions are assumed to have peaked and individual and employer behavior to have fully adjusted to the reforms).

Marketplaces in which the federal government has taken on at least some of the responsibilities of administration are often referred to as federally facilitated marketplaces (FFMs). For purposes of this analysis, we include 34 states, including those where the federal government has taken on complete responsibility (19), those with explicit agreements with the federal government where the state takes on some responsibilities but not others (7), and states without explicit agreements but which have taken responsibility for plan management nonetheless (8). We do not include states that had created the legal framework for a state-based marketplace (SBM) but for which technical problems led to use of the federal IT system (healthcare.gov).

Estimates presented in this analysis reflect effects at a point in time, and therefore understate the number of people who would be affected over the course of a year and over multiple years, as individuals' employment and income fluctuate.

Financial burdens associated with the purchase of nongroup coverage are computed as premiums, net of any premium tax credits, relative to family income. Premium levels for individuals and families for each age and geographic location are determined under full simulations of two scenarios: (A) a simulation of the ACA as currently implemented, including tax credits and (B) a simulation of the ACA without tax credits. Financial burdens for all individuals and families simulated to enroll in nongroup under scenario A are computed, and the median financial burdens for purchasers of single and family policies are provided, separating those purchasing with and without tax credits. Next, for each individual and family simulated to enroll in nongroup under scenario A, we identify the premium that would apply to them under scenario B if they were to enroll (regardless of their actual simulated decision under scenario B), and compute their alternate financial burden.

Figure 1. Individuals Becoming Uninsured Under King v. Burwell, by Source of Insurance Under ACA as Currently Implemented



Source: HIPSM-CPS 2015. ACA modeled in 2016.

As estimated in our previous analysis of the implications of King v. Burwell, the number of people uninsured would increase, on net, by 8.2 million. As we describe below, approximately 6.3 million of these would have enrolled in nongroup coverage using federal tax credits under current implementation of the law, about 1.2 million would have otherwise enrolled in nongroup coverage fully at their own cost, about 445,000 would otherwise have had Medicaid or CHIP coverage, and about 300,000 would otherwise have had employer-based insurance (Figure 1). The principal emphasis of this analysis is on the two largest portions of this group, those that would otherwise have had nongroup insurance.

Those Losing Tax Credits Under a Finding for King

Table 1 shows the characteristics of the 9.3 million people losing tax credits if the Supreme Court rules in favor of the plaintiff (i.e., King). This entire group would lose the financial assistance that has made coverage affordable for many of them, leading to approximately two-thirds becoming uninsured. Of those obtaining coverage with the tax credits under the current implementation of the law, 885,000 are children, a relatively small share (9.5 percent) as so many children in this income category are eligible for Medicaid or CHIP, making them ineligible for tax credits. Over 35 percent are between the ages of 45 and 64. Of adults losing tax credits, 70 percent (just under 6

million people) would become uninsured as a consequence. The share losing insurance varies between 67.6 percent and 74.8 percent, depending upon the age group. Only 34.0 percent of children losing tax credits become uninsured. The differential rates occur because, on average, the children who lose tax credits are in families with higher incomes compared to adults (lower income children tend to be eligible for Medicaid or CHIP), and most children would have nongroup insurance coverage even if the ACA were not in place. The adults losing tax credits, on the other hand, are much more likely to have lower incomes and thus only 30 percent would have insurance coverage if not for the premium tax credits.

Not surprisingly, most individuals losing tax credits have incomes between 138 percent and 400 percent of the FPL; 35.2 percent have incomes between 138 and 200 percent of the FPL and 48.1 percent have incomes between 200 and 400 percent of the FPL. The lower income individuals (between 100 and 138 percent FPL) losing tax credits are those living in states that elected not to expand Medicaid under the ACA, as well as lower income individuals who are legal immigrants who have not yet been in the country long enough to qualify for Medicaid. Over 70 percent of those with incomes below 200 percent of the FPL who would lose tax credits would become uninsured. Over half (56.1 percent) of those with incomes between 200 and 400 percent of the FPL who would lose tax credits would become uninsured, as well.

A large share of those who would lose tax credits are white, non-Hispanic (65.5 percent), largely consistent with the white share of the population as a whole. About 12.9 percent are black, non-Hispanic, and another 16.3 percent are Hispanic. The remainder are from other racial/ethnic groups. Almost 62 percent of whites who would lose their tax credits under King would become uninsured; over 70 percent of all other racial/ethnic groups would become uninsured.

A very large percentage of people who would lose tax credits live in southern states (58.7 percent), reflecting the large number of states in the South (with the exception of Kentucky) that have FFMs. Another large share of those who would lose tax credits (27.0 percent) live in the Midwest (Wisconsin, Indiana, Ohio, and Illinois have FFMs and relatively large populations). Only a small share of those losing tax credits are in the Northeast or West. Of those losing credits in the South, 70.5 percent would become uninsured, the highest rate among the four regions.

Among adults losing credits, just about 50 percent have a high school education or less; only a small share (15.9 percent) have graduated from college. The share that would become uninsured after losing tax credits increases for those with lower levels of education. Most of those losing tax credits are reasonably healthy, reporting excellent, very good, or good health status (90.3%). Those in fair or poor health are less likely to become uninsured, 58.2 percent, compared to 67.9 percent of those in better health.

Eighty percent of adults who would lose tax credits are working, with 46.5 percent working full time and 33.7 percent working part time. We estimate that 70.1 percent of full-time workers losing tax credits, 73.0 percent of part-time workers and 66.8 percent of those not working would become uninsured.[3] Of those who would lose tax credits, 26.3 percent have a family member who is self-employed and 62.5 percent have a family member employed by a small firm (50 or fewer workers). Among those who would lose tax credits, 65.2 percent of those with a self-employed worker and 70.2 percent of those with a small firm worker in the family would become uninsured.

Those Purchasing Nongroup Coverage Under the Law as Currently Implemented Without Tax Credits

We estimate that in 2016, 4.9 million people will enroll in nongroup coverage that they purchase on their own, without financial assistance, through plans offered inside or outside the marketplaces under the law as currently implemented (Table 2). These people, who tend to have higher incomes than those receiving tax credits, are significantly more likely to remain insured under a ruling in favor of King. Still, about one quarter of this group, or 1.2 million people, would become uninsured. Once 9.3 million marketplace enrollees lose their tax credits and two-thirds of them become uninsured as a consequence, the composition of the nongroup insurance market would change significantly. Many fewer healthy adults would enroll, increasing the average health care cost and risk of those remaining. As a result, as we demonstrated in our earlier analysis, average premiums in the nongroup market would increase by 35 percent.[4] Such a price increase would affect virtually everyone purchasing coverage in the nongroup market, both inside and outside the marketplaces.[5] Therefore, even those never eligible for tax credits would be significantly less likely to enroll in nongroup insurance coverage under a Supreme Court finding for King.

Over 70 percent of those paying full price for nongroup coverage as the law is currently implemented have incomes above 400 percent of the FPL. Of these 3.5 million people, only 15.5 percent would become uninsured under a finding for King. Many of those in this higher income category would continue to be bound by the ACA's individual mandate and would have purchased nongroup coverage in the absence of any reform at all, since their high incomes mean that even the increased premium would be manageable for them.[6] However, there are 1.4 million lower income people who are estimated to buy coverage without assistance in 2016; they do not qualify for tax credits due to having affordable employer-based offers of insurance in their family, or, particularly in the case of young adults, the full premiums for Silver coverage are low enough that they fall below the level covered by the tax credits (i.e., the premium is less than their applicable percent of income cap). The rates at which these lower income purchasers would become uninsured are much higher, ranging from 78.0 percent for individuals below 138 percent of the FPL to 44.6 percent for those between 200 and 400 percent of the FPL.

A very large share of those buying nongroup coverage fully at their own cost under the current implementa-

Table 1. Characteristics of Those Enrolled in Nongroup Marketplace with Tax Credits Under ACA as Currently Implemented & Those Becoming Uninsured Under Supreme Court Finding for King, 2016

	Enrolled in Marketplace Coverage with Tax Credits as ACA is Currently Implemented			
	Total and Composition of Each Subgroup		Number and Percentage Becoming Uninsured Under Decision for King	
	Number	Share of Subgroup	Number	Percent Becoming Uninsured
Total	**9,346,000**	**100.0%**	**6,255,000**	**66.9%**
Age				
0 – 18	885,000	9.5%	308,000	34.8%
19 – 24	1,488,000	15.9%	1,005,000	67.6%
25 – 34	1,861,000	19.9%	1,345,000	72.3%
35 – 44	1,715,000	18.3%	1,191,000	69.5%
45 – 54	2,012,000	21.5%	1,371,000	68.1%
55 – 64	1,384,000	14.8%	1,035,000	74.8%
Income				
< 138% FPL	1,558,000	16.7%	1,138,000	73.1%
138 - 200% FPL	3,291,000	35.2%	2,593,000	78.8%
200 - 400% FPL	4,497,000	48.1%	2,524,000	56.1%
400% FPL +	0,000	0.0%	0,000	0.0%
Race/Ethnicity*				
White, non-Hispanic	6,122,000	65.5%	3,786,000	61.8%
Black, non-Hispanic	1,207,000	12.9%	910,000	75.4%
Hispanic	1,522,000	16.3%	1,213,000	79.7%
Other, non-Hispanic	495,000	5.3%	346,000	70.0%
Region				
Northeast	757,000	8.1%	467,000	61.7%
Midwest	2,520,000	27.0%	1,554,000	61.7%
South	5,488,000	58.7%	3,869,000	70.5%
West	580,000	6.2%	365,000	62.8%
Education**				
Less than High School	1,100,000	13.0%	906,000	82.4%
High School Graduate	3,178,000	37.6%	2,361,000	74.3%
Some College	2,829,000	33.5%	1,906,000	67.4%
College Graduate	1,341,000	15.9%	775,000	57.8%
Health Status				
Fair/Poor	906,000	9.7%	527,000	58.2%
Better than Fair/Poor	8,440,000	90.3%	5,728,000	67.9%
Employment Status**				
Full-Time	3,928,000	46.5%	2,753,000	70.1%
Part-Time	2,846,000	33.7%	2,078,000	73.0%
Not Working	1,672,000	19.8%	1,116,000	66.8%
Small-Firm Worker in Family				
No	3,503,000	37.5%	2,151,000	61.4%
Yes	5,843,000	62.5%	4,104,000	70.2%
Self-Employed Work in Family				
No	6,888,000	73.7%	4,654,000	67.6%
Yes	2,457,000	26.3%	1,601,000	65.2%

Source: HIPSM-CPS 2015. ACA modeled in 2016.
** Not available for dependents living alone (NIU).*
*** Analyzed for adults only. This category excludes a small number of dependents age 19-22.*
Analysis assumes the effects of a decision for the plaintiff are limited to the 34 Federally Facilitated Marketplace states.

Table 2. Characteristics of Those Enrolled in Nongroup Insurance Without Tax Credits Under ACA as Currently Implemented & Those Becoming Uninsured Under Supreme Court Finding for King, 2016

	Enrolled in Nongroup Coverage without Tax Credits			
	Total and Composition of Each Subgroup		Number and Percentage Becoming Uninsured Under Decision for King	
	Number	Share of Subgroup	Number	Percent Becoming Uninsured
Total	**4,881,000**	**100.0%**	**1,218,000**	**24.9%**
Age				
0 – 18	783,000	16.1%	54,000	7.0%
19 – 24	569,000	11.7%	252,000	44.2%
25 – 34	838,000	17.2%	239,000	28.5%
35 – 44	849,000	17.4%	197,000	23.2%
45 – 54	1,096,000	22.5%	245,000	22.4%
55 – 64	745,000	15.3%	231,000	31.0%
Income				
< 138% FPL	152,000	3.1%	119,000	78.0%
138 - 200% FPL	101,000	2.1%	59,000	57.9%
200 - 400% FPL	1,109,000	22.7%	494,000	44.6%
400% FPL	3,520,000	72.1%	547,000	15.5%
Race/Ethnicity*				
White, non-Hispanic	3,575,000	73.2%	744,000	20.8%
Black, non-Hispanic	354,000	7.3%	132,000	37.1%
Hispanic	608,000	12.5%	266,000	43.7%
Other, non-Hispanic	336,000	6.9%	76,000	22.7%
Region				
Northeast	670,000	13.7%	137,000	20.5%
Midwest	1,282,000	26.3%	304,000	23.7%
South	2,597,000	53.2%	703,000	27.1%
West	332,000	6.8%	74,000	22.2%
Education**				
Less than High School	284,000	7.0%	151,000	53.1%
High School Graduate	1,064,000	26.1%	357,000	33.6%
Some College	1,282,000	31.4%	392,000	30.6%
College Graduate	1,454,000	35.6%	264,000	18.1%
Health Status				
Fair/Poor	384,000	7.9%	76,000	19.9%
Better than Fair/Poor	4,497,000	92.1%	1,142,000	25.4%
Employment Status**				
Full-Time	2,427,000	59.4%	622,000	25.6%
Part-Time	1,030,000	25.2%	333,000	32.3%
Not Working	627,000	15.3%	209,000	33.3%
Small-Firm Worker in Family				
No	1,461,000	29.9%	381,000	26.1%
Yes	3,420,000	70.1%	837,000	24.5%
Self-Employed Work in Family				
No	2,878,000	59.0%	855,000	29.7%
Yes	2,003,000	41.0%	363,000	18.1%

Source: HIPSM-CPS 2015. ACA modeled in 2016.
** Not available for dependents living alone (NIU).*
*** Analyzed for adults only. This category excludes a small number of dependents age 19-22.*
Analysis assumes the effects of a decision for the plaintiff are limited to the 34 Federally Facilitated Marketplace states.

tion of the law (73.2 percent) are white, non-Hispanic. Only 7.3 percent are black, non-Hispanic and 12.5 percent are Hispanic. Most whites are estimated to remain insured if tax credits are eliminated; only 20.8 percent, or 744,000, are estimated to become uninsured, although they would comprise the largest share of those becoming uninsured. However, a much larger share of individuals from other racial/ethnic groups (37.1 of blacks or 132,000 people, and 43.7 percent of Hispanics or 266,000 people) buying nongroup coverage fully at their own cost would become uninsured.

Over half of those buying nongroup coverage without federal assistance under the current implementation of the law live in the South (53.2 percent). Another 26.3 percent live in the Midwest; the remainder reside in the Northeast or West. As many as 27.1 percent of these people living in the South would become uninsured under a decision in favor of King, the highest of any region.

A much larger proportion of adults buying nongroup coverage at full price as the law is currently implemented have at least some college education (67.0 percent), as compared to those purchasing nongroup with tax credits (49.4 percent). Still, a quarter of these would become uninsured under a finding for King. While only 7.0 percent of adults purchasing nongroup at full cost have less than a high school degree, more than half, 53.1 percent, would become uninsured. As education increases, the share that would become uninsured declines.

As is true in the population at large, the vast majority of those purchasing nongroup coverage at full price under the current implementation of the law are generally healthy, with 92.1 percent reporting being in good, very good, or excellent health. Those reporting being in worse health are somewhat more likely to remain insured under a finding for King (19.9 percent would become uninsured compared to 25.4 percent of their healthier counterparts), likely reflecting a lower responsiveness to premium increases among those expecting to use significant medical services.

A majority of adults buying nongroup coverage at full price under the current implementation of the law work full-time (59.4 percent), another 25.2 percent work part-time, and 15.3 percent do not work, although they are very likely to have a working spouse. Of those who work full-time, 25.6 percent would become uninsured under a victory for King, as would a third of those working part-time or not working.

Seventy percent of those buying nongroup coverage at full cost under the current implementation of the law have at least one family member employed in a small firm. This reflects the significantly lower rate of employer-sponsored insurance offers among small firms compared to large firms.[7] In addition, about 40 percent of individuals buying nongroup coverage at full cost have at least one self-employed family member. Most of these individuals would remain insured under a finding for King.

Summing up, over half of those enrolling in nongroup insurance coverage as the law is currently implemented would become uninsured if the Supreme Court finds in favor of King. Those that are able to retain insurance, either through the nongroup market at significantly higher premiums or through another source, are more likely to be older adults and children, are much more likely to have incomes above 400 percent of the FPL, are more likely to be in fair or poor health, to be white, to be highly educated and to live in regions outside of the South.

Those Losing Other Types of Coverage

Some individuals covered by public insurance (Medicaid or CHIP) or by employer-sponsored insurance as the ACA is currently implemented would also be affected by a Supreme Court ruling in favor of King. Approximately 445,000 individuals otherwise enrolled in Medicaid or CHIP coverage would become uninsured instead. Most of these people are children whose parents would not investigate marketplace coverage due to the lack of financial assistance, thus their children would not be identified as eligible for public insurance and enrolled at the same time. About 72 percent of these individuals have incomes below 138 percent of the FPL, 25.6 percent have incomes between 138 and 200 percent of the FPL, and about 2.6 percent have incomes between 200 and 400 percent of the FPL (data not shown). On net, an additional 300,000 individuals who would be covered by employer-based insurance under the current implementation of the law would also become uninsured, because changes in nongroup insurance premiums and enrollment would lead to changes in some employer decisions whether to offer insurance coverage, as well as some decisions by workers to take up those offers. However, these represent very small changes in an estimated employer market of 104 million people under the ACA in 2016.[8] In total, a finding for King would increase the number uninsured, on net, by approximately 8.2 million people.

Health Care Financial Burdens

Table 3 shows the implications of the loss of tax credits and the consequent increase in nongroup insurance premiums for those who would have enrolled in coverage under the law as currently implemented. In order to maintain the insurance coverage that individuals and families would otherwise have, the share of income devoted to health insurance premiums would increase significantly, with the largest increased financial burdens falling on those otherwise eligible for the credits and those with the lowest incomes.

For those with incomes below 200 percent of the FPL purchasing nongroup insurance with tax credits under the current implementation of the law, the median (50th percentile) individual and family pays approximately four percent of their income for premiums; this takes into account the tax credits that reduce their direct premium costs. Absent the tax credits, if they were to retain the same coverage, the median financial burden for a single adult would be 29.6 percent of income, and the median share of income for a family would be 48.9 percent of income. As a result of the extremely large increase in financial burden, the vast majority of these

Table 3. Potential Changes in Financial Burden for Those Purchasing Nongroup Coverage Under ACA as Currently Implemented
Median Direct Payments by Individuals/Families for Nongroup Market Premiums Under Current Implementation & Under Finding for King, 2016

	Median Premium Payment as ACA is Currently Implemented	Median Premium Payment Under Finding for Plaintiff in King v. Burwell	Difference	Median Premium Payment as % of Income as ACA is Currently Implemented	Median Premium Payment as % of Income Under Finding for Plaintiff in King v. Burwell
Purchasing with Tax Credits Under ACA as Currently Implemented					
< 200% of the Federal Poverty Level					
Single Policies	$763	$5,589	$4,826	4.1%	29.6%
Family Policies	$1,114	$14,318	$13,204	3.6%	48.9%
200-400% of the Federal Poverty Level					
Single Policies	$2,366	$6,427	$4,061	7.8%	19.7%
Family Policies	$4,318	$15,563	$11,245	8.8%	28.9%
Purchasing without Tax Credits Under ACA as Currently Implemented*					
Single Policies	$3,693	$5,693	$2,000	5.8%	9.0%
Family Policies	$9,952	$15,439	$5,487	8.6%	13.5%

Source: HIPSM-CPS 2015. ACA modeled in 2016.

**Note: About 3/4 of those purchasing nongroup insurance without a tax credit have incomes above 400 percent of the FPL. Those with lower incomes purchasing without a credit either have a family member with affordable, adequate insurance coverage available to them or the cost of their premium is sufficiently low that it falls below the percent of income cap for which the individual/family is eligible; the latter occurs most frequently for young adults who face lower premiums due to age-rating.*

individuals and families would drop their coverage. For tax credit recipients with incomes between 200 and 400 percent of the FPL purchasing nongroup insurance, median financial burdens would increase from 7.8 percent for singles and 8.8 percent for families to 19.7 percent and 28.9 percent of income, respectively. Again, many of these people, otherwise enrolled in nongroup coverage, would not be able to maintain health insurance coverage under these circumstances.

In fact, if the Court decides in favor of King, 99 percent of those who would otherwise have purchased nongroup coverage using premium tax credits would face premiums deemed by the ACA to be unaffordable to them, as they would exceed 8.0 percent of family income (data not shown).

Those not receiving tax credits under the current implementation of the law would be affected by a finding for King, as well, as the premiums for everyone would increase due to the worsening health status of those enrolled. Their median financial burden would increase from 5.8 percent to 9.0 percent for singles and from 8.6 percent to 13.5 percent for families. Again, these calculations reflect the difference in financial burdens that would be faced by any particular nongroup purchaser if they choose to purchase coverage in the market that prohibited tax credits, regardless of their actual decision whether or not to enroll. Those that choose to enroll under a ruling for King would have a different age and income distribution compared to those choosing to enroll under the current implementation of the law.[9]

Conclusion

With a ruling in favor of the plaintiff in King v. Burwell, a large number of Americans in the 34 FFM states would be affected by the loss of tax credits and all nongroup purchasers would face large premium increases. Average premiums would increase by an estimated 35 percent and 8.2 million more Americans would become uninsured compared with the law as currently implemented. About two-thirds of those who would lose tax credits would become uninsured as would one-quarter of other purchasers. Not surprisingly, those with incomes below 400 percent of the FPL would be most likely to become uninsured, although over 500,000 individuals with incomes above 400 percent FPL would lose coverage. Those that would become uninsured are more likely to be white, have lower education levels, live in the South, and to have a family member who works for a small firm.

The large increases in financial burdens required to maintain the same coverage would lead to large numbers of people becoming uninsured. These increased burdens are particularly profound for the low-income population (below 200 percent of the FPL), for whom the median cost of premiums relative to income would increase from about 4 percent with tax credits to about 30 percent for singles and 50 percent for families without them. Those between 200 and 400 percent of the FPL would see median financial burdens rise from about 8 to 9 percent of income with tax credits to about 20 percent of income for singles and about 30 percent for families without them.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

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Notes

1 Blumberg LJ, Buettgens M, and Holahan J. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell: 8.2 million More Uninsured and 35% Higher Premiums*. Washington: The Urban Institute, 2014. http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf (accessed January 2015).

2 Blumberg, Buettgens and Holahan. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell.*

3 The vast majority of non-working adults in this income category have a working spouse. Employment status as measured here reflects the status of the individual adult, not their family members.

4 Blumberg, Buettgens and Holahan. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell.*

5 A small share of those purchasing nongroup insurance are expected to remain in grandfathered (non-ACA compliant) policies in 2016. This small share would not be affected by the increased premiums in the ACA compliant market until they ultimately left their grandfathered plans.

6 If these higher income individuals are more likely to drop their coverage in these circumstances, even in the presence of the individual mandate, then the number uninsured as a consequence of King would be considerably higher, likely more consistent with the results in our prior analysis for the alternative scenario without an individual mandate.

7 According to the 2013 Medical Expenditure Panel Survey Insurance Component, 34.8 percent of establishments in firms of fewer than 50 employees offers health insurance coverage to their workers, compared to 95.7 percent of establishments in firms of 50 or more workers. See Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Table I.A.2 (2013), available at: http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2013/tia2.pdf (accessed January 2015).

8 Blumberg, Buettgens and Holahan. *The Implications of a Supreme Court Finding for the Plaintiff in King v. Burwell.*

9 The relative differences in median premiums shown in table 3 between the current implementation of the ACA and under a finding for King are about 55 percent, higher than the 35 percent of premium increase that we estimated in the nongroup market as a consequence of a finding for the plaintiff. It is important to note that these two measures are calculated in very different ways. The 35 percent estimate from our previous analysis compares the average premium per covered life for a person simulated to enroll under the law with tax credits to the average premium per covered life for a person simulated to enroll in the absence of credits. The people who would remain enrolled in coverage absent the tax credits are a somewhat younger population (since older adults are more likely to become exempt from the individual mandate), although in less good health, on average. Hence, the sicker population increases average premiums, but the shift to a somewhat younger enrollee population also means the average premium does not go up by as much as it might have if the age distribution had not changed. In addition, the 35 percent difference reflects the fact that as premiums increase, some individuals who continue to purchase nongroup coverage would shift to purchase lower actuarial value options (e.g., move from a Silver or Gold plan to a Bronze plan). The estimates presented in table 3 compare median premiums for those simulated to enroll under the law with tax credits, and then we use the premiums computed in the no tax credit scenario to compute what the premiums would be for each of these individuals and families if they remained enrolled. This approach implicitly recognizes that one individual or family making a decision to remain in the nongroup market would act as a premium "taker" – their presence would not affect average premiums. The median difference is even larger than 35 percent because those choosing not to enroll absent the credits are disproportionately older than those that choose to remain, and we are holding the type of coverage they are purchasing constant.

Health Insurance Marketplace Calculator

Financial Help for Health Insurance Coverage through Marketplaces

ABOUT THIS TOOL

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Enter Information About Your Household

1. Select a State	US Average	?	6. Number of adults (21 to 64) enrolling in Marketplace coverage	1 Adult	?
2. Enter income as	2015 Dollars				
3. Enter annual income (dollars)	35000	?	Age? 40 Uses Tobacco? No		?
4. Is coverage available from your or your spouse's job?	No	?	7. Number of children (20 and younger) enrolling in Marketplace coverage	No Children	
5. Number of people in family	1	?			

Clear

RESULTS

You are likely eligible for financial help

Based on the information you provided, your income is equal to **300%** of the poverty level. This means you are likely eligible for financial help through the Health Insurance Marketplace. An estimate of your cost for coverage and amount of financial help in 2015 are provided below. To find out your actual amount of financial help and to get coverage, you must go to Healthcare.gov or your state's Health Insurance Marketplace.

Estimated financial help:	**$0** per month ($0 per year) as a premium tax credit. This covers 0% of the monthly costs. *(Although your income would qualify you for help, insurance premiums in your area may not be expensive enough for this help to kick in. For more information, see the FAQ).*
Your cost for a silver plan:	**$276** per month ($3,312 per year) in premiums (which equals 9.46% of your household income).
The most you have to pay for a silver plan:	**9.56%** of income for the second-lowest cost silver plan
Without financial help, your silver plan would cost:	**$276** per month ($3,312 per year)

OTHER LEVELS OF COVERAGE

The costs above are for a silver plan in your area. Silver plans are one of four levels of coverage that you can buy with financial help. These levels -- bronze, silver, gold, and platinum -- tell you about how much financial protection the plan will offer you if you get sick. Bronze plans have the lowest monthly costs, but when you need medical care, you will pay more for your care. Gold and platinum plans offer more financial protection if you get sick, but these plans have higher monthly costs. You can receive financial help to purchase any of these levels of coverage.

For example, you could enroll in a bronze plan for about **$213** per month ($2,556 per year), which is **7.3%** of your household income, after taking into account $0 in subsidies). For most people, the Bronze plan represents the minimum level of coverage required under health reform. Although you would pay less in premiums by enrolling in a Bronze plan, you will face higher out-of-pocket costs than if you enrolled in a silver plan.

OUT OF POCKET COSTS

Although your insurance company may cover most of the cost of your medical care, you generally have to pay something when you go to the doctor or have a hospital stay. These costs – which are in addition to the amount you pay each month – are called your "out-of-pocket" costs. The health reform law sets limits on the amount you have to pay out-of-pocket each year. Your out-of-pocket limit for a silver plan can be no more than **$6,600** in 2015. Whether you reach this maximum level will depend on the amount of health care services you use. Keep in mind that this only protects you when you go to doctors and hospitals that are in your insurer's network. If you go to a doctor or hospital that is not in the network, you could end up paying much more.

You are guaranteed access to a silver plan with an actuarial value of **70%** . This means that for all enrollees in a typical population, the plan will pay for 70% of expenses in total for covered benefits, with enrollees responsible for the rest. If you choose to enroll in a bronze plan, the actuarial value will be **60%**, meaning your out-of-pocket costs when you use services will likely be higher. Regardless of which level of coverage you choose, deductibles and copayments will vary from plan to plan, and out-of-pocket costs will depend on your health care expenses. Preventive services will be covered with no cost sharing required.

NOTES

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FREQUENTLY ASKED QUESTIONS

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Responses to Senator Shaheen on Testimony Provided During the April 29, 2015 Hearing Entitled, "King vs. Burwell Supreme Court Case and Congressional Action that Can be Taken to Protect Small Businesses and their Employees"

Linda J. Blumberg, Ph.D.

1. In Jeffrey Anderson's testimony, he indicates that the projected costs of the ACA are much higher now than when the law was originally passed. That seems to directly contradict recent news reports and a recent analysis done by your colleagues, John Holahan and Stacey McMorrow. Can you explain how he came to such a different conclusion?

Mr. Anderson's conclusion that the projected costs of the ACA are much higher now than when the law was originally passed is predicated on a clear misuse of the data. His written testimony states, "What's more, the Congressional Budget Office (CBO) now projects that Obamacare will cost American taxpayers $1.7 trillion over ten years for its insurance-coverage provisions alone – roughly double the $871 billion tab that was cited at the time of its passage through this body on Christmas Eve 2009." In making this comparison, Mr. Anderson is comparing CBO's 10 year estimated gross cost of the ACA's coverage provisions for the period 2010-2019 (the budget window at the time it was prepared) to CBO's 10 year estimated cost for the period 2016-2025 (the current budget window). Comparing those completely different time periods and suggesting that the most recent number being higher is an indication that the costs of the program are higher than anticipated is entirely inappropriate. First, medical prices (as tends to be true for prices in general) increase over time, making the latter period not comparable to the first. Second, and even more egregious, is that the first period estimates include four years preceding the 2014 implementation of all the major coverage provisions of the law (so costs during those years were trivial) and two more years where the enrollment behavior of individuals was phasing in, so costs were anticipated to be lower than steady state. The later period to which he compares those partial implementation costs is a 10 year period of fully phased in reform.

If, however, you compare the earlier and later CBO reports only on the 5 years that they have in common (2015 to 2019), the most recent CBO estimate for that period is $648 billion compared to their earlier 2009 estimate of $805 billion. Therefore, the most recent CBO cost estimates are well below the original ones. It is worth noting as well, however, that the 2009 estimates were not the final cost estimates for the legislation as enacted, and it did not take into account that some states would not expand Medicaid.

The bottom line, however, is that Mr. Anderson presents estimates from different years and his remarks are misleading, suggesting that the ACA's costs thus far are higher than originally anticipated when in fact they are significantly lower. I strongly recommend anyone wanting a better understanding of the recent slowdown in medical spending and the lower than anticipated spending on the ACA to read John Holahan and Stacey McMorrow's analysis, "The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act," which is available at: http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000176-The-Widespread-Slowdown-in-Health-Spending-Growth-Implications-for-Future-Spending-Projections-and-the-Cost-of-the-Affordable-Care-Act-ACA-Implementation-1.pdf

2. At the hearing, a Committee Member brought up that her constituents who have been able to get health insurance under the ACA are finding that the cost sharing is higher than they can afford. The Senator seemed to believe that Mr. Anderson's proposed replacement for the ACA would provide relief from that problem. Do you agree that his plan would be an improvement and lead to lower cost-sharing plans?

No, I do not believe that Mr. Anderson's plan would address the problem raised by the senator; in fact, in all likelihood, it would make it significantly worse. Under the ACA, fully insured products sold in the small group and nongroup insurance markets must comply with one of the actuarial value (AV) tiers named for precious metals (platinum for 90 percent AV, gold for 80 percent AV, silver for 70 percent AV, and bronze for 60 percent AV), and they must provide the essential health benefits outlined in the law and delineated further by each state's chosen benchmark plan. Premium tax credits are pegged to limit the individual or family's premium contributions relative to income for a silver level plan, but the tax credits can be applied to any level of coverage that the beneficiary chooses. Very low income individuals eligible for tax credits are also eligible for cost-sharing reductions if they enroll in a silver plan. However, many, still modest income, enrollees are not eligible for this extra assistance to lower deductibles, co-insurance, out-of- pocket maximums, etc. and the assistance for some of those that are eligible for them (particularly those between 200 and 250 percent of the federal poverty level) could stand to be improved.

While policy could admittedly do better with regard to lowering the financial burdens of cost-sharing for modest income people under the ACA, Mr. Anderson's approach would not do so. In fact, the most likely outcome of his proposal is that the out-of-pocket costs for individuals in the nongroup insurance market would get appreciably higher, in many ways reverting back to the pre-ACA problems that existed with the then highly unregulated products. The proposal he outlines would eliminate all of the benefit and actuarial value standards included in the ACA and would significantly decrease the size of the financial assistance for purchasing nongroup insurance coverage. He would also eliminate risk adjustment payments across insurers, thereby allowing them to reap the financial benefits of having a healthier group of enrollees if they could attract one. As a consequence, insurers would once again have strong financial incentives to enroll the healthiest individuals. They could do so, as they did regularly prior to the ACA, through a variety of benefit design strategies, in addition to denying coverage or charging much higher premiums to those not staying permanently and continuously enrolled in private insurance coverage.

Prior to the ACA, an enrollee interested in purchasing a comprehensive policy covering all necessary benefits and limited cost-sharing responsibilities was considered by insurers to be signaling their expectation of using significant medical services. As a consequence, before the ACA's "level playing field" requirements were put in place in 2014, insurers tended to offer *only* high cost sharing plans, and these generally excluded large categories of benefits, including maternity care, mental health care, prescription drugs, durable medical equipment, etc. Some even excluded hospitalizations or other specific high cost services, and some included low annual or lifetime benefit limits. So while enrollees were required to contribute substantial amounts out-of-pocket for covered services, there were also many services that were not even covered that, if they needed them, enrollees would have to pay for entirely out-of-pocket. Any insurer that did differently in this market could be expected to enroll higher cost individuals, driving up premiums, lowering profits, and making them less competitive.

Thus, removing benefit and actuarial value standards from the nongroup market place would certainly lead to an increase in cost-sharing requirements and a reduction in covered benefits. This change would be exacerbated by the fact that the proposal's premium tax credits to individuals would be significantly lower and would grow more slowly than those provided under the ACA. Even in the extremely unlikely event that more comprehensive coverage was available, with substantially reduced financial assistance, many fewer individuals would be able to afford it anyway, and that number would fall over time as medical prices increased faster than the three percent Mr. Anderson allows for.

There is a legitimate argument to be made that the cost-sharing responsibilities of ACA compliant plans may be too high to feel affordable for individuals and families in some income categories. The answer to addressing that problem is to improve the cost-sharing assistance provided, not make the problem even worse by eliminating the coverage standards completely, as Mr. Anderson would have you do.